AMERICAN PSYCHIATRIC ASSOCIATION

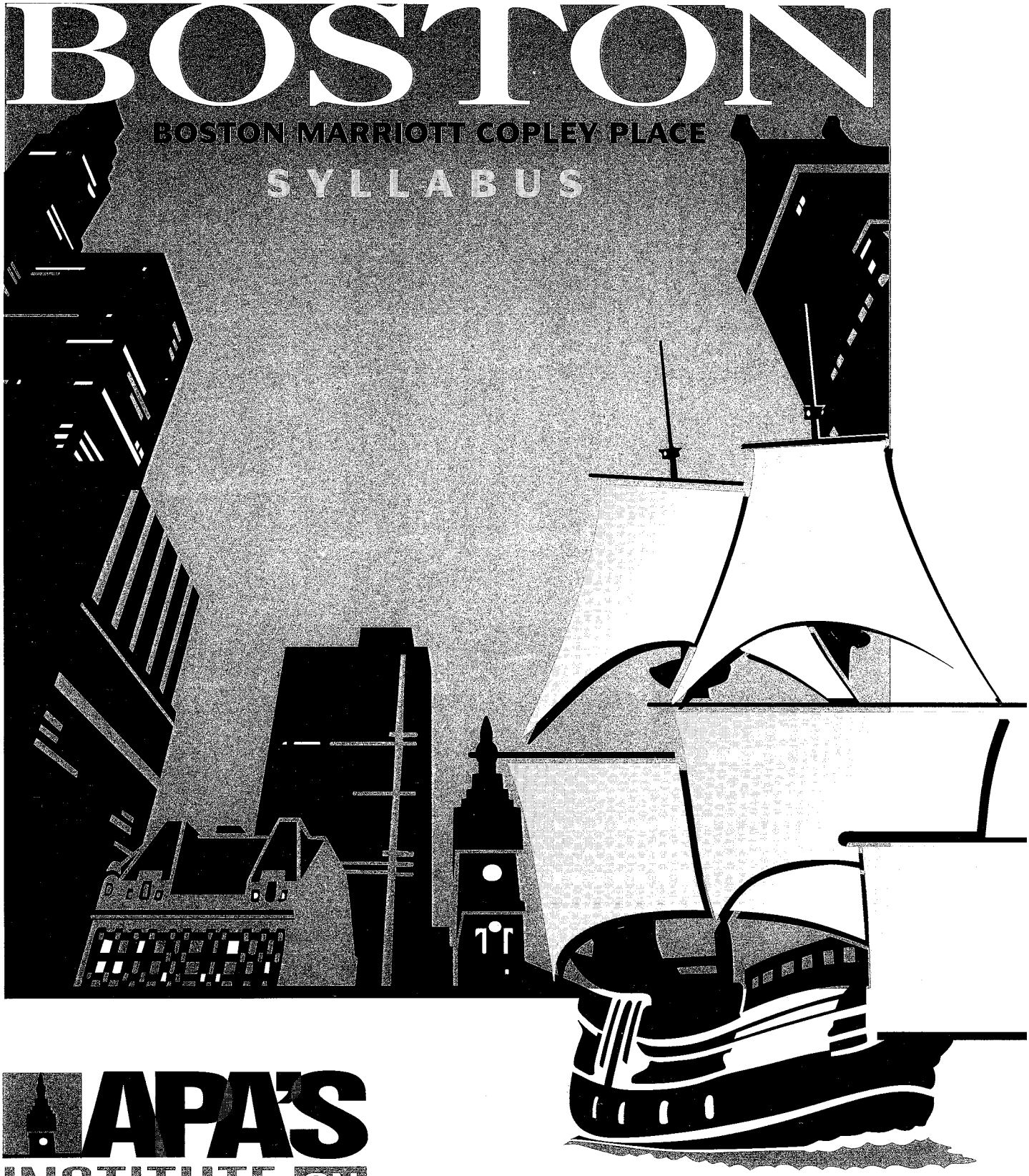
OCTOBER 6-10, 1995

New Frontiers in Psychiatric Treatment & Managed Care

BOSTON

BOSTON MARRIOTT COPLEY PLACE

SYLLABUS



APA'S INSTITUTE ON PSYCHIATRIC SERVICES

FOR YOUR RECORDS

The Certificate of Attendance is for your personal records.

This is to certify that

_____

at the 1995 Institute on Psychiatric Services of the
American Psychiatric Association
October 6-10, 1995
Boston, Massachusetts

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

Melvin Sabshin, M.D.
Melvin Sabshin, M.D.
Medical Director

James H. Scully, Jr. M.D.
James H. Scully, Jr., M.D.
Deputy Medical Director
Director, Office of Education

Mary Jane England
Mary Jane England, M.D.
APA President

This certificate provides verification of your completion of CME activities at the 1995 Institute.

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.

DAILY LOG FOR ATTENDANCE AT CME FUNCTIONS AT THE 1995 INSTITUTE ON PSYCHIATRIC SERVICES, OCTOBER 6-10, 1995, BOSTON, MA

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	SESSION TITLE	# OF HOURS/ CME CATAGORY
	TOTAL	

CONTINUING MEDICAL EDUCATION 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 1995 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 sessions of the official Institute program, with some exceptions, meet the criteria for Category 1 CME credit, these include Allied Sessions, CME Courses, Debates, Full and Half-Day Sessions, Industry Supported Symposia, Lectures, Symposias and Workshops. Other Sessions are designated Catagory 2; these include Multimedia Sessions, Poster Sessions, and Table Topics.

To claim credit, registrants should **claim one hour of credit for each hour of participation** in sessions. To document that credit, participants should record the session(s) attended on the back page of the **Certificate of Attendance** in the *Syllabus* (page ii). Please note: **APA members must maintain their own record of CME hours** throughout the three-year reporting cycle. Documentation of all CME credit is done on an honor system. Once an APA member has accumulated 150 hours (60 in Category 1), he/she should report that to the APA Office of Education, on the Continuing Medical Education Form or postcard, both of which may be obtained by contacting the Office at the APA. The Certificate of Attendance (or copy thereof) may be forwarded to other organizations requiring verification of participation in the Institute.

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. APA certificates are issued only upon receipt of a complete report of CME activities.

CME Credit at the Institute

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

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

SYLLABUS

47TH INSTITUTE ON PSYCHIATRIC SERVICES

October 6-10, 1995

Boston, Massachusetts

The American Psychiatric Association

Institute on Psychiatric Services

1400 K Street NW

Washington DC 20005

(202) 682-6314

The Institute wishes to acknowledge the outstanding editorial services
of Springhouse Editing Services, Marshall, Virginia,
in editing the abstracts for this syllabus.

CONTENTS

ALLIED GROUP SESSIONS

Allied Session 1

Saturday, October 7
10:30 a.m.-12 noon

CLINICAL PROGRAMMING FOR COMMUNITY REINTEGRATION

with the U.S. Department of Veterans Affairs

Richard T. Suchinsky, M.D., *Associate Director, Mental Health and Behavioral Science Service, Department of Veterans Affairs, VACO, 810 Vermont Avenue, N.W., Washington, DC 20420;* T. Michael Kashner, Ph.D., Michael O'Malley, M.A., William Daniels, M.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe a model for rehabilitation programming for the seriously mentally ill that focuses on system integration as a mechanism in the normalization process.

SUMMARY:

For over 30 years the field of psychiatric rehabilitation has directed itself toward the conceptualization and delivery of services that allow people with disabilities to live and work in the community in a manner as close to normal as their abilities permit. Thus, efforts to improve physical and psychological functioning are supplemented by programs aimed at development of life skills in a community-centered approach.

The Department of Veterans Affairs, the federal department responsible for treatment and rehabilitation of disabled and handicapped veterans of the armed services, uses this principle in the programs it operates. In this session the presenters will describe the comprehensive demonstration projects that have been developed to provide rehabilitation services focusing on community integration for psychiatric patients with chronic mental illness or substance abuse, and those who have become homeless as a result.

By utilizing a variety of systems, such programs are integrated into a seamless continuum, starting with outreach programs on the street and in shelters, leading to inpatient or outpatient substance abuse treatment, then to domiciliary programs for extended care and rehabilitation, and finally to supported housing collaborations established by the Department of Veterans Affairs and the Department of Housing and Urban Development. At each step these components are supplemented by vocational assessment, training, and skills development through transitional and supported work restoration services. All are specifically established and operated to engage the individual in treatment, and they begin the process of allowing the veteran to make choices that will lead to reintegration into the mainstream of society.

REFERENCES:

1. Anthony W, Liberman R: Practice of psychiatric rehabilitation: historical, conceptual, and research base. *Schizophr Bull* 12:542-559, 1986.
2. Wolfensberger W: *The Principle of Normalization in Human Services.* Canadian National Institute on Mental Retardation, Toronto, 1972.

Allied Session 2

Saturday, October 7
10:30 a.m.-12 noon

EDUCATION FOR PSYCHIATRIC ADMINISTRATION: NATURE VERSUS NURTURE

with the American Association of Psychiatric Administrators

L. Mark Russakoff, M.D., *Director of Psychiatry, Phelps Memorial Hospital, 701 North Broadway, North Tarrytown, NY 10591-1096;* Paul Rodenhauser, M.D., Jules M. Ranz, M.D., Dova D. Marder, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify the elements that certified and noncertified psychiatric administrators indicated were helpful in their career development, describe a program for the training of psychiatrists in psychiatric administration, and discuss the experience and perspective of a graduate of such a training program.

SUMMARY:

Psychiatrists are often placed in administrative positions by virtue of their medical authority, but too often psychiatrists have not acquitted themselves well in such roles. The results of a survey of psychiatrists certified in administrative psychiatry by APA will be presented.

A total of 427 psychiatrists nationwide were surveyed. Because responses differed by age cohort, results broken down by age of the respondents will be reported. Key experiences that influenced the respondents in their professional development will also be explored, and a program designed to train recent psychiatric graduates for careers in psychiatric administration will be described. A recent graduate of the program will describe how the training program has affected her career development. Problems and opportunities in the development of training for careers in psychiatric administration will be explored.

REFERENCES:

1. Rodenhauser P, Bashook G: On education in administrative psychiatry. *Admin Policy Ment Health* 18:285-298, 1991.
2. Arnold WM, Rodenhauser P, Greenblatt M: Residency education in administrative psychiatry: a national survey. *Acad Psychiatry* 15(4):188-194, 1991.

ALLIED GROUP SESSIONS

Allied Session 3 — Saturday, October 7 10:30 a.m.-12 noon

PATIENT AND FAMILY EDUCATION ABOUT SCHIZOPHRENIA

with the Therapeutic Education Association

Kim T. Mueser, Ph.D., *Associate Professor of Psychiatry, Dartmouth Medical School, Main Building, 105 Pleasant Street, Concord, NH 03301;* William C. Torrey, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to design their own programs for engaging patients with schizophrenia and their relatives and for communicating essential facts about the management of the disorder.

SUMMARY:

In recent years mental health professionals have begun to recognize that patients with schizophrenia and their relatives are important allies in the management of the disorder. However, in order for families to actively participate alongside professionals, they need to know basic facts about the illness, such as characteristic symptoms, onset and course, theories of etiology, and fundamentals of treatment. To meet the needs of families coping with schizophrenia, researchers and clinicians have developed different models of family intervention and have validated them in controlled clinical trials. This presentation will review different models of family intervention, discuss their relative advantages and disadvantages, and summarize the principles shared by effective programs. Special attention will be paid to strategies for engaging patients and their relatives in education about schizophrenia.

REFERENCES:

1. Mueser KT, Gingerich S: *Coping with Schizophrenia: A Guide for Families.* New Harbinger Publications, Oakland, CA, 1994.
2. Mueser KT, Glynn SM: *Behavioral Family Therapy for Psychiatric Disorders.* Allyn & Bacon, Needham Heights, MA, 1995.

Allied Session 4 — Saturday, October 7 10:30 a.m.-12 noon

PSYCHOTHERAPY WITH HIV-NEGATIVE GAY MEN IN THE AGE OF AIDS

with the Association of Gay and Lesbian Psychiatrists

Marshall Forstein, M.D., *Director, Zinberg HIV Mental Health Clinic, Cambridge Hospital, 1493 Cambridge Street, Cambridge, MA 02139;* Stephen Brady, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the psychological needs of gay men who remain HIV seronegative, discuss the impact of seronegative status on a gay man's sexual and social functioning, and incorporate primary prevention models and strategies into psychotherapy with gay men seeking treatment.

SUMMARY:

HIV is the leading cause of death among men between the ages of 19 and 59 years. The epidemic continues to devastate the gay male community. In the second decade of the epidemic, prevention efforts must incorporate more than information and must be part of any mental health efforts in work with gay men. Additionally, with seroprevalence rates in some areas being as high as 50% of gay men, staying seronegative becomes increasingly difficult over the long term. Many younger gay men coming out talk about not "if" they will get AIDS, but "when."

This session will highlight some of the social, psychological, and cultural factors that make prevention and mental health treatment inextricably related; it will focus on the particular dilemmas of gay men who are seronegative but who face a lifetime of surviving their friends and trying to make sense of unremitting loss and bereavement.

The presenters will review some aspects of prevention that can be incorporated into psycho-therapeutic work and will explore the role of psychotherapy in helping gay men find ways to remain seronegative in the face of this catastrophic epidemic.

REFERENCES:

1. Caldwell S, Burnham R, Forstein M: *Therapists on the Front Lines: Psychotherapy with Gay Men in the Age of AIDS.* American Psychiatric Press, Washington, DC, 1994.
2. King MB: *AIDS, HIV and Mental Health.* Cambridge University Press, Cambridge, England, 1993.
3. Odets W, Shernoff M: *The Second Decade of AIDS: A Mental Health Practice Handbook.* Hatherleigh Press, New York, 1994.

Allied Session 5 — Saturday, October 7 10:30 a.m.-12 noon

MIXING MEDICAID AND MANAGED CARE: THE MASSACHUSETTS EXPERIENCE WITH BEHAVIORAL HEALTH CARE

with the National Association of Social Workers

Rita E. Vandivort-Warren, M.S.W., *Senior Policy Associate for Mental Health and Addictions, National Association of Social Workers, Suite 700, 750 First Street, N.E., Washington, DC 20002-4241;* Richard H. Beinecke, M.A., D.P.A., Gary Bailey, M.S.W., Andrew W. Brotman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe at least two changes in costs and service utilization and at least three major changes for providers brought about by the Massachusetts Medicaid program.

SUMMARY:

As states rush to put state Medicaid programs under managed behavioral health care, the relationship with public and private providers is being redefined. The evaluation of year 3 of the Massachusetts Medicaid program, the first statewide managed care arrangement for behavioral health care, will be presented. This program has important implications for providers, program planners, and policy makers in other states. The presentation will first briefly examine national trends in managed care under Medicaid and will then review the Massachusetts experience in detail with regard to its effects on costs, service utilization, and providers. A social worker and a psychiatrist will then describe how the professions have responded in Massachusetts.

REFERENCE:

1. Beinecke RH, Callahan JF Jr, Shepard DS, et al: The Massachusetts Mental Health/Substance Abuse Program: the providers' perspective. *Admin Policy Ment Health,* in press.

Allied Session 6 — Saturday, October 7, 10:30 a.m.-12 noon

PARTIAL HOSPITALIZATION FOR TRAUMA VICTIMS

with the American Association for Partial Hospitalization

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

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

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

The partial hospital for these patients should be comprehensive and offer 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 daily living skills.

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

REFERENCES:

1. Kelly KA: Multiple personality disorders: treatment coordination in a partial hospital setting. *Bull Menninger Clinic* 57:390-398, 1993.
2. Turkus JA: Psychotherapy and case management for multiple personality disorder: synthesis for continuity of care. *Psychiatr Clin North Am* 14:649-660, 1991.

Allied Session 7 — Saturday, October 7, 10:30 a.m.-12 noon

PRINCIPLES OF EFFECTIVE PROGRAM PLANNING FOR INDIVIDUALS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS

with the American Occupational Therapy Association

Leona L. Bachrach, Ph.D., *Research Professor of Psychiatry, Maryland Psychiatric Research Center, 19108 Annapolis Way, Gaithersburg, MD 20879-2122;* Tina Barth, M.A., O.T.R./L.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to summarize principles of effective program planning for individuals with long-term mental illness and describe how principles of occupational therapy were used in the effective program design of a not-for-profit social service agency serving individuals with mental illness and chemical addiction.

SUMMARY:

This session will present 11 principles of program planning extracted from observations of programs effectively serving persons with severe and persistent mental illness. These principles serve as the least common denominator of effective program design. The presenters will then describe the creative program development process in a not-for-profit social service agency in New York that serves individuals with mental illness and chemical addiction. The congruency of occupational therapy principles with effective program design will be discussed.

ALLIED GROUP SESSIONS

REFERENCE:

1. Bachrach L: *Leona Bachrach in the Netherlands: Toward a Comprehensive Mental Health.* Netherlands Institute of Mental Health, Utrecht, The Netherlands, 1991.

Allied Session 8 — Saturday, October 7 10:30 a.m.-12:30 p.m.

ROLES OF SOCIAL APPROACHES IN THE CONCEPT OF PSYCHIATRIC MANAGEMENT

with the American Association for Social Psychiatry

Roger Peele, M.D., *Chair, Department of Psychiatry, Saint Elizabeths Campus, Commission on Mental Health Services, 2700 Martin Luther King Jr. Avenue, S.E., Washington, DC 20032;* John S. McIntyre, M.D., Shervert H. Frazier, M.D., David L. Cutler, M.D., Donna M. Norris, M.D., Anne M. Bell, M.D., Gerald J. Sarwer-Foner, M.D., Katharine A. Phillips, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the degree to which social approaches should be a part of psychiatric management.

SUMMARY:

A growing concept in American psychiatry is psychiatric management. Psychiatric management is consistent with a biopsychosocial orientation in psychiatry, but what should be the social aspects?

Dr. Peele will provide background. "Psychiatric management" was first conceptualized in 1993 by the APA Task Force to Develop Practice Guidelines. This important concept consists of a number of complex activities that are essential in the treatment of psychiatric patients. The actual delivery of psychiatric management must be skillfully improvised and individually tailored within the framework of a helpful and trusting psychiatrist-patient relationship. Although there is variation among disorders, an outline that fits most is (a) assessing and monitoring the patient's psychiatric condition, (b) deciding the diagnosis and formulation, (c) determining the treatment goals, (d) establishing and maintaining a therapeutic relationship, (e) conveying an understanding of the illness to the patient and others, (f) providing guidance to the patient and others, and (g) selecting the specific treatments (psychiatric assessment).

Other members of the panel will cover social aspects of psychiatric management in general and as they relate to bipolar disorder, schizophrenia, and child and adolescent disorders. The discussion will include considerable audience participation.

Allied Session 9 — Saturday, October 7 10:30 a.m.-12 noon

THE IMPACT OF MANAGED CARE ON PUBLIC MENTAL HEALTH PROGRAMS (PART 1)

with the American Association of Community Psychiatrists

Kenneth Minkoff, M.D., *Chief of Psychiatry, Choate Health Systems, 23 Warren Avenue, Woburn, MA 01801-4979;* Robert A. Dorwart, M.D., Michael A. Hoge, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the general principles of managed care and how they are theoretically applied to public mental health service systems, and, from among several practical models of implementation of managed mental health care, participants should be able to identify which models 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 prove that service is of sufficient quality may compromise their efforts to contain costs. Some providers consider that the principles of managed care are contrary to those of public mental health.

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

In this session the presenters will discuss the history of public sector managed care. They will also provide an overview of the principles of managed mental health care and the ideological basis for its implementation in community and other public sector programs.

REFERENCE:

1. Goldman W, Feldman S (eds): Managed Mental Health Care. *New Dir Ment Health Serv* 59, 1993.

Allied Session 10 — Saturday, October 7 10:30 a.m.-12 noon

PHARMACOTHERAPY OF DRUG AND ALCOHOL USE DISORDERS

with the American Academy of Psychiatrists in Alcoholism and Addictions

Timothy E. Wilens, M.D., *Staff, Psychopharmacology Clinics, Massachusetts General Hospital, ACC 725, Boston, MA 02114;* John H. Renner, Jr., M.D., Robert M. Swift, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the pharmacotherapy of opioid and alcohol dependence and describe the monitoring requirements of the various agents used for treatment.

SUMMARY:

Within psychiatry there is an increasing interest in the treatment of addictive disorders. Although traditional interventions have relied on self-help groups and psychotherapy, there is an emerging literature on the use of pharmacotherapy for the treatment of drug and alcohol use disorders. In this session the available agents currently being used for alcohol and opioid addiction will be discussed. The adverse effects of naltrexone, disulfiram, methadone, buprenorphine, and other agents will be critically reviewed. The indications, clinical management, pharmacokinetics, important drug interactions, and monitoring requirements of the various medications will be presented.

REFERENCE:

1. Ball JC, Ross A: *The Effectiveness of Methadone Maintenance Treatment.* Springer-Verlag, New York, 1991.

Allied Session 11 — Saturday, October 7, 1:30 p.m.-3:00 p.m.

THE IMPACT OF MANAGED CARE ON PUBLIC MENTAL HEALTH PROGRAMS (PART 2)

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;* Eunice Hartman, M.S.W., Hunter L. McQuistion, M.D., Clifton R. Tennison, Jr., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the general principles of managed care and how they are theoretically applied to public mental health service systems, and, from among several practical models of implementation of managed mental health care, participants should be able to identify which models 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 prove that service is of sufficient quality may compromise their efforts to contain costs. Some providers consider that the principles of managed care are contrary to those of public mental health.

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

This session will present three different state systems and their current programs for managed mental health care. The presenters will discuss service delivery and provide current information on system design, evaluation, and outcomes.

REFERENCE:

1. Goldman W, Feldman S (eds): Managed Mental Health Care. *New Dir Ment Health Serv* 59, 1993.

COURSES

Course 1

Friday, October 6
8:00 a.m.-12 noon

THE IMPACT OF MANAGED CARE ON PSYCHIATRIC EMERGENCY SERVICES

Director: Ole J. Thienhaus, M.D., *Director of Psychiatric Services, University of Cincinnati Hospital, and Associate Professor of Psychiatry, University of Cincinnati College of Medicine*

Faculty: Peter L. Forster, M.D., Douglas H. Hughes, M.D., James M. Schuster, M.D., M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to (a) describe the history of the managed care movement and its impact on delivery of mental health care in the 1990s; (b) discuss legal and ethical issues related to managed care in psychiatric emergency services; and (c) explain how managed care has affected planning, budget, and contractual issues in psychiatric emergency services.

DESCRIPTION:

This course will begin with a review of the basic conceptual tenets of managed care, including the historical background (from the original introduction of utilization review through the proposed managed competition system of the 1990s) and specific references to the interface of the managed care concept with mental health providers and with the traditional function of emergency services. The faculty will then address specific areas of contact between the managed care environment and the psychiatric emergency room. Psychiatric emergency services, as both partners to managed care companies and an integral part of a managed system of care, will also be addressed; both conflictual and symbiotic aspects will be covered. An in-depth study of the legal and ethical issues confronting the emergency psychiatrist working in the managed care environment, including pertinent legislation and court decisions, will follow. Case vignettes will be used to illustrate the practical consequences of these recent developments. Finally, a detailed review of management issues for psychiatric emergency services in the managed care environment will be presented. This segment will include questions of planning, budget, contractual arrangements, and management of organizational behavior within the service, as they are affected by managed care.

REFERENCES:

1. Ballenger JC: The clinical use of carbamazepine in affective disorders. *J Clin Psychiatry* 49:13-21, 1988.
2. Barklage NE, Jefferson JW: Alternative uses of lithium in psychiatry. *Psychosomatics* 28:239-256, 1987.

Course 2

Friday, October 6
8:30 a.m.-4:00 p.m.

INTRODUCTION TO BEHAVIOR THERAPY

Co-Directors: Robert M. Goisman, M.D., *Department of Psychiatry, Massachusetts Mental Health Center;* Philip G. Levendusky, Ph.D., *Department of Psychiatry, McLean Hospital, Belmont, MA*

EDUCATIONAL OBJECTIVE:

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

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. It 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, and cognitive therapy. The faculty will then examine 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. Behavioral treatment of serious and persistent mental illness, including psychosocial rehabilitation and social skills training for schizophrenia, dialectical behavioral therapy of borderline personality disorder, and contingency management on inpatient services, will also be addressed. Finally, the integration of these methods with other commonly used modalities, specifically psychotropic medication and psychodynamic psychotherapy, will be discussed. This course will emphasize the acquisition of concrete and practical skills that participants can incorporate into their own 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.

COURSES

Course 3 — Friday, October 6, 2:15 p.m.-6:15 p.m.

PSYCHIATRIC EMERGENCY SERVICE UPDATE

Director: Douglas H. Hughes, M.D., *Department of Psychiatry, Cambridge Hospital, Cambridge, MA*

Faculty: Michael H. Allen, M.D., Todd R. Griswold, M.D., Deborah M. Moran, M.D.

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) address the challenges involved in providing emergency psychiatric care to special populations, such as children and the homeless; 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 issues of violence and suicide assessment. It will also address the challenges posed by special populations, such as children and the homeless, and will describe the usefulness and limitations of a mobile crisis team. Finally, this course will review the rapidly changing area of alternatives to hospitalization and the impact of managed care on psychiatric emergency services.

REFERENCES:

1. Galanter M, Kleber HD (eds): *Textbook of Substance Abuse.* American Psychiatric Press, Washington, DC, 1994, pp 67-223.
2. Hillard JR (ed): *Manual of Emergency Psychiatry.* American Psychiatric Press, Washington, DC, 1993.

Course 4 — Friday, October 6, 1:00 p.m.-5:00 p.m.

ADULT AND ADOLESCENT ATTENTION DEFICIT DISORDER

Co-Directors: Thomas E. Brown, Ph.D., *Department of Psychiatry, Yale University;* Timothy E. Wilens, M.D., *Department of Child Psychiatry, Massachusetts General Hospital*

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to (a) recognize subtypes of adolescent and adult attention deficit disorders (ADDs), (b) assess and diagnose ADD subtypes by using updated instruments and methods, (c) select appropriate medications for ADD and comorbid conditions, and (d) design multimodal treatment programs for adolescents and adults with ADD.

DESCRIPTION:

Most people who have ADDs in childhood continue to be impaired by ADD symptoms throughout adolescence and adulthood. Many of these adolescents and adults are not correctly diagnosed or effectively treated, especially if they are bright and their ADD does not include hyperactivity. This course will offer research and clinical data to provide (a) an overview of the variety of subtypes of ADDs in adolescence and adulthood; (b) descriptions of how ADDs affect the education, employment, social relationships, and family life of adolescents and adults; (c) a model that uses updated clinical, psychological, and laboratory measures to assess ADDs and make differential diagnoses of subtypes; (d) research-based selection criteria for medications for treatment of ADDs and various comorbid disorders; and (e) guidelines for integration of pharmacological, educational, behavioral, and family interventions into a multimodal treatment plan tailored for specific adolescents and adults with various subtypes of ADDs.

REFERENCES:

1. Brown TE: Differential diagnosis of ADD vs. ADHD in adults. In Nadeau KG (ed): *A Comprehensive Guide to Attention Deficit Disorder in Adults.* Brunner/Mazel, New York, 1995.
2. Brown TE: *Brown Attention Deficit Disorder Scales.* Psychological Corporation, San Antonio, TX, 1995.

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

ORAL BOARD REVIEW COURSE

Director: Kenneth S. Duckworth, M.D., *Clinical Instructor in Psychiatry, Harvard Medical School*

Faculty: James Feldman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to (a) review videotapes similar to those presented on the American Board of Psychiatry and Neurology (ABPN) part II examination; (b) organize a presentation of the pertinent data; (c) present a formulation, including differential diagnosis based on *DSM-IV*; and (d) develop a treatment plan that includes biological, psychological, and sociocultural aspects.

DESCRIPTION:

This course is being presented to assist psychiatrists interested in the format of the ABPN part II, oral examination. Participants will learn techniques for organizing a comprehensive presentation of the clinical data. Presentations consistent with the type of questions asked on the part II examination will be emphasized. Participants will discuss ways to present differential diagnoses and treatment plans that involve biological, psychological, and sociocultural aspects of treatment. Techniques to help participants prepare for the particular format of the oral examination will be presented. The faculty will present videotapes of clinical cases to stimulate discussion.

REFERENCES:

1. Morrison JR, Munoz R: *Boarding Time: A Psychiatry Candidate's Guide to Part II of the ABPN Examination.* American Psychiatric Press, Washington, DC, 1991.
2. Othmer E, Othmer S: *The Clinical Interview Using DSM-IV,* vols I and II. American Psychiatric Press, Washington, DC, 1994.

Course 6

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

SEXUAL ABUSE: EVALUATION AND TREATMENT

Director: Maria C. Sauzier, M.D., *Clinical Instructor in Psychiatry, Harvard Medical School, and Department of Child and Adolescent Psychiatry, Cambridge Hospital*

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to (a) identify the principles of evaluating sexually abused children, their families, and offenders; (b) understand the psychodynamics of victims, families, and offenders; (c) assess the complexities of each case; and (d) treat those appropriate for their practices.

DESCRIPTION:

This course addresses the complex clinical issues involved in evaluating and treating sexually abused children and their families, as well as alleged incest offenders. A brief review of prevalence and current research will be presented, with a focus on the clinical relevance of such data. Identification of victims, intervention strategies, legal issues, and interagency cooperation will be addressed. Clinical information will be provided through a framework of core cases that illustrate psychodynamics, treatment modalities, and age-dependent variables. Participants are encouraged to review their past and present cases in order to enhance the pertinence of the learning process to their practice situations.

COURSE LEVEL:

Participants should have training in child psychiatry and some experience in treating sexually abused children.

REFERENCES:

1. Herman J: *Trauma and Recovery: The Aftermath of Violence From Domestic Abuse to Political Terror.* Basic Books, New York, 1992.
2. Schetky D, Benedek E (eds): *Clinical Handbook of Child Psychiatry and the Law.* Williams & Wilkins, Baltimore, 1992.

Course 7

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

PROVIDERS AND REVIEWERS TEACH INFORMED MANAGED CARE

Director: Vincenzo R. Sanguineti, M.D., *Associate Clinical Professor, Department of Psychiatry, Thomas Jefferson University, Philadelphia, PA*

Faculty: Janis G. Chester, M.D., William M. Glazer, M.D., Mary E. Roff, R.N., Steven E. Samuel, Ph.D., Stephen L. Schwartz, M.D., Chandra A. Kee, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to (a) describe rationales and criteria involved in managed care systems and decisions on such issues as patient care versus cost containment, psychiatric acuity, documentation, and integrated vertical systems; (b) identify review methods that realistically adapt to actual models of clinical care giving and decision making; and (c) experiment with dialogue styles that facilitate collegial, rather than adversarial, interactions.

DESCRIPTION:

This course will begin with a presentation about the main topics involved in managed care. A psychiatric provider will present a clinical case contested by a managed care reviewer, which illustrates criteria for admission, acuity in emergency psychiatry, and documentation requirements. Weighted factors pertinent to the decision process will be described by providers and reviewers. An expert consultant will discuss both points of view, address the concept of psychiatric acuity, and present tools for better quantification of need. The participants will meet in small groups, chaired by a faculty member, and will attempt to reach a decision. The actual outcome of the case will then be presented and discussed.

The second case presented will illustrate multispecialty involvement, complicating clinical care, length of stay, and options for alternative levels of care. This presentation will

follow the same format as the first, with the discussant being an expert in hospital utilization review. Small groups will focus on the complexity of multispecialty involvement versus considerations of length of stay and levels of care. The participants will again reconvene, and open discussion with the faculty will follow.

REFERENCES:

1. Feldman JL, Fitzpatrick RJ (eds): *Managed Mental Health Care: Administrative and Clinical Issues.* American Psychiatric Press, Washington, DC, 1992.
2. 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.

Course 8

Sunday, October 8
8:30 a.m.-4:00 p.m.

MANAGEMENT AND TREATMENT OF THE VIOLENT PATIENT

Director: Gary J. Maier, M.D., *Director of Psychiatric Training Forensic Programs, Mendota Mental Health Facilities, Troy, WI*

Faculty: William R. Dubin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to describe the following aspects of work with aggressive or violent patients: (a) the need for sophisticated interventions; (b) a comprehensive model for management and treatment; (c) verbal, physical, and pharmacologic approaches to acute conditions; (d) state-of-the-art psychopharmacologic approaches; (e) legal issues in commitment, release, and prosecution; (f) ambulatory restraints; and (g) methods of addressing the countertransference feelings of fear, anger, and helplessness.

DESCRIPTION:

This course will present a comprehensive model for the management and treatment of acute and chronic aggressive/violent patients in both inpatient and outpatient settings. The need for clinicians to provide safe working conditions will be outlined. Architectural design for inpatient units with high rates of violence will be reviewed. Management of the prodromal syndrome that precedes physical aggression will be described; the discussion will include talk-down techniques for de-escalating a potentially aggressive 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. How to build a case that will result in successful prosecution of a willfully aggressive patient will be described. Aggression cycles, or repetitive aggression, will be discussed from the perspectives of both staff and the aggressive patient. Ambulatory restraints can liberate a patient from seclusion. Finally, but most important, countertransference reactions will be discussed. The forums where the patient's feelings should be resolved and the process of resolution will be described. A model countertransference policy for institutions will also be presented.

REFERENCES:

1. 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.
2. Maier GJ, Van Rybroek GJ, Doren D, et al: A comprehensive model for understanding and managing aggressive inpatients. *Am J Continuing Educ Nursing,* Section C, pp 11-18, 1988.

Course 9

Sunday, October 8
1:00 p.m.-5:00 p.m.

INTERPERSONAL PSYCHOTHERAPY

Director: John C. Markowitz, M.D., *Associate Professor of Clinical Psychiatry and Director, Psychopharmacology Clinic, Payne Whitney Clinic, New York, NY*

Faculty: Sabrina Cherry, M.D., Kathleen F. Clougherty, A.C.S.W., Holly Swartz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to describe the principles, techniques, and various applications of interpersonal psychotherapy.

DESCRIPTION:

Interpersonal psychotherapy, a manualized, time-limited therapy, was developed by the late Gerald L. Klerman, M.D., in collaboration with Myrna M. Weissman, Ph.D., and colleagues to treat outpatients with major depression. It employs specific strategies to help the patient understand the links between environmental stressors and the onset of his or her episode of mood disorder, and to explore options for solving interpersonal problems and achieving desired goals. Interpersonal psychotherapy has had considerable success in controlled clinical trials for the treatment of depression and other axis I disorders. Among the time-limited manualized psychotherapies, it is probably closest to what most clinicians practice. Despite this, there have until recently been few opportunities for clinicians to learn interpersonal psychotherapy. This course provides an

overview of the principles, structure, techniques, and clinical and research applications of interpersonal psychotherapy. However, this course will not provide certification as an interpersonal psychotherapy therapist, a process that requires ongoing training and supervision. Participants are invited to present cases to which interpersonal psychotherapy might be applied.

COURSE LEVEL:

Participants should have several years of experience with psychotherapy and with mood disorders and should have read *Interpersonal Psychotherapy of Depression* by Gerald L. Klerman.

REFERENCES:

1. Klerman GL, Weissman MM: *New Applications of Interpersonal Therapy.* American Psychiatric Press, Washington, DC, 1993.
2. Markowitz JC, Klerman GL, Perry SW: Interpersonal psychotherapy of depressed HIV-seropositive patients. *Hosp Community Psychiatry* 43:885-890, 1992.
3. Klerman GL: *Interpersonal Psychotherapy of Depression.* Basic Books, New York, 1984.

Course 10 — Monday, October 9, 8:00 a.m.-12 noon

ORAL BOARD REVIEW COURSE

Director: Mary K. McCarthy, M.D., *Department of Psychiatry, Brigham and Women's Hospital, Boston, MA*

Faculty: Kenneth S. Duckworth, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to (a) review videotapes similar to those presented on the American Board of Psychiatry and Neurology (ABPN) part II examination; (b) organize a presentation of the pertinent data; (c) present a formulation, including differential diagnosis based on *DSM-IV*; and (d) develop a treatment plan that includes biological, psychological, and sociocultural aspects.

DESCRIPTION:

This course is being presented to assist psychiatrists interested in the format of the ABPN part II, oral examination. Participants will learn techniques for organizing a comprehensive presentation of the clinical data. Presentations consistent with the type of questions asked on the part II examination will be emphasized. Participants will discuss ways to present differential diagnoses and treatment plans that involve biological, psychological, and sociocultural aspects of treatment. Techniques to help participants prepare for the particular format of the oral examination will be presented. The faculty will present videotapes of clinical cases to stimulate discussion. Participants who take the oral examination at a later date will be asked to evaluate the helpfulness of this course for refinement of future courses.

REFERENCES:

1. Morrison JR, Munoz R: *Boarding Time: A Psychiatry Candidate's Guide to Part II of the ABPN Examination.* American Psychiatric Press, Washington, DC, 1991.
2. Othmer E, Othmer S: *The Clinical Interview Using DSM-IV,* vols I and II. American Psychiatric Press, Washington, DC, 1994.

Course 11 — Monday, October 9, 8:30 a.m.-4:00 p.m.

PRACTICAL TECHNIQUES IN CHILD AND ADOLESCENT PSYCHOPHARMACOLOGY

Director: Charles W. Popper, M.D., *Editor,* Journal of Child and Adolescent Psychopharmacology, *and Faculty, Harvard Medical School, Boston, MA*

Faculty: Barbara J. Coffey, M.D., Daniel F. Connor, M.D., Ronald J. Steingard, M.D., Martin H. Teicher, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to (a) select sequential therapies for psychiatric disorders on the basis of psychopharmacological decision trees and (b) use advances in pharmacology, pharmacokinetics, patient education, patient management, psychotherapy, and health care systems to maximize the effectiveness of treatment of children and adolescents.

DESCRIPTION:

Pharmacological decision trees for treating the major child and adolescent psychiatric disorders will be presented. Drugs of first choice, subsequent drugs, supplemental drugs, helpful polypharmacy, trial durations, target symptoms, and outcome assessment scales will be recommended for attention deficit disorder, major depression, bipolar disorder, psychoses, aggressivity, anxiety disorders, autistic disorder and pervasive developmental disorder, obsessive-compulsive disorder, and Tourette's disorder. The faculty will address advanced approaches to treating comorbid psychopathology, drug interactions and practical aspects of pharmacokinetics, management suggestions for daily practice, how to educate children and parents about disorders and drug treatments, interactions of pharmacotherapy and psychotherapy, the effects of brief hospitalizations and managed care on psychopharmacological practice, and recent research advances.

COURSE LEVEL:

Participants should have general knowledge of psychopharmacology and child and adolescent psychopathology.

REFERENCES:
1. Popper C, Zimnitzky B: Update. *J Child Adolescent Psychopharmacology,* January-December 1994.
2. Popper CW (ed): *Psychiatric Pharmacosciences of Children and Adolescents.* American Psychiatric Press, Washington, DC, 1987.

Course 12 — Monday, October 9, 1:00 p.m.-5:00 p.m.

PSYCHODYNAMIC GROUP PSYCHOTHERAPY

Director: Anne Alonso, Ph.D., *Associate Clinical Professor of Psychology, Department of Psychiatry, Harvard Medical School, Boston, MA*

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to (a) describe the theory that underlies psychodynamic group psychotherapy, (b) identify psychotherapy patients who are most likely to benefit from group psychotherapy, (c) prepare patients for a successful group experience, (d) recognize basic group themes, and (e) intervene productively.

DESCRIPTION:

Group therapy is an exceptionally efficient modality for using psychodynamic principles in psychotherapy. This is an introductory course for participants who have a substantial background in the principles of individual psychodynamics and who have had several years of experience in treating patients in individual psychodynamic psychotherapy. The faculty will briefly review relevant psychodynamic principles as they apply to group therapy, consider therapeutic factors, and examine productive group norms. The nature of transference and working through will be discussed. Indications and contraindications for group therapy will be reviewed, as will principles of patient preparation and the nature of the group therapy contract. Therapist technique, psychodynamic interventions, the concept of the group as a whole, affect management, gender issues, and termination will also be addressed. Participants will have the opportunity to observe and discuss a demonstration group therapy session.

COURSE LEVEL:

Participants should have experience with individual psychodynamic psychotherapy.

REFERENCES:
1. Alonso A, Rutan JS: Uses and abuses of transference interpretations in groups. In Aronson MI, Wolberg IW (eds): *Progress in Group and Family Therapy.* Brunner/Mazel, New York, 1983, pp 22-30.
2. Alonso A, Rutan JS: The treatment of shame and the restoration of self-respect in groups. *Int J Group Psychotherapy* 38:3-14, 1988.

Course 13 — Tuesday, October 10, 8:00 a.m.-12 noon

SUICIDE AND CLINICAL PRACTICE

Director: Douglas G. Jacobs, M.D., *Assistant Clinical Professor of Psychiatry, Harvard Medical School, Boston, MA, and Executive Director, National Mental Illness Screening Project*

Faculty: Douglas H. Hughes, M.D., Michael C. Miller, M.D., Katharine A. Phillips, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to describe models for suicide assessment and detection of suicidality, understand medication issues for suicidal patients, and assess their own use of "no suicide" contracts and the quality of their documentation.

DESCRIPTION:

Suicide continues to be a major concern for psychiatrists; therefore, we must be aware of the psychiatric conditions that increase the risk for suicide. In particular, there are many treatment decisions that confront a psychiatrist caring for a suicidal patient, including when and how to medicate, when to hospitalize, when to acknowledge countertransference, and when to ask for a consultation. The clinical guidelines offered will review (a) current assessments integrating the state-of-the-art models of assessment for suicide, (b) medication issues for suicidal patients, (c) the importance of detecting suicidality, (d) the risks and benefits of "no suicide" contracts, and (e) effective documentation as an integral part of liability prevention.

COURSE LEVEL:

Participants should be actively working with suicidal patients.

REFERENCES:
1. Jacobs D: Evaluating and treating suicidal behavior in the borderline patient. In Jacobs DG (ed): *Suicide and Clinical Practice.* American Psychiatric Press, Washington, DC, 1992.
2. Jacobs D: Psychotherapy with suicidal patients: the empathic method. In Jacobs DG, Brown HN (eds): *Suicide: Understanding and Responding: Harvard Medical School Perspectives.* International Universities Press, Madison, CT, 1989.

FULL-DAY SESSIONS

Full-Day Session 1 — Friday, October 6, 8:30 a.m.-4:00 p.m.

THE ROLE OF MENTAL HEALTH PROVIDERS IN HIV PREVENTION

Co-Chairpersons: Marshall Forstein, M.D., *Director, Zinberg HIV Mental Health Clinic, Cambridge Hospital, 1493 Cambridge Street, Cambridge, MA 02139;* Stephen M. Brady, Ph.D., *Solomon Carter Fuller Mental Health Center, 85 East Newton Street, Boston, MA 02118-2337*

Plenary: The Role of Mental Health Professionals in HIV Prevention
Speaker: Stephen M. Brady, Ph.D.

Plenary: What We Know About Prevention
Moderator: Ralph Edwards, M.P.H.
Panelists: Belinda Dunn, Jasper J. Lawson, Ph.D., Cynthia Tellingator, M.D., Nan Stromberg, R.N., C.S.

Plenary: Neuropsychiatric and Psychodynamic Factors in Risk Behavior
Speakers: Marshall Forstein, M.D., Cheryl S. Weinstein, Ph.D.

Small Group Discussions
Facilitators: Marshall Forstein, M.D. (gay/bisexual men), Stephen M. Goldfinger, M.D. (severely and persistently mentally ill persons), Louisa Madrano, Ph.D. (women), Cynthia Tellingator, M.D. (adolescents), Jose Pares-Avila (people of color), Brad Cohen (substance abusers)

Plenary: Integrating Prevention into the Clinical Setting
Speaker: Barbara Ogur, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify contributions that they can make to HIV prevention and describe how prevention can be incorporated into their clinical work.

SUMMARY:

Mental health care providers have a crucial role to play in the prevention of HIV infection among their patients and clients. This all-day symposium will explore the contributions that mental health providers can make, as well as ways in which they can integrate HIV prevention into their respective clinical settings. This session will look at what is known about prevention, neuropsychiatric and psychodynamic factors in risk behavior, how to conduct risk assessment in the clinical setting, and the prevention issues of special patient groups, including gay men, women, racial/ethnic minorities, adolescents, substance abusers, and the severely and persistently mentally ill.

REFERENCES:

1. DesJarlais DC, Padian NS, Winkelstein W: Targeted HIV prevention programs. *N Engl J Med* 331:1451-1453, 1994.
2. Odets W: AIDS education and harm reduction for gay men: psychological approaches for the 21st century. *AIDS Public Policy J* 9(1), 1994.
3. Bayer R: AIDS prevention and cultural sensitivity: are they compatible? *Am J Public Health* 84:895-898, 1994.
4. Gold RS: Rethinking HIV prevention strategies for gay men. *Focus: A Guide to AIDS Research and Counseling* 10(3), 1995.

Full-Day Session 2 (Part 1) — Monday, October 9, 8:30 a.m.-12 noon

MANAGED CARE

Chairperson: Alan M. Elkins, M.D., *Executive Director, Green Spring of Maine, 48 Free Street, Portland, ME 04101*

Moderator: Mary Jane England, M.D.

Evolution of Managed Care
Speaker: Jeremy A. Lazarus, M.D.

Ethical Issues in Managed Care
Speaker: Donna E. Frick, M.D.

Legal Issues in Managed Care
Speaker: Alan A. Stone, M.D.

Professional Values in Organized Mental Health Delivery Systems
Speaker: Steven S. Sharfstein, M.D.

A Consultant's View of Managed Care
Speaker: David R. Selden, A.C.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to (a) describe how managed care has evolved over the last 20 years; (b) discuss ethical principles governing professional relationships with individual patients, a physician's ethical responsibility to society as a whole, and challenges to traditional medical ethics that occur in managed care settings; (c) identify legal issues that arise in managed care; (d) discuss cost management and its relationship to access and quality; and (e)

describe how a clinician works as a consultant within a business setting, identify key purchaser needs, discuss the needs of professional training programs, and describe what corporate purchasers expect from providers.

SUMMARY:

Dr. Lazarus will present a general overview of the evolution of managed care. This will begin with prepaid health systems in the 1970s and will include benefit restriction, utilization review, health maintenance organizations (HMOs), carve-outs, managed behavioral care companies, integrated specialty clinics, group practices, and other practice arrangements. In addition, the relationship between Medicaid and managed care and its potential evolution will be discussed. The potential future course of managed care will conclude the presentation.

Dr. Frick will briefly review and evaluate some of the origins of contemporary Western medical ethics. This review will be followed by a discussion of the ethical principles that guide professional relationships with individual patients. The challenge of balancing ethical responsibilities to society with responsibilities to individual patients will then be explored, with emphasis on the integration of principles of distributive justice, patient autonomy, fiduciary care, honesty, and confidentiality.

Dr. Stone will discuss market forces, private sector regulation, oligopsony, and ERISA. These are the primary factors that make managed care the dominant element in the transformation of psychiatry in the United States.

Dr. Sharfstein will describe how managed care has transformed health care delivery and will continue to do so well into the twenty-first century. From initial efforts to contain costs by controlling physician decision making through various forms of utilization review to selective contracting and discounting, we are now moving rapidly into an era of prospective payment and capitation as HMOs grow and prosper. What happens to patients with mental illness and substance use problems in this transformation? How do we forge public/private partnerships, provider/managed care partnerships, integrated multidisciplinary teams, and a close relationship with general medical care? "Carve out" versus "carve in" is also an issue to consider. The role of the psychiatrist is a key variable in these allocative decisions and in the bringing together of medical standards and ethics to moderate the economic emphasis of the marketplace. The need for public oversight through governmental regulation of the market will also be discussed.

Mr. Selden will discuss the decisive gap between the corporate purchaser and the provider communities. A variety of efforts are underway to close this gap and to reach a common understanding of issues such as cost and quality in the provision of behavioral health benefits. Mr. Selden, a clinician who works as a consultant to corporate purchasers, will describe his work and key areas of concern for providers of behavioral health services. Attendees will hear how professional clinical experience and values are integrated (or not) into the corporate setting. Examples of consultant activities and results will be described. The presentation will also review what corporate purchasers are looking for from behavioral health services and will describe some concerns about professional training programs.

REFERENCES:

1. Gorski T: The evolution of managed care practices. *Treatment Today,* Spring 1995, pp 10-12.
2. Lazarus JA, Sharfstein SS: Changes in the economics and ethics of health and mental health care. In Oldham JM, Riba MB (eds): *American Psychiatric Press Review of Psychiatry,* vol 13. American Psychiatric Press, Washington, DC, 1994, pp 389-413.

Full-Day Session 2 (Part 2) Monday, October 9 1:30 p.m.-4:45 p.m.

MAJOR POLICY ISSUES IN MANAGED BEHAVIORAL HEALTH CARE

Chairperson: Allan Beigel, M.D., *Professor of Psychiatry, University of Arizona*

Managed Behavioral Health Care and Academic Medical Centers
Speaker: Miles F. Shore, M.D.

Education and Training Issues in Psychiatry
Speaker: Allan Beigel, M.D.

Outcome Measures and Effectiveness Evaluation: What Is the Meaning of Quality?
Speaker: Barbara Dickey, Ph.D.

Privatization: Is It the Result of Managed Care?
Speaker: Martin Cohen, M.S.W.

The Current and Future State of the Managed Behavioral Health Care Industry
Speaker: John C. Bartlett, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the major policy issues that now exist and those that will influence the development of managed behavioral health care during the next several years.

SUMMARY:

A policy and research program involving managed behavioral health care has been established at Harvard University by the Consolidated Department of Psychiatry in

collaboration with the Kennedy School of Government. The program is intended to be a neutral setting in which complex and often controversial policy issues pertaining to service delivery and training can be explored. The working agenda for this program was developed in the spring of 1994 in conjunction with a small group of executives from managed mental health care corporations, benefit consultants, academic psychiatrists, and government officials. Among the priorities defined at the time were (a) tracking the development of the managed behavioral health care industry; (b) assessing how the new competitive managed care environment will affect the future of academic health centers and, in particular, departments of psychiatry; (c) determining the current and future training needs of providers working in managed behavioral health care and assessing the implications of these needs for psychiatric education programs; (d) analyzing the impact of managed behavioral care on the quality of available services; and (e) examining the implications of using managed behavioral health care approaches within the public sector. The presentations in this session will provide perspectives on each of these issues based on work completed within the program.

Because the mental health benefits of more than 102 million Americans are managed by one or another of the managed behavioral health care companies, the academic departments of psychiatry that rely on patient care for training, clinical research, and revenue have inevitably become threatened. In May of 1994 the American Association of Chairmen of Departments of Psychiatry funded a survey of 137 departments to assemble data on the effect of managed care on their programs. The survey included information about modifications of their teaching and research programs, faculty development efforts, and establishment of faculty practice groups to contract as service providers. Some departments created their own managed behavioral health care companies to bid on contracts. Dr. Shore will review the findings of this survey, which picture the current state of psychiatry as it responds to managed behavioral health care.

Dr. Beigel will present results of a study that assessed the impact of managed behavioral care on psychiatric residency education. The study was performed for the Substance Abuse and Mental Health Services Administration with the cooperation of the Association of Directors of Psychiatric Education and Residency Training, the American Association of Chairmen of Departments of Psychiatry, the Association of Academic Psychiatrists, the APA Office of Education, and other organizations and individuals. Actual and potential changes in the following areas will be covered: (a) the training and supervision process, (b) curriculum, (c) settings for residency education, (d) utilization of state hospitals and other chronic-care settings, (e) financing of residency education, (f) educational and administrative leadership in academic psychiatry, (g) the practice of psychiatrists, and (h) strategies for recruitment into psychiatry.

Dr. Dickey will provide the audience with an understanding of the role of outcomes measurement in the clinical management of patients, the continuous quality improvement of services, and the utilization management of resources devoted to patient care. The national debate on the reform of health care has sharpened the interest in holding providers of care accountable for patient outcomes. The methods for measuring these outcomes are being developed by academics, health care providers, and professional guilds. This presentation will review the different methods available by using actual case studies of systems of care that have instituted outcomes measurement in their day-to-day operations. Dr. Dickey will review specific outcome instruments being used today to meet the demands of purchasers of care.

The advent of managed care in mental health has brought with it new interest in privatization of once publicly operated mental health care services. Mr. Cohen will look at how several states have approached privatization, the influence of managed care in bringing about this privatization of services, and the upside and downside potential of privatization in a publicly financed mental health care delivery system. Specific reference will be made to privatization efforts in Ohio, Massachusetts, Tennessee, and Arizona.

In the past several years, the managed behavioral health care industry has shown remarkable growth. In 1992 total enrollment in managed behavioral health care plans was 78.1 million persons; by 1994 it had grown to 102.5 million persons. The largest number of those individuals were employed by corporations. During the past year there has been a major expansion of the industry into the operation of programs that have heretofore been the responsibility of public mental health authorities. As a result, the dynamics and patterns of growth of the managed behavioral health care industry have had profound effects on the delivery of mental health services in this country. Dr. Bartlett will review the recent complicated developments in the managed behavioral health care industry and the projected scenario of events in the next few years as they are likely to influence the care of patients and the practice of all mental health professionals.

REFERENCES:

1. Sabin J, Borus J: Mental health teaching and research in managed care. In Feldman J, Fitzpatrick R (eds): *Managed Mental Health Care: Administrative and Clinical Issues.* American Psychiatric Press, Washington, DC, 1992.
2. Borus JF: Economics and psychiatric education: the irresistible force meets the movable object. *Harvard Rev Psychiatry* 2:15-21, 1994.
3. Beigel A: Psychiatric education at the crossroads: future directions. *Am J Psychiatry* 136:1525-1529, 1979.
4. Dickey B, Wagenaar H: Evaluating mental health care reform: including the clinician, client, and family perspective. *J Ment Health Admin* 21:313-319, 1994.
5. Dickey B, Cohen MD: Changing the financing of state mental health programs: using carrots, not sticks, to improve care. *Admin Policy Ment Health* 20:343-355, 1993.
6. Oss ME: *Managed Behavioral Health: Market Share in the United States, 1994.* Open Minds, Gettysburg, PA, 1994.

HALF-DAY SESSIONS

Half-Day Session 1 — Friday, October 6, 8:30 a.m.-11:45 a.m.

CLINICAL ASPECTS OF PSYCHOPHARMACOLOGY

Carl Salzman, M.D., *Department of Psychiatry, Massachusetts Mental Health Center, 74 Fenwood Road, Boston, MA 02115-6106;* Alan I. Green, M.D., Michael A. Jenike, M.D., Jerrold F. Rosenbaum, M.D., Andrew A. Nierenberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to treat patients with schizophrenia, obsessive-compulsive disorder, anxiety, treatment-resistant depression, and complicated clinical conditions.

SUMMARY:

The purpose of this session is to provide a clinical update on the use of psychotropic drugs for treatment of common but serious psychiatric conditions. Each presenter will limit his or her comments to practical clinical guidelines and recommendations; literature review and presentation of research data will be minimized.

Dr. Green will review current treatment strategies for psychotic illness, with an emphasis on the use of atypical neuroleptics.

Dr. Jenike will review current treatment strategies for obsessive-compulsive disorder and other disorders considered to be related to the obsessional disorder spectrum. Special emphasis will be on pharmacological treatments of these disorders and management of refractory conditions. Other treatment approaches, including behavior therapy and psychosurgical approaches, will be briefly described.

Dr. Rosenbaum will review the treatment of anxiety disorders and disorders of the related anxiety spectrum. Population-based studies indicate that over 3% of the U.S. adult population meet criteria for panic disorder and that an additional 2-5% suffer from agoraphobia with or without panic. Both biological and behavioral models have been proposed for this disorder and have given rise to empirically based therapeutic interventions. Nonetheless, as with mood disorders, anxiety disorders feature substantial comorbidity and chronicity, and the field is continually challenged to enhance therapeutic interventions. The complexity of factors contributing to these disorders and the rule, rather than the exception, of residual symptoms, relapse, and recurrence suggest the need for integrated treatment involving pharmacological and psychosocial interventions to generate the best possible outcome.

Dr. Nierenberg will review the treatment of depression and current therapeutic strategies for treatment-resistant depression.

The session will conclude with overall synthesizing comments by Dr. Salzman.

REFERENCES:

1. Schatzberg AF, Nemeroff C (eds): *American Psychiatric Press Textbook of Psychopharmacology.* American Psychiatric Press, Washington, DC, 1995.
2. Janicak P, Davis J, Preskorn S, et al (eds): *Principles and Practice of Psychopharmacotherapy.* Williams & Wilkins, Baltimore, 1994.
3. *Benzodiazepine Dependence, Toxicity, and Abuse: A Task Force Report of the American Psychiatric Association.* American Psychiatric Association, Washington, DC, 1990.
4. Salzman C: *Clinical Geriatric Psychopharmacology,* 2nd ed. Williams & Wilkins, Baltimore, 1992.
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6. Rosenbaum JF, Pollock RA, Otto MW, et al: Integrated treatment of panic disorder. *Bull Menninger Clin* 59(2, suppl A):A4-A26, 1995.

Half-Day Session 2 — Friday, October 6, 8:30 a.m.-11:45 a.m.

PSYCHOTHERAPY IN MANAGED CARE

James E. Sabin, M.D., *Acting Director, Teaching Programs, Harvard Community Health Plan, Suite 202, 126 Brookline Avenue, Boston, MA 02215;* William E. Greenberg, M.D., Michael J. Bennett, M.D., Elizabeth A. Williams, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to formulate psychotherapy strategies for patients whose treatment requires more than short-term intervention in terms that are congruent with the kinds of resource limitations associated with managed care.

SUMMARY:

Managed care is currently the chosen public vehicle of policy for influencing the way health care is planned, financed, and delivered. Psychotherapy services have been an area of much conflict and confusion. This session will address the application of individual psychotherapy in the psychodynamic tradition within a managed care framework. An effort will be made to define the "active ingredients" of effective psychotherapy and to consider ways in which these ingredients can be delivered in the cost-attentive systems of the future. The primary technical focus will be patients for whom short-term therapy is not an adequate approach for reaching the treatment goals. Presentations will emphasize learning for the new environments, practical treatment strategies, and the concept of "medical necessity" as applied to psychotherapy.

Another important issue is the treatment of patients for

whom short-term therapy is not enough, which will be discussed by Dr. Sabin. Ethical managed care has as its objective enhancing value, not cutting costs. When short-term psychotherapy can achieve the therapeutic objectives, it is clearly a value-enhancing strategy. Many patients, however, need years--not weeks or months. Experienced managed care clinicians have developed substantial experience in time-efficient, long-term treatment techniques that seek a highly leveraged use of the clinician's time and use substantially fewer sessions than would occur in weekly psychotherapy. The clinician needs to adopt a stance modeled on that of a primary care practitioner, acting more as a catalyst and coach than as a transference object. For many patients, special techniques are required for addressing difficulties with object constancy and the sense of aloneness. Time-efficient treatment requires an especially resilient therapeutic alliance.

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Half-Day Session 3 — Friday, October 6, 8:30 a.m.-11:45 a.m.

CLINICAL AND POLICY ISSUES IN THE ASSESSMENT AND TREATMENT OF PATIENTS WITH ALCOHOL OR DRUG ABUSE

Robert B. Millman, M.D., *Saul P. Steinberg Distinguished Professor of Psychiatry and Public Health, Cornell University Medical College, 411 East Sixty-Ninth Street, New York, NY 10021-5603;* Roger D. Weiss, M.D., Dominic A. Ciraulo, M.D., Steven M. Mirin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify current epidemiologic patterns and models of abuse of various drugs; discuss etiologic models by which patients are assessed and outline the diversity of treatment philosophies and practices that are based on these models; identify current psychotherapeutic and pharmacotherapeutic practices, including new developments; and discuss the rapidly changing interactions of the political climate and the economic exigencies facing treatment delivery.

SUMMARY:

The history, epidemiology, and patterns of drug abuse have in large part determined the models by which the pathogenesis of drug and alcohol abuse and dependence is viewed. The major treatment programs based on these models have evolved significantly in recent years, although there are serious deficiencies associated with persisting parochial views of substance abuse and dependence.

Psychotherapy and pharmacotherapy with substance abusers are important elements in a comprehensive treatment program. Current and innovative developments in these areas will be explored, with particular emphasis on new pharmacotherapies. The recent remarkable changes in U.S. health care delivery systems and their payment methods have already had significant effects on substance abuse treatment and psychiatric practice. Consideration will be given to the various ways the delivery systems and the field are likely to change in the next few years and how patient care and treatment programs can survive, remain effective, and even improve in the current economic and conceptual climate.

Dr. Millman will discuss the impact of epidemiologic and conceptual views of substance abuse and dependence on treatment development. The prevalence and patterns of use and abuse of drugs and alcohol in the United States continue to change in response to cultural, economic, and pharmacologic factors. Similarly, the conceptual models by which we attempt to understand these behaviors remain in flux. These models are based as much on belief systems as on science, and they influence the assessment and treatment of drug and alcohol abuse patients. The epidemiology and patterns of abuse of the various drugs and the programs for treating these patients will be discussed. Despite the significant evaluation of treatments in the past three decades, treatment effectiveness is limited by the parochial perspectives of many treatment providers. The treatment of drug abuse patients with coexisting psychopathology (dual diagnosis) will be discussed to demonstrate both the recent development of more effective treatments and the significant gaps that persist.

Dr. Weiss will discuss psychotherapy and counseling techniques for substance abusers as they relate to matching patients and their problems to specific treatments.

Dr. Ciraulo's presentation will cover pharmacotherapeutic interventions for substance abusers, including new developments.

Dr. Mirin will discuss substance abuse treatment in an integrated delivery system. Dramatic changes in the financing and delivery of mental health care over the past decade pose both problems and opportunities for providers of substance abuse treatment. Although insurance coverage for such treatment has expanded considerably, managed care severely constrains access to, and utilization of, inpatient treatment while encouraging use of residential/ambulatory settings for both acute and follow-up care. As the financing of substance abuse treatment moves from volume-driven, fee-for-service payment toward episode-of-care and/or capitated reimbursement mechanisms, providers will be under increasing pressure to deliver services in the most cost-effective manner possible. Moreover, as hospitals and delivery

systems compete for capitated contracts, the pressure to carve out substance abuse services will intensify. Countering these trends is a growing awareness that cost-effective, high-quality care for this patient population has the potential to dramatically reduce morbidity, mortality, and associated costs in other sectors of health care, including medical and surgical care. Demonstrations of these cost-offset effects, coupled with development of valid and reliable measures of treatment outcome, will ensure that providers of substance abuse care will maintain a place within tomorrow's integrated health care delivery system.

REFERENCES:

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2. Millman RB, Beeder AB: Treatment of patients for specific drugs of abuse: cannabis. In Galanter M, Kleber HD (eds): *The American Psychiatric Press Textbook of Substance Abuse Treatment,* vol 2. American Psychiatric Press, Washington, DC, 1994, pp 91-109.
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Half-Day Session 4 — Friday, October 6, 2:15 p.m.-5:30 p.m.

INTERFACES AND INTEGRATION OF PSYCHIATRY WITH GENERAL MEDICAL CARE: CARVING OURSELVES BACK IN

Richard J. Goldberg, M.D., *Psychiatrist-in-Chief, Rhode Island Hospital, 593 Eddy Street, Providence, RI 02903;* Paul Summergrad, M.D., Randall H. Paulsen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe several models of integrated medical-psychiatric networks, the redesign of practice and financing mechanisms to better integrate psychiatry and primary care, and specific strategies for enhancing collaboration between the two disciplines.

SUMMARY:

Three psychiatrist presenters, with several years of hands-on experience in building bridges between--and networks including--psychiatric health care and primary care, will share their visions of and expertise in (a) redesigning practice and financial mechanisms to better integrate the two disciplines and treat the whole patient, (b) negotiating with managed care to create integrated medical-psychiatric networks, and (c) setting up and developing a co-practice model for psychiatry in primary care practices.

Dr. Goldberg will discuss the integration of the two disciplines. Although psychiatric factors play a major role in general medical care, psychiatry and general medicine currently are not integrated. In addition to historical and conceptual differences, the economics driving the mental health carve-out have reinforced this separation. There is increasing documentation of the significant impact of psychiatric problems on the course and costs of medical care. Psychiatric disorders account for many common presenting problems in general medicine. In addition, psychiatric comorbidity frequently influences conditions such as stroke, myocardial infarction, and cancer. On the basis of prevalence and economic data, the future primary care system must improve recognition, prevention, and treatment of psychiatric disorders and substance abuse and must develop ways to integrate preventive psychotherapeutic and behavioral interventions. These challenges have implications for the educational system and the design of practice and financing mechanisms.

Dr. Summergrad will discuss the development of integrated medical-psychiatric networks and the impact of carve-outs. As managed care increases its strength, a logical response is for providers to form geographically distributed networks to effectively organize care and balance the power of payers. Within general medicine these networks often organize around primary care physicians and, to a lesser degree, community-based specialists and general hospitals. Models for the development of psychiatric networks are more varied. In part, this is due to the different services required for distinct psychiatric populations (commercial versus public sector). Additionally, the strength of carve-out contracting and behavioral managed care organizations makes formation of integrated medical-psychiatric networks more complex. This presentation will review options for the creation of integrated networks.

Dr. Paulsen will discuss the concept of psychiatry and primary care as neighbors. A successful 8-year experience developing and enhancing a co-practice model for psychiatry in a primary care practice will be described. Familiar themes, such as availability, shared location, and continuity of interdisciplinary relationships, will be discussed, as will (a) important fiscal, organizational, and leadership factors in creating a successful bridge between psychiatry and primary care; (b) how individual tailoring for the setting (e.g., rural versus urban) affects the collaboration; (c) adaptations psychiatrists must make to function well in such settings; (d) skill development across disciplines; (e) the broadening of psychiatric service delivery to primary care; and (f) the gradual development of a teaching program and a training track for medical and psychiatric house staff.

A roundtable discussion addressing questions from the audience will follow the presentations.

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1. Goldberg RJ: Psychiatry and the practice of medicine: the need to integrate psychiatry into comprehensive medical care. *South Med J* 88:260-267, 1995.
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3. Sturm R, Wells K: How can care for depression become more cost effective? *JAMA* 273:51-58, 1995.
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Half-Day Session 5

Friday, October 6
2:15 p.m.-5:30 p.m.

USING OUTCOMES TO IMPROVE CARE: QUALITY ASSURANCE FOR MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

Laurie M. Flynn, M.A., *Executive Director, National Alliance for the Mentally Ill, Suite 1015, 200 North Glebe Road, Arlington, VA 22203;* Grayson S. Norquist, M.D., Judith L. Feldman, M.D., Susan Dime-Meenan, C.B.A., John S. McIntyre, M.D., Donald Steinwachs, Ph.D., Steven M. Mirin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to (a) discuss the state of the art of outcomes measurement in mental health and substance abuse treatment, (b) identify current issues and perspectives in quality assessment and outcomes management in a managed care environment, and (c) describe a unique multistakeholder collaboration to define principles and data required for measuring and managing outcomes of mental health and substance abuse treatment.

SUMMARY:

Society is grappling now to contain health care costs while ensuring the delivery of quality care to real people. Mental and addictive disorders present special challenges. Because concrete measures have received insufficient attention, people who suffer from these disorders are at special risk of being underserved and undertreated. Thus, we need to articulate what success means in the treatment of mental and addictive disorders and how to achieve this success through a collaborative relationship. Outcomes measures are tools that allow us to do that.

This roundtable will be unique in that it will represent the full spectrum of those involved in the care of people with mental and addictive disorders--from families and consumers of services for mental illness and addictive disorders to insurers, employers, public and private providers, researchers, and government agencies.

The three task forces through which participants continue their involvement are the Task Force on Principles and Recommendations, the Task Force on Standards and Data Collection, and the Task Force on Communications.

REFERENCES:
1. Steinwachs DM, Wu AW, Skinner EA: How will outcomes management work? *Health Aff (Millwood)* 13:153-162, 1994.
2. Mirin S (ed): *Psychiatric Treatment: Advances in Outcomes Research.* American Psychiatric Press, Washington, DC, 1991.

Half-Day Session 6

Friday, October 6
2:15 p.m.-5:30 p.m.

CRITICAL ISSUES IN LAW AND PSYCHIATRY: VIOLENCE, COMPETENCE, AND BOUNDARY ISSUES

Paul S. Appelbaum, M.D., *A.F. Zeleznik Professor and Chair of Psychiatry, University of Massachusetts Medical Center, 55 Lake Avenue North, Worcester, MA 01655;* John Monahan, Ph.D., Thomas Grisso, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss new data on the incidence and correlates of violence among persons with mental illness, problems associated with crossing physician-patient boundaries in mental health treatment, and new approaches to assessing the competence of persons with mental illness to consent to treatment.

SUMMARY:

This session will explore three areas in which the law affects mental health practice, all of which have undergone important changes in recent years. The first issue is the incidence and correlates of violent behavior among the mentally ill--the likelihood of violence is an important consideration for clinicians making decisions regarding involuntary commitment, release from hospitalization, and protection of third parties. Although the conventional wisdom has been that mentally ill persons are no more violent than the general population, recent data suggest that certain kinds of mental illness may be associated with a greater risk of violence. The second area to be discussed is appropriate boundaries between clinicians and patients--boundary violations are among the most important causes of malpractice suits against clinicians and facilities. Although most clinicians are now aware of proscriptions against sexual contact with patients, more recent cases and guidelines have emphasized the problems associated with nonsexual transgression of boundaries, including entering into economic, social, and other nonprofessional relationships with patients. The third topic is decision-making capacities of persons with

mental illness–clinicians are required to obtain patients' consent in a variety of situations. Confusion about what constitutes competent consent and which patients are at risk of incompetence has been widespread. Recent data from a major study of patients' decision-making competence will be presented, along with suggestions for implementing an approach to assessing patient competence in the clinical setting.

Dr. Monahan will discuss the relationship between violence and mental disorder, which have been linked in public opinion throughout history and in all known cultures. In modern times behavioral scientists have concentrated on providing answers to two questions: Is mental disorder a risk factor for violence? and How valid are clinical predictions of violence? Dr. Monahan will describe published and unpublished results of several recent studies, supported in part by the MacArthur Research Network on Mental Health and the Law. Among the conclusions are the following: (a) Major mental disorder is indeed a significant risk factor for violence directed at others, particularly when comorbid alcohol or other drug abuse is present. (b) Particular symptom patterns, rather than broad diagnostic groupings, appear to characterize the relationship between mental disorder and violence. (c) Clinicians seem to have modest validity in assessing the risk that at least some patients will be violent.

Dr. Appelbaum will discuss clinician-patient boundaries. The breakdown of such boundaries relates in part to the loss of dominance of the psychoanalytic model of treatment, which restricted clinician-patient interactions on theoretical grounds, namely, because they would contaminate the transference. The confusion resulting from the adoption of other models of treatment has been manifest in the growth of lawsuits and complaints to licensure boards and professional societies. The unacceptability of sexual contact with patients, and in most cases with former patients, is now clear. Somewhat more ambiguous are the proper boundaries in other kinds of interactions. Guidelines for maintenance of boundaries in psychotherapeutic relationships have been developed recently. These guidelines cover economic relationships with patients, gifts, barter arrangements, nonsexual social interactions, self-disclosure by clinicians to patients, and relationships with patients' families. Discussion with the audience will address the applicability of these guidelines to different types of patients and therapeutic situations and in different areas of the country.

Dr. Grisso will describe how to deal with patients who may have serious decision-making incapacities (and be legally incompetent). Questions of decision-making incompetence may arise in patients' release of medical information, consent to hospitalization, consent to treatment, and consent to participate in research. The response to such patients should be based on several principles that can help to maintain patient autonomy yet protect patients from the potential harm of their incompetent choices. These principles focus on the relation of the mental illness to incapacity to make decisions, functional evaluation of abilities, and the demands of the decision task and the situation. Mental illness may, but does not always, impair decision-making ability in three areas: understanding, appreciation, and reasoning. Serious deficits in decision-making ability may require that someone make decisions for the patient, but alternative approaches, including aids for decision processing, interpersonal shared decision making, and situational modifiers, allow the patient to retain as much autonomy as possible.

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Half-Day Session 7 — Friday, October 6, 2:15 p.m.-5:30 p.m.

MANAGED CARE IN THE PUBLIC SECTOR: IMPLICATIONS FOR PSYCHIATRIC CARE

Kevin W. Concannon, *Commissioner, Maine Department of Human Resources, Suite 11, State House, Augusta, ME 04333;* Michael F. Hogan, Ph.D., Joseph J. Bevilacqua, Ph.D., David L. Cutler, M.D., Henry T. Harbin, M.D., Elizabeth Pattulo, M.Ed., Susan E. Dore, Charles R. Goldman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the rapid introduction of managed care into public psychiatric and mental health care systems, identify different approaches being pursued by state governments in mental health managed care, and relate the growth of public mental health managed care to evolving Medicaid managed care systems.

SUMMARY:

An overview of the rapidly growing reliance on managed care in public mental health systems will be provided by a variety of public-sector representatives.

The rapid growth of managed care and managed psychiatric care in regions of the country with previously minimal managed care is contributing to the rapid expansion and pursuit of managed care as a recommended means of providing a range of services and supports to people with severe and persistent mental illness.

The panel will discuss experiences with Medicaid managed care in South Carolina, Oregon, Maine, and elsewhere. The impact on patients, public mental health systems, Medicaid financing strategies, and evolving practices will be highlighted.

Half-Day Session 8 — Friday, October 6 2:15 p.m.-5:30 p.m.

PSYCHIATRIC NURSES: STAYING AHEAD OF THE TURBULENCE

Elizabeth C. Poster, R.N., Ph.D., *Dean and Professor, School of Nursing, University of Texas at Arlington, P.O. Box 19407, Arlington, TX 76019;* Gail W. Stuart, Ph.D., R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe challenges faced by providers and consumers in mental health care reform; compare traditional and evolving mental health care systems, focusing on continuum of care and treatment outcomes; and analyze the impact of mental health care reform on the psychiatric nursing role, including practice skills and opportunities.

SUMMARY:

This session will focus on the challenges posed by mental health care reform to psychiatric treatment and psychiatric nursing practice. It will review changes related to the continuum of care and the need for treatment outcome assessment, with a focus on the implications of these issues for the redesign of the psychiatric nursing role. The session will first cover national trends in psychiatry and mental health care reform, including elements of a reformed mental health care system. Traditional and evolving components of care will be compared, and emerging issues in the continuum of care and outcomes of treatment will be described. Political issues, including wavering unity and threats from many fronts (e.g., licensure regulation, reimbursement, and replacement by UAPs), will also be identified.

Specific inward and outward perspectives on the psychiatric nursing role will be presented. Issues to be covered include knowledge of capitated systems, participation in managed care organizations, research linking nursing care to patient care outcomes, nursing roles in a new context of care, and choice of career paths in an uncertain environment. Strategies for surviving the transition and coping with change will be identified. These will focus on business as usual, changing mental health care norms, values and structures, and reframing the challenges for professional success as a psychiatric nurse. The value of networking for clinical and practice issues will be described.

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1. Feldman S: *Managed Mental Health Services.* Charles C Thomas, Springfield, IL, 1992.
2. Stuart GW, Sundeen S: *Principles and Practice of Psychiatric Nursing.* Mosby Yearbook, St. Louis, 1995.

Half-Day Session 9 — Friday, October 6 2:15 p.m.-5:30 p.m.

TREATING ETHNIC MINORITIES: CLINICAL PERSPECTIVES

Renato D. Alarcon, M.D., M.P.H., *Professor and Vice Chairman, Department of Psychiatry, Emory University School of Medicine, 1670 Clairmont Road, Atlanta, GA 30033;* Juan E. Mezzich, M.D., Russell Lim, M.D., Francis G. Lu, M.D., Albert F. Samuelson, M.D., David F. Briones, M.D., Michelle O. Clark, M.D., Keh-Ming Lin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the important features of managing minority patients, use *DSM-IV*'s cultural formulation to assess the minority patient's clinical picture, and apply appropriate pharmacological and psychotherapeutic interventions to the management of ethnic minority patients.

SUMMARY:

The growth of ethnic minorities in the U.S. population poses numerous challenges to care delivery systems in general and to the mental health professions in particular. The problems related to the care of these groups may result from a lack of awareness or neglect of the cultural features of the minority patient's illness and relationships with care providers. The cultural formulation included in *DSM-IV* is aimed at correcting this situation. The presenters will explore specific concerns for Asian-American, Native American, Latino, and African-American patients. Clinical vignettes and examples will illustrate each presentation. Theoretical and practical implications of ethnopsychopharmacology and its place in the treatment of ethnic minority patients will be discussed.

It is important that the clinician take into account the individual's ethnic and cultural context in the evaluation of each *DSM-IV* axis. Dr. Mezzich will discuss the use of the *DSM-IV* cultural formulation to enhance comprehensive treatment for minorities. The cultural formulation is meant to supplement the multiaxial diagnostic assessment and to address difficulties encountered in applying *DSM-IV* criteria in a multicultural environment. The cultural formulation reviews the individual's cultural background, the role of the cultural context in the expression and evaluation of symptoms and dysfunction, and

the effect of cultural differences on the relationship between the individual and the clinician. The clinician should provide a narrative summary for (a) cultural identity of the individual, (b) cultural explanations for the individual's illness, (c) cultural factors relating to psychosocial environment and functioning, (d) cultural elements of the relationship between the individual and the clinician, and (e) overall cultural assessment for diagnosis and care.

Drs. Lu and Lim will demonstrate the application of the *DSM-IV* outline for cultural formulation in clinical assessment and treatment planning for Asian-Americans. Specific issues will include (a) ethnic identity as one aspect of cultural identity; (b) the heterogeneity of ethnic identities within the Asian-American category; (c) culture-bound syndromes, explanatory models, and help-seeking patterns associated with Asian-Americans; (d) the support provided by family and religion and the stress of migration; and (e) interpersonal dynamics between clinician and patient in the clinical encounter. Transference and countertransference issues across ethnic identities, as well as the use of interpreters, will be discussed. Treatment planning based on the cultural formulation will focus on devising the most appropriate care.

Dr. Samuelson will describe clinical experience with Northern Plains Indians. Cultural factors that influence multiaxial diagnostic formulations will be identified, and the role of these factors in clinical care will be emphasized.

Dr. Briones will discuss treatment approaches to psychiatric conditions in Latino patients. Recent literature has pointed out the danger of stereotyping Hispanics or overemphasizing the role of ethnicity (as opposed to socioeconomic status) in their underutilization of mental health services. How to address cultural issues in the treatment of Latino patients will be illustrated by a case of *mal de ojo* (evil eye) in which major family stresses found expression in a teenage girl's disturbed behavior. A resident psychiatrist worked hand in hand with a *curandera* (female spiritual healer) to effect a positive outcome. Sensitive, nonjudgmental treatment of culture-specific complaints of the Mexican-American community, such as *mal de ojo, susto* (fright sickness), *nervios* (nerves), and *brujeria* (witchcraft), will be discussed. The presentation will emphasize the need for a multiaxial diagnostic approach that separates cultural adaptational responses from more serious psychopathology (such as psychosis).

Dr. Clark will discuss diagnosis and treatment issues for African-American patients. Attention to special populations through inclusion of culture in diagnosis and treatment situations is now formalized in *DSM-IV*. Traditionally, the history and scientific, psychological, nosological, and anthropological information regarding people of African descent has been obscure. It is believed that the *DSM-IV* cultural formulation is a tool to mainstream such information. This presentation will outline cultural issues for people of African descent and will model application of this new tool.

Dr. Lin will discuss the theory and practice of ethnopsychopharmacology. The last decade has witnessed substantial progress in understanding ethnic differences and similarities in response to various psychotropics. Substantial pharmacokinetic differences between Asians and Caucasians receiving haloperidol, diazepam, and alprazolam have been consistently reported. Similar comparisons of tricyclic antidepressants have led to contradictory findings. Pharmacokinetic differences between African-Americans and Caucasians have been demonstrated with tricyclics and adinazolam but not with phenothiazines. Although several studies have suggested that Hispanics may be more sensitive than Anglos to tricyclics and neuroleptics, these observations have not yet been adequately examined. Ethnic differences in protein binding and in the pharmacodynamics of psychotropics have also been reported. The review of research findings will be followed by discussion of genetic factors and environmental elements (e.g., diet and exposure to enzyme inducers) that may contribute to such differences. Future research directions will be suggested.

REFERENCES:

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5. Lin KM, Poland RE, Nakasaki G (eds): *Psychopharmacology and Psychobiology of Ethnicity.* American Psychiatric Press, Washington, DC, 1993.

Half-Day Session 10 — Saturday, October 7, 1:30 p.m.-4:45 p.m.

PSYCHOGERIATRIC PERSPECTIVES

Marshal F. Folstein, M.D., *Psychiatrist-in-Chief, New England Medical Center, NEMC 1007, 750 Washington Street, Boston, MA 02111;* Benjamin Liptzin, M.D., Andrew Satlin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the epidemiology, diagnosis, pathology, treatment, and outcome of delirium, depression, and dementia in the elderly.

SUMMARY:

Dr. Liptzin will review aspects of delirium, which is an important condition in general hospital psychiatry. The *DSM-IV* criteria for delirium represent minor changes. Other issues to be covered include incidence and prevalence, risk factors, etiologies, course, and outcomes. Possible pathophysiologic mechanisms will be discussed, and recommendations for the management of patients with delirium will be made.

Dr. Satlin will discuss the epidemiology, clinical evaluation, differential diagnosis, and risk factors for depression in elderly patients. Data on the prognosis and morbidity associated with this condition will be presented. The pharmacologic/somatic treatment of depression in the elderly will also be discussed. Topics will include general pharmacokinetic and pharmacodynamic considerations in selecting an appropriate medication, the effects of other pathologic conditions and medication interactions, the cardiovascular effects of antidepressant agents, and general guidelines and research regarding the use of different pharmacologic classes of drugs, including tricyclic antidepressants, monoamine oxidase inhibitors, selective serotonin reuptake inhibitors, bupropion, venlafaxine, psychostimulants, and augmentation strategies. Electroconvulsive therapy will also be discussed.

Dr. Folstein will discuss dementia in the elderly. Dementia is a syndrome characterized by a deterioration of multiple cognitive functions in clear consciousness. Six percent of the population over 65 years of age are affected by dementia syndromes. Dementia is caused by many pathological conditions, but the three most common are Alzheimer's disease, multi-infarct disease, and mixed-type diseases. Alzheimer's disease is a clinically, pathologically, and etiologically heterogeneous condition that can now be classified into five variants corresponding to genetic defects in chromosomes 14, 19, and 21. A substantial proportion of cases are still of unknown etiology, and environmental factors, including low education, head trauma, and the use of nonsteroidal anti-inflammatory drugs and estrogens, are being investigated. The treatment of dementias requires the management of noncognitive symptoms, including depression, delusions, hallucinations, and behavior disorders. It is differentiated from lifelong cognition impairment, delirium, and focal cognitive defects.

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Half-Day Session 11 — Saturday, October 7 1:30 p.m.-4:45 p.m.

VIOLENCE, CRIMINALITY, AND SOCIETY

Robert T.M. Phillips, M.D. Ph.D., *Deputy Medical Director, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005;* Carl C. Bell, M.D., Donald H. Williams, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the effects of violence in the media on children and adolescents, identify differences between various acts of social violence, and discuss the complexity of the mental health needs of incarcerated persons.

SUMMARY:

We are a society that is infatuated with violence. Violence, which is romanticized in film and in the electronic and print media, has emerged as the most significant public health crisis in the United States. Children have become not only the victims of violence but also its fastest-growing segment of perpetrators.

This workshop will explore the effects of violence and explicitness in the media on children and adolescents, it will examine the numerous types of violence perpetrated in society, and it will address the significant mental health problems faced by people who are incarcerated for committing violent crimes.

Dr. Phillips will discuss the effects of violence and explicitness in the media on children and adolescents. Numerous studies have clearly established the relationship between actual exposure to violence and negative consequences in childhood development. This presentation will detail some of these recent findings and will examine the effects of free and gratuitous media exposure to violence in our society. Multiple video and audio examples will be presented.

Dr. Bell will highlight the numerous types of violence: individual versus mob, legitimate versus illegitimate, predatory versus interpersonal; hate crimes; drug-related violence; gang-related violence; violence in the brain injured; violence in the mentally ill; mass murder; serial killing; murder sprees; institutional violence; and lethal and nonlethal violence. In addition, he will identify the differing patterns of violence in African-Americans, Latinos, and whites. Finally, Dr. Bell will outline various strategies for addressing the complex nature of violence in society.

Dr. Williams will discuss the mentally ill in jails and prisons. His paper is part of an ongoing analysis of data from an epidemiologic survey of mental illness in the Michigan prison system. At the time of the survey, African-Americans made up 63% of the prison population. This survey was conducted in two waves. The first wave evaluated a random sample of prisoners by using the NIMH Diagnostic Interview Schedule. The second wave evaluated prisoners found to have psychiatric symptoms in the first wave. In the second wave the Structured Clinical Interview for DSM-III-R (SCID) was administered by a group of experienced psychiatrists and psychologists, most of whom were African-Americans. Findings on the prevalence of mental illness among prisoners in the higher security levels of prisons will be presented. The implications of these findings for assessment of dangerousness and criminality of prisoners in high-security settings will also be covered. The impact of racial and ethnic factors on how corrections staff address prisoner behavior in high-security settings will be discussed.

REFERENCES:

1. Baxyter et al: Current analysis of music videos. *J Broadcast Electron Media* 29:333-340, 1985.
2. Phillips RTM, Caplan CS: Administrative and staffing problems for psychiatric services in correctional and forensic settings. In Rosner R: *Principles and Practice of Forensic Psychiatry.* Chapman and Hall, New York, 1994.
3. Bell CC, Jenkins EJ: Violence prevention and intervention in juvenile detention and correctional facilities. *J Correctional Health Care* 2(1):17-38, 1995.
4. Hollinger PC, Offer D, Barter JT, et al: *Suicide and Homicide Among Adolescents.* Guilford Press, New York, 1994.

Half-Day Session 12 — Saturday, October 7 — 1:30 p.m.-4:45 p.m.

ISSUES IN PSYCHOTHERAPY

David G. Greenfeld, M.D., *Director of Graduate Education and Clinical Professor of Psychiatry, Department of Psychiatry, Yale University School of Medicine, Room 611, 25 Park Street, New Haven, CT 06519;* William H. Sledge, M.D., Howard C. Blue, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe how to approach such difficult psychotherapeutic issues as combining medication and psychotherapy, medication and treatment compliance, and racial and ethnic transference and countertransference.

SUMMARY:

The presenters will address some problems inherent in psychotherapy with specific populations. Drs. Sledge and Greenfeld will address issues that characterize work with psychotic patients, and Dr. Blue will focus on ethnocultural differences and their effect on psychotherapeutic work. The presentations will explore new approaches to issues that commonly interfere with successful work with these populations.

REFERENCES:

1. Greenfeld D (ed): Psychotherapy of Various Disorders. *New Dir Ment Health Serv* 55, 1992.
2. Greenfeld D: *The Psychotic Patient: Medication and Psychotherapy.* Jason Aronson, Northvale, NJ, 1994.

Half-Day Session 13 - Multimedia Presentation — Saturday, October 7 — 1:30 p.m.-4:45 p.m.

INTERNET COMMUNICATIONS FOR MENTAL HEALTH PROFESSIONALS IN RESEARCH, TRAINING, AND CLINICAL CARE

Russell Lim, M.D., *Clinical Instructor, University of California at Los Angeles, Santa Monica West, 1525 Euclid Street, Santa Monica, CA 90404;* Charles Stinson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe (a) the Internet and World Wide Web and the types of communications possible now and in the near future, (b) InterPsych and how it facilitates exchange of information among mental health professionals worldwide, (c) the principles of World Wide Web "home pages" and how they can be used to obtain publicly available information about departments of psychiatry, and (d) the steps and equipment necessary for mental health professionals to connect to and use the Internet.

SUMMARY:

The Internet allows the exchange of most forms of data, including text and graphics, among geographically distant mental health clinicians, trainees, and researchers.

Connecting to and navigating the Internet has historically required the use of complex and cryptic line commands. The recent development of graphical interfaces to the Internet has made access to its resources much easier. The presenters will describe and demonstrate the Internet and hypertext browsers such as Mosaic, which allows clinicians to use a mouse pointing device to quickly locate and retrieve information from a remote user.

The presentation will also include description and demonstration of InterPsych, a rapidly emerging international effort

that is helping to organize psychiatric and psychological information resources, including information relevant to psychiatry residency training programs, such as descriptions of sites, research, and curricular materials.

REFERENCES:

1. Elmer-Dewitt P: Battle for the soul of the Internet. *Time,* July 25, 1994, pp 5-6.
2. Engst AC: *Internet Starter Kit for the MacIntosh.* Hayden Books, Indianapolis, 1993.
3. Hafner K: Making sense of the Internet. *Newsweek,* October 24, 1994, pp 46-48.
4. Kantrowitz B, Rodgers E, Tanaka J: Oh, what a tangled web. *Newsweek,* October 31, 1994, p 60.
5. Krol E: *The Whole Internet: User's Guide and Catalog.* O'Reilly and Associates, Sebastapol, CA, 1993.

Half-Day Session 14 — Sunday, October 8 8:30 a.m.-11:45 a.m.

ADMINISTRATIVE PSYCHIATRY

John A. Talbott, M.D., *Professor and Chairman of Psychiatry, University of Maryland School of Medicine, 645 West Redwood Street, Baltimore, MD 21201-1542;* David R. McDuff, M.D., Miles F. Shore, M.D., Jose M. Santiago, M.D., Steven S. Sharfstein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to outline current issues in psychiatric administration.

SUMMARY:

Organized psychiatric services and managed care will be described in terms of historical backgrounds and essential organizational features, such as governance, staffing, and financing. The discussion will also cover the current market for mental health care; changes include efforts to contain costs, growth in prospective payment and capitation, integrated service delivery networks, and downsizing of hospitals and growth of alternative care. The process of planning will be described: not as an exercise in abstraction, but as gathering data about a problem, devising a feasible solution, and figuring out how to make it happen. Discussion of implementation and systems will follow; an implementation process lists the participants and delineates the procedures for change, and it constantly adapts and adjusts.

Dr. McDuff will describe organized psychiatric service systems. Individuals with mental illness receive services in a variety of clinical settings. Services occur in primary care physicians and social service agencies within the general medical sector and by specialty sector providers within organized service systems. Within the specialty mental health sector nearly 75% of patient care episodes occur in three organized psychiatric service systems: general hospitals, community mental health centers, and psychiatric hospitals. These three systems differ greatly in their historical backgrounds and essential organizational features, such as governance, staffing, and financing. On the basis of the level of governance (federal, state/local, and private), the specialty sector service systems have responded differently to the development of managed systems of care. The impact of managed care on specialty sector programs will be reviewed.

Dr. Sharfstein will discuss the market for mental health care as it is affected by the new rules of reimbursement and new delivery systems. Efforts to contain costs in managed care are transforming the market for mental health care in the United States. Prospective payment and capitation redefine the incentives for clinicians and organized systems of care in the delivery of mental health and substance abuse services. Integrated service delivery networks in the private sector resemble community mental health centers in the public sector. The downsizing of hospitals is continuing, and the growth of alternative care in the continuum is expanding. Residential group homes, day treatment, and home visits are increasingly part of a redesigned system of care. Fee for service continues in a market of its own, even with less availability of private third-party insurance, but there remains a demand for psychotherapy that is private and efficient.

Although it is easy for harried administrators to dismiss planning as an exercise in abstraction, it is hard to imagine launching any new program without planning--gathering data about a problem, devising a feasible solution, and figuring out how to make it happen. Dr. Shore will present the essentials of successful planning: (a) establishing the relationship of the proposed project to the values and goals of the organization; (b) assembling the basic data about needs and resources; (c) estimating demand; (d) defining the market niche to avoid duplication; (e) establishing performance indicators as a basis for program evaluation, including quality, productivity, cost, outcomes, and consumer satisfaction; (f) identifying those who have a significant stake in the outcome; and (g) achieving consensus about the plan among individuals or groups essential to implementation. Examples will illustrate the process of planning as applied to a local program and to a statewide initiative.

Dr. Santiago will discuss implementation and systems. As a result of a process for improving care, a plan to design or redesign how care is delivered is submitted. Beyond establishing an implementation process that carefully lists the participants and delineates the procedures for change, an important task is constant adaptation and adjustment of the improvement plan to the conditions encountered in a particular area. Two major implementation efforts, one public and the other private, will be presented.

REFERENCES:

1. McDuff DR, Keill SL: Organized psychiatric service systems. In Talbott JA, Hales RE, Keill SL (eds): *Textbook of Administrative Psychiatry.* American Psychiatric Press, Washington, DC, 1992, pp 59-89.
2. Sharfstein SS, Goldman HH, Arana J: The market for mental health care: new rules of reimbursement and new delivery systems. In Talbott JA, Hales RE, Keill SL (eds): *Textbook of Administrative Psychiatry.* American Psychiatric Press, Washington, DC, 1992, pp 91-115.
3. Shore MF, Day SL, Bennett MB: Planning. In Talbott JA, Hales RE, Keill SL (eds): *Textbook of Administrative Psychiatry.* American Psychiatric Press, Washington, DC, 1992, pp 137-157.
4. Santiago JM, Beigel A: Implementation and systems. In Talbott JA, Hales RE, Keill SL (eds): *Textbook of Administrative Psychiatry.* American Psychiatric Press, Washington, DC, 1992, pp 159-178.

Half-Day Session 15 — Sunday, October 8, 8:30 a.m.-11:45 a.m.

ECT UPDATE: INDICATIONS AND PRACTICE

Max Fink, M.D., *Professor of Psychiatry and Neurology, State University of New York at Stony Brook, P.O. Box 457, St. James, NY 11780-0457;* Charles A. Welch, M.D., Anthony J. Bouckoms, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify patients for whom ECT is indicated, describe systemic risks and their management, identify changes in the administration of ECT, describe posttreatment continuation strategies, and discuss the place for ECT in managed care of the severely mentally ill.

SUMMARY:

ECT is changing rapidly. The indications have been broadened to encompass patients with delusional depression, mania, catatonia, neuroleptic malignant syndrome, and psychoses with a predominance of positive symptoms. ECT is safe and has no absolute contraindications. The risks have largely been overcome by the use of anesthetics, muscle relaxants, oxygenation, monitoring of cardiovascular and respiratory physiology, and pre- and posttreatment medications. We now seek to elicit "adequate" seizures by monitoring seizure duration, using individual electrode placements and energy dosing, and administering seizure-enhancing medications, such as caffeine.

A major criticism of ECT has been the relapse rate. Much attention has been paid to continuation treatment strategies, both medications and continuation ECT after a successful course of ECT. These changes in practice have occurred simultaneously with the expansion of managed care in medical practice. The relationships between these changes in skills and the demands of the marketplace will be discussed.

Dr. Fink will discuss ECT indications and practice. ECT was introduced for the treatment of dementia praecox. Early research showed its efficacy in the relief of affective disorders. Modern experience shows ECT to be effective for a wide range of severe mental disorders. To be considered for ECT, patients must be ill enough to warrant consideration for hospital care. Primary indications include suicidality and severe inanition. Secondary indications include major depressive or bipolar mood disorder, catatonia, schizophrenia, and schizoaffective disorders that have been unresponsive to two trials of medications. Research indications include parkinsonian syndromes, neuroleptic malignant syndrome, and severe obsessive-compulsive disorder. In the treatment of severe mental illnesses, other treatments usually continue for a minimum of 6 months and, after relapse, for years. ECT is the only treatment that is usually administered for 3-4 weeks and then suspended. Recent experience has shown the merits of continuing ECT in addition to continuing drug treatments.

Dr. Welch will discuss the risks of ECT and their management. The principal risks of ECT are fracture, panic and anxiety, cardiovascular events, prolonged seizures, and cognitive impairments. Death has become rare; the rate approximates the rate for delivery of infants. Fracture has become rare with the introduction of muscle relaxation during treatment. Panic before treatment is reduced by the use of sedative drugs and education before treatment. Agitation after treatment is managed by the use of benzodiazepines. Prolonged seizures are identified by EEG monitoring of seizure duration, and prolonged seizures are interrupted by intravenous diazepam or methohexital. Cognitive effects are modified by oxygenation and attention to electrode placement, energy above threshold, and number and frequency of treatments. Cardiovascular risks are reduced by detailed monitoring of blood pressure and heart rate and by ECG during the procedures. Cardiovascular effects are modified by the administration of beta blockers, ganglionic blockers, and other agents to modify immediate cardiovascular effects.

Dr. Bouckoms will present three questions that managed care has posed to ECT practitioners and those who care for the severely affectively disordered: (a) Who is the most likely to respond, and not to respond, to ECT? (b) How does one enhance the quality of care and patient satisfaction with or without ECT in the treatment of affective illness? (c) What organizational (and administrative) structure is best suited to the delivery of care? Either the psychiatric profession will answer these questions or they will be answered by someone else. The answers will likely come from non-physicians or others with no

experience with ECT or severely ill or affectively disordered patients. One solution is development of partnerships between dedicated small groups of practitioners and the managed care organizations wherein there is a conjoint mission with common objectives. Patient outcomes need to be considered in the managed care market. This presentation will focus on ECT in relation to response, outcomes, and organizational structure and will describe how ECT can be an optimal package of treatment that makes all parties winners.

REFERENCES:

1. Fink M: *Convulsive Therapy: Theory and Practice.* Raven Press, New York, 1979.
2. Abrams R: *Electroconvulsive Therapy.* Oxford University Press, New York, 1992.
3. American Psychiatric Association: *The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training, and Privileging.* American Psychiatric Association, Washington, DC, 1990.

Half-Day Session 16 — Sunday, October 8 8:30 a.m.-11:45 a.m.

MASSACHUSETTS PUBLIC MANAGED CARE: A WORK IN PROGRESS

Eileen Elias, M.Ed., *Commissioner, Massachusetts Department of Mental Health, 25 Staniford Street, Boston, MA 02114;* Curtis B. Flory III, M.B.A., M. Annette Hanson, M.D., Richard A. Hogarty, Ph.D., T. Scott Stroup, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the development of public managed care, the barriers to its implementation, and the impact of the changes.

SUMMARY:

The Massachusetts Department of Mental Health has embarked on a major restructuring initiative to create a system of public managed care. The basis of this restructuring initiative is the establishment of comprehensive community support systems. This workshop will explore public managed care and will highlight both its successes to date and the barriers and resistance that have impeded its implementation.

The presentation will begin with an overview of the general initiative, with an emphasis on steps taken to create an infrastructure to support public managed care. Next, a general review of the successes achieved to date and the political, administrative, and fiscal barriers encountered will be presented. The responses of families, consumers, and employees to the closing of a state hospital, the reactions of consumers to service system changes, and an analysis of the data on the impact of managed care and privatization will be included. For the last hour the presenters will be joined by core staff and will field questions from the audience.

Ms. Elias will describe the mission, values, and principles that have shaped the implementation of a public managed care system. Priorities include participation of consumers, families, providers, public officials, and academics in policy development and planning; consumer empowerment; protection of the local service systems; a range of services within a continuum of care; removal of cultural, linguistic, and financial barriers; and fostering of recovery through rehabilitation. The infrastructures created to support this major initiative, including quality and utilization management systems, will be discussed. The presentation will focus on the goal of reducing the time consumers spend in inpatient settings, which are the most restrictive, regressive, and expensive option. The efforts to use savings derived from the closing of state hospitals to increase community programming will also be described.

Dr. Hanson will discuss barriers to creating a system of public managed care. Implementing such a system requires attitude changes by consumers, family members, providers, clinicians, and policy makers. She will describe the fiscal, political, administrative, and policy barriers encountered in the early years of implementation, the resistance to the proposed changes, and strategies designed to manage both. Among the barriers were actions taken by other state agencies. An interagency conflict was created when the Division of Medical Assistance decided to seek a federal waiver to carve out mental health and substance abuse services for most Medicaid recipients and subcontracted this responsibility to a for-profit organization. Other resistance was based on consumers' and families' fear of losing their safety net and on employees' fear of losing jobs, power, and status. Dr. Hanson will explore some of the strategies developed to assist the affected stakeholders in managing both real and perceived loss.

Dr. Hogarty will discuss the closing of a state hospital as a part of the initiative to establish a system of public managed care. The closing was a complicated administrative, clinical, and political task with few research studies to guide policy makers. Dr. Hogarty was asked to review documents, talk to those affected, and prepare a case study and an analysis of such a closing. He will present a case study of the downsizing and closing over 2.5 years of Metropolitan State Hospital, a 400-bed urban hospital that employed 778 individuals and provided both acute and long-term care. The multiple challenges encountered in transferring patients while sustaining quality of care, working with unions and employees, and meeting family and community needs will be described.

Dr. Stroup will discuss the effects of variations among service areas on managed care and privatization. He will present data on the impact of managed care and privatization initiatives in Massachusetts between July 1991 and December

1994. Data are available for a year before the implementation of managed care, for a 6-month transition period, and for 2 years after implementation. Three areas of the state that differ in their organization of services will be highlighted. Comparisons between and within areas, for the pre- and post-intervention periods, will be made.

In general, these policy interventions had effects in the direction anticipated by policy makers, but the nature and the magnitude of the effects varied across service areas. Furthermore, some interventions designed to affect specific consumer populations had broad spillover effects on other groups. Implications for mental health systems and the evaluation of mental health system reforms will be discussed.

REFERENCES:

1. Leadholm BA, Kerzner JP: Public managed care: developing comprehensive community support systems in Massachusetts. *Managed Care Quality* 2:25-30, 1994.
2. England MJ, Goff VV: Healthcare reform and organized systems of care. *New Dir Ment Health Serv* 59:5-12, 1993.
3. Hogarty RA et al: *Public Higher Education in the Commonwealth: Turnabout Time,* in press.
4. Fisher WH, Dorwart RA, Schlesinger M, et al: The role of general hospitals in the privatization of inpatient treatment for serious mental illness. *Hosp Community Psychiatry* 43:1114-1119, 1992.
5. Dorwart RA, Epstein SS: *Privatization and Mental Health Care: A Fragile Balance.* Auburn House, Dover, MA, 1993.

Half-Day Session 17 — Sunday, October 8, 8:30 a.m.-11:45 a.m.

THE FEMALE PATIENT: SPECIAL CONSIDERATIONS ACROSS THE LIFE CYCLE

Leah J. Dickstein, M.D., *Professor, Associate Chair for Academic Affairs and Associate Dean for Faculty and Student Advocacy, University of Louisville, 550 South Jackson Street, Louisville, KY 40202;* Randy L. Gollub, M.D., Ph.D., Malkah T. Notman, M.D., Carolyn B. Robinowitz, M.D., Tana Grady, M.D., Carol C. Nadelson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss women's unique issues involving sex, work, minority status, reproduction, violence, and mental illness.

SUMMARY:

Although violence and abuse involving women, primarily as victims and survivors, have been the focus of increasing research and recognition in the past 2 decades, the majority of women patients, regardless of presenting symptoms and signs, are not asked in appropriate ways about such personal experiences by all their physicians and other health care professionals. Among the important repercussions of such oversight may be nonresponse to therapy and perception of such women as chronic and difficult patients. Unique issues related to the diagnosis, treatment, and outcome of mental illness in women are often unknown by health professionals.

Dr. Gollub will discuss sexual issues in women's lives.

Dr. Notman will describe how the reproductive part of the life cycle offers women particular opportunities for growth and development but also creates periods of vulnerability. These will be reviewed with reference to (a) menstruation, (b) pregnancy and the postpartum period, and (c) menopause. Current views, major disorders, and treatment strategies will be described.

Dr. Robinowitz will discuss women and work. Women have been entering the workforce at ever-increasing rates, but this increase has not been reflected by an increase in female leaders or by greater pay equity. Many of the women in the workforce are thwarted by glass ceilings, and others are in survival situations, mainly hoping to maintain themselves and their families. The working woman still faces a number of issues not affecting men. This presentation will address developmental issues for women in relation to work, e.g., independence and autonomy; ways of learning, working, and interacting; "girl-friendly" classrooms and workplaces; and sexual harassment. There will be a subfocus on issues for female psychiatrists, involving both career development and provision of care.

Dr. Grady will relate women's issues to those of minorities.

Dr. Dickstein will describe how clinicians can better appreciate the unique sexual, reproductive, minority, and work issues of women, in addition to violence, abuse, and mental illness. The importance of including these issues as part of every woman patient's initial medical history will become obvious as experts share research findings and clinical experiences involving women patients. The implications of failure to ask about these areas will also be highlighted. Experiences in these areas can be interrelated, and professionals should be alert to possible hidden issues that must be further explored.

REFERENCES:

1. Dickstein LJ, Nadelson CC (eds): *Family Violence.* American Psychiatric Press, Washington, DC, 1989.
2. Notman MT, Klein R, Jordan JV, et al: Women's unique development issues across the life cycle. In Tasman A, Goldfinger SM (eds): *American Psychiatric Press Annual Review of Psychiatry,* vol 10. American Psychiatric Press, Washington, DC, 1991, pp 556-577.
3. Yamamoto J, Silva JA, Justice LR, et al: Cross-cultural psychotherapy. In Gaw AC (ed): *Culture, Ethnicity, and Mental Illness.* American Psychiatric Press, Washington, DC, 1993, pp 101-124.

HALF-DAY SESSIONS

Half-Day Session 18 — Sunday, October 8, 1:30 p.m.-4:45 p.m.

BRIEF PSYCHODYNAMIC INSIGHT PSYCHOTHERAPY: ITS NATURE AND THERAPEUTIC INDICATIONS

John C. Nemiah, M.D., *Professor of Psychiatry, Dartmouth Medical School, 1 Medical Center, Lebanon, NH 03756;* Peter E. Sifneos, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the theoretical model underlying brief dynamic insight psychotherapy, its goals and basic procedures, and the criteria for the appropriate selection of patients for its application.

SUMMARY:

The program is planned as a half-day session presented jointly by Drs. Nemiah and Sifneos. There will be no formal papers by the two program participants. The primary focus will be on the viewing of extensive segments from videotapes of clinical interviews designed to demonstrate the aspects of brief psychodynamic psychotherapy noted in the "Educational Objective" above. The two presenters will (a) provide brief comments throughout the session aimed at linking the segments of the taped material together in a systematic and coordinated presentation and (b) serve as facilitators of continuous audience participation throughout the session.

REFERENCE:

1. Sifneos P, Nemiah J: Assessing the suitability of patients with character disorders for insight psychotherapy. In Zales M (ed): *Character Pathology, Theory and Treatment.* Brunner/Mazel, New York, 1984, pp 119-139.

Half-Day Session 19 — Sunday, October 8, 1:30 p.m.-4:45 p.m.

THE WAY TO WORK: ASSERTIVE COMMUNITY TREATMENT AS VOCATIONAL REHABILITATION

William R. McFarlane, M.D., *Chief, Department of Psychiatry, Maine Medical Center, 22 Bramhall Street, Portland, ME 04102;* Mary Ann Test, Ph.D., Robert E. Drake, Jr., M.D., Gary Bond, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe (a) the means by which assertive community treatment fosters increased competitive and other forms of employment for persons with severe mental illness, (b) the evidence that this method is more effective than several traditional approaches, and (c) the different methods by which these results are achieved.

SUMMARY:

Assertive community treatment for schizophrenia and other psychotic disorders has been in use in the United States for over 20 years. During that time it has been applied in many states and in a recent series of NIMH-sponsored research demonstration studies, with nearly universally positive clinical outcomes, especially in hospitalization rates and severity and duration of symptoms.

Only recently has there been evidence that adaptations of assertive community treatment hold promise for vocational rehabilitation. In the past there was some evidence that by putting the clinician in the community, side by side with the person being treated, much more focused intervention could occur in and around potential and actual workplaces. This has now been shown to be one of the crucial elements that allow persons with major mental illness to find and hold competitive jobs.

The presentations in this session will describe new and highly consistent evidence that assertive community treatment is a reliable method, and to date the only one, for achieving truly competitive employment. The discussion will focus on important differences among the presenters' approaches.

Dr. Test will report findings from a prospective controlled study of long-term community treatment of young adults with schizophrenic disorders. The 122 study clients were a difficult-to-treat group; many had substance use disorders. They were randomly assigned to assertive community treatment or to the usual system of care in Dane County, Wisconsin. The treatment of the control subjects was very good but was less assertive, intensive, and continuous. The clients receiving assertive community treatment had remarkably sustained community tenure that was significantly more favorable than that of the control subjects. They spent significantly more time in normative work over the first 2 years. The late-entry clients receiving assertive community treatment received an intensive supported employment intervention. They showed significantly more favorable work outcomes during years 6 and 7 than did early-entry clients in the same treatment group or early- or late-entry control subjects. The discussion will include client perspectives on assertive community treatment.

Dr. Drake will describe the New Hampshire Study of Supported Employment for People with Severe Mental Illness. Supported employment services in a best-practice exemplar of the traditional vocational rehabilitation vendor model were compared with services in a system in which mental health and vocational services were integrated. People with severe mental disorders who expressed interest in competitive employment (N = 143) were randomly assigned to two programs: (a) group skills training, which included preemployment skills training and support in obtaining and maintaining jobs from a professional rehabilitation agency outside the mental health center, and (b) individual placement and support, an integrated program in which employment specialists were attached directly to clinical teams. Subjects receiving individual placement and support obtained jobs faster and were statistically more likely to

be competitively employed throughout most of the 18-month follow-up. These findings support the integration of vocational and clinical services at the program level rather than in the traditional vocational rehabilitation vendor model.

Dr. McFarlane will report a trial of a new type of vocational rehabilitation for severely mentally ill patients: family-aided assertive community treatment, which combines key elements of assertive community treatment and psychoeducational multifamily groups. The trial compared vocational outcomes of the new approach with those of conventional vocational rehabilitation. Sixty-nine stabilized but unemployed patients with schizophrenia, schizoaffective disorder, bipolar disorder, or major depression were matched, randomly assigned to the two treatment conditions, treated and rehabilitated, and assessed over 18 months. The study was conducted at two community mental health centers with excellent conventional vocational rehabilitation services. After 12 months, more patients receiving family-aided assertive community treatment than those receiving conventional rehabilitation were vocationally active (60% versus 32%, $p < 0.05$). Differences in rates of competitive employment were large at 12 months (35% versus 3%, $p < 0.05$) and 18 months (26% versus 4%, $p < 0.05$). Rates of employment of all types showed a trend-level difference (55% versus 44%) at 18 months. These results demonstrate the superiority of family-aided assertive community treatment.

Dr. Bond will report preliminary findings from an experimental evaluation of a supported employment model known as individual placement and support, developed by Becker and Drake. Individual placement and support is being compared with an enhanced service system in which mental health services are linked with vocational services through the state vocational rehabilitation office to provide rehabilitation agencies, called vendors. This study is taking place within a mental health program that serves adults who are predominantly African-American, formerly homeless, and dually diagnosed with major mental illness and substance use disorders. Each participant in the comparison condition is referred to a vendor on the basis of an individualized assessment. The vendors range from a psychiatric rehabilitation agency to a clubhouse model, but they all focus on competitive employment. Preliminary vocational outcomes are dramatic. Of the first 100 consumers in the study, 46% of those receiving individual placement and support obtained competitive employment, compared to just 2% of those assigned to vendors.

REFERENCES:

1. Test MA: Training in community living. In Liberman RP (ed): *Handbook of Psychiatric Rehabilitation.* Macmillan, New York, 1992.
2. Becker DR, Drake RE: Individual Placement and Support--a community mental health center approach to vocational rehabilitation. *Community Ment Health J* 30:193-206, 1994.
3. McFarlane WR et al: Family-aided assertive community treatment. In Liberman RP (ed): *Effective Psychiatric Rehabilitation.* Jossey-Bass, San Francisco, 1992, pp 43-54.

Half-Day Session 20 — Sunday, October 8 1:30 p.m.-4:45 p.m.

PTSD: CURRENT BIOLOGICAL AND BEHAVIORAL PERSPECTIVES

Arthur T. Meyerson, M.D., *Professor, Vice-Chairman, and Clinical Director, University of Medicine and Dentistry of New Jersey, Community Mental Health Center, 215 South Orange Avenue, Newark, NJ 07103;* J. Douglas Bremner, M.D., Gary S. Aston-Jones, Ph.D., Jonathan R.T. Davidson, M.D., Penny K. Randall, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to (a) discuss current issues in the diagnosis and biology of PTSD, including neurotransmitter systems and basic brain mechanisms, and (b) describe recent findings on outcome of treatment of the condition and the biological implications of pharmacological studies.

SUMMARY:

The papers in this symposium will focus on bringing the attendees up to date on the current literature relevant to basic brain mechanisms associated with PTSD, including brainstem, cortical, neurotransmitter, and sympathetic nervous system research. Current findings from psychopharmacological studies will be summarized and presented, and clinical and biological implications will be discussed. Recently described clinical concomitants, including memory deficits and dissociative states, and a human model of PTSD with potential for prospective study of biological and psychological variables will also be discussed. A prospective clinical research model of PTSD will be presented as well.

Preclinical studies suggest that extreme stress is associated with long-term changes in brain structures involving memory, such as the hippocampus, and with impaired memory function. Dr. Bremner will discuss clinical studies of memory in PTSD. Vietnam veterans with histories of exposure to combat and the diagnosis of PTSD underwent neuropsychological tests of memory and magnetic resonance imaging measurement of the hippocampus. There was no difference in prorated full-scale WAIS-R IQ between PTSD patients ($N = 26$) and matched control subjects ($N = 15$). PTSD patients scored significantly lower on the Wechsler Memory Scale logical (verbal) memory measures for immediate recall (mean = 11.6, SD = 3.3, versus mean = 20.9, SD = 6.6) and delayed recall (mean = 8.0, SD = 3.3, versus mean = 17.8, SD = 6.4). The results of

hippocampus measurements will be presented. Similar studies of adult survivors of childhood physical and sexual abuse are currently in progress, as are studies of memory and cerebral metabolism after administration of the noradrenergic alpha-2 antagonist yohimbine to patients with combat-related PTSD.

Dr. Aston-Jones will discuss the locus ceruleus as it relates to stress and attention. Previous work indicates that locus ceruleus neurons are activated by physiological or cognitive stressors. Recent experiments by Valentino et al. have demonstrated that corticotropin-releasing factor is a neurotransmitter in the locus ceruleus. Moreover, this peptide is directly responsible for activation of locus ceruleus neurons by certain physiological stressors. Other transmitters (e.g., glutamate) mediate locus ceruleus activation by other stressors, suggesting a stress-transmitter code in afferents to the locus ceruleus. In awake monkeys, locus ceruleus cells are physically activated by attended stimuli. In addition, changes in the level of tonic locus ceruleus activity are closely but inversely correlated with focused attentiveness in a continuous performance task, indicating that tonically elevated locus ceruleus activity in response to immediate or remembered stressors leads to high distractibility and inability to filter or differentiate salient from irrelevant sensory events. This hypothesis is consistent with the behavioral symptoms of stress-related disorders, such as PTSD, that are associated with hyperactivity in the locus ceruleus system. Finally, recent findings indicate that the major afferent to the locus ceruleus is the nucleus pargigantocellularis in the rostral ventrolateral medulla. The prominent role of the pargigantocellularis in sympathoexcitation and the prominent effects of stress on this autonomic function lead us to propose that stress disorders may coordinately affect the locus ceruleus and sympathetic systems by dysregulation of the pargigantocellularis. Neurotransmitters involved in these circuits and mechanisms, as well as implications for the pharmacology of stress disorders, will be discussed.

Dr. Davidson will discuss pharmacotherapy for PTSD. There has been growing interest in such treatment. The accumulated data raise important questions of interpretation and allow identification of currently unstudied issues. Questions of interpretation involve characteristics of the sampling, dose of drug, type of drug, length of treatment, nature of the response, prediction of outcome, and choice of rating scales. Several areas remain uninvestigated: studies of pharmacokinetics and dose ranging, investigation of maintenance and relapse, comparison of combinations of pharmacotherapy and psychotherapy, and comparison of active drugs.

Dr. Randall will discuss clinical research on PTSD and $GABA_A$ receptors. Evidence from preclinical and clinical studies suggests that abnormalities in the benzodiazepine/$GABA_A$ receptor complex are involved in stress and anxiety. Dr. Randall will describe the effect of the benzodiazepine receptor antagonist flumazenil, which has been shown to be panicogenic in patients with panic disorder but not in control subjects, on Vietnam combat veterans with PTSD. Flumazenil, 2 mg i.v., or placebo was administered in a double-blind crossover design. There was no significant difference in effect on PTSD and anxiety symptoms between flumazenil and placebo. Panic attacks occurred with equal frequencies after flumazenil and placebo. It was concluded that administration of the benzodiazepine/$GABA_A$ antagonist flumazenil does not produce an increase in anxiety and PTSD symptoms in patients with PTSD.

Dr. Meyerson will present two pilot studies of a psychoiatrogenic model of PTSD. In the first, psychiatric inpatients who experienced major stress as part of their hospitalizations were assessed for the development of PTSD by using both standard psychological instruments and physiological assessments (described by Murburg et al.). Patients were assessed for PTSD on admission, at discharge, and at follow-up. The second study involved outpatients who had experienced similar stress during recent hospitalizations; they were also evaluated according to psychological and biological criteria. The model allowed for the study of vulnerability factors, and pilot data will be presented on these as well. It was found that patients may experience stress sufficient to bring about PTSD under the following conditions: involuntary hospitalization, seclusion for extended periods, restraints for extended periods (physical or by staff), involuntary medication, physical violence or threats of physical violence, sexual assault or threats of sexual assault, and side effects of medication.

REFERENCES:

1. Bremner JD, Scott TM, Delaney RC, et al: Deficits in short-term memory in posttraumatic stress disorder. *Am J Psychiatry* 150:1015-1019, 1993.
2. Aston-Jones G, Valentino RJ, Van Bockstaele E, et al: Nucleus locus coeruleus and post-traumatic stress disorder: neurobiological and clinical parallels. In Murburg MM (ed): *Catecholamine Function in Posttraumatic Stress Disorder: Emerging Concepts.* American Psychiatric Press, Washington, DC, 1994.
3. Davidson JR, Kudler HS, Saunders WB, et al: Predicting response to amitriptyline in posttraumatic stress disorder. *Am J Psychiatry* 150:1024-1029, 1993.
4. Randall P, Bremner JD, Krystal J, et al: *Lack of Anxiogenic Effects of Flumazenil in PTSD.* National Center for PTSD, West Haven VA Medical Center and Department of Psychiatry, Yale University School of Medicine, West Haven, CT.
5. Davidson JR, Foa EB: Diagnostic issues in PTSD: consideration for DSM-IV. *J Abnorm Psychol* 100:346-355, 1991.

HALF-DAY SESSIONS

Half-Day Session 21 — Sunday, October 8, 1:30 p.m.-4:45 p.m.

CLINICAL UPDATE IN CHILD AND ADOLESCENT PSYCHIATRY

Sharon R. Weinstein, M.D., *Instructor in Psychiatry, Harvard Medical School;* Timothy E. Wilens, M.D., Douglas R. Robbins, M.D., Daniel A. Geller, M.D., Bruce M. Meltzer, M.D., Maria C. Sauzier, M.D., Charles W. Popper, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to delineate salient features in the differential diagnoses and presentations of attention deficit hyperactivity disorder, major depression, bipolar disorder, obsessive-compulsive disorder, posttraumatic stress disorder, and aggressive disorders in children and adolescents and compare these disorders to the same disorders in adults.

SUMMARY:

This session will be a clinical update in the field of child and adolescent psychiatry, with attention to the diagnostic categories of attention deficit hyperactivity disorder (ADHD), major depression, bipolar disorder, obsessive-compulsive disorder, posttraumatic stress disorder, and aggressive disorders. The presenters will discuss the differential diagnoses, clinical presentations, and evaluation and treatment of these syndromes. Distinctions will be made between the presentations of these disorders in children and those in adults.

Dr. Wilens will discuss the diagnosis, characterization, and treatment of ADHD in children and adolescents. ADHD, a prevalent, heterogeneous disorder estimated to affect 2-9% of school-age children, persists into adulthood in 10-60% of cases. Although its precise etiology is unknown, family, adoption, and twin studies and segregation analysis have indicated that genetic risk factors may be operant in this disorder. High rates of anxiety and depressive disorders in addition to conduct and oppositional disorders have been found in children and adolescents with ADHD. Recent research has shown that girls with ADHD have higher rates of familiality than do boys and have profiles of specific comorbid disorders that are different from those of boys. The treatment of ADHD largely relies on medications. Psychostimulants, shown effective in over 100 controlled studies, remain the mainstay for the treatment of ADHD. Tricyclic and atypical antidepressants, also shown to be effective in controlled studies, are considered second-line treatments. Antihypertensives are also useful in the treatment of ADHD, but they are less well studied than antidepressants.

Dr. Robbins will discuss recent research on major depression and bipolar disorder in children and adolescents, including studies of antidepressant medications (selective serotonin reuptake inhibitors), psychosocial treatment (cognitive-behavioral treatment, interpersonal psychotherapy), and maintenance treatments. Clinical difficulties in the diagnosis of these disorders in prepubertal children and adolescents will be discussed.

REFERENCE:

1. Barkley RA: *Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment.* Guilford Press, New York, 1990.

Half-Day Session 22 — Sunday, October 8, 1:30 p.m.-4:45 p.m.

RACE, ETHNICITY, AND PSYCHIATRIC SERVICES

Robert T.M. Phillips, M.D. Ph.D., *Deputy Medical Director, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005;* Chester M. Pierce, M.D., Sc.D., Ezra E.H. Griffith, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the important roles of race and ethnicity in the therapeutic encounter and describe strategies for improving the cultural competence of psychiatric service delivery.

SUMMARY:

How one responds to being different from others and what it means are issues rarely given attention in clinical training. Experiences related to racial and ethnic differences can cause patients and practitioners to develop negative, ambivalent, or confused perceptions, feelings, and attitudes about themselves and others. This session will address the need for attention to these issues and will focus on what patients and practitioners bring to the cross-cultural treatment encounter.

Dr. Phillips will discuss racism in the United States. Within the world of psychiatric service delivery, racism influences clinical decision making. Racial disparity across ethnic groups will be considered, with particular focus on juveniles, adolescents, and the criminal justice system.

Dr. Pierce will discuss cross-racial therapy. The presentation will begin with an overview of the importance of the topic in the coming decade. Then racism as a critical object in cross-racial interactions will be considered. Next will follow a discussion of the special problems of white and black therapists in their work with patients of different races. Finally, treatment approaches based on the areas of the presentation will be provided for persons employed in heteroracial practices.

Dr. Griffith will discuss forensic and policy implications of the debate on transracial adoption. The adoption of black children by white families continues to provoke heated discussion. There is still considerable disagreement about whether the

integrity of a given family unit is best consolidated by following tradition and ensuring that the family has a single racial identity. The subject evokes such passion that scholarly attempts to explore the issue have largely been ignored. In addition, although forensic and child psychiatrists and other mental health professionals are often asked for their views, their testimony often does not reflect the accumulated knowledge or the application of scientific principles, and many mental health professionals are unaware of their own views about whether families should be racially homogeneous. The presentation will review developments in the continuing debate, highlighting the latest research findings, the status of laws governing transracial adoption, and recent political efforts that seek to modify the present policy. Such knowledge is a prerequisite to formulating a solid forensic opinion on this issue.

REFERENCES:

1. Pinderhughes E: *Understanding Race, Ethnicity, and Power.* Free Press, New York, 1989.
2. Locke DC: *Increasing Multicultural Understanding.* Sage Publications, Thousand Oaks, CA, 1992.
3. Twemlow SW: DSM-IV from a cross-cultural perspective. *Psychiatr Ann* 25:46-52, 1995.

Half-Day Session 23 — Monday, October 9, 8:30 a.m.-11:45 a.m.

PRESENTING *DSM-IV*

Michael B. First, M.D., *Research Psychiatrist, New York State Psychiatric Institute, 722 West 168th Street, New York, NY 10032-2603;* Harold Alan Pincus, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the 5-year process of developing *DSM-IV,* outline the major changes in each section of the manual, discuss why these revisions were made, and identify possible effects of these changes on clinical and research practices.

SUMMARY:

In this session Dr. Pincus will begin with an overview of the general concepts underlying *DSM-IV* and the three-stage empirical process used for its development. His presentation will include the definition of mental disorder, caveats regarding the use of *DSM-IV,* and the phenomenological/prototypical approach to diagnosis. In addition, system changes, including increasing the attention to differential diagnosis, improving clinical utility, and increasing the focus on development and cultural issues, will be described.

Dr. First will then summarize the changes in each *DSM-IV* section and will detail important differences from *DSM-III-R.* He will emphasize new features, such as the text sections that address culture, age, and gender.

Other innovations in *DSM-IV* will be discussed, with attention to the implications for clinical and research practices. The presentation will end with a discussion of the future of the *DSM* system.

REFERENCES:

1. First MB, Frances AJ, Pincus HA, et al: DSM-IV in progress: changes in substance-related, schizophrenic, and other primarily adult disorders. *Hosp Community Psychiatry* 45:18-20, 1994.
2. First MB, Vettorello N, Frances AJ, et al: DSM-IV in progress: changes in mood, anxiety, and personality disorders. *Hosp Community Psychiatry* 44:1034-1036, 1993.
3. Frances AJ, First MB, Pincus HA, et al: DSM-IV in progress: changes in child and adolescent disorders, eating disorders, and the multiaxial system. *Hosp Community Psychiatry* 45:212-214, 1994.

Half-Day Session 24 — Monday, October 9, 8:30 a.m.-11:45 a.m.

APA PRACTICE GUIDELINE FOR SCHIZOPHRENIA

Marvin I. Herz, M.D., *Professor of Psychiatry, University of Rochester, 300 Crittenden Boulevard, Rochester, NY 14642-1018;* Stephen R. Marder, M.D., Richard Jed Wyatt, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the recommendations contained in the current draft of the *APA Practice Guideline for Treatment of Patients with Schizophrenia.*

SUMMARY:

The APA Work Group on Schizophrenia has prepared a draft of the guideline. Work group members include Marvin I. Herz, M.D., chairperson; Robert P. Liberman, M.D.; Jeffrey A. Lieberman, M.D.; Stephen R. Marder, M.D.; Thomas H. McGlashan, M.D.; and Richard Jed Wyatt, M.D. The recommendations are based as much as possible on the results of controlled studies where applicable. The guidelines are based on what the work group members consider to be optimal treatment, with recognition that adequate resources may not be available in some communities. Key recommendations for the treatment of individuals with schizophrenia will be presented. Participants will learn about psychotherapeutic, psychosocial, and psychopharmacological treatments, as well as community care and rehabilitative programs, contained in the draft

recommendations and will have an opportunity to share their views with the presenters. The draft will be revised after it is reviewed by consultants and relevant APA components.

Dr. Wyatt will briefly review the recommendations regarding patient assessment, patient features that affect treatment decisions during the first episode, special considerations for patients with concurrent medical disorders, and the use of ECT. The attendees will be given considerable opportunity to make suggestions and raise questions.

Dr. Marder will provide an overview of the recommendations regarding pharmacotherapy. Issues that may be discussed include treatment of acute schizophrenia, drug selection, evaluation of drug response, management of refractory cases, and long-term maintenance treatment. After the overview there will be an opportunity for questions and comments from the attendees.

Dr. Herz will describe the recommendations for psychosocial and rehabilitative treatments. The interventions include individual, group, and family psychoeducation and treatment; monitoring for prodromal symptoms and early intervention to prevent relapse; assertive community treatment; behavioral approaches (e.g., social skills training, cognitive remediation); vocational rehabilitation; and other relevant components of a comprehensive treatment approach.

REFERENCES:

1. Wyatt RJ: *Practical Psychiatric Practice: Clinical Interview Forms, Rating Scales, and Patient Handouts.* American Psychiatric Press, Washington, DC, 1994.
2. Marder SR, Van Putten T: Antipsychotic medications. In Schatzberg AF, Nemeroff CB (eds): *The American Psychiatric Press Textbook of Psychopharmacology.* American Psychiatric Press, Washington, DC, 1995, pp 435-456.
3. Nasrallah HA, Herz MI, Keith SJ, et al (eds): *Psychosocial Treatment of Schizophrenia,* Handbook of Schizophrenia, vol 4. Elsevier, New York, 1990.

Half-Day Session 25 — Monday, October 9, 1:30 p.m.-4:45 p.m.

REVIEW OF APA PRACTICE GUIDELINES

John S. McIntyre, M.D., *Chair, APA Steering Committee on Practice Guidelines, Suite 210, 919 Westfall Road, Rochester, NY 14618-2670;* Deborah A. Zarin, M.D., Robert M.A. Hirschfeld, M.D., Steven M. Mirin, M.D., Deborah I. Blacker, M.D., Sc.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the broad array of issues relating to practice guidelines, including content, overall development procedures, dissemination and evaluation strategies, future topics, and implications for the field.

SUMMARY:

The APA practice guidelines project has moved forward according to a previously approved process designed to result in documents that are both scientifically sound and clinically useful to practicing psychiatrists. On the basis of nationally recognized standards for the development of practice guidelines (sometimes termed "practice parameters"), APA guidelines reflect (a) comprehensive literature reviews; (b) classification of supporting evidence and the nature of the recommendations; and (c) a series of revisions based on input from the Steering Committee, individual work groups, the Assembly, the Board of Trustees, the Joint Reference Committee, related APA components, psychiatric consultants, nonpsychiatrist experts, and representatives from related organizations.

This session will explore the treatment recommendations contained in practice guidelines on bipolar disorder, substance use disorders, and Alzheimer's and related dementias. Persons attending the session will be invited to comment on the broad array of issues relating to practice guidelines, including content, overall development procedures, dissemination and evaluation strategies, future topics, and implications for the field.

Dr. McIntyre will present an overview of APA's practice guideline project. Practice guidelines are systematically developed documents in a standardized format that present patient care strategies for psychiatrists. APA's practice guidelines are developed according to nationally recognized standards. The project includes (a) initial drafting by a work group that includes psychiatrists with clinical and research expertise in the particular disorder, (b) a comprehensive literature review, (c) multiple drafts and widespread review involving over 600 individuals and approximately 100 related organizations, (d) approval by the APA Assembly and Board of Trustees, and (e) planned revisions every 3 to 5 years. Although guidelines may be used for many purposes, their expressly stated purpose is to assist psychiatrists in the care of patients. To date, APA has published three practice guidelines (eating disorders, major depressive disorder in adults, and bipolar disorder), has two more in press (substance use disorders, psychiatric evaluation of adults), and has six in development (Alzheimer's disease, anxiety and panic, nicotine dependence, delirium, geriatric care, and mental retardation).

Dr. Zarin will discuss challenges in developing practice guidelines in psychiatry. First, the development of guidelines is time and resource intensive. Second, research on outcomes and patient preferences is severely lacking. Third, the nature of psychiatric disorders and their treatments poses particular challenges to guideline development. In psychiatry, randomized controlled trials necessarily use a narrow range of patients, interventions, and outcome measures to eliminate confounding variables. This leads to problems in generalizing data collected

in tertiary-care settings to clinical practice and in determining the external validity of the research. Accordingly, the data on efficacy must be translated into data on effectiveness. Finally, synthesizing data from a range of studies, or secondary data analysis, is often difficult because of the uneven quality of data in terms of reliability and internal validity. Procedures for maximizing the quality of the guidelines have been developed, but the ultimate goal is to determine whether following the guidelines leads to better patient outcomes.

Dr. Hirschfeld will review the practice guideline for treatment of patients with bipolar disorder. The guideline begins at the point at which the psychiatrist has established the diagnosis of bipolar I disorder and has evaluated the patient for comorbid psychiatric and general medical conditions that could mimic bipolar disorder or be important in its treatment. First, treatment options, including psychiatric management, pharmacologic interventions, psychotherapeutic interventions, and electroconvulsive therapy, are reviewed along with evidence for their efficacy. Second, issues to be considered in choosing and implementing these treatment options, including choice of treatment setting, are discussed 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 are elucidated.

Dr. Mirin will review the practice guideline for treatment of patients with substance use disorders, which addresses issues common to substance use treatment and specifically deals with abuse of or dependence on alcohol, cocaine, and opioids. The guideline begins at the point at which the psychiatrist has established the diagnosis and has evaluated the patient for the presence of any comorbid psychiatric conditions and/or general medical conditions. This discussion will focus on assessment and appropriate goals of treatment for patients with substance use disorders. Guidelines for choosing among the many treatment options, including psychiatric management and pharmacologic and psychotherapeutic interventions, along with the evidence for their efficacy for selected patients, will be explored. The factors influencing the choice of treatment setting will also be discussed.

Dr. Blacker will discuss the practice guideline for Alzheimer's disorder and related dementias, which covers Alzheimer's disorder, vascular dementia, and other dementing disorders associated with aging, including Parkinson's disease, Pick's and other frontal lobe dementias, and Lewy body disease. It is intended for the psychiatrist who has already established the presence of dementia in a patient who is middle-aged or older and has evaluated the patient for the presence of comorbid psychiatric and general medical conditions that could be important in the treatment of dementia. First, treatment options for behavioral and cognitive symptoms, including psychiatric management, pharmacologic interventions, and psychosocial interventions, are reviewed along with evidence for their efficacy. Second, issues to be considered in choosing and implementing these treatment options, including choice of treatment setting, are discussed. Finally, the effects of particular features of the illness on the general treatment recommendations are elucidated.

REFERENCES:

1. Zarin DA, Pincus HA, McIntyre JS: Practice guidelines (editorial). *Am J Psychiatry* 150:2, 1993.
2. American Psychiatric Association: APA Practice Guideline for Treatment of Patients with Bipolar Disorder. *Am J Psychiatry* 151(Dec suppl), 1994.
3. American Psychiatric Association: APA Practice Guideline for Treatment of Patients With Substance Use Disorders: Alcohol, Cocaine, Opioids. *Am J Psychiatry,* in press.

Half-Day Session 26 — Monday, October 9 1:30 p.m.-4:45 p.m.

CLINICAL NEUROIMAGING IN PSYCHIATRY

Scott L. Rauch, M.D., *Director, Psychiatric Neuroimaging Research, Massachusetts General Hospital, Room 9130, MGH-East, 149 Thirteenth Street, Charlestown, MA 02129;* Perry F. Renshaw, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to enumerate and describe contemporary neuroimaging techniques, discuss their relative advantages and limitations, and explain their appropriate use in clinical psychiatry.

SUMMARY:

This session will review pertinent information on neuroimaging techniques and their applications in psychiatry.

Dr. Rauch will review practice aspects of the structural modalities of magnetic resonance imaging (MRI) and computed axial tomography (CT) and the functional modalities of positron emission tomography (PET) and single photon emission computed tomography (SPECT). Relative indications, contraindications, advantages, and limitations will be presented. Guidelines will be provided for the cost-efficient use of these techniques in clinical practice. It will be shown that structural neuroimaging techniques are most useful for evaluating medical etiologies of mental status disturbances, whereas functional neuroimaging techniques currently have a more limited adjunctive role in the assessment of dementia and other neuropsychiatric conditions.

Dr. Renshaw will review MRI technologies and applications to highlight differences between T_1-weighted, T_2-weighted, and proton-density-weighted MR images. Slides of brain images that clearly demonstrate common pathological features will be presented. The role of MRI in clinical practice will also be reviewed. The appropriate use of contrast and the significance

of specific pathological findings in patients with mental illness will be discussed. Recent research findings that illustrate abnormalities in neuroanatomy associated with psychiatric syndromes will also be presented.

Dr. Renshaw will then discuss magnetic resonance spectroscopy (MRS) and functional MRI (fMRI). MRS provides a means for directly measuring levels of brain chemicals *in vivo*. MRS has also been used to determine brain levels of lithium (^{7}Li MRS) and fluorinated psychotropic drugs (^{19}F MRS). Proton (^{1}H) and phosphorous (^{31}P) MRS have been used to demonstrate both trait-dependent (schizophrenia) and state-dependent (depression) neurochemical abnormalities in patients with psychiatric disorders. Neurochemical abnormalities associated with drug abuse and aging have also been documented in MRS studies, and at least one new therapeutic approach has been developed on the basis of *in vivo* findings. fMRI uses high-speed MR scanning to construct images that are sensitive either to regional cerebral blood volume or to changes in regional cerebral metabolism. fMRI images of cerebral blood volume, which are comparable to images of brain perfusion or metabolism obtained with SPECT or PET, may be useful for clinical evaluation of patients with dementia. fMRI has also been used to document low frontal lobe activation in patients with schizophrenia.

Dr. Rauch will review the integrated use of different neuroimaging techniques in psychiatric research. Contemporary neuroimaging techniques are powerful tools for the *in vivo* study of brain structure and function. Morphometric MRI is used to make volumetric measurements of specific brain territories. PET, SPECT, and fMRI allow for the mapping of normal brain functions and for probing the mediating anatomy of psychiatric disease. PET, SPECT, and MRS provide exciting new approaches for measuring neurochemical and pharmacologic indices. The relative advantages and limitations of these various techniques will be presented. Model strategies for the integrated use of these techniques in psychiatric research will be proposed, and examples of recent findings will be presented.

REFERENCES:

1. Rauch SL, Renshaw PF: Clinical neuroimaging in psychiatry. *Harvard Rev Psychiatry* 2:297-312, 1995.
2. Andreasen NC (ed): Brain imaging. In Oldham JM, Riba MB, Tasman A (eds): *American Psychiatric Press Review of Psychiatry,* vol 12. American Psychiatric Press, Washington, DC, 1993, pp 311-511.
3. Lyoo IK, Seol HY, Byun HS, et al: Unsuspected multiple sclerosis in patients with psychiatric disorders: a magnetic resonance imaging study. *J Neuropsychiatry Clin Neurosci,* in press.
4. Dager SR, Steen GR: Applications of magnetic resonance spectroscopy to the investigation of neuropsychiatric disorders. *Neuropsychopharmacology* 6:249-266, 1992.
5. Levin JM, Ross MH, Renshaw PF: Clinical applications of fMRI in neuropsychiatry. *J Neuropsychiatry Clin Neurosci,* in press.
6. Rauch SL, Jenike MA, Alpert NM, et al: Regional cerebral blood flow measured during symptom provocation in obsessive-compulsive disorder using oxygen-15-labeled carbon dioxide and positron emission tomography. *Arch Gen Psychiatry* 51:62-70, 1994.

Half-Day Session 27 — **Monday, October 9**
1:30 p.m.-4:45 p.m.

MAJOR MENTAL ILLNESS, WOMEN, AND REPRODUCTION: INNOVATIVE PROGRAMS

Roberta J. Apfel, M.D., *Associate Clinical Professor of Psychiatry, Harvard Medical School, 170 Chestnut Street, West Newton, MA 02165-2711;* Jeffrey L. Geller, M.D., M.P.H., Jill M. Goldstein, Ph.D., Brenda R. Schwab, Ph.D., Joanne Nicholson, Ph.D., Anna M. Spielvogel, M.D., Joanne R. Wile, M.S.W., Laura J. Miller, M.D., Maryellen H. Handel, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the prevalence of motherhood among those with serious mental illness, describe the problems associated with this population, and identify new treatment and program options.

SUMMARY:

This half-day session will delineate the unique experiences of presenters who have separately (or in two-person teams) worked with women with major mental illness. Many of the presenters have not met each other, but they have independently discovered the importance of childbearing, child rearing, and family to women with major mental illness. Sharing the findings from separate disciplines and viewpoints, and having an opportunity to bring together the most creative thinkers and clinicians involved with this topic, promises to provide cross-fertilization of ideas for the benefit of these patients.

As moderator of this panel, Dr. Geller will bring the perspective of a psychiatrist who has studied the treatment of women with major mental illness. For many years it has been apparent that women have a spectrum of mental illness that is different from that of men. Particular problems concerning pregnancy and reproduction have been ignored until relatively recently, when new attention and programs have developed.

Dr. Goldstein will discuss the impact of gender on the expression, course, and treatment of schizophrenia. Gender differences in schizophrenia have been noted for many years. However, only recently has there been a concerted effort to understand the impact of gender. Past literature has shown that schizophrenic men have an earlier onset, poorer premorbid history, poorer course, poorer response to neuroleptics, and a lower family risk for schizophrenia, and they express more negative symptoms and have more structural and functional brain abnormalities than do schizophrenic women. These

findings suggest that men and women may have different risks for expressing the various forms of the illness. Dr. Goldstein will discuss the evidence for different expressions of schizophrenia in men and women, possible mechanisms for this difference, and the implications for treatment and community care needs. Since potential determinants of gender differences in schizophrenia are genetic and hormonal factors, the implications for fertility and reproductive issues will be discussed.

Dr. Schwab will discuss the sense of community among mothers with mental illness. Many clinical programs underestimate the role of motherhood and reproductive losses in women's identity and in their ability to cope with their illnesses. In a study of two case management approaches for treating dually diagnosed individuals, the themes that emerged in female clients' narratives of their lives were violence, victimization, and loss, and their roles as mothers or potential mothers were crucial. Analysis of these themes can help us to understand some women's resistance to treatment and the inadequacy of the medical model of disease and addiction. The natural discourse among the study clients created strong bonds that enabled them to care for one another in times of need and to share resources, such as information, food, housing, and child care. This paper will suggest alternatives to the privatization of suffering encouraged by the medical model of disease; by such alternatives women can become empowered, even while sharing their grief. The bonds created and strengthened by women who have suffered similar losses can help them to cope, survive, and even fight for what they need.

Dr. Nicholson will discuss the *parenting careers* of women with severe mental illness in the public sector. Deinstitutionalization increases the likelihood that such women will have sexual encounters. They therefore are more likely to be bearing and caring for children. Parental competence is related to background factors that contribute to an individual's current functioning, e.g., illness-related factors and available formal and informal supports, and to the characteristics and needs of the children involved. To address past neglect of these issues by public sector mental health providers, seven focus groups of mothers with mental illness (N = 54), randomly recruited through the Massachusetts Department of Mental Health case management system, and five focus groups of case managers (N = 54) met in sites across Massachusetts. Participants discussed problems these women and their families face and suggested solutions. The identified factors that help women care for their children include aspects of the structure and organization of public sector systems of care.

Dr. Spielvogel will discuss women's psychiatric programs at San Francisco General Hospital. These programs are designed to incorporate the unique sociocultural and biological factors that affect women's lives. The Women's Issues Task Force, Women's Issues Consultation Team, Rape Treatment Center, Infant-Parent Program, and Psychiatric Consultation Service and Liaison with Obstetrics and Gynecology include psychiatric inpatient and outpatient services for adult women, their partners, and their children. The activities range from innovative clinical interventions to education, research, community liaison, and political advocacy. However, women's programs that provide optimal services can be expensive. For example, pregnant mentally ill women may need hospitalization to ensure safe deliveries, and women with severe mental illnesses need regular gynecological examinations. Funding for these services is provided because the cost of unsafe deliveries or undetected gynecological problems is greater without early intervention. Advantages and drawbacks of gender-sensitive programs in the era of managed care will be discussed, with examples from these services.

Ms. Wile will discuss the development of a women's issues curriculum. Effective clinical and training programs addressing women's issues need to be based on educational objectives and a core curriculum that encompass the main gender-related psychiatric content areas: developmental theories as they relate to gender differences, psychological aspects of women's health care, the influence of gender on coping mechanisms, psychiatric symptoms and diagnosis, substance use patterns, medication responses, the effects of violence and trauma, reproductive issues throughout the life cycle, lesbian identity issues, HIV disease, and gender issues in psychiatric research. A curriculum must also focus on skill and attitude objectives, such as eliciting accurate and complete sexual and reproductive histories, obtaining information regarding traumatic events common to women, and formulating diagnoses with an understanding of gender and cultural contributions to different presentations. Staff and trainees who complete a women's issues program should demonstrate in their behavior and demeanor sensitivity to gender stereotypes and awareness of their own countertransference reactions and the influence of such reactions on assessment and treatment decisions.

Dr. Miller will discuss the comprehensive care of pregnant mentally ill women. Pregnancies among such women are usually unplanned and are associated with high rates of poverty, homelessness, and drug addiction. Pregnant mentally ill women are at risk for exacerbation of symptoms and loss of housing and treatment opportunities, and their offspring are at risk because of genetic vulnerability, drug teratogenicity, and possible obstetric complications, inadequate parenting, and custody loss. To meet the needs of this high-risk population, the University of Illinois at Chicago created the Pregnancy and Postpartum Treatment Program. The program addresses (a) refusal of prenatal care; (b) risk of violence against self, fetus, or neonate; (c) delusions about the fetus; (d) labor; (e) concomitant drug addiction; (f) parenting capabilities; (g) parenting skills; (h) coping with custody loss; (i) understanding of family planning, birth control, and sexuality; and (j) collaboration with other departments and institutions.

Dr. Handel will present an overview. Increasing awareness of the differences in mental illness between women and men has produced innovative new programs in the last decade. A review of previous programs and research on reproductive

issues for women with mental illness show that childbearing concerns become more pressing with the shift to community-based living for patients with long-term mental illness. Pregnancy with mental illness has been known, treated, and then ignored. Clinical programs for this population will be described. Also, the topic of this session will be framed to focus on epidemiologic, ethnographic, educational, and practical clinical approaches. The need for interdisciplinary and innovative programming will be discussed.

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Half-Day Session 28 — Monday, October 9, 1:30 p.m.-4:45 p.m.

INNOVATIONS IN DUAL DIAGNOSIS TREATMENT: DEVELOPING AN INTEGRATED CARE SYSTEM

Kenneth Minkoff, M.D., *Chief of Psychiatry, Choate Health Systems, Inc., 23 Warren Avenue, Woburn, MA 01801-4979;* Lucille Traina, M.S.W., Elizabeth A. Irvin, M.S.W., Shelley Steenrod, M.S.W., L.C.S.W., Lisa B. Dixon, M.D., Gregory J. McHugo, Ph.D., Janice L. O'Keefe, R.N., M.P.H., Timothy E. Wilens, M.D., Kathy Lanning, M.A., C.A.D.A.C.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe innovative models of treatment and/or intervention strategies for dual diagnosis patients with serious mental illness and be able to apply these models in their own clinical settings.

SUMMARY:

In recent years efforts to provide integrated treatment to individuals with the 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, the implementation of an increasing variety of treatment methods and models, and an expansion of the data base by which these models are evaluated.

This session will provide an overview of the dual diagnosis care system and a description of a variety of innovative interventions: integrated dual diagnosis detoxification, dual diagnosis case management outreach, methods for applying addiction treatment to seriously mentally ill populations, an interagency integrated program involving state mental health and substance abuse agencies, and gender-specific dual diagnosis engagement strategies. Each treatment model is supported by at least preliminary research data.

Using an integrated conceptual framework for the dual diagnosis of mental illness and substance use disorder based on the disease and recovery model, Dr. Minkoff will describe a comprehensive dual diagnosis care system and will identify particular treatment needs within the system. Models of addiction treatment in psychiatric settings will be described, and their role in the total care system will be outlined.

Ms. Traina, Ms. Irvin, and Ms. Steenrod will describe the collaboration of the Massachusetts Department of Mental Health, the Department of Public Health--Bureau of Substance Abuse Services, and the Department of Medical Assistance's subcontracted managed care program for Medicaid recipients, Mental Health Management of America, to develop quality services for dually diagnosed individuals in a targeted geographical area. The discussion will highlight the process of translating a mandate issued by the respective department commissioners into practical, concrete service delivery, system changes, and planning initiatives. Areas addressed will include staff training strategies, differences and similarities in assessment and treatment planning, flexible models of service delivery, and identification of practical and philosophical challenges in collaboration.

Dr. Dixon will discuss assertive community treatment of homeless individuals with a dual diagnosis. Principles of assertive community treatment have been demonstrated to be effective in stabilizing individuals with severe mental illness.

Special techniques are necessary to apply these principles to individuals who also have severe substance use disorders and/or who are also homeless. Methods of clinical intervention will be discussed, and outcome data will be described.

Ms. O'Keefe and Dr. Wilens will describe the philosophy and organizational concerns of a public inebriate program that was modified to detoxify and stabilize a homeless dually diagnosed population. A manual describing the conceptual framework, clinical practice, and recommendations for this population will be highlighted and will be distributed during the workshop. The manual was funded by a Substance Abuse and Mental Health Services Administration grant for the study of special projects for this population. Typical case presentations will be discussed, and the presenters will summarize a published study that compared 70 consecutively referred alcohol-dependent psychiatric inpatients with 70 primarily alcohol-dependent referrals. The demographic and patient care variables indicated unique differences in the dually diagnosed cohort. A recent pilot study indicated short-term efficacy of treatment and areas for further research.

Ms. Irvin will present an overview of addiction techniques appropriate for use with the seriously mentally ill. The presentation will focus on relapse prevention techniques developed by Marlatt and Gordon (1987) and adapted by Donovan (1987) and Penk, Irvin, and Peterson (1991). Adaptations of addiction techniques for the seriously mentally ill must include (a) segmenting the techniques into even smaller steps than for most persons with addiction disorders only; (b) increasing practice on behavioral principles that make relapse prevention work; (c) addressing generalization of learned principles of relapse prevention for the seriously mentally ill, who confront an array of difficulties in transferring learned principles from treatment environments to the home and community; and (d) modifying social-environmental conditions that contribute to addiction maintenance. Relapse prevention is especially effective when taught *after* a general introduction to psychosocial symptom management techniques, and it is especially effective when it is presented to patients *after* they have left an alcohol-free/drug-free environment and have re-entered their homes and a community environment. Pretraining before encounters with the social environment of drugs and alcohol is virtually wasted on the seriously mentally ill who are addicted. The presentation will review new techniques for classifying the social environment of the dually diagnosed, with special attention to determining the risk of relapse and identifying significant others who can help buffer social isolation and serve as bridges to sobriety.

Ms. Lanning will discuss group techniques for addiction treatment of seriously mentally ill individuals in a state hospital. Even the most seriously disabled patients require, and can respond to, 12-step-oriented addiction treatment when the interventions are geared to their cognitive abilities. Ms. Lanning will describe specific techniques and program models used in a state hospital to provide dual diagnosis group treatment.

Although substance abuse is common among persons with severe mental illness, there are few measures for evaluating treatment progress. Dr. McHugo will discuss a scale for assessing the stage of substance abuse in persons with severe mental illness. The Substance Abuse Treatment Scale combines a motivational hierarchy with explicit substance use criteria to form an eight-stage model of the recovery process. Data from its use in a community-based sample of persons with dual disorders support the reliability and validity of this scale. The Substance Abuse Treatment Scale can be used as either a process or an outcome measure, for individuals or for groups. Its value in making explicit the stages of substance abuse treatment will be discussed.

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Half-Day Session 29 — Tuesday, October 10 8:30 a.m.-11:45 a.m.

NO THANKS FOR THE MEMORIES: A MOCK TRIAL ON A RECOVERED MEMORY CASE

Thomas G. Gutheil, M.D., *Co-Director, Program in Psychiatry and Law, Massachusetts Mental Health Center, 74 Fenwood Road, Boston, MA 02115;* Rose Zoltek-Jick, J.D., Laurence Hardoon, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the complex legal issues in a "recovered memory" experience that goes to litigation and should be able to describe the risks involved.

SUMMARY:

Current controversy about "recovered memories" of childhood sexual abuse rends the mental health field, disturbed by several high-profile cases in this area. Through the vehicle of a mock trial on a specific case, the audience will have an opportunity to observe in action the various issues that emerge in such cases. The procedure will involve the direct examination and cross-examination of a psychiatrist witness. After that, the faculty (a psychiatrist and two attorneys) will discuss the issues and will be open to audience participation. The relevant risk-management principles will be enumerated.

REFERENCE:

1. Gutheil TG: True or false memories of sexual abuse? A forensic psychiatric view. *Psychiatr Ann* 23:527-531, 1993.

INDUSTRY SUPPORTED SYMPOSIA

Industry Supported Symposium 1
Friday, October 6 6:30 a.m.-8:30 a.m.

CLINICAL DEVELOPMENTS IN ALZHEIMER'S DISEASE

Supported by Parke-Davis, Division of Warner-Lambert Company

Lon S. Schneider, M.D., *Associate Professor of Psychiatry, University of Southern California School of Medicine, Room 135E, 2250 Alcazar Street, Los Angeles, CA 90033;* Gary W. Small, M.D., John C.S. Breitner, M.D., M.P.H., George S. Alexopoulos, M.D., Pierre N. Tariot, M.D., Peter V. Rabins, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to outline the genetics and risk factors involved in Alzheimer's disease; describe the clinical utility of diagnostic imaging; list treatments for depression, psychosis, and agitation in persons with dementia; and identify interventions for cognitive impairment in Alzheimer's disease.

SUMMARY:

This symposium will review new developments in selected aspects of Alzheimer's disease, with a focus on clinical practice. The brief review of diagnostic criteria by Dr. Schneider will be followed by individual presentations, comments by a discussant, and audience participation.

Dr. Breitner will review genetic markers and protective and risk factors for Alzheimer's disease. Several identifiable genotypes predispose to development of the disease at different ages. It is not yet clear whether the common genes, including allele $\epsilon 4$ at *APOE*, suffice to provoke Alzheimer's disease in old age or whether other factors may protect against this outcome. Twin and sibling studies suggest that onset of some forms of the disease can be delayed or prevented by sustained use of anti-inflammatory drugs or, possibly, histamine H_2 blockers. By contrast, early-onset forms of Alzheimer's disease lacking both $\epsilon 4$ and a family history of Alzheimer's disease are not rare: in studies of such disease in 15 twin pairs (8 monozygous), all at-risk co-twins remained unaffected for many years (mean, 11.3). The probands apparently had strong environmental provocation; many had life histories of "hay fever" or asthma or employment in machining, metal working, or welding. These studies indicate the value of considering alteration in risk *within* the various genetically identifiable forms of Alzheimer's disease, and they may have implications for pathogenetic mechanisms in this disease.

Dr. Small will discuss the clinical utility of structural and functional neuroimaging studies. Structural imaging techniques (e.g., computerized tomography, magnetic resonance imaging) can exclude space-occupying lesions and aid in the diagnosis of vascular disease or normal-pressure hydrocephalus in cognitively impaired patients. Studies of brain function (e.g., positron emission tomography, single photon emission computed tomography) demonstrate low parietal and temporal metabolism and blood flow in Alzheimer's disease. These approaches could potentially identify patients at preclinical stages, who could be treated with antidementia drugs (e.g., tacrine), and assist in differentiating depression from dementia. Despite such utility, the NIH Consensus Development Conference recommended that neuroimaging studies generally be considered optional. There are few data on sensitivity, specificity, and predictive value or on clinical utility, cost-effectiveness, and variations in use. Scan costs and risks (e.g., radiation exposure) must be weighed against potential benefits (e.g., diagnostic accuracy, assessment efficiency, patient/family satisfaction). This review will help clinicians choose particular scans for various clinical settings.

Since the majority of patients with Alzheimer's disease develop significant symptomatic behaviors during their illness, the next two presentations will cover treatment strategies for depression, psychosis, and agitation. Dr. Alexopoulos will describe effective treatment of depression in demented patients, which can (a) reduce patient and caregiver suffering, (b) improve overall functioning, and (c) help the clinician ascertain the stage of dementia by alleviating the cognitive disturbance contributed by depression. Diagnosis of depression in patients with Alzheimer's disease is hindered by the similarities in the two syndromes, fluctuations of depressive symptoms, and unreliable reports of symptoms by the demented patients. The few available studies suggest that tricyclic antidepressants improve depressive symptoms in these patients, although the cognitive dysfunction in elderly depressed patients appears to alter the relationship between plasma concentration and efficacy. Enlargement of lateral brain ventricles appears to be associated with poor response to tricyclics and altered relationship of efficacy with plasma concentration. Findings on efficacy and potential side effects can be used to form a rational strategy for recognizing and treating the depression of demented patients.

Treatment of agitation and psychosis ideally entails identification and alteration of physical, environmental, social, and psychiatric precipitants. Dr. Tariot will present evidence demonstrating that environmental modification, education of caregivers, and therapeutic activities programs can reduce these symptoms. For remaining symptoms, empirical trials of pharmacotherapy may be appropriate. One approach is to inventory the specific behaviors and develop a "therapeutic metaphor," i.e., subtype the behaviors according to the presence of target symptoms likely to respond to specific classes of drugs. Such subtypes are supported by recent studies of psychopathology in dementia. Dr. Tariot will review available evidence regarding the efficacy of the following therapies for agitation: antipsychotics, including haloperidol, clozapine, and risperidone; antidepressants, including trazodone and selective serotonin reuptake inhibitors; anticonvulsants, particularly carbamazepine and valproic acid; benzodiazepines; beta

blockers; and ECT. Reports on toxicity and on duration and withdrawal of therapy will also be presented.

Dr. Schneider will discuss new pharmacological approaches to treating symptoms of cognitive impairment and slowing the rate of cognitive decline. For improving cognitive symptoms, cholinergic agents appear most promising currently, and a cholinesterase inhibitor is available. Indications, contraindications, methods of administration, management of side effects, and expected clinical response to cholinergic medications will be discussed. Agents for slowing the rate of cognitive decline include neurotrophic factors, antioxidants, monoamine oxidase inhibitors, and anti-inflammatory medications. The possibility that cognitively enhancing drugs may affect behavioral symptoms, severe dementia, and non-Alzheimer's dementia will be discussed. In the future, efforts in therapy development will focus on encouraging theoretical leads to the pathogenesis of Alzheimer's disease, reasonable empirical trials, and research on symptomatic treatment. In planning therapy it is important to consider only results from carefully controlled clinical trials, since case reports and pilot studies can be misleading.

Dr. Rabins will provide the perspective of the APA work group developing the practice guideline on Alzheimer's disease and other dementing illnesses (excluding HIV dementia). Effective pharmacological therapies are available for the cognitive impairment and for some noncognitive behavioral impairments of Alzheimer's disease. Many prosthetic environmental therapies are effective, but there is no evidence that any specific treatment has a unique benefit. Emotional support of caregivers is effective in diminishing the psychiatric morbidity associated with caregiving and may be effective in delaying nursing home placement.

REFERENCES:

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

RAPID STABILIZATION AND TREATMENT OF BIPOLAR DISORDER IN THE PSYCHIATRIC EMERGENCY SERVICE

Supported by Abbott Laboratories

Peter L. Forster, M.D., *Director, Psychiatric Emergency Service, San Francisco General Hospital, San Francisco, CA;* Mark A. Frye, M.D., Paul E. Keck, Jr., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to (a) discuss the use of antipsychotics, anticonvulsants, benzodiazepines, lithium, and valproate in the management of acute mania; (b) identify the potential benefits of using loading doses to manage bipolar disorder; and (c) describe the rates of response associated with various antimanic agents.

SUMMARY:

New approaches to management of bipolar disorder include use of anticonvulsants and loading doses of medication. Potential benefits of loading doses are faster therapeutic effect and less use of benzodiazepines and neuroleptics than is possible with traditional therapies. Findings from a study of use of loading doses in a psychiatric emergency service will be presented. Research on use of lithium and anticonvulsant medications for treating inpatients with bipolar disorder will also be described. The session will end with a panel discussion of general management issues in treatment of bipolar disorder.

Dr. Keck will present strategies for shortening the time to recovery from acute mania. Although lithium has been the mainstay of treatment of bipolar disorder for over 25 years, the onset of lithium's antimanic activity ranges from 5 days to 3 weeks. Controlled studies of valproate and carbamazepine suggest that the efficacy of these agents for acute mania may be comparable to that of lithium but that their therapeutic effects may begin sooner. Antimanic activity was seen within 7-14 days after carbamazepine treatment began and several days after achievement of therapeutic plasma concentrations of valproate. Two studies have recently examined the possibility that valproate, when administered at 20 mg/kg/day, may produce therapeutic plasma concentrations within 24 hours and exert a more rapid antimanic effect. Both of these studies found that a majority (52% and 77%, respectively) of patients with acute mania who received valproate by oral loading displayed a marked reduction in manic symptoms within the first 5 days of treatment. This treatment strategy, which was well tolerated, may provide more rapid antimanic activity, decrease the duration of hospitalization, and prove to be cost-effective.

Dr. Forster will present a research study application of Dr. Keck's findings as related to psychiatric emergency services. The study showed that clients treated with loading doses of the

antimanic medication divalproex required less nonspecific treatment and had better general outcomes.

Dr. Frye will describe a retrospective study on the use of lithium and anticonvulsant medications for treating inpatients with bipolar disorder. The study evaluated the relationship between hospital length of stay and use of lithium, carbamazepine, divalproex sodium, or lithium plus carbamazepine. Raters who were blind to drug treatment reviewed 78 patients' medical records and rated each patient's degree of improvement as minimal, mild, moderate, or euthymia/return to baseline. The individual survival curves of the four treatment groups revealed that by the second week of hospitalization the divalproex and lithium-carbamazepine groups were significantly different from the lithium and carbamazepine monotherapy groups (χ^2 = 13.83, df = 3, p = 0.003). The mean (•SD) length of stay was approximately 40% shorter for divalproex (10.2 • 2.0 days) and lithium-carbamazepine (11.7 • 2.1 days) than for lithium alone (17.6 • 1.0 days) or carbamazepine alone (18.1 • 3.0 days). Regression analysis of possible confounding variables revealed no statistically significant effect. The findings suggest that the currently available antimanic medications are associated with different rates of response.

A panel moderated by Dr. Keck will discuss general management issues in bipolar disorder for 30 minutes, in response to audience questions.

REFERENCES:

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Industry Supported Symposium 3
Friday, October 6 7:00 p.m.-10:00 p.m.

CLINICAL AND ADMINISTRATIVE STRATEGIES TO SUCCEED IN A MANAGED CARE ENVIRONMENT

Supported by Mead Johnson Pharmaceuticals, a Bristol-Myers Squibb Company

Robert E. Hales, M.D., *Medical Director, Sacramento County Mental Health Treatment Center, 2150 Stockton Boulevard, Sacramento, CA 95817;* Stuart C. Yudofsky, M.D., Wayne J. Katon, M.D., Michael G. Wise, M.D., Steven L. Dubovsky, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to list several administrative techniques for dealing with managed care companies, summarize treatment guidelines for pharmacotherapy of depression in a managed care environment, and outline a treatment strategy for major depression complicated by dysthymia.

SUMMARY:

This program is intended to provide an overview for the clinician on important topics related to managed mental health care and depression. Dr. Wise will provide important tips for psychiatrists on how to survive in a managed care world. Dr. Katon will outline guidelines for the treatment of depression in a managed care environment. Dr. Dubovsky will present treatment strategies for managing major depression complicated by dysthymia. All presenters will emphasize practical administrative and clinical approaches that may be applied in their private practices.

REFERENCES:

1. Hales RE, Yudofsky SC, Talbott JC: *The American Psychiatric Press Textbook of Psychiatry,* 2nd ed. American Psychiatric Press, Washington, DC, 1994.
2. Yudofsky SC, Hales RE: *Synopsis of Neuropsychiatry.* American Psychiatric Press, Washington, DC, 1994.

Industry Supported Symposium 4
Saturday, October 7 6:30 a.m.-8:30 a.m.

OBSESSIVE-COMPULSIVE DISORDER: A DECADE OF PROGRESS

Supported by CoCensys, Inc.

Eric Hollander, M.D., *Department of Psychiatry, Box 1230, Mount Sinai Medical Center, 1 Gustave Levy Place, New York, NY 10029;* Michael A. Jenike, M.D., Lewis R. Baxter, M.D., Joseph Zohar, M.D., Daphne Simeon, M.D., Dan J. Stein, M.B., Lisa J. Cohen, Ph.D., Bonnie R. Aronowitz, Ph.D., Concetta M. DeCaria, Ph.D., Robert A. Grossman, M.D., Rivka Cohen, M.D., Seth Kindler, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe advances in the understanding of obsessive-compulsive disorder over the past decade, including developments in diagnostic and rating scales, imaging, and knowledge of the relationship between impulsivity and serotonin function, and should be able to discuss how these phenomenological and neurobiological developments have led to specific and effective biological and psychological treatments.

SUMMARY:

Over the past decade (1985 to 1995), obsessive-compulsive disorder (OCD) has evolved from an obscure illness with uncertain etiology and poor response to treatment to one of the most common psychiatric disorders, associated with reliable neuroanatomic and serotonergic abnormalities and having

specific and highly effective psychological and pharmacological treatments. This symposium will document important developments over the past decade and assess the current state of the art in OCD. The participants will describe developments in their respective fields and where the next decade may lead for this fascinating disorder.

Dr. Jenike will discuss the diagnostic and epidemiologic evolution of OCD. Although the general concept of how to describe OCD has remained relatively consistent for many years, there have been changes in specific details as our classification systems have evolved. Some pertinent changes in *DSM-IV* will be reviewed. The Epidemiologic Catchment Area study showed that OCD is orders of magnitude more prevalent than was previously thought; lifetime prevalence is estimated to be about 2.5%, and 6-month point prevalence is estimated to be about 1.6%. Many considered these estimates to be high, but more recent studies, in a number of cultures, have confirmed that these prevalence figures not only are probably accurate for the United States, but are similar to those for the majority of other cultures that have been studied. These epidemiologic findings have profound implications for research funding and development of new drugs.

In the past decade there has been an explosion of knowledge about how dysfunctions in specific brain regions may mediate the symptoms of OCD. This insight has resulted from brain imaging studies, which will be reviewed by Dr. Baxter. Although not all agree, nearly a dozen studies using positron emission tomography, single photon emission computed tomography, and functional magnetic resonance imaging indicate orbital cortex hyperfunction in OCD, which is different from findings on major depression and schizophrenia. Studies of drug and behavioral interventions suggest that the basal ganglia and thalamus are involved, along with the cerebral cortex, in a system that may mediate some OCD symptoms. This system's purpose, when it is functioning correctly, seems to be the capture of attention of preprogrammed whole-being responses directed to the most pressing needs of the moment, excluding less important responses. When it is dysfunctional, such a system may allow the output of behavioral routines in inappropriate circumstances. Brain imaging studies are now probing the neurochemical operations of these specific brain systems.

Compulsivity and impulsivity will then be compared in terms of phenomenology, biology, and treatment. Compulsivity involves a heightened estimation of harm and greater risk avoidance, whereas impulsivity involves a decreased sense of harmful consequences and more risk-seeking behavior associated with a sense of pleasure. Peripheral serotonin (5-HT) measures and behavioral/neuroendocrine responses to 5-HT agonists, such as *m*-chlorophenylpiperazine (*m*-CPP), suggest that compulsivity is associated with increased 5-HT sensitivity, whereas impulsivity is associated with a 5-HT deficiency. Evidence from the neurosurgical, neuropsychological, and functional imaging literature suggests that compulsivity is associated with *hyper*frontality, whereas impulsive/disinhibited activity is associated with *hypo*frontality. Both compulsive and impulsive disorders may respond to selective serotonin reuptake inhibitors (SSRIs) and behavior therapy, but with subtle differences. OCD, body dysmorphic disorder, hypochondriasis, anorexia nervosa, and compulsive disorders have a delayed onset but sustained response to SSRIs, whereas impulse control and impulsive-style personality disorders respond rapidly but for a short time in some cases.

Drs. Zohar, Cohen, and Kindler will review evidence for serotonergic abnormalities and will highlight studies that implicate specific 5-HT subsystems in OCD. SSRIs are effective in the treatment of OCD, whereas nonserotonergic reuptake inhibitors are not. This specific response renders OCD unique among affective and anxiety disorders and lends support to the serotonergic hypothesis for this disorder. In double-blind, placebo-controlled studies, OCD symptoms were exacerbated after oral administration of *m*-CPP, a 5-HT agonist. These findings indicate hypersensitivity to the behavioral effects of *m*-CPP, which has comparably high affinities for the 5-HT_{1A} and 5-HT_{1D} receptors but an even higher affinity for the 5-HT$_2$ receptor. Administration of MK-212, which has a high affinity for the 5-HT_{1A} and 5-HT_{2C} receptors, and of the 5-HT_{1A} ligand ipsapirone to OCD patients and control subjects was not associated with any noticeable behavioral effects in either group. The *m*-CPP, MK-212, and ipsapirone studies suggest that the 5-HT_{1D} receptor merits further investigation. Preliminary data on the 5-HT_{1D} agonist sumatriptan support a specific role for 5-HT_{1D} in OCD symptoms.

Dr. Jenike will also discuss the considerable progress in the pharmacologic and behavioral treatment of OCD made during the past decade. The finding that SSRIs are effective in OCD has advanced the management of the disorder and stimulated research into its neurobiological underpinnings. Likewise, the introduction of specific behavioral techniques, known as exposure and response prevention, offers an important alternative to SSRIs and has raised intriguing theoretical questions about how (and where in the brain) the mechanisms of action of drug and behavioral treatments converge. This presentation will trace the evolution of the pharmacotherapy of OCD. Questions to be addressed include (a) What is the adequate duration of treatment? (b) Must high doses be used? (c) Does comorbidity (e.g., depression, panic disorder, chronic tics) help guide selection of combination strategies for treatment-resistant patients? Baer's published guidelines for conducting behavior therapy in an office-based practice will be discussed to help clinicians integrate multiple treatment modalities. Despite much progress, additional research is needed to refine existing therapies, develop new treatments, and answer questions regarding the acute and long-term management of OCD.

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2. Baxter LR: Neuroimaging studies of human anxiety disorders: cutting paths of knowledge in the field of neurotic phenomena. In Bloom F, Kupfer D (eds): *Neuropsychopharmacology: The 4th Generation of Progress.* Raven Press, New York, 1994.

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4. Zohar J, Zohar-Kadouch RL, Kindler S: Current concepts in the pharmacological treatment of obsessive-compulsive disorder. *Drugs* 43:210-218, 1992.
5. Goodman WK, McDougle CJ, Price LH: Pharmacotherapy of obsessive compulsive disorder. *J Clin Psychiatry* 53(suppl):29-37, 1992.

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

DEPRESSION: WHOSE COST? AT WHAT COST?

Supported by Eli Lilly and Company

William M. Glazer, M.D., *Associate Clinical Professor of Psychiatry, Yale University School of Medicine, New Haven, CT;* Jerrold F. Rosenbaum, M.D., Wayne J. Katon, M.D., Daniel J. Conti, Ph.D., Mary Jane England, M.D., Michael Von Korff, Sc.D., Elizabeth Lin, M.D., Edward A. Walker, M.D., Terry Bush, Ph.D., Gregory E. Simon, M.D., Patricia Robinson, Ph.D., Wayne N. Burton, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the effect of managed care principles on the treatment of depression and the role of the psychiatrist in response to this paradigm shift.

SUMMARY:

The changing climate in U.S. health care delivery means that psychiatrists must reassess the manner in which they treat patients. There is opportunity. In this symposium the principles and practice of treating depression will be considered in light of the paradigm shift that is upon us.

Dr. England will begin the program with an overview of managed care themes and principles that are influencing psychiatric practice, e.g., competition, consolidation, risk, cost-effectiveness, and outcomes. Clinicians are increasingly being held responsible for both the cost and quality of care delivered to individuals and patient populations. The benefits to be realized from treatment decisions must be weighed against the costs to payers and the use of scarce national health care resources. Employers and governments, as purchasers of care, are demanding accountability for the quality of that care. Purchasers have become actively involved in managing the cost and quality of mental health services. The success of the Washington Business Group on Health and NIMH in working with employers to mitigate the financial and human impact of clinical depression offers valuable lessons. Dr. England will share these lessons and data on the prevalence and economic impact of clinical depression. Innovative steps taken by employers to form systems for managing mental health care will also be discussed.

Drs. Glazer and Rosenbaum will discuss the physician's emerging role as care allocator. The psychiatrist must attend to the impact of treatment decisions for the patient, the health plan, the payer, and society in general. Many psychiatrists are uncomfortable with this role because they have been trained to serve as advocates for patients without regard to economic concerns. This presentation will explore how the psychiatrist can treat depression by balancing the allocator role with that of patient advocate. The medical offset effect, i.e., reduction of total health care costs through accurate identification and treatment of psychiatric illness, will be demonstrated. The advocate and allocator roles will be acted out. Dr. Rosenbaum will take the thesis position in a case presentation of a patient with a major depression. Dr. Glazer will assume the antithesis position by attending to the costs of the case. The presenters and the audience will explore the synthesis of the advocate and allocator roles.

Quantitative data were collected in a study in which primary care physicians and psychiatrists collaborated on treating depression among patients seeking primary care. A total of 217 depressed patients were randomly assigned to an experimental intervention or to care as usual. The experimental intervention included increased patient education, didactic education of primary care physicians, and case-by-case supervision of the care of the patients' depression. The patients alternated visits to primary care physicians and psychiatrists over 4 to 6 weeks. Patients with either major or minor depression who received the experimental intervention were significantly more likely to receive an adequate dose of antidepressant medication. Patients with major depression in the experimental group showed significantly greater improvement over time in SCL depression scores ($p < 0.004$); they also had a higher rate of 50% or more improvement on SCL-20 items at 4 months than did the control patients (74.4% versus 48.8%, $p < 0.01$).

Drs. Conti and Burton will present research from an employer group that illustrates the value of psychiatrists in the treatment of depression in the workplace. At First Chicago Corporation an integrated approach to managing the costs (both human and monetary) of mental health problems has evolved from the mid-1980s. A major component of the integrated approach is the management of mental health short-term disability by the employee assistance program. Previously published research has documented the success of the program in lowering lengths of mental health disability while not increasing recidivism. Key to the success of the program is getting employees the specialty medical care they need, i.e., psychiatric treatment. Employees on short-term disability for mental health problems who were originally treated by nonpsychiatrist physicians are being followed up. Early results

demonstrate that these patients have a longer average disability period. It appears that for major contributors to medical plan costs, such as depressive illness, appropriate and timely psychiatric treatment can contribute to corporate savings.

REFERENCES:

1. Buxton MJ: Health economics in the 1990s. In Jonsson B, Rosenbaum J (eds): *Health Economics of Depression.* Wiley, New York, 1993.
2. Glazer W: Evaluating psychiatric disorders in primary care settings: anxiety, depression and somatoform disorders. *Med Interface* 6:78-84, 1993.
3. Katon W, Gonzales J: A review of randomized trials of psychiatric consultation-liaison studies in primary care. *Psychosomatics* 35:268-278, 1994.
4. Conti DJ, Burton WN: The economic impact of depression in the workplace. *J Occup Med* 36, 1994.

Industry Supported Symposium 6
Sunday, October 8 6:30 a.m.-8:30 a.m.

PSYCHOPHARMACOLOGY OF EATING DISORDERS

Supported by Eli Lilly and Company

B. Timothy Walsh, M.D., *Director, Eating Disorders Unit, New York State Psychiatric Institute, 722 West 168th Street, New York, NY 10032-2603*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to select appropriate pharmacological interventions for patients with anorexia nervosa or bulimia nervosa.

SUMMARY:

In recent years there has been great interest in the pharmacological treatment of eating disorders. A substantial body of knowledge regarding bulimia nervosa has now been developed, demonstrating that antidepressant medications are more effective than placebo in short-term alleviation of binge eating, vomiting, and the characteristic psychological disturbances associated with this syndrome. What is less clear is for which patients medication should be prescribed, how long it should be continued, and how it should be combined with other forms of treatment, particularly cognitive behavioral psychotherapy.

There has been less progress in the treatment of anorexia nervosa. Although some patients with this illness may benefit from pharmacological intervention, no medication has been demonstrated to be of general benefit. However, recently it has been suggested that fluoxetine may help prevent relapse after acute treatment of patients with anorexia nervosa.

Finally, studies of the psychopharmacology of obesity are provocative. Fluoxetine is clearly of significant short-term benefit, but there are important questions about its benefits during long-term treatment.

This presentation will review the current knowledge of the use of psychotropic medication in anorexia nervosa, bulimia nervosa, and obesity.

REFERENCE:

1. Walsh BT, Devlin MJ: Eating disorders. In Riddle M (ed): Psychopharmacology II. *Child and Adolescent Psychiatric Clinics of North America,* in press.

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

LATE-LIFE DEPRESSION: RECENT ADVANCES IN ASSESSMENT AND TREATMENT

Supported by Wyeth-Ayerst Laboratories

Andrew F. Leuchter, M.D., *Associate Professor of Psychiatry and Director, QEEG Laboratory, University of California at Los Angeles;* Charles F. Reynolds III, M.D., Ira R. Katz, M.D., George S. Alexopoulos, M.D., Barry D. Lebowitz, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify the common presentations of late-life depression, examine the interaction between physical illness and depression, evaluate the common outcomes of late-life depression, discuss common neuroimaging findings and their relationship to prognosis, and identify issues in diagnosis and treatment and trends in research.

SUMMARY:

Depression in late life is a serious public health problem. Many elderly patients with depression have excellent recoveries from their illness. During the course of depression, however, many elderly patients experience a worsening of chronic physical illnesses and are frequent utilizers of health care. Patients with late-life depression have higher than average mortality rates and are at high risk for suicide. Depression also may be difficult to diagnose in the elderly because of different presentations of the illness. This symposium will review recent advances in the diagnosis and treatment of late-life depression. The applicability of diagnostic criteria to special populations, particularly those with physical illness, will be reviewed. Recent research on the outcome of depressive illness and on predictors of treatment response will be presented. Directions of research in the field will be discussed.

Dr. Reynolds will discuss depression as a treatable source of suffering, excess disability, and caregiver strain in late life. It is important to take a long-term view of the treatment of late-life

depression because of the high risk for relapse, recurrence, and chronic illness. Elderly patients with medical and neurological illness or bereavement-related depressions also merit greater attention. Recent data highlight (a) the role of medical and psychosocial factors in the course of major depression; (b) the need for additional studies of depression in primary and long-term care facilities, particularly for patients over 75 years of age; and (c) the importance of continuation and maintenance treatment to lower the risk for chronic illness. Nortriptyline, desipramine, and the newer selective medications (fluoxetine, nefazodone, sertraline, and venlafaxine) are preferred pharmacotherapy for short-term and long-term treatment. The newer agents should be further studied in controlled trials of elderly depressed patients, including those over 75 years of age and those with medical or neurological illness. Psychotherapy also appears to be of major importance in successful outcome.

Dr. Katz will discuss psychiatric-medical comorbidity in depression among the frail elderly. Findings from ongoing research in nursing home residents and other chronic care populations demonstrate that depressive disorders, both major depression and less severe but nevertheless clinically significant depressions, are common among elderly patients with chronic disease and disability. These depressions are, in general, persistent states that are associated with increased pain complaints, biochemical markers for subnutrition, and high mortality rates, even after correction for the effects of medical comorbidity. They are associated with self-care deficits; when studied over time, depression emerges as both a cause and a result of disability. In addition, there is evidence that it can increase health care costs and the utilization of general medical services. Although few well-controlled studies have been conducted, available evidence suggests that major depression as diagnosed with *DSM-III* and *DSM-III-R* criteria is responsive to antidepressant medication, even in older patients with chronic disease and disability.

Dr. Alexopoulos will discuss outcomes of late-life depression. Elderly depressed patients have a recovery rate comparable to that of younger adults, but specific syndromes have unfavorable outcomes. Onset of first depressive episode in late life is associated with chronicity, a high relapse rate, cognitive dysfunction, and a high rate of dementia development during follow-up. Geriatric depressed patients with initially reversible dementia appear to have a high rate of irreversible dementia at follow-up. Dementing disorders or brain lesions may influence response to pharmacologic treatment. In a controlled study, depressed patients with Alzheimer's disease responded equally well to imipramine and placebo. Similarly, a poor response to nortriptyline was reported in geriatric depressed patients with large lateral brain ventricles. Finally, there is some evidence that cognitively impaired geriatric depressed patients do not have the same relationship between nortriptyline dose and plasma level as cognitively intact patients. Pharmacologic studies and studies of the course of geriatric depression should take into consideration cognitive status, medical burden, imaging, and psychosocial variables.

Dr. Leuchter will present findings from brain imaging studies. Although most patients with late-onset depression recover from the illness, some may have an unremitting depression. Depressed elderly patients also have mortality rates that are significantly higher than those for control subjects. Imaging techniques have revealed abnormalities in brain function that provide insights into the physiology of depressive illness in the elderly and may predict the outcome of treatment. Compared with young depressed patients, elderly patients are more likely to show lower global cerebral blood flow and metabolism as measured with single photon emission computed tomography or positron emission tomography. Elderly depressed patients also are likely to show lower global cerebral electrical activity as measured with quantitative electroencephalography. Patients with the greatest suppression of normal electrical activity before treatment may have the highest risk of chronic depression or 2-year mortality. Normalization of electrical activity during the course of medication treatment may precede a clear clinical response and predict successful outcome of treatment.

Dr. Lebowitz will conclude with a summary of the diagnosis and treatment of depression in late life. The National Institutes of Health Consensus Development Conference on the Diagnosis and Treatment of Depression in Late Life was a landmark event in research and practice in geriatric psychopathology. The conference examined scientifically established knowledge to determine the conclusions that could be made on issues of epidemiology, pathogenesis, pathophysiology, prevention, and treatment of depression in the elderly. A major concern was to alert both professionals and the lay public to the seriousness of depression in late life and to identify useful treatments. A final issue was the specification of the most promising areas for future study. This presentation will review the background and outcome of the conference, will describe progress on the implementation of the conference's recommendations, and will identify directions for future initiatives.

REFERENCES:

1. Reynolds C III: Treatment of depression in late life. *Am J Med* 97:39-46, 1994.
2. Katz IR: Drug treatment of depression in the frail elderly: discussion of the NIH Consensus Development Conference on the Diagnosis and Treatment of Depression in Late Life. *Psychopharmacol Bull* 29:101-109, 1993.
3. Alexopoulos GS, Chester J: Outcomes of geriatric depression. *Clin Geriatr Med* 8:363-376, 1992.
4. Leuchter AF, Simon SL, Daly KA, et al: Quantitative EEG correlates of outcome in elderly psychiatric patients I: cross-sectional and longitudinal assessment of patients with dementia. *Am J Geriatr Psychiatry* 2:200-209, 1994.
5. Schneider LS, Freidhoff A III (eds): *Diagnosis and Treatment of Depression in Late Life: Results of the NIH Consensus Development Conference.* American Psychiatric Press, Washington, DC, 1993.
6. Consensus Panel: Diagnosis and treatment of depression in late life. *JAMA* 268:1018-1024, 1992.

INDUSTRY SUPPORTED SYMPOSIA

Industry Supported Symposium 8
Monday, October 9 6:30 a.m.-8:30 a.m.

MANAGEMENT OF DEPRESSION IN TODAY'S WORLD

Robert M.A. Hirschfeld, M.D., *Department of Psychiatry and Behavioral Science, University of Texas Medical Branch, 301 University Boulevard, Galveston, TX 77555;* Martin B. Keller, M.D., Karen D. Wagner, M.D., Ph.D., Jan A. Fawcett, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe up-to-date treatments for depression and describe how such treatments are affected by managed care, national health care reform, and litigation.

SUMMARY:

The practice environment for psychiatrists has changed markedly in the last several years. Traditional fee-for-service private practice is becoming a rarity, and restricted panel managed care with deep discounts is emerging as the norm. How did we get into this situation, and how can we cope effectively with it? This presentation will briefly review the history of influences on our practices. These began with essentially unregulated direct-payment fee for service, followed by the introduction of third-party payers, which evolved into the new health care delivery systems. What impact did these changes have on our practices? They profoundly affect how patients get referred to us, the types of patients we see, and the options we can provide to these patients. This presentation will suggest ways by which we can cope effectively with the changes wrought by the new environment.

Dr. Keller will discuss the management of acute episodes of depression under managed care. The effectiveness of the psychiatrist depends on his or her ability to correctly diagnose major depression, assess other comorbid conditions, apply treatment, and monitor the response to treatment. Rating scales are essential for quantifying the condition and the patient's response. In a managed care setting the diagnosis of depression will be made by the gatekeeper, who will refer the patient if he or she believes that the patient's condition warrants a specialist's care. A first step in treatment is to assess other comorbid conditions: bipolar disorder, anxiety symptoms or disorder, somatization disorder, alcohol or drug use disorder, personality disorder, and sexual or physical abuse in the past or present. The patient should be seen each week for a minimum of half an hour. The most significant change in depressive symptoms occurs in the first week after the start of antidepressant or placebo administration. If the symptoms do not show some change, the psychiatrist should not increase the dose until the third visit; after several weeks the dose can be pushed to its maximum. In addition, the patient and his or her family should be educated about depressive disorder.

Dr. Wagner will discuss the management of adolescent depression under managed care conditions. Major depression in children and adolescents is highly prevalent and underrecognized. It is associated with marked impairments in familial, social, and academic functioning. Suicidal behavior does occur with depression in children and adolescents, and completed suicides have been reported in children as young as 5 years of age. In addition, chronicity and recurrence rates are very high. Unfortunately, the research base on the diagnosis and treatment of major depression in children and adolescents is modest in comparison with that for adults, and clinicians have few scientific data to guide them in the management of this disorder. This presentation will review the current status of the diagnosis, clinical course, and treatment of major depression in children and adolescents, sup-plemented by the author's clinical experience in this area. Published data about the use of antidepressants (particularly serotonin reuptake inhibitors) will be discussed. Psychotherapies specifically modified for the treatment of depressed adolescents will be included. Special problems in diagnosing and treating children and adolescents with major depression under managed care procedures will be highlighted.

Dr. Fawcett will discuss the management of complicated depressions. Although 60-70% of depressed patients respond to the first antidepressant drug trial, the remaining 30-40% are treatment challenges for clinicians. Increasingly, in the managed care environment family practitioners and other nonpsychiatric clinicians treat uncomplicated depressions. This has resulted in an increase in the proportion of psychiatric practices devoted to the management of complicated depressions. These cases encompass patients with treatment-refractory depression, comorbid mental disorders, more than one primary psychiatric disorders, or bipolar depression. This presentation will comprehensively review the treatment of complicated depressions; the discussion will cover diagnostic issues in these difficult cases and an algorithm for managing treatment-resistant depression. The use of a combination of pharmacotherapies, a combination of psychotherapy and pharmacotherapy, or electroconvulsive therapy for this patient population will be described.

REFERENCES:

1. American Psychiatric Association: Practice Guideline for the Treatment of Patients with Bipolar Disorder. *Am J Psychiatry* 151(Dec suppl), 1994.
2. Howland RH: Pharmacotherapy of dysthymia: a review. *J Clin Psychopharmacol* 11(2):83-92, 1991.
3. Jensen PS, Ryan ND, Prien R: Psychopharmacology of child and adolescent depression: present status and future direction. *J Child Adolesc Psychopharmacol* 2:31-43, 1992.
4. Boyer W, Nemeroff CB: Somatic approaches to treatment-resistant depression. In Docherty J (ed): *Inpatient Psychiatry in the 90's.* American Psychiatric Press, Washington, DC, in press.
5. DeBatista C, Schatzberg AF: An algorithm for the treatment of major depression and its subtypes. *Psychiatr Ann* 24:341-347, 1994.

INDUSTRY SUPPORTED SYMPOSIA

Industry Supported Symposium 9
Monday, October 9 5:15 p.m.-8:15 p.m.

PROGRESS IN PSYCHOSES

Supported by Janssen Pharmaceutica and Research Foundation

Jack M. Gorman, M.D., *Chief, Department of Clinical Psychobiology, Columbia University, 722 West 168th Street, New York, NY 10032;* Daniel E. Casey, M.D., David Pickar, M.D., Richard L. Borison, M.D., Ph.D., Stephen R. Marder, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the neurobiology of dopamine and serotonin in schizophrenia, discuss current hypotheses regarding factors in schizophrenia's pathophysiology, describe appropriate use of atypical neuroleptic drugs, discuss clinical aspects of positive and negative symptoms of schizophrenia, identify the adverse side effects of drugs for schizophrenia, and describe approaches to treating patients with refractory schizophrenia.

SUMMARY:

The introduction of a new class of drugs, called atypical neuroleptics, has substantially changed both our current thinking about the etiology of schizophrenia and our approach to treatment. Two atypical agents are already available in the United States, clozapine and risperidone, and a host are now under investigation. In this symposium the speakers will thoroughly review current etiological and treatment ideas about schizophrenia.

Dr. Casey will review the neurobiology of the two neurotransmitter systems now believed to be most affected in schizophrenia, dopamine and serotonin. Data implicate critical interactions between these neurotransmitters in neuroanatomy, receptor subtypes, and metabolites. The neuroanatomically overlapping dopamine and serotonin systems in the prefrontal cortex, limbic, and striatal regions of the brain are the basis of a potentially rich interaction. Post-mortem and CSF studies suggest that ratios of receptor subtypes to neurotransmitter metabolites may identify clinical subgroups. Studies of new medications for schizophrenia support the hypothesis of dopamine-serotonin interactions. The atypical neuroleptics have the ability to block both serotonin type 2 (5-HT_2) receptors and dopamine receptors. Clozapine and risperidone have potent serotonin 5-HT_2 antagonism, as well as dopamine D_2 receptor blockade. These agents have unique antipsychotic efficacy and fewer motor side effects. Further investigation of dopamine-serotonin interactions may increase our knowledge of the causes of schizophrenia and improve treatment of schizophrenia and related psychoses.

Dr. Gorman will review current hypotheses about the relative contributions of genetic and epigenetic factors in disease pathophysiology. There is no longer any question that schizophrenia is, at least in part, the result of abnormal genes. Not only is the condition clearly familial, but the concordance rate for monozygotic twins is substantially higher than for dizygotic twins. Because the genetic etiology is multifactorial, it may be years before the abnormal genes are located in the genome, although many laboratories are making important progress. On the other hand, heritable factors cannot explain the etiology of schizophrenia entirely. Sporadic cases exist, and the concordance rate for monozygotic twins is well below 100%. Most modern theories posit that a set of factors, called epigenetic, interact with abnormal genes to produce schizophrenia. They are (a) viral and other infectious agents affecting brain development during gestation; (b) autoimmunity, possibly triggered by infections, which destroys neural tissue or disrupts normal neuronal processes; (c) obstetrical complications; and (d) severe maternal nutritional deprivation during the first trimester of pregnancy.

Dr. Pickar will discuss the development of the atypical neuroleptic drugs and their proper clinical use. After the success of clozapine in the treatment of otherwise poorly responsive patients with schizophrenia, high expectations have arisen for risperidone, a benzisoxazole derivative recently approved for clinical use, and for other new antipsychotics in various stages of development. It is no longer sufficient for new drugs to be effective antipsychotics; they are expected to (a) produce few or no extrapyramidal side effects, (b) reduce positive and negative symptoms, (c) be superior to a reference typical neuroleptic and at least as potent as clozapine, and (d) improve cognitive function. In addition to drugs based on D_2 and 5-HT_2 blockade, other compounds with either partial dopamine agonist properties or specific D_1-blocking effects are in clinical trials. In coming years compounds with selective effects on the D_4 receptor may also become available. Furthermore, the excitatory amino acid glutamate has received attention recently, and it may hold promise as a target for drug development.

Dr. Borison will explain the unique effects of three new atypical antipsychotic drugs on both positive and negative symptoms of schizophrenia and the adverse effects of these drugs. Risperidone (2-16 mg/day) has been the most widely used in clinical trials. Its efficacy for positive symptoms is at least as great as that of haloperidol (10-20 mg/day), and it has shown greater efficacy for negative symptoms. Risperidone produced significantly fewer extrapyramidal side effects than did haloperidol. In comparison to perphenazine, risperidone was equally efficacious but produced one-third the number of dystonic reactions. The data for olanzapine show that at a high dose (12.5-17.5 mg/day) it is as effective as haloperidol for positive symptoms, is more effective for negative symptoms, and produces significantly fewer extrapyramidal side effects. Sertindole (20 mg/day) decreased psychosis significantly better than did placebo and did not produce extrapyramidal side effects. The new atypical antipsychotic drugs appear to be as effective as traditional treatments, to be more effective in treating negative symptoms, and to have few extrapyramidal side effects.

Dr. Marder's presentation will focus on strategies for managing patients with schizophrenia who respond poorly to antipsychotic medications. Before patients are considered refractory, they should have adequate trials of their current medications. An adequate trial is defined in terms of its length, the dose of antipsychotic prescribed, and the presence of treatable side effects. If available, plasma level monitoring may provide some assurance that the dose is neither too high nor too low. The role of newer antipsychotics, such as risperidone and clozapine, for refractory patients will be reviewed. Practical issues in changing from one drug to another will also be discussed.

REFERENCES:

1. Casey DE: Schizophrenia: psychopharmacology. In Jefferson JW, Greist JH (eds): *The Psychiatric Clinics of North America: Annual of Drug Therapy*. Saunders, Philadelphia, 1994, pp 81-99.
2. Liberman JA, Brown AS, Gorman JM: Schizophrenia. In Oldham JM, Riba MB (eds): *American Psychiatric Press Review of Psychiatry*, vol. 13. American Psychiatric Press, Washington, DC, 1994, pp 133-170.
3. Pickar D, Owen RR, Litman RE, et al: Clinical and biologic response to clozapine in patients with schizophrenia: cross-over comparison with fluphenazine. *Arch Gen Psychiatry* 49:345-353, 1992.
4. Marder SR, Meibach RC: Risperidone in the treatment of schizophrenia. *Am J Psychiatry* 151:825-835, 1994.
5. Kane JM, Marder SR: Psychopharmacologic treatment of schizophrenia. *Schizophr Bull* 19:287-302, 1993.

LECTURES

Lecture 1

Saturday, October 7
3:30 p.m.-5:00 p.m.

AMERICAN PSYCHIATRY: PAST, PRESENT, AND FUTURE

Shervert H. Frazier, M.D., *Psychiatrist in Chief Emeritus and Director, Department of Postgraduate and Continuing Education, McLean Hospital, 115 Mill Street, Belmont, MA 02178-1048*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the issues involved in changing psychiatric graduate education to meet the needs of the future.

SUMMARY:

From a descriptive and classificatory past to an increasingly scientific basis for emotional problems, psychiatry has become a part of the rapid reorganization of health care delivery. Specialists who know a plethora of procedures fare better than those who engage in verbal and emotional interventions. But mentally ill patients still persist, and their behaviors increasingly become either self-monitored or family monitored outside inpatient settings-in community residential facilities with self-help, recovery, and consumer-organized groups and professionally monitored pharmacological interventions. New services are usually derived from research and educational ventures, which clearly need to set goals of realistic and attainable functions and interventions. Psychiatric graduate medical education lags behind in establishing a curriculum for the new psychiatry, guidelines for practice, interventions, and support and management that are based on (a) a clearer understanding of neurobiologic, psychosocial, and developmental etiologies; (b) more precise knowledge of psychoactive drugs, somatic therapies, imaging and laboratory findings, and scientific behavioral scales; and (c) familiarity with domestic abuse, stress evaluation and management, and other psychosocial considerations in a profoundly changed rehabilitative environment.

Techniques for introducing change, coping with the loss of a stable past, accepting a new knowledge base, and adapting to a computerized environment are the tasks of the moment. Major demands for patient and family education, exchange of information, and team coordination that maintains confidentiality are required to assure the care of patients and provide up-to-the-minute communication regarding every patient's illness and progress.

These changes in graduate psychiatric education, research, and knowledge transfer become the major goals in preparing professionals for a more rehabilitational approach with emphasis on appropriate expenditures to prevent chronicity of maladaptive behaviors.

Lecture 2

Saturday, October 7
3:30 p.m.-5:00 p.m.

THE PSYCHODYNAMICS OF MEDICATING

Harold I. Eist, M.D., *APA President-Elect and Medical Director, Montgomery Child and Family Health Services, 5705 Rossmore Drive, Bethesda, MD 20814-2227*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the essential importance of individual psychodynamics in the medicating process and how pharmacology alone is inadequate for proper, effective medicating.

SUMMARY:

Educational and training issues for current and future residents will be discussed in this session. The full implementation of proposed changes in health care will clearly take several years. The impact on residency training is likely to be significant; such effects may include changes in funding for trainers in professional roles (i.e., psychiatrist/patient options) and, equally important, in future practice opportunities. Together with more information about brain function and psychopharmacologic treatments for psychiatric patients, residents want and must receive greater understanding of how to integrate humanism into residency education and the treatment of patients. Equally pertinent, despite increasing fiscal pressure on programs and residents, major consideration must be given to residents' individual and often unique personal and professional goals.

REFERENCE:

1. Paine R, Sachs R, Krause T, et al: Educating medical students and residents as health protectors and patient advocates. *Am J Prev Med* 9:117-121, 1993.

Lecture 3

Saturday, October 7
3:30 p.m.-5:00 p.m.

CREATING A SYSTEM OF MANAGED CARE IN AN URBAN SETTING

Areta Crowell, Ph.D., *Director of Mental Health, County of Los Angeles, 2415 West Sixth Street, Los Angeles, CA 90057*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the approach taken by Los Angeles County to assure effective services for adults with serious mental illnesses and seriously emotionally disturbed children and youth in the current era of entrepreneurial managed care.

SUMMARY:

Los Angeles County is not only the largest county in the United States; it is also the most ethnically diverse. Nearly half the population is uninsured or Medicaid eligible: approximately 30% and 15%, respectively. Available public resources have been very limited for many years. Systems of care for both adults and children/youth have been developed to emphasize state-of-the-art wraparound services for the persistently disabled population and shorter-term crisis-oriented and triage services for the rest of the target population. A capitated wraparound pilot project was established for adults with the highest costs in the system over 5 years. The demonstrated cost-effective benefits of this model and its role in planning for managed Medicare mental health services will be described. Similar pilot results for the Children System of Care will also be described.

For many years California has had a two-track Medicaid system (a county-operated system with a fixed budget plus independent, fee-for-service providers with open-ended billing). The state is now moving all Medicaid-eligible persons into managed care. The county's implementation of the mental health carve out of inpatient Medicaid services and future plans will be described. Information about the clients, the service utilization in the two parallel systems, and California outcomes will also be presented.

REFERENCE:

1. Austin MJ, Blum SR (eds): Public Sector Planning for Managed Mental Health Care. *Admin Policy Ment Health* 22(3), 1995.

Lecture 4

Sunday, October 8
8:30 a.m.-10:00 a.m.

THE MARRIAGE OF MENTAL ILLNESS AND MENTAL HEALTH: ISN'T IT TIME FOR A DIVORCE?

E. Fuller Torrey, M.D., *Guest Researcher, NIMH Neuroscience Center at St. Elizabeths Hospital, 2700 Martin Luther King Avenue, S.E., Washington, DC 20032*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to distinguish issues of mental illness from issues of mental health, describe the historical antecedents of their marriage, and discuss how the marriage affects the participants' own ideas and careers.

SUMMARY:

The marriage of mental illness and mental health took place on September 10, 1909, with Dr. Sigmund Freud presiding. The union assumed a continuum from mental health to mental illness and evolved into the mental hygiene, orthopsychiatry, and community mental health center movements. From the beginning these movements embraced liberal political thought, from socialism in the 1930s to campus radicalism in the 1960s, and this trend has continued through the Kennedy, Carter, and Clinton administrations.

The marriage has produced many unwanted children: (a) mental illness, which is inherently apolitical, has become politicized through association with mental health; (b) the continuum theory allows virtually everyone to qualify as "mentally ill," as can be seen from *DSM-IV*; (c) resources, both fiscal and professional, have shifted from mental illness to mental health, one consequence of which is the Woody Allen syndrome; and (d) the concept of personal responsibility has become grossly obfuscated.

It is time for a divorce of mental illness and mental health on the grounds of incompatibility. The former is concerned with brain disease and science, is inherently apolitical, and attempts to treat a person. The latter is concerned with behavior and values, is inherently political, and attempts to save mankind. Proposed terms for a divorce will be outlined.

REFERENCE:

1. Torrey EF: *Freudian Fraud.* HarperCollins, New York, 1992.

Lecture 5

Sunday, October 8
10:30 a.m.-12 noon

INTEGRATING PSYCHOSOCIAL REHABILITATION AND PSYCHIATRY: WHAT ARE THE ISSUES?

Leona L. Bachrach, Ph.D., *Research Professor of Psychiatry, Maryland Psychiatric Research Center, University of Maryland School of Medicine, 19108 Annapolis Way, Gaithersburg, MD 20879-2122*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to assess the goodness of fit between psychosocial rehabilitation and psychiatric interventions for long-term mental patients.

SUMMARY:

Psychiatry and psychosocial rehabilitation, two disciplines identified with the care of severely disabled mental patients, are sometimes isolated from one another as the result of certain misconceptions and biases. On a conceptual level, biopsychosocial rehabilitation supports the notion that multiple biological, psychological, and sociological factors in interaction influence the lives of mentally ill individuals and contribute to their problems and disabilities. Because the field's belief system is entirely consistent with the increased focus on biopsychosocial interventions in psychiatry, the division between the two disciplines may be regarded as unnecessary, counterproductive, and countertherapeutic. Mentally ill individuals are best served when the two fields come together in a common cause. In order to achieve that end, certain practices, which are sometimes called psychosocial rehabilitation but in fact violate the discipline's basic belief system, must be eliminated; each field must cede some territory and exhibit some acceptance of the other.

REFERENCE:
1. Bachrach LL: Psychosocial rehabilitation and psychiatry in the care of long-term patients. *Am J Psychiatry* 149:1455-1463, 1992.

Lecture 6

Sunday, October 8
1:30 p.m.-3:00 p.m.

MANAGED CARE OVERVIEW: EVOLVING SYSTEMS OF MENTAL HEALTH CARE

Mary Jane England, M.D., *APA President and President, Washington Business Group on Health, Suite 800, 777 North Capitol Street, N.E., Washington, DC 20002-4239*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to understand paradigm shifts motivitating market-driven health care reform, and appreciate innovation in both public and private sector performance contracting for mental health care.

SUMMARY:

Market-driven health care reform has dramatically changed the delivery system for mental health and substance abuse treatment. Underlying paradigm shifts will be examined. Innovative purchasing standards will be presented, emphasizing quality, accountability and outcomes.

REFERENCES:
1. Schreter R., Sharfstein S. and Schreter C.; Allies and Adversaries: The Impact of Managed Care on Mental Health Services. *American Psychiatric Press, 1994.*
2. England, MJ; Protecting Patient Welfare in a Managed Care Enviroment. *Treatment Today, Summer 1995.*

Lecture 7

Monday, October 9
10:30 a.m.-11:30 a.m.

FUTURE OF HEALING

Leston L. Havens, M.D., *Professor of Psychiatry, Harvard Medical School and Cambridge Hospital, 151 Brattle Street, Cambridge, MA 02138*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the healing process in a systematic context.

SUMMARY:

Healing generally means the nonscientific part of treatment or cure. In the light of modern neuroscience, how can healing be exempt from a scientific approach? Dr. Havens will suggest a systematic approach to healing in the light of our emerging knowledge of the brain.

REFERENCES:
1. Talley PF, Strupp H, Butler SF (eds): *Psychotherapy Research and Practice.* Basic Books, New York, 1994, chap 5.
2. Havens L: *Making Contact.* Harvard University Press, Cambridge, MA, 1986.

Lecture 8

Monday, October 9
1:30 p.m.-3:00 p.m.

PSYCHIATRIC EPIDEMIOLOGY OF SCHIZOPHRENIA

Ming T. Tsuang, M.D., *Stanley Cobb Professor of Psychiatry, Harvard Medical School and Massachusetts Mental Health Center, 74 Fenwood Road, Boston, MA 02115*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the evidence for genetic factors in schizophrenia and the current status of research on the location of specific genes responsible for schizophrenia.

SUMMARY:

A substantial majority of recent studies provide evidence for the familial transmission of schizophrenia. Results of these projects show that relatives of schizophrenic patients have a higher risk for schizophrenia than do control subjects; this finding is consistent with theories of both genetic and environmental transmission. However, the findings from adoption and twin studies suggest that it is the genes provided by one's parents, rather than the environment, that are most important in imparting risk for schizophrenia. Twin studies consistently show higher rates of schizophrenia among co-twins in monozygotic pairs than in dizygotic pairs, and adoption studies show that familial transmission is mediated by genetic, not adoptive, relationships.

Even though family, twin, and adoption studies have provided strong evidence for the role of genetic factors in schizophrenia, the mode of transmission remains unclear. The results of rigorous mathematical modeling studies do not support the single-gene model. There is somewhat more support for the multifactorial polygenic model, but that model has also been rejected in several studies. Thus, the pattern of inheritance of schizophrenia has eluded an unambiguous characterization. Genetic linkage analysis promised to clarify the mechanisms of transmission, but early positive reports were subsequently overturned, and to date there are no consistently replicated positive linkage findings for schizophrenia. The current status of a worldwide search for the location of the genes on specific chromosomes that are responsible for schizophrenia will be discussed.

REFERENCES:
1. Tsuang MT, Gilbertson MW, Faraone SV: The genetics of schizophrenia: current knowledge and future directions. *Schizophr Res* 4:157-171, 1991.
2. Tsuang MT, Faraone SV: The genetic epidemiology of schizophrenia. *Compr Ther* 20:130-135, 1994.

Lecture 9 — Monday, October 9, 3:30 p.m.-5:00 p.m.

AUTHORITARIANISM AND THE PRACTICE OF PSYCHIATRY

Milton Greenblatt Memorial Lecture

Melvin Sabshin, M.D., *Medical Director, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005-2403*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss how some cultural, moral, political, and economic authoritarianism inhibits the practice of psychiatry and how democratic principles facilitate the practice of psychiatry.

SUMMARY:

The practice of psychiatry has always been profoundly affected by social, cultural, moral, political, and economic factors; more than in any other part of medicine, these external forces shape the boundaries of psychopathology, the availability of treatments, and attitudes toward mental illness. As psychiatry has become more objectified and influenced by empirical findings, it seems useful to reiterate how authoritarian societies can still influence the field.

During this century, blatant examples of the misuse of psychiatry have occurred in many countries, with the Soviet Union and Germany serving as significant prototypes. Ideological beliefs were insinuated into psychiatric practice, professionals were harassed, and hospitalization was used as a political threat and, indeed, an actual punishment. In this presentation these obvious examples will be discussed, but an effort will be made to look at other contexts in which authoritarianism was and is less blatant.

Psychiatric practice requires careful protection of patient confidentiality. Although this principle pervades all types of psychiatric diagnosis and treatment, it is absolutely essential in any process requiring free association. In many ways the principles of free association and confidentiality are directly antithetical to authoritarianism. Stigma against psychiatric patients (and psychiatrists) has decreased in many countries, but it still remains as a potent force. When clinical information revealed in psychiatric diagnosis and treatment involves cognitive, sexual, or abnormal behavior patterns (especially those that violate rigid norms), the impact of the external pressures is enormous. In certain countries with strict moral and religious precepts, exploration of these patterns may be explicitly and implicitly prohibited. Economic authoritarianism is also an important force shaping the practice of psychiatry. Although originally couched in terms of the need to restrict outrageous spending, in many countries restrictions on length and type of treatment are inextricably fused with residual stigma.

REFERENCE:
1. Strauss A, Schatzman L, Bucher R, et al: *Psychiatric Ideologies and Institutions.* Free Press of Glencoe, New York, 1964.

Lecture 10 — Tuesday, October 10, 10:30 a.m.-12 noon

PREVENTION: WHAT BIOLOGIC RESEARCH CAN CONTRIBUTE TO CAPITATED CARE

Joseph T. Coyle, Jr., M.D., *Chairman, Consolidated Department of Psychiatry, Harvard Medical School and McLean Hospital, 115 Mill Street, Belmont, MA 02178-2828*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss how advances in biologic research have created the opportunity for using indicated, selective, and universal preventive interventions to lower the risk of psychiatric disorders.

SUMMARY:

Until recently, the possibility of meaningful interventions that could alter biologic risk factors for psychiatric disorders seemed quite remote. This session will present three examples in which indicated, selective, or universal preventive interventions now seem feasible.

First, recent research has disclosed three genes that account for most cases of Alzheimer's disease: mutations of the amyloid precursor gene on HSA 21 and mutations on HSA 14, and apo E alleles on HSA 19. Understanding the molecular mechanisms that account for the neuropathology with each gene--likely mediated by abnormal disposition of amyloid--will permit pharmacologic interventions that arrest the pathologic process. Because individuals inheriting these genes can be identified, *indicated* preventive intervention based on presymptomatic treatment of individuals at risk for Alzheimer's disease will become possible through the use of drugs that alter the disposition of amyloid.

Second, epidemiologic studies indicate that children born to parents with major depression are at high risk for depression, substance abuse, and poor school performance. These adverse outcomes likely reflect an interplay of genetic and family

environmental factors. *Selective* psychologic interventions in families with parental affective disorder may reduce psychiatric morbidity in children.

Third, childhood conduct disorder is a diagnosis of high reliability and predictability for adverse outcome in adolescence and adulthood. Although conduct disorder is viewed as resulting primarily from psychosocial stressors, associated risk factors include prenatal exposure to abused substances, poor prenatal care, low birth weight, exposure to toxins (e.g., lead), and abuse or neglect. *Universal* interventions that enhance quality of perinatal care, reduce toxin exposure, and enhance parenting skills would likely reduce the prevalence of conduct disorder.

Effective preventive interventions for these three prevalent disorders could result in substantial reductions in mental health care costs.

REFERENCE:

1. Mrazek PJ, Haggerty JR: *Reducing Risks for Mental Disorders: Frontiers for Preventive Interventions.* National Academy Press, Washington, DC, 1994.

MULTIMEDIA SESSIONS

Multimedia Session 1 — Friday, October 6, 8:30 a.m.-10:00 a.m.

MILTON ERIKSON, M.D., EXPLORER IN HYPNOSIS AND THERAPY

Produced by Jay Haley and Madeleine Richeport, 1994. Available from Filmakers' Library.

Chairperson: Theodore Nadelson, M.D., *Professor of Psychiatry, Boston VA Medical Center*

SUMMARY:

This video contains archival footage of Erikson at work. Colleagues, students, and patients describe their contacts with this therapeutic innovator.

Multimedia Session 2 — Friday, October 6, 10:30 a.m.-12 noon

ANXIETY DISORDERS: *DSM-IV*--NEW DIAGNOSTIC ISSUES

Produced by American Psychiatric Video Source, 1995. Available from American Psychiatric Press, 1400 K Street, N.W., Washington, DC 20005; phone: (800) 368-5777.

Chairperson: Carol C. Nadelson, M.D., *Clinical Professor of Psychiatry, Harvard Medical School, Boston, MA*

SUMMARY:

This is one of three new clinical video programs revealing additions and changes in *DSM-IV* for anxiety disorders. It features the clinical work of Andrew E. Skodol II, M.D., associate professor of clinical psychiatry at the College of Physicians and Surgeons of Columbia University. Segments of actual clinical interviews provide a focus for the moderated discussion.

Multimedia Session 3 — Friday, October 6, 2:15 p.m.-3:30 p.m.

COMPUTER DEMONSTRATION--(A) MACROS FOR WORD PROCESSING IN RELATION TO MANAGED CARE; (B) ON-LINE USE OF COMPUTERS FOR PATIENT CARE

Chairperson: Ian Alger, M.D., *The New York Hospital-Cornell Medical Center, 500 East Seventy-Seventh Street, New York, NY 10168*

Presenter: Zebulon C. Taintor, M.D., *19 E. 93rd Street, New York, NY 10128-0609*

SUMMARY:

Using actual programs, these applications for enhancing medical and psychiatric care will be demonstrated. Time-saving and error-reducing macros in word processing will be shown to more easily fulfill managed care criteria.

The on-line computer applications in the enhancement of patient care will also be shown.

Multimedia Session 4 — Friday, October 6, 3:30 p.m.-4:30 p.m.

THE INVISIBLE DISABILITY: MENTAL ILLNESS

Produced by Thomas Gugliotti and Karen A. Kangas, Ed.D., 1994. Available from Office of Community Education/ Communications, Connecticut Department of Mental Health, 90 Washington Street, Hartford, CT 06106; phone: (203) 566-5837; fax: (203) 566-6195.

Chairperson: Alan Manevitz, M.D., *Clinical Assistant Professor of Psychiatry, The New York Hospital-Cornell Medical College, New York, NY*

Presenter: Karen A. Kangas, Ed.D., *Director of Communications, Connecticut Department of Mental Health, 90 Washington Street, Hartford, CT 06106*

SUMMARY:

Aired on prime-time television in December 1994, this program features people from all walks of life, including a Presidential aide, a classical musician, and a college professor, who have psychiatric disabilities and lead successful, productive lives. The camera follows them, using the professional and creative activities they do best as background, as they share their experiences with mental illness, stigma, struggle, and recovery. This presentation uses the power of video to influence perceptions, challenge assumptions, and encourage careful thought about the negative cultural images of mental illness. It is designed to work in a variety of settings and for a variety of audiences. It is both intellectually stimulating and moving and is a technically rich work.

Multimedia Session 5 — Friday, October 6, 4:30 p.m.-5:30 p.m.

COPE WITH HOPE: LEARNING FROM EXPERIENCE HOW TO RECOVER

Produced by Dan Davis and Gene Palmer, William S. Hall Psychiatric Institute, Columbia, SC, 1995.

MULTIMEDIA SESSIONS

Chairperson: Alan Manevitz, M.D., *Clinical Assistant Professor of Psychiatry, The New York Hospital-Cornell Medical College, New York, NY*

Presenters: Kay J. McCrary, Ed.D., *Director, Patient and Family Education, Bryan Psychiatric Hospital, 220 Faison Drive, Columbia, SC 29203;* Victoria C. Cousins, B.A., *Director, Office of Consumer Affairs, South Carolina Department of Mental Health, P.O. Box 485, Columbia, SC 29202*

SUMMARY:

"Cope with Hope" is a series of videotapes, each featuring one person's own account of how he or she recovered satisfaction in life and a lifestyle in the community despite a diagnosis of either schizophrenia or bipolar affective disorder. Each speaker makes suggestions for maintaining personal wellness and preventing relapses. While sharing life experiences, the speaker notes his or her own turning point, when he or she began to control the illness, instead of being controlled by it.

Currently there are three tapes in the series, two more are scheduled for production, and a total of 15 are planned. The series reflects the South Carolina Department of Mental Health's commitment to partnership with consumers of mental health services to improve the consumers' quality of life. Consumer Affairs Coordinators employed by community mental health centers in South Carolina are the individuals videotaped. Making such a tape served to prepare each coordinator for public disclosure, for the role of spokesperson, and for public education duties.

In South Carolina the tapes are being shown only when a consumer representative cannot be present in person to speak to new employees, civic groups, church groups, and public school students. Another significant use of the tapes is in a state psychiatric admissions hospital. One tape is shown daily on closed circuit, on a rotating basis, after the morning ward meeting to provide positive and encouraging role models for inpatients.

Multimedia Session 6 — Saturday, October 7, 7:30 a.m.-8:30 a.m.

THE RISK: OBSESSIVE-COMPULSIVE DISORDER

Produced by James R. Callner, Kimberly Schwartz, and Michael Morris, 1995. Available from Awareness Films, Suite 3, 435 Alberto Way, Los Gatos, CA 95032; phone: (408) 395-8509; sale: $19.95.

Chairperson: Hunter L. McQuistion, M.D., *Medical Director, Project Renewal, Inc., 200 Varick Street, New York, NY 10014*

Presenter: James R. Callner, M.A.

SUMMARY:

This video focuses on a young mother who has severe obsessive-compulsive disorder (OCD) that includes debilitating contamination and germ phobias, extending to an inability to touch her own 7-year-old daughter. With great anxiety and trepidation, she reaches out to an OCD support group. Her fears are so overwhelming that she is able only to stand outside the door of the support group's meeting. With a qualified therapist leading the group, this young woman overhears and identifies with the emotional stories of the group members, which prompt her to recall her own childhood, adolescent, and adult OCD traumas and the reactions of her family.

After several compelling flashbacks of her own life, she finds the courage to take the risk to enter the room. With the willingness to take more emotional risks to help herself through a process of treatment, this young mother reaches the point of recovery where she is able to move through her fears and phobias, reclaiming her family and being freed to hold and comfort her daughter.

The video emphasizes the importance of family treatment and support and the usefulness of various treatment modalities. It is intended for OCD sufferers and their families, educators and counselors in schools and support groups, and psychiatric and other medical professionals.

Multimedia Session 7 — Saturday, October 7, 10:30 a.m.-12 noon

COMPUTER DEMONSTRATION--LOOKING FOR SHAREWARE GEMS ON THE INTERNET

Chairperson: Ian Alger, M.D., *The New York Hospital-Cornell Medical Center, 500 East Seventy-Seventh Street, New York, NY 10168*

Presenter: Marvin J. Miller, M.D.

SUMMARY:

This talk will summarize various places to find computer software on the Internet. Downloading and unpacking the software and putting it to work will be discussed. Several shareware packages will be demonstrated.

Multimedia Session 8 — Saturday, October 7, 12 noon-1:30 p.m.

SURVIVING SCHIZOPHRENIA: PORTRAITS ON FILM

Produced by Royal Ottawa Hospital, 1992. Available from Lyn Williams-Keeler, M.A., Schizophrenia Service, Royal Ottawa Hospital, Carmichael Building, 1145 Carling Avenue, Ottawa, Ontario K1Z 7K4, Canada; phone: (613) 722-6521, ext. 6240; fax: (613) 722-5048.

MULTIMEDIA SESSIONS

Chairperson: Peter Stastny, M.D., *Associate Clinical Professor of Psychiatry, Albert Einstein College of Medicine, Bronx, NY*

Presenters: Heather Milliken, M.D., F.R.C.P.(C.), *Clinical Director, Schizophrenia Service, Royal Ottawa Hospital, Second Floor, Whitney Building, 1145 Carling Avenue, Ottawa, Ontario K1Z 7K4, Canada;* Lyn Williams-Keeler, M.A., *Research Associate, Schizophrenia Service, Royal Ottawa Hospital, Carmichael Building, 1145 Carling Avenue, Ottawa, Ontario K1Z 7K4, Canada*

SUMMARY:

The seven improvisational scenes that form the core of this presentation are designed to impart to high school students the impact of schizophrenia on young lives. Part of this educational process involves the demystification of this illness by members of their own peer group--talented teenaged improvisational actors, a high school team of competitors in the Canadian Improv Olympics.

In making this video, a group of family members and two separate groups of people with schizophrenia (inpatient and outpatient) shared with the actors their experiences and feelings related to living with schizophrenia. The actors were also given extensive instruction by members of the Schizophrenia Clinic at the Royal Ottawa Hospital in order to develop both personal insight and practical knowledge of the toll and social complications of the disease. From this experience, the team developed the seven improvisational scenes in the video to realize a compelling statement about a difficult theme.

Multimedia Session 9 — Saturday, October 7, 1:30 p.m.-3:00 p.m.

PSYCHOTIC DISORDERS: *DSM-IV*--NEW DIAGNOSTIC ISSUES

Produced by American Psychiatric Video Source, 1995. Available from American Psychiatric Press, 1400 K Street, N.W., Washington, DC 20005; phone: (800) 368-5777.

Chairperson: Carolyn Robinowitz, M.D., *Associate Dean for Students, Georgetown University Medical Center, Washington, DC*

SUMMARY:

This presentation is one of three new clinical video programs revealing additions to and changes in *DSM-IV* for psychotic disorders. Featuring the clinical work of Nancy C. Andreasen, M.D., Ph.D., Andrew H. Woods Professor of Psychiatry, University of Iowa College of Medicine, segments of actual clinical interviews provide a focus for the moderated discussions.

Multimedia Session 10 — Saturday, October 7, 3:00 p.m.-4:30 p.m.

UNCERTAIN JOURNEY: FAMILIES COPING WITH SERIOUS MENTAL ILLNESS

Produced by Department of Psychiatry, Duke University Medical Center, 1995. Available from Department of Psychiatry, Box 3173, Duke University Medical Center, Durham, NC 27710; phone: (919) 684-3332; rental: $10.00 for 30 days; sale: $50.00 (includes shipping).

Chairperson: Malkah T. Notman, M.D., *Clinical Professor of Psychiatry, Harvard Medical School, 54 Clark Road, Brookline, MA 02146*

Presenters: Marvin S. Swartz, M.D., *Associate Professor of Psychiatry, Box 3173, Duke University Medical Center, Durham, NC 27710;* Bridget Harron, M.S.N., M.S.W., *Nurse Manager, Inpatient Services, VA Medical Center, Box 3173, Duke University Medical Center, Durham, NC 27710*

SUMMARY:

Serious mental illness often has devastating effects on families of individuals with these disorders. In the past, families were often viewed as pathogenic agents, and this perception further added to the pain and shared stigma of these disorders. This videotape tells the stories of three families with members who suffer from serious mental illness. The perspectives of parents, spouses, and siblings are illustrated, with additional commentary from experts in the field. The problems of coping with these illnesses, the accompanying stigma, and the difficulty in obtaining services for these disorders are discusses, with suggestions for helpful resources.

Multimedia Session 11 — Saturday, October 7, 4:30 p.m.-5:30 p.m.

PHYSICIANS LIVING WITH PSYCHIATRIC ILLNESS

Produced by Michael F. Myers, M.D., Department of Psychiatry, St. Paul's Hospital, Vancouver, British Columbia, Canada.

Chairperson: Malkah T. Notman, M.D., *Clinical Professor of Psychiatry, Harvard Medical School, 54 Clark Road, Brookline, MA 02146*

SUMMARY:

Two physicians engage in a conversation with Dr. Myers as they describe their own reactions, and the reactions of colleagues, during and after the time they experienced stressful psychiatric illness. This presentation is moving and a most educational experience for all those who treat patients with psychiatric illness.

MULTIMEDIA SESSIONS

Multimedia Session 12 — Sunday, October 8, 8:30 a.m.-10:00 a.m.

A RIGHT TO DECIDE: OLDER PEOPLE TALK WITH THEIR PHYSICIANS ABOUT LIFE SUPPORT INTERVENTION

Produced by Peter Walsh and Doug Boyd, Fanlight, 1991.

Chairperson: Anita Menfi, R.N., M.Ed., *School of Education, New York University, 15 East Ninety-Second Street, New York, NY 10028*

Presenter: F. Russell Kellogg, M.D., *Suite 414, 36 Seventh Avenue, New York, NY 10111*

Discussant: Deanna Perlmutter, R.N., Ed.D., *281 Beacon Street, Boston, MA 02116*

SUMMARY:

Three elderly patients and their physicians discuss the decision to use life support interventions if faced with life-threatening illness.

Multimedia Session 13 — Sunday, October 8, 10:00 a.m.-11:30 a.m.

COMPUTER DEMONSTRATION--COMPUTER-ASSISTED INTERACTIVE THERAPY PROGRAMS

Chairperson: Ian Alger, M.D., *The New York Hospital-Cornell Medical Center, 500 East Seventy-Seventh Street, New York, NY 10168*

Presenter: Roger L. Gould, M.D., *Apt. 9C, 20 East Seventy-Fourth Street, New York, NY 10021*

SUMMARY:

Computer-assisted interactive therapy is a brief therapy that uses a model of adult development and focuses on life-course decisions and action conflicts. The program has already been used by over 14,000 patients

Multimedia Session 14 — Sunday, October 8, 11:30 a.m.-12:30 p.m.

COMPUTER DEMONSTRATION--VIRTUAL REALITY, THE INTERNET, AND BEHAVIOR MODIFICATION

Chairperson: Ian Alger, M.D., *The New York Hospital-Cornell Medical Center, 500 East Seventy-Seventh Street, New York, NY 10168*

Presenter: Hans B. Sieburg, Ph.D., *Department of Mathematics, University of California, San Diego, Mail Code 0112, San Diego, CA 92103*

SUMMARY:

Virtual reality is a very enhanced computer simulation which allows full immersion of the user in a totally interactive enviroment. This presentation will attempt to demonstrate these phenomena through the use of the Internet, and the World Wide Web.

Multimedia Session 15 — Sunday, October 8, 12:30 p.m.-1:45 p.m.

MOOD DISORDERS: *DSM-IV*--NEW DIAGNOSTIC ISSUES

Produced by American Psychiatric Video Source, 1995. Available from American Psychiatric Press, 1400 K Street, N.W., Washington, DC 20005; phone: (800) 368-5777.

Chairperson: Alan S. Pollack, M.D., *24 Littlefield Road, Newton, MA 02159*

SUMMARY:

This is one of three new video programs revealing additions to and changes in *DSM-IV* for mood disorders. Featuring the clinical work of Ellen Frank, Ph.D., professor of psychiatry and psychology, University of Pittsburgh, segments of actual clinical interviews provide a focus for the moderated discussion.

Multimedia Session 16 — Sunday, October 8, 1:45 p.m.-3:00 p.m.

COMPUTER DEMONSTRATION--CD-ROM HEALTHGUIDE: MAJOR DEPRESSION

Produced by Clinical Tools, Inc., 1995. Available from Clinical Tools, Inc., Suite 720, 5001 Baum Boulevard, Pittsburgh, PA 15213; phone: (412) 688-8970.

Chairperson: Alan S. Pollack, M.D., *24 Littlefield Road, Newton, MA 02159*

Presenter: T. Bradley Tanner, M.D., *Assistant Professor of Psychiatry, University of Pittsburgh and Western Psychiatric Institute and Clinic, Room 182, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

The presenter will discuss recent technological advances and the opportunities these provide for developing innovative ways of educating patients about their mental illnesses. The presentation will focus on demonstration of a CD-ROM prototype, which can be used to educate patients with major depression about the illness and antidepressants. The presenter will describe the process of developing a curriculum for teaching patients through the CD-ROM medium, highlighting several of the steps involved, including background research, text creation, and integration of visual and auditory imagery. The roles of patients, families, and mental health professionals in developing such an educational product will also be discussed. Finally, measurements of product effectiveness will be covered.

Multimedia Session 17 — Sunday, October 8 3:00 p.m.-5:00 p.m.

(A) PHYSICIANS WITH AIDS: AN INTERVIEW WITH PETER (PART 2)

Produced by Michael F. Myers, M.D., Department of Psychiatry, St. Paul's Hospital, Vancouver, British Columbia, Canada, 1993.

Chairperson: Stephen M. Goldfinger, M.D., *Massachusetts Mental Health Center, 74 Fenwood Road, Boston, MA 02115*

SUMMARY:

In a previous videotape (Part 1) Dr. Myers interviewed Peter, a physician who discovered that he had AIDS. In this final interview, shortly before Peter's death, Dr. Myers documented this moving and revealing conversation that speaks to all of us, physicians and patients, loved ones and friends.

(B) THE DROP-IN GROUP

Produced by Stephen Brady, Ph.D., 1993. Available from Fanlight Productions.

Chairperson: Stephen M. Goldfinger, M.D., *Massachusetts Mental Health Center, 74 Fenwood Road, Boston, MA 02115*

SUMMARY:

This video for staff education presents an overview of an AIDS education and prevention program for the mentally ill conducted at the Dr. Solomon Carter Fuller Mental Health Center in Boston. It includes interviews with the participants in the program.

POSTER SESSIONS

Poster 1

Saturday, October 7
12 noon-1:30 p.m.

BOUNDARY ISSUES IN THE PRACTICE OF CASE MANAGEMENT

Taylor B. Anderson, M.S.W., L.S.W., *Associate Director, Medical College of Pennsylvania, 3200 Henry Avenue, Philadelphia, PA 19129;* George R. Lucey, M.Ed., N.O.C.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify specific boundary conditions that differ between case management and clinical practice, discuss the reasons for such differences and the risks inherent in these differences, and use the information from the poster to create conscious discussion and negotiation of these boundary differences.

SUMMARY:

The issue of boundaries in case management practice has been neglected until recently, although it has experienced renewed attention in the psychiatric community. The field of case management is expanding because of both managed care and the emphasis on connecting seriously mentally ill persons with services and means of intervention that are effective in reaching and treating them. Case managers may come from other disciplines that have codes of ethics (e.g., nursing, social work), or they may be hired with no particular professional identity or experience in case management. In either case, the role and functions are different from those they have performed in the past.

The need for conscious identification of the major boundary issues for ethical practice of case management is critical. The presenters have coauthored a major course aimed primarily at case managers and supervisors and have field-tested this course many times in large regions of Pennsylvania. This poster will present boundary issues that *must* be negotiated and the means of building consciousness regarding practices that may be risky for both case managers and those receiving their services.

REFERENCES:

1. Epstein RC: *Keeping Boundaries: Maintaining Safety and Integrity in the Psychotherapeutic Process.* American Psychiatric Press, Washington, DC, 1994.
2. Gutheil TG, Gabbard GO: The concept of boundaries in clinical practice: theoretical risk-management dimensions. *Am J Psychiatry* 150:188-196, 1993.

Poster 2

Saturday, October 7
12 noon-1:30 p.m.

CROSS-SECTIONAL AND LONGITUDINAL RESEARCH DESIGN IN EVALUATION OF COMMUNITY MENTAL HEALTH CENTERS

Helle Charlotte Knudsen, M.D., Ph.D., *Staff Psychiatrist, Institute of Preventive Medicine, Kobenhavns Kommunehospital, 1399 Copenhagen K, Denmark*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe advantages and disadvantages of different research designs used in evaluating community mental health services/ centers.

SUMMARY:

The impact of a community mental heath center (CMHC) is often measured by the changes observed after its introduction. It is conceivable, however, that some of the changes measured may just as well have occurred without the introduction of the CMHC. This possibility may be investigated by pre- and post-CMHC assessments carried out in comparable districts with and without CMHCs.

Within a quasi-experimental research design (that included control districts) the effects of new CMHCs on service provision and on the population's utilization of services were measured through the use of a preintervention assessment and a postintervention assessment 2 years later. The research consisted of both cross-sectional and longitudinal studies. These two methods yielded different insights into the effects of the changes in the services.

Results of the studies will be presented, and advantages and disadvantages of the research designs and their implications for interpretation of the results will be discussed.

REFERENCES:

1. Knudsen HC, Krasnik A, Jessen-Petersen B, et al: Patients in the care of private psychiatric practitioners: comparison with public hospital patients and the background district's population. *Soc Psychiatry Psychiatr Epidemiol* 27:156-160, 1992.
2. Schene AH, Henderson JH, Knudsen HC, et al: The evaluation of mental health care transformation in the cities of Europe. *Int J Soc Psychiatry* 38:40-49, 1992.

Poster 3

Saturday, October 7
12 noon-1:30 p.m.

HOME/COMMUNITY-BASED INTERVENTIONS FOR MULTIPROBLEM FAMILIES

Sylvia Levitan, L.C.S.W, B.C.D., *Director, Family Preservation Program and In-Home Programs, Hillsides Home for Children, 940 Avenue 64, Pasadena, CA 91105;* Gladys Garcia, L.C.S.W., B.C.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify and use comprehensive interventions and innovative treatment approaches to treat abused and troubled children and their families.

SUMMARY:

The Family Preservation Program is an integrated, comprehensive community-based approach to service delivery that ensures child safety while strengthening families who are experiencing problems in functioning characterized by child abuse, neglect, or exploitation. This program also serves severely emotionally disturbed and academically impaired children (and their families) who are at imminent risk of residential placement or who are currently placed in residential programs. These children have been identified by the school district and have axis I diagnoses.

The Family Preservation Program addresses the complex problems of children at imminent risk of removal from their homes because of abuse or neglect, as well as children with mental illness. It is family centered, and treatment is tailored to meed a family's individual needs. Culture and ethnicity are considered in working with these families.

This poster will focus on clinical issues in conducting these therapeutic interventions, which may include cognitive-behavioral problems, psychoeducation, case management, systems intervention, family therapy, crisis intervention, medication, and a systematic approach (family-community interaction). It emphasizes empowering the family and recognizing family members' strengths and capacity for change. Case examples will be included.

REFERENCES:

1. Yaryura-Tobias JA, Neziroglu F: *Over and Over Again: Understanding Obsessive-Compulsive Behavior,* 1991.
2. Mahoney MJ, Freeman A (eds): *Cognition and Psychotherapy.* Plenum, New York, 1985.

Poster 4 — **Saturday, October 7, 12 noon-1:30 p.m.**

RESPONSE TO MOBILE CRISIS INTERVENTION: FOLLOW-UP II

David C. Lindy, M.D., *Chief Psychiatrist, Community Mental Health Services, Visiting Nurse Service, 350 Fifth Avenue, New York, NY 10118;* Neil Pessin, Ph.D., Leila Laitman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to list several characteristics of patients receiving mobile crisis services and discuss the impact and effectiveness of these services.

SUMMARY:

Mobile crisis teams are often acknowledged as essential components of community-based mental health service delivery systems. However, the literature contains relatively few empirical studies regarding their impact. The Visiting Nurse Service of New York operates three mobile crisis teams in New York City, which make approximately 3,000 patient visits per year. In 1991 the presenters reported data based on a chart review of Visiting Nurse Service mobile crisis team cases (N = 262) and follow-up telephone data from a sample of those cases (N = 43). Most telephone respondents had found the visit by the mobile crisis team to be helpful, regardless of whether they were patients or family members or whether the visit had resulted in hospitalization, including involuntary hospitalization.

In this poster the presenters will report prospective data on a recent sample of patients treated by mobile crisis teams; patient demographic variables and diagnosis, family and social supports, results of intervention, and availability of appropriate dispositions will be discussed. Follow-up data from a larger sample of patients and/or family members interviewed 3 months after the initial visit will also be presented. The data will include measures of patient and family satisfaction with mobile crisis team intervention, adequacy in meeting special needs (e.g., of geriatric patients), effectiveness of disposition, and each patient's current status.

REFERENCE:

1. Cohen NL (ed): *Psychiatry Takes to the Streets: Outreach and Crisis Intervention for the Mentally Ill.* Guilford Press, New York, 1990.

Poster 5 — **Saturday, October 7, 12 noon-1:30 p.m.**

THE CRISIS RECEIVING UNIT: AN ALTERNATIVE TO INTENSIVE HOSPITAL CARE

Susan E. Pearlson, M.D., *Medical Director, Zumbro Valley Mental Health Center, 2116 Southeast Campus Drive, Rochester, MN 55904*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to (a) describe the low-intensity crisis receiving unit model of care as an alternative to more intensive, hospital-based treatment and (b) discuss the advantages, both economic and treatment-related, of using less-intensive residential settings for crisis stabilization.

SUMMARY:

The purpose of this study was to examine the cost-effectiveness of a residential crisis service for stabilization of patients

experiencing stress or exacerbation of chronic symptoms of mental illness who do not require full hospitalization.

All mental health admissions ($N = 201$) to a crisis receiving unit were reviewed for a 6-month period. Each patient was evaluated according to admission criteria for a local acute care hospital to determine which patients would have met criteria for admission. The actual cost of admission of these patients to the crisis unit was compared to the estimated cost of care had they been admitted to either the local hospital or the state regional facility.

Eighty-five percent of the patients admitted to the crisis receiving unit would have met the criteria for emergency admission to a hospital. Admission of these patients to the crisis receiving unit cost approximately $50,000 less than admission to the regional treatment center would have cost and approximately $150,000 less than admission to the local acute care hospital.

In conclusion, many patients who experience a mental health crisis can be served in a less-intensive, nonhospital setting, thus allowing continuity of community care and substantial cost savings.

REFERENCES:

1. Lurie N, Moscovice L, Finch M, et al: Does capitation affect the health of the chronically mentally ill? results from a randomized trial. *JAMA* 267:3300-3304, 1992.
2. Santos A, Hawkins G, Julius B, et al: A pilot study of assertive community treatment for patients with chronic psychotic disorders. *Am J Psychiatry* 150:501-504, 1993.
3. Creed F, Black D, Anthony P, et al: Randomized controlled trial of day patient versus inpatient psychiatric treatment. *Br Med J* 300:1033-1037, 1990.
4. Parker S, Knoll J: Partial hospitalization: an update. *Am J Psychiatry* 147:156-160, 1990.

Poster 6 **Saturday, October 7**
12 noon-1:30 p.m.

THE CLOTHING PROJECT: TEACHING SKILLS, GIVING CHOICES

Kathy Shook, M.S., R.N., *Associate Clinical Professor, University of California at San Francisco School of Nursing, San Francisco General Hospital, Room 7E27, 1001 Potrero Avenue, San Francisco, CA 94110;* Ann Schultz, B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify two ways in which chronic psychiatric patients can benefit from a skills-building project.

SUMMARY:

Chronic psychiatric patients can be easy to spot in a crowd--many are unkempt and disheveled or wear ill-fitting, mismatched, or inappropriate clothing. This high visibility accounts for much of the negative attention these patients receive in the community. This poster will describe the Clothing Project, a rehabilitation-focused project aimed at meeting chronic patients' needs related to selecting and wearing appropriate clothing. Having a choice of clothing from which to select and a supportive staff person to assist and give feedback can help patients to develop a range of skills, including decision making, communication, and conflict resolution. Patients have responded positively to the pilot project. Several have improved their overall grooming, many have expressed pride in how they look, and conversation among patients now includes ordinary small talk about clothes and appearance. The project helps patients to improve their self-esteem, gain new social skills, learn to dress, and, ultimately, behave in more socially acceptable ways.

REFERENCE:

1. Liberman RP: *Handbook of Psychiatric Rehabilitation.* Macmillan, New York, 1992.

Poster 7 **Saturday, October 7**
12 noon-1:30 p.m.

FROM HOSPITAL-BASED TO COMMUNITY-BASED PSYCHIATRY IN DENMARK

Hans Jorgen Sogaard, Ph.D., *Senior Research Fellow, Department of Psychiatric Demography, Institute for Basic Psychiatric Research, Psychiatric Hospital in Aarhus, 8240 Risskov, Aarhus, Denmark*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the consequences for Denmark's public health service, through which all citizens have health insurance, of transferring the responsibility for psychiatric services to the social welfare system and making them community based instead of hospital based.

SUMMARY:

The health care and social welfare system in Denmark will be described. A quasi-experimental design was used to study a catchment area of 72,000 inhabitants. The responsibility for psychiatric service was transferred from the health authority to the social welfare authority. The investigation included a cross-sectional study, a study of all screenings a year before and a year after the change in service, and interviews relating to mental status, social networks, social dysfunction, and distress to relatives. The intention was to treat more patients in a local community-based service and to reduce the number of patients treated at a remote mental hospital.

After the change in service, the treatment of psychotic patients received higher priority in the local service than it had in the hospital-based service, whereas patients characterized as having severe social problems had lower priority. In particular, the most severely mentally ill, as characterized by severe social dysfunction and severe distress to relatives, required treatment at a remote hospital after the change in service.

REFERENCES:

1. Sogaard HJ, Godt HH, Blinkenberg S: Trends in psychiatric hospitalization and changes in admission patterns in two Danish counties from 1977 to 1989. *Soc Psychiatry Psychiatr Epidemiol* 27:263-269, 1992.
2. Munk-Jorgensen P, Lutzhoft JH, Jensen J, et al: Trends in psychiatric hospitalization in Denmark: a 10-year register-based investigation. *Acta Psychiatr Scand* 86:79-83, 1992.

Poster 8 — **Sunday, October 8, 12 noon-1:30 p.m.**

REHABILITATION FOR THE MOST RECIDIVISTIC CONSUMERS: THE LOUISIANA WAY--"DOIN' IT NATURALLY"

Constance Corson, M.A., M.D., *Director of Public Psychiatry, Tulane University, 6845 Memphis Street, New Orleans, LA 70129;* Cheryl Bower-Stephens, M.D., Gail A. Veal, B.C.S.W., Daisy D. Gray

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the importance of respecting consumers' strengths and the community's resources in designing rehabilitation that does not further institutionalize and stigmatize those with serious mental illness.

SUMMARY:

There have previously been several different models of psychosocial rehabilitation, which fall into three basic subtypes: day hospitals, psychosocial clubhouses, and day treatment centers. The last several years have seen the development of a newer model that emphasizes an old concept elaborated by Cutler and others: consumers can do well when the resources emphasize the naturally existing supports within their own communities.

In Louisiana, services for serious mental illness have only recently begun to vary from the hospital medical management approach. There were some psychosocial clubhouses in the state, but most consumers were relegated to the hospital medication-check, limited-support regimen. With the development of assertive community outreach for consumers who were cycling from hospitals to jails, often remained home-less, and lacked access to formal rehabilitation, it was discovered that consumers do extremely well by participating in activities that they choose and that are a part of their natural lifestyle. When they are allowed to do what they do best, their symptoms improve and at times disappear, and they demonstrate competencies that would never have been predicted from their initial presentations.

Examples of activities emphasized in the skills-building program include exercising in the parks and on the levees, fishing, crabbing, designing native jewelry, finding natural food resources (e.g., banana trees, Japanese plum trees), and visiting the new casinos. At all times the consumer is considered first as a person with skills and capacities that we can discover and develop despite descriptions of these persons in the referral process as "hopeless."

REFERENCES:

1. Perris C: A cognitive-behavioral treatment program for patients with a schizophrenic disorder. *New Dir Ment Health Serv* 53:21-32, 1992.
2. McFarlane WR, Stastny P, Deakins S: Family-aided assertive community treatment: a comprehensive rehabilitation and intensive case management approach for persons with schizophrenic disorders. *New Dir Ment Health Serv* 53:43-54, 1992.

Poster 9 — **Saturday, October 7, 12 noon-1:30 p.m.**

MENTAL HEALTH SERVICE DELIVERY TO THE ELDERLY IN NATURALLY OCCURRING RETIREMENT COMMUNITIES

Mark R. Nathanson, M.D., *Assistant Professor of Psychiatry, St. Vincent's Hospital, Suite 930, 85 Fifth Avenue, New York, NY 10003*

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 their individual clinical settings.

SUMMARY:

The population of the United States is aging in place. Increased longevity and the strong desire of the elderly to remain where they live have created naturally occurring retirement communities. These communities usually lack the social, health, and other supportive services needed to maintain independence. These communities are concentrations of the elderly in urban, suburban, and rural areas. These housing units were not originally designed for the elderly and are therefore age integrated.

The elderly are at high risk for mental illness, including depression, dementia, and delirium. They are poorly served by the current health care delivery system. This poster will describe a model of community-based psychiatric service delivery to the elderly.

Recent experience at the Penn South Housing Cooperative in Manhattan, an urban naturally occurring retirement community in which 75% of the residents are over age 76, suggests how mental health services can be efficiently and economically organized. Case management, combined with psychiatric intervention in a team approach, was successful in maintaining most of the referred elders in the community, thus avoiding hospitalization and nursing home placement.

REFERENCES:

1. Hunt M, Ross L: Naturally occurring retirement communities: a multiattribute examination of desirability factors. *Gerontologist* 30:667-674, 1990.
2. Meyers P: *Aging in Place: Strategies to Help the Elderly Stay in Revitalizing Neighborhoods.* Conservation Foundation, Urban Institute, Washington, DC, 1990.

Poster 10 — **Saturday, October 7, 12 noon-1:30 p.m.**

THE CRISIS RESIDENCE AS AN ALTERNATIVE TO THE ACUTE PSYCHIATRIC HOSPITAL: A COMPARATIVE OUTCOME STUDY

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.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to (a) describe a crisis residential alternative to hospitalization for acute psychiatric care and a comprehensive model for health outcome studies, the Clinical Outcome/Program Evaluation model, and (b) compare treatment outcome results of crisis residential and hospital programs.

SUMMARY:

This poster will present preliminary outcome data on five crisis residential facilities, which provide an alternative to acute psychiatric hospital care in San Diego County, California. Treatment outcome and the stability of improvements over time were assessed in a repeated measures design and were then compared with similar data on hospital patients.

Three hundred patients admitted to crisis residential programs completed a battery of instruments and demographic questionnaires at admission and discharge and at 3- and 6-month follow-ups. Standardized instruments were used to assess symptoms, emotional and physical health, functioning, subjective quality of life, and satisfaction with services received. Outcome data and cost were compared with those for 193 hospitalized patients.

The results of this study support crisis residential programs as a cost-effective alternative to hospitalization in the management and treatment of voluntary adult acute psychiatric patients. Despite some demographic differences between the patients admitted to crisis residential facilities and the hospital patients, the two groups reported similar levels of severity at the time of admission. Multiple analyses comparing the two treatment types indicate robust improvements and short-term stability of treatment gains in both types of programs.

REFERENCES:

1. Brunton J, Hawthorne WB: The acute non-hospital: a California model. *Psychiatr Hosp* 20:95-99, 1989.
2. Bond GR, Witheridge TF, Wasmer D, et al: A comparison of two crisis housing alternatives to psychiatric hospitalization. *Hosp Community Psychiatry* 40:177-183, 1989.

Poster 11 — **Saturday, October 7, 12 noon-1:30 p.m.**

A SYSTEMS MODEL FOR RURAL MENTAL HEALTH CARE: THE ALASKA COMMUNITY CONSULTATION PROGRAM

John Battaglia, M.D., *Consultant Psychiatrist, State of Alaska Division of Mental Health and Development Disabilities, 2900 Providence Drive, Anchorage, AK 99508-4677;* Kerry J. Ozer, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to compare traditional psychiatric care (direct to patient) with psychiatric systems consultation and to describe the Alaska Community Consultation Program, a working systems model.

SUMMARY:

Providing psychiatric services to rural areas with limited resources is a problem in many regions; it is epitomized in Alaska, where population density averages one person per square mile. This poster will outline the conceptual premises and development of a community consultation program for delivery of psychiatric services to rural Alaska. Direct patient care (traditional psychiatric services) and a systems consultation

program will be described, and the pros and cons of each approach will be discussed.

The Alaska Community Consultation Program will be outlined. In this program two psychia-trists, employed by the State of Alaska Division of Mental Health and Development Disabilities, provide case consultation, training, and program and systems consultation to the community mental health centers and other community providers. "Community providers" includes anyone involved in caring for individuals with emotional and/or behavioral problems. Examples include, but are not limited to, medical providers (family physicians, nurse practitioners, physician assistants, nursing home personnel, and village health aides), legal personnel, teachers, police, family, and native groups. Emphasis is on developing and enhancing *collective ability* within the community to care for a broader range (in severity and scope) of biological, psychological, social, and cultural illnesses. Experience with the Alaska Community Consultation Program may be of value to other regions faced with the challenge of providing mental health services to rural and remote populations.

REFERENCES:

1. Loschen EL: The challenge of providing quality psychiatric services in a rural setting. *QRB Qual Rev Bull* 12:376-379, 1986.
2. Miles JE: A psychiatric outreach project to a rural community. *Hosp Community Psychiatry* 31:822-825, 1980.
3. *Mental Health and Rural America 1980-1993: An Overview and Annotated Bibliography,* Publication 94-3500. National Institute of Mental Health, Bethesda, MD, 1994.

Poster 12 — **Saturday, October 7, 12 noon-1:30 p.m.**

BEYOND SCHIZOPHRENIA SUBTYPES: IMPLICATIONS FOR SERVICE DELIVERY

Geri Scheller-Gilkey, Ph.D., *Coordinator, Advanced Treatment Strategies Clinic, Department of Psychiatry, Grady Memorial Hospital, 80 Butler Street S.E., Atlanta, GA 30335;* Rosalind M. Mance, M.B., B.S., Bobbi Woolwine, B.S., Cheryl Swofford, M.A., M.S., Nan B. Chadwick, R.N., M.S., C.S., Andrew H. Miller, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss factors and symptoms that are associated with subtypes of schizophrenia and their implications for treatment and service delivery.

SUMMARY:

In a retrospective chart review of 251 patients with schizophrenic spectrum disorders enrolled in an inner-city community mental health clinic, three subtypes of schizophrenia were diagnosed most commonly. These were schizoaffective (N = 62), paranoid (N = 65), and chronic undifferentiated (N = 61). These patients differed on a number of variables distinct from symptoms. The paranoid group had a significantly higher rate of substance abuse (alcohol or other drugs of abuse) and had greater noncompliance with appointments than either the chronic undifferentiated group or the schizoaffective group. The schizoaffective group had a significantly higher rate of hospitalization. The chronic undifferentiated group had significantly higher rate of negative symptoms, cognitive deficiency, and tardive dyskinesia (as measured on the Abnormal Involuntary Movement Scale). The groups did not vary significantly from one another on other variables, such as age, gender, years since first hospitalization, or rate of positive symptoms.

Taken together, these findings underline the importance of considering factors in addition to symptoms that differentiate diagnostic subtypes and have important implications for treatments and service delivery. Although prediction of outcome based on diagnostic subtype is not a new idea, in this era of dwindling resources for treatment and service delivery it is important to direct our efforts with maximum efficiency. Understanding the specific needs of each subgroup will provide direction for maximizing efficient treatment and service delivery.

REFERENCE:

1. Andreasen NC, Carpenter WT: Diagnosis and classification of schizophrenia. *Schizophr Bull* 19:199-219, 1993.

Poster 13 — **Saturday, October 7, 12 noon-1:30 p.m.**

EXPERIENCES OF INDIVIDUALS WITH CHRONIC MENTAL ILLNESS PARTICIPATING IN COMMUNITY-BASED SHELTERED WORK PROGRAMS: A QUALITATIVE STUDY

Elizabeth Griffin Lannigan, M.A., O.T.R., C.V.E., *Doctoral Candidate, New York University, 160 Grove Street, Montclair, NJ 07042*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe contradictory feelings of the chronically mentally ill about their participation in community sheltered work programs and discuss resolution of these feelings.

SUMMARY:

The role of worker is achieved by almost none of the chronically mentally ill. Vocational programs that train such persons for competitive work demonstrate little effect. Little research has focused on consumers' participation in sheltered work.

A qualitative method with in-depth interviews and constant-comparative data was selected for this study. The site was a sheltered work program for psychiatric clients, and the subjects were participants with chronic mental illness and diverse demographic characteristics.

The first-person data were used to produce client profiles and to characterize participants' feelings about sheltered work participation. Themes included feelings of being different from typical workers. Clients struggled with contradictory feelings of being helped by their activities while being a failure for needing vocational assistance. Participation in vocational programs with inferior work and wages created a great stigma.

Resolution of these discrepant feelings facilitated the participants' assimilation into society, coming to terms with themselves, and greater satisfaction with life. The structure of work created an orderliness in their lives that facilitated resolution of these conflicts.

REFERENCES:

1. Estroff SE: *Making It Crazy: An Ethnography of Psychiatric Clients in an American Community.* University of California, Berkeley, CA, 1981.
2. Bachrach LL: The chronic patient: perspectives on work and rehabilitation. *Hosp Community Psychiatry* 42:890-891, 1991.

Poster 14

Saturday, October 7
12 noon-1:30 p.m.

CHARACTERISTICS OF HOMELESS PERSONS REFERRED TO AN ASSERTIVE COMMUNITY TREATMENT TEAM

Hillel T. Grossman, M.D., *Co-Director, Bay Cove Community Treatment Team, Department of Psychiatry, Mail Stop 1007, New England Medical Center, 750 Washington Street, Boston, MA 02111;* Carl Fulwiler, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe clinical differences between homeless and domiciled mentally ill persons requiring assertive community treatment.

SUMMARY:

Homeless persons with mental illness are often seen as recidivist or noncompliant. The assertive community treatment model has recently been reported as a promising approach to this needy but difficult-to-treat population. The presenters will report on the characteristics of 58 persons consecutively referred to the New England Medical Center/Bay Cove Community Treatment Team. Comparisons of demographic characteristics, diagnoses, and historical antecedents in the homeless ($N = 35$) and the domiciled ($N = 23$) subjects will be made.

Preliminary analyses demonstrated highly significant differences. The homeless persons were less likely to have psychotic or affective disorders and were more likely to have alcohol-related diagnoses and histories of violent behavior (all $p < 0.01$). The homeless persons also had lower mean Mini-Mental State scores. Further analyses are underway.

These data suggest that homeless persons referred for assertive treatment have a unique profile, with less psychosis and greater cognitive and behavioral dysfunction than are found among domiciled persons who are referred for such treatment.

REFERENCES:

1. Bachrach LL: What we know about homelessness among mentally ill persons: an analytical review and commentary. *Hosp Community Psychiatry* 43:453-464, 1992.
2. Dixon L, Friedman N, Lehman A: Compliance of homeless mentally ill persons with assertive community treatment. *Hosp Community Psychiatry* 44:581-583, 1993.

Poster 15

Saturday, October 7
12 noon-1:30 p.m.

IMPLEMENTATION OF A RELAPSE PREVENTION PROGRAM IN A COMMUNITY MENTAL HEALTH CENTER AND PRELIMINARY IMPACT ON PATIENT READMISSIONS

H. Rowland Pearsall, M.D., *Director, Inpatient Services, Connecticut Mental Health Center, P.O. Box 1842, 34 Park Street, New Haven, CT 06508;* Therese Engel DiCosmo, M.S., Elizabeth Grottole, M.S.W., M.P.H., Jeanne L. Steiner, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify elements that may contribute to recurrence of psychiatric symptoms and describe the impact of a relapse prevention program in a community mental health center on readmissions to inpatient services.

SUMMARY:

The Connecticut Mental Health Center is a facility funded by the State of Connecticut that provides both inpatient and outpatient services. Over the past few years the larger state psychiatric hospitals have decreased their census substantially, placing a number of patients with chronic illness into community settings. During the past year, inpatient services at

the Connecticut Mental Health Center have experienced a 38% increase in admissions, and length of stay has shortened from 23 to 12.5 days to accommodate the volume of admissions. The rate of readmission within 90 days of discharge has increased from 17% to 29%.

In an effort to decrease the readmission rate, a relapse prevention program was introduced. It involved two key elements: (a) having outpatient clinicians see their patients daily in the hospital and (b) implementing a program to identify signs of relapse and to provide education and prevention planning.

This program will be described, and preliminary data on the impact of these interventions on the readmission rate will be reported.

REFERENCE:

1. Hogarty GE: Prevention of relapse in chronic schizophrenic patients. *J Clin Psychiatry* 54:18-23, 1993.

Poster 16 **Saturday, October 7**
12 noon-1:30 p.m.

TEACHING HEALTH MANAGEMENT IN PSYCHOSOCIAL REHABILITATION

E. Alexandra Ashleigh, M.D., *Chief, Day Treatment Programs, Seattle Veterans Affairs Medical Center, 1660 South Columbian Way, Seattle, WA 98108;* Patricia D. Larsen, R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to design a program to improve the health of mentally ill clients.

SUMMARY:

Patients with serious mental illnesses have a rate of mortality from natural causes that is twice that of the general population. This poster will present a program designed to improve the health care of these clients through a multilayer approach.

The objectives of the 10-week health management program are to (a) provide basic health screening, (b) improve patients' communications with health care providers, and (c) through exposure, increase the mentally ill patients' and medical providers' mutual comfort. The methods include routine screening of vital signs and laboratory tests; a minicourse in health communication that uses skits, role playing, and handouts that demonstrate barriers to and scripting of effective communication; and presentations by nonpsychiatric health care providers that incorporate the patients' own laboratory results and allow practice in framing questions relating to the subject.

Results have included the spontaneous reporting of previously unknown physical problems by patients, discovery of several serious but treatable illnesses, and facilitation of treatment in medical clinics.

REFERENCE:

1. Berren MR, Hill KR, Merikle E, et al: Serious mental illness and mortality rates. *Hosp Community Psychiatry* 45:604-605, 1994.

Poster 17 **Saturday, October 7**
12 noon-1:30 p.m.

COMMUNITY-BASED ALTERNATIVES TO PSYCHIATRIC HOSPITALIZATION: EFFICACY AND OUTCOMES

Sharon G. Dott, M.D., *Associate Professor, University of Texas Medical Branch--Galveston, Mail Stop D-28, 301 University Boulevard, Galveston, TX 77555-0428;* David P. Walling, Ph.D., Cheryl C. Folkes, B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe one community-based alternative to psychiatric hospitalization and the essential needs of patients in residential treatment programs.

SUMMARY:

One current trend in psychiatric treatment is the development of residential treatment programs for severe mental illness. One advantage of residential treatment is the ability to treat patients in the community while avoiding the need for costly hospitalization. Another advantage is post-hospital stabilization in a more normative environment.

The Galveston Crisis Resolution Unit offers a model for an alternative facility. It is a joint project of the local mental health authority and a university medical school. Since September 1992 a total of 326 acute and chronic patients have been admitted. Patients receive round-the-clock supervision, medication monitoring, structured day treatment, and therapeutic activities within a residential setting. The need for psychiatric hospitalization is avoided as patients receive comparable care in a less expensive setting ($200/day versus $600/day). As budgetary concerns increase, future emphasis will be on the development of innovative, non-hospital-based programs for the severely mentally ill.

REFERENCES:

1. Stein L: System approach to reducing relapse in schizophrenia. *J Clin Psychiatry* 54(suppl):7-12, 1993.
2. Bedell J, Ward J: An intensive community based treatment alternative to state hospitalization. *Hosp Community Psychiatry* 40:533-535, 1989.

POSTER SESSIONS

Poster 18 — **Saturday, October 7, 12 noon-1:30 p.m.**

PORTABLE PSYCHIATRIC RECORD: STANDARDIZING PSYCHIATRIC HISTORY REPORTING IN THE PUBLIC PSYCHIATRIC SETTING

Zafar Y. Ibrahim, M.D., *Fellow, Chronic Mental Illness, Department of Psychiatry, University Hospitals of Cleveland, 11100 Euclid Avenue, Cleveland, OH 44106;* Mujeeb Rehman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the use of portable psychiatric records in settings such as community mental health centers, state hospitals, partial hospitalization programs, and outpatient clinics.

SUMMARY:

There are many occasions on which patients are seen by attending physicians, fellows, and residents in emergency situations. Most of the time physicians are not familiar with the patient because he or she is not their patient. In this case a hurried review of old charts is required. Most of the old charts for psychiatric patients have several hundred pages, and relevant information is not available for quick review.

When relevant patient information needs to be transferred by fax or telephone in an emergency, the portable psychiatric record can be extremely helpful to both the patient and the physician. The portable psychiatric record also contains room for updates regarding changes in the patient's behavior and therapy.

Poster 19 — **Saturday, October 7, 12 noon-1:30 p.m.**

THE IMPACT OF PSYCHIATRIC REHABILITATION ON HOSPITAL ADMISSIONS

Carol J. VanderZwaag, M.D., *Medical Director, Psychiatric Rehabilitation Unit, John Umstead Hospital, 1003 Twelfth Street, Butner, NC 27509-1626;* Rosa F. Merino, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify the diagnostic groups likely to benefit most from psychiatric rehabilitation programs and list other factors associated with rehabilitation admission that predict community tenure.

SUMMARY:

Hospital admission rates are one measure of outcome in chronic illness. Admissions 2 years before and 2 years after index hospitalizations on a psychiatric rehabilitation unit were compared to evaluate the effect of treatment.

There were 173 discharges from the John Umstead Hospital Psychiatric Rehabilitation Unit between 1992 and 1994. Preliminary analysis of 52 records is complete. Schizophrenia (N = 28, mean length of stay = 49 months) and mental retardation plus schizophrenia (N = 12, mean length of stay = 114 months) had the greatest reductions in the percentage of patients hospitalized after admission to the rehabilitation unit (60% to 4% and 58% to 0%, respectively).

The patients with bipolar disorder (N = 5, mean length of stay = 8 months) and personality disorder (N = 2, mean length of stay = 11 months) showed no change in admission rates after admission to rehabilitation.

Psychiatric rehabilitation can positively affect community tenure in schizophrenic illness. There may be an association between longer length of stay and improved outcome.

REFERENCES:

1. Lamb HR: A century and a half of rehabilitation in the United States. *Hosp Community Psychiatry* 45:1015-1020, 1994.
2. Bachrach LL: Psychosocial rehabilitation and psychiatry in the care of long-term patients. *Am J Psychiatry* 149:1455-1463, 1992.

Poster 20 — **Saturday, October 7, 12 noon-1:30 p.m.**

ASSERTIVE COMMUNITY TREATMENT IN NEW YORK CITY

Sylvia D. Wright, M.S.W., C.S.W., *Program Coordinator, Visiting Nurse Service, Community Mental Health Services, 1250 Broadway, New York, NY 10001;* Howard W. Telson, M.D., Neil Pessin, Ph.D., David C. Lindy, M.D., Scott Masters, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the principles of assertive community treatment and identify the essential elements of the Visiting Nurse Service Manhattan Act program.

SUMMARY:

Assertive community treatment was designed to treat chronically mentally ill individuals who have had difficulty using and responding to traditional mental health treatment modalities. The Visiting Nurse Service of the New York

Community Mental Health Services division established an assertive community treatment program in July 1995 to address the vast needs of this group. By providing individualized treatment, the program attempts to reduce unnecessary hospitalizations.

Developing such a program in New York City's Lower East Side presents some unique challenges. New York has an extremely diverse ethnic mix and large pockets of socio-economic deprivation. A high proportion of seriously mentally ill individuals have concurrent substance abuse problems and few family or social supports. This poster will describe the population served by the program and the interdisciplinary approach to providing round-the-clock comprehensive services to meet the multiple needs of clients.

REFERENCES:

1. Stein LI: *Innovating Against the Current.* Mental Health Research Center, New York, January 1992.
2. Witheridge TF: The assertive community treatment worker: an emerging role and its implications for professional training. *Hosp Community Psychiatry* 40:620-624, 1989.

Poster 21 — **Saturday, October 7, 12 noon-1:30 p.m.**

PATIENT-CENTERED CASE MANAGEMENT PSYCHIATRY

Irwin M. Shapiro, M.D., *Assistant Clinical Professor, City-Wide Case Management, University of California at San Francisco, 251 Hyde Street, San Francisco, CA 94102*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the function of a psychiatrist as an integral member of a clinical case management team, discuss the basic principles of patient-centered medication monitoring, and describe the effective use of short-term psychiatric crisis intervention in the treatment of long-term psychiatric illness.

SUMMARY:

City-Wide Case Management is a University of California School of Medicine program contracted to serve psychiatric patients with the most severe long-term illness throughout San Francisco. In its over 10 years of existence, the program has developed a unique role for its psychiatrists. Their function as integral members of clinical case management teams will be examined as it relates to a patient-centered psychodynamic model.

The centrality of medication monitoring will be shown to depend on the positive relationship between the medication team and the patient. The significance of the partnership between the patient and the medication team will be examined. The proper understanding of transference and counter-transference issues in compliance will be addressed.

The significance of a positive, supportive therapeutic relationship can be used in the middle of an acute psychotic disintegration to both adjust medications and buffer relationships with existing support systems.

REFERENCE:

1. Surber RW (ed): *Clinical Case Management: A Guide to Comprehensive Treatment of Serious Mental Illness.* Sage Publications, London, 1994.

Poster 22 — **Saturday, October 7, 12 noon-1:30 p.m.**

COMMUNITY SUPPORT SYSTEMS NEEDS OF PSYCHIATRIC OUTPATIENTS

Llewellyn W. Joseph, M.D., F.R.C.P.(C), *Psychiatrist-in-Chief and Clinical Director, London Psychiatric Hospital, 850 Highbury Avenue, London, Ontario, Canada;* Shahe S. Kazarian, Ph.D., C.Psych.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the qualitative and quantitative needs of psychiatric outpatients for community support systems.

SUMMARY:

The presenters rated 913 adult psychiatric outpatients in terms of 11 community support services: identification/outreach, treatment/crisis support, consultation, coordination with other service agencies, residential support, case coordination/case management, social support, vocational support, self-help/peer support, family support, and advocacy.

The mean age of the group was 43.7 years. There were more men (52.4%) than women. Of the patients, 44.9% were single, 56.9% had a high school education, and 55.8% were diagnosed with schizophrenia. Treatment and crisis support was identified as the most-needed community support service (92.4%), followed by residential support (77.5%), coordination of services (70.2%), and consultation (61.7%). Age and marital status were better predictors of both type and level of community support systems needed than was sex, education, or diagnosis.

The findings indicate that younger patients and those who are single, separated, or divorced require more of the surveyed community support services than do other patients.

REFERENCES:

1. Baker F, Intagliata J: The New York State community support system: a profile of clients. *Hosp Community Psychiatry* 35:39-44, 1984.
2. Provincial Community Mental Health Committee, Graham R, Chairman: *Building Community Support for People: A Plan for Mental Health in Ontario.* July 1988.

POSTER SESSIONS

Poster 23 **Saturday, October 7**
12 noon-1:30 p.m.

CAUSE OF DEATH AND EXCESS MORTALITY IN A SERIOUSLY MENTALLY ILL POPULATION

Bruce Dembling, Ph.D., *Research Fellow, Massachusetts Department of Mental Health/Harvard University, 25 Staniford Street, Boston, MA 02114;* Stephen M. Goldfinger, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify factors that contribute to a mortality rate among seriously mentally ill individuals in Massachusetts that is higher than that of the general population.

SUMMARY:

A study of 49,000 seriously mentally ill consumers who have used the Massachusetts Department of Mental Health since 1986 identified 1,253 cases that could be positively linked to state death records for a 48-month period in 1990-1993. The age-sex standardized mortality ratio (i.e., the ratio of observed deaths to expected deaths) for this population was 1.5. Excess mortality was found in all cause-of-death categories. The mean age at death was 54.4 years for Department of Mental Health clients versus 72.8 years for the general population. Excess mortality in years lost was calculated to be 22,253 relative to the mean age at death by sex in the general population.

Causes of death also varied significantly from those of the general population. Per capita, people in the Department of Mental Health population had 10 times as many unexplained deaths, 10 times as many suicides, 4 times as many deaths from HIV-related causes, and 3 times as many homicides as people in the general population. The five leading causes of excess mortality were suicide, unexplained death, heart disease, other natural causes, and HIV-related conditions.

REFERENCE:

1. Tsuang MT, Dempsey GM, Dvoredsky A, et al: Mortality in patients with schizophrenia, mania, depression and surgical conditions: a comparison with general population mortality. *Br J Psychiatry* 130:162-166, 1977.

Poster 24 **Saturday, October 7**
12 noon-1:30 p.m.

HOUSING FOR HOMELESS MENTALLY ILL ADULTS: OUTCOME DIFFERENCES BETWEEN INDEPENDENT APARTMENTS AND ALTERNATIVE GROUP HOMES

Stephen M. Goldfinger, M.D., *Assistant Professor of Psychiatry, Harvard Medical School, Massachusetts Mental Health Center, 74 Fenwood Road, Boston, MA 02115;* Russell K. Schutt, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss policy and implementation issues for addressing the needs of homeless mentally ill adults.

SUMMARY:

The Boston McKinney Demonstration Project housed 118 homeless adults with severe and persistent mental illness. The sample was drawn from persons living in Boston's three public shelters that serve mentally ill individuals (only those who were imminently dangerous were excluded). Participants were randomly assigned to either independent apartments (N = 55) or "evolving consumer households" (N = 63). The latter were developed with the joint aims of empowering consumers and phasing out on-site staff involvement.

Individuals were assessed at regular intervals with questionnaires; case managers compiled client tracking data on service utilization and housing status, and data on housing status, housing costs, and service utilization costs were assessed. Outcome dimensions included (a) self-reported levels of symptoms, social support, physical status, and substance use; (b) pre- and postintervention data on neuropsychological functioning; (c) observer ratings of social functioning and substance use; and (d) cost data on housing and service utilization.

Over 75% of the sample were in some type of housing at 18 months. Multivariate models of housing outcomes revealed significant explanatory power when the effects of the interaction of ethnicity, housing condition, and substance use were included. Interview data yielded no differences between the two housing conditions in symptom or functioning change. Costs involved in maintaining the group homes were several times those for maintaining the independent apartments.

REFERENCE:

1. Goldfinger SM et al: The Boston Project: promoting housing stability and consumer empowerment. In *Making a Difference: Interim Status Report of the McKinney Demonstration Program for Homeless Adults with Serious Mental Illness.* Center for Mental Health Services, U.S. Department of Health and Human Services, Washington, DC, 1994.

Poster 25 **Saturday, October 7**
4:30 p.m.-6:00 p.m.

FRAGMENTATION TO INTEGRATION: TREATING TRAUMA ON A GENERAL HOSPITAL UNIT

William W. Adams, M.D., *Director, Psychiatric Inpatient and Partial Hospital Service, Mount Auburn Hospital, Cambridge, MA 02238;* Jodie Shapiro, Psy.D., Emily H. Oswalt, B.S.N., R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe a programmatic design for treating acutely hospitalized trauma patients, identify specific therapeutic interventions from a multidisciplinary perspective, and predict conflicts and problems in the management of such a program.

SUMMARY:

The evolution of a trauma recovery program on an open unit of a general hospital will be described, with particular attention to aspects of organizational development and program design. The history of these efforts and description of the ongoing process will be used to examine the possibility for application of such programs on other general units. The specific interventions developed will be described, with emphasis on the need for an integrative, multidisciplinary, and focused therapeutic program in today's health care environment. Specific therapeutic interventions to be described include nursing interventions and individual, family, and group therapies.

REFERENCE:

1. Herman JL: *Trauma and Recovery.* Basic Books, New York, 1992.

Poster 26 — Saturday, October 7 4:30 p.m.-6:00 p.m.

EDUCATING PRACTITIONERS IN ISSUES OF SEXUAL MINORITIES

Taylor B. Anderson, M.S.W., L.S.W., *Associate Director, Medical College of Pennsylvania, 3200 Henry Avenue, Philadelphia, PA 19129;* George R. Lucey, M.Ed., N.O.C., Anita L. Kinsley, M.A., Miguel A. Jimenez, M.D., Jo Ellen Brainin-Rodriguez, M.D., Emily K. Lee, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify sexual minorities' concerns that affect their self-concepts and use of treatment, discuss the relationship between stage of "coming out" and issues that arise in treatment, and apply the material presented to persons and issues in the participants' own practices.

SUMMARY:

The presenters have coauthored two major courses on human sexuality for educating mental health practitioners in knowledge and attitudes concerning this basic area of human functioning and in how to educate others, particularly those with serious and persistent mental illness, substance abuse/chemical dependency, or co-occurring diagnoses. During presentation of these courses to physicians and other mental health professionals, it was discovered that other sexually related issues need more specific exploration and (re)education. One major area is heterosexual practitioners who treat persons who are gay, lesbian, or bisexual (whether or not they identify themselves as such).

This poster will present a synopsis of a 1-day course that educates practitioners regarding specific identity, developmental, and relational issues involved in being a sexual minority in this culture (copies of the curriculum will be available). It will engage practitioners in discussing their own treatment issues, questions, and concerns, and it will provide a cognitive map for thinking, both empirically and empathetically, about approaches to the treatment of sexual minorities.

REFERENCES:

1. Isay RA: *Being Homosexual.* Farrar, Straus & Giroux, New York, 1989.
2. Moses AE, Hawkins R: *Counseling Lesbian Women and Gay Men: A Life Approach.* Mosby, St. Louis, 1982.
3. Wolman BB, Money J (eds): *Handbook of Human Sexuality.* Jason Aronson, Northvale, NJ, 1993.

Poster 27 — Saturday, October 7 4:30 p.m.-6:00 p.m.

EXAMINING THE RECOVERY PROCESS

Kenneth S. Thompson, M.D., *Medical Director, Division of Public Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213;* Wesley E. Sowers, M.D., Stephen D. Mullins, M.D., M.P.H., Ronald Gibson, Peter D. Murray, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the process of recovery as it occurs in a variety of clinical settings and in different populations.

SUMMARY:

In recent years increasing attention has been paid to the concept and process of recovery. It is now frequently involved in care not only for persons with substance use disorders, but also for trauma survivors, persons with severe and persistent mental illness, and others. Clearly, this incorporation of the idea of recovery into mental health care reflects a fundamental shift from the paternalism of "treatment" to a more empowered notion of the patient, who owns the process of recovery. Other aspects of recovery are only now beginning to emerge. This poster will examine and further elucidate the concept and process of recovery by considering several different populations–mentally ill persons, homeless persons, addicts–and from the perspectives of providers and consumers.

REFERENCE:

1. Anthony WA: Recovery from mental illness: the guiding vision of mental health service systems in the 1990s. *Psychosoc Rehab J* 16(4):11-23, 1993.

POSTER SESSIONS

Poster 28 — **Saturday, October 7, 4:30 p.m.-6:00 p.m.**

PATIENTS' ATTITUDES TOWARD SECLUSION AND RESTRAINING PROCEDURES IN THE MANAGEMENT OF DISTURBED BEHAVIOR

Llewellyn W. Joseph, M.D., F.R.C.P.(C), *Psychiatrist-in-Chief and Clinical Director, London Psychiatric Hospital, 850 Highbury Avenue, London, Ontario, Canada;* Shahe S. Kazarian, Ph.D., C.Psych., Oloruntoba J. Oluboka, M.B., B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss patients' attitudes toward seclusion and be more sensitive to the clinical use of these procedures.

SUMMARY:

The advent of civil libertarianism and advances in psychopharmacology have challenged the use of seclusion and restraining procedures as part of the management armamentarium for behavioral disturbances in psychiatric patients.

Judgments about how patients experience these procedures and about their level of intrusiveness were based on the perceptions of individual clinicians, advocates, and lawyers rather than on the experience of the patients themselves. These often-conflicting views leave the clinician with the dilemma of which management options to institute first in order to meet the potentially controversial requirements of patients' best interests and individual rights.

This poster will review the literature on patients' attitudes toward seclusion, the results of a study of 151 adult patients at the London Psychiatric Hospital, the hierarchy of the intrusiveness/restrictiveness of these procedures, and how to use them.

REFERENCES:

1. Binder RL, McCoy SM: A study of patients' attitudes toward placement in seclusion. *Hosp Community Psychiatry* 34:1052-1054, 1983.
2. Harris GT, Rice ME, Preston DL: Staff and patient perceptions of the least restrictive alternatives for the short-term control of disturbed behavior. *J Psychiatry Law* 17:239-263, 1989.

Poster 29 — **Saturday, October 7, 4:30 p.m.-6:00 p.m.**

MENTALLY ILL, CHEMICAL-ABUSING PATIENTS IN A PUBLIC GENERAL HOSPITAL IN SPAIN

Natalia Sartorius, M.D., *Clinical Psychiatrist, Hospital 12 Octubre, Kilometer 5.4, Andalucia Avenue, 25041 Madrid, Spain;* Guillermo Ponce, M.D., Pablo Del Pino, M.D., Isabel Herman, M.D., E. Garcia Bernardo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the clinical, socioeconomic, and service-utilization patterns of a sample of mentally ill, chemical-abusing patients in Madrid, Spain, and to compare those patients with substance-abusing psychiatric patients in the United States.

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 mentally ill chemical-abusing patients in a public general hospital in Spain and will describe their clinical, social, and service-utilization profiles.

The psychiatric records of all patients (N = 789) 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 (13.4%) 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 (52.8%) and schizophrenia (29.2%). 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.

The prevalence of substance-abusing psychiatric 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.

REFERENCES:

1. Regier DA: Comorbidity of mental disorders with drug abuse: results from the Epidemiologic Catchment Area (ECA) study. *JAMA* 264:2511-2518, 1990.
2. Caton CLM: Young chronic patients and substance abuse. *Hosp Community Psychiatry* 40:1037-1040, 1989.

Poster 30 — **Saturday, October 7, 4:30 p.m.-6:00 p.m.**

CREATIVE APPROACHES TO TEACHING PEOPLE ABOUT SERIOUS MENTAL ILLNESS

Cynthia C. Bisbee, Ph.D., *Executive Director, JBS Mental Health Authority, Suite 200, 940 Montclair Road, Birmingham, AL 35213;* Patricia L. Scheifler, M.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to use a variety of entertaining and innovative methods for teaching people about serious mental illness and to identify the advantages of such creative approaches.

SUMMARY:

The presenters will describe innovative methods for teaching consumers and families about serious mental illness. The techniques demonstrated will include a variety of therapeutic learning activities, such as word-search and crossword puzzles, fill-in-the-blank questionnaires, quiz cards, and an educational board game. The presenters will discuss the advantages of using these techniques and will describe settings in which these methods can be appropriately applied.

REFERENCES:

1. LeBas J: Comprehensibility of patient education literature. *Aust N Z J Psychiatry* 23:542-546, 1989.
2. Bisbee C: *Educating Patients and Families About Mental Illness: A Practical Guide.* Aspen, Gaithersburg, MD, 1991.

Poster 31 — **Saturday, October 7, 4:30 p.m.-6:00 p.m.**

NEGOTIATING PREAUTHORIZATIONS AND AUTHORIZATIONS FOR INPATIENT ADMISSION FOR SEVERELY MENTALLY ILL PATIENTS: HOW TO MAKE IT WORK

Geetha Jayaram, M.D., *Assistant Professor, Johns Hopkins University School of Medicine, Johns Hopkins Hospital, Meyer 101, Baltimore, MD 21287-7101*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe what constitutes "severity of need" and appropriately organize and communicate patient data for continued authorization of patient stay.

SUMMARY:

Severity or intensity criteria commonly used by third-party insurers include levels of psychiatric and medical morbidity, information on which is often poorly disseminated among medical personnel. Also, procedures for documenting such criteria vary by setting and are not uniform among subgroups of psychiatric patients.

To successfully obtain authorization of stay for patients it is necessary to study and document criteria systematically, establish uniformity and support through utilization review, and educate medical staff about competitive forces in the market-place, the reasons for denial of stay, and the process of appeal. Cohort studies promote the investigation of factors and variables that complicate patient care and may be used to tailor services efficiently.

This poster will show examples of forms and methods currently used for psychiatric inpatients of the Johns Hopkins Hospital.

REFERENCES:

1. *Maryland Medical Assistance Admission Criteria.* Delmarva Foundation for Medical Care.
2. Saravay SM, Steinberg MD, Weinschel B, et al: Psychological comorbidity and length of stay in the general hospital. *Am J Psychiatry* 148:324-329, 1991.

Poster 32 — **Saturday, October 7, 4:30 p.m.-6:00 p.m.**

INDIVIDUAL PLACEMENT AND SUPPORT: THE CAPSTONE OF AN INTEGRATED SYSTEM OF VOCATIONAL SERVICES FOR PERSONS WITH SEVERE MENTAL ILLNESS

Kendall A. Snow, M.S.W., A.C.S.W., *Director of Community Services, Mental Health Center of Greater Manchester, 401 Cypress Street, Manchester, NH 03103;* Matthew A. Lavey, M.Ed., C.R.C., Marion Lounsberry, B.S.E.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify the essential vocational rehabilitation tenets of the individual placement and support model, describe methods for integrating the model into the case-management/treatment system of care, and discuss the necessity of a continuum of vocational services and the contribution of each element.

SUMMARY:

Recent research concerning employment outcomes for persons with severe mental illness highlights the necessity of a coordinated treatment approach. As part of that research effort, the Mental Health Center of Greater Manchester participated in a project of the New Hampshire/Dartmouth Psychiatric Research Center to develop a vocational rehabilitation model called "individual placement and support."

This poster will describe the model and the principles of its integration into a total system of care for persons with severe mental illness. The method for linking case-management and treatment staff with vocational staff will be highlighted. The continuum of vocational service needed to support the placement of clients in competitive jobs will also be described. These elements include prevocational activities, vocational planning and assessment, sheltered work, enclaves, client-run businesses, and other creative options.

Employment outcomes, unanticipated problems, and suggestions for ongoing development and systems change will be presented.

REFERENCES:

1. Becker D, Drake R: *A Working Life--The Individual Placement and Support (IPS) Program.* New Hampshire/ Dartmouth Psychiatric Research Center, Concord, NH, 1993.
2. Becker DR, Drake RE: Individual Placement and Support--a community mental health center approach to vocational rehabilitation. *Community Ment Health J* 30:193-206, 1994.

Poster 33 **Saturday, October 7**
4:30 p.m.-6:00 p.m.

BARRIERS THAT PREVENT CONSUMERS WITH SEVERE MENTAL ILLNESS FROM ACHIEVING WANTS AND NEEDS

Catana E. Brown, M.A., O.T.R., *Assistant Professor, Department of Occupational Therapy Education, University of Kansas Medical Center, 4415 Oxford, Prairie Village, KS 66208*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify the differences between the barriers to goal attainment perceived by consumers and those perceived by their case managers.

SUMMARY:

Consumer-driven practice begins with the consumer identifying wants and needs. Intervention involves removal of barriers so that the wants and needs can be met. Barriers can be classified as either personal (e.g., limited social skills, lack of motivation) or contextual (e.g., restricted housing options, poverty). The purpose of this study was to compare the perceptions of consumers and those of their case managers regarding barriers preventing consumers from achieving wants or needs. Because of practice focuses that emphasize removing consumers' deficits rather than developing contextual supports, it was hypothesized that case managers would identify more personal and fewer environmental barriers than would consumers. Data were obtained from 20 consumers with severe mental illness and from their case managers by means of a structured interview. As predicted, case managers identified significantly more personal barriers ($t = 2.54$, $p < 0.01$) and significantly fewer environmental barriers ($t = 2.05$, $p < 0.05$) than did consumers. Conflicts in perceptions regarding goal attainment between health care professionals and consumers may limit the effectiveness of interventions.

REFERENCES:

1. Freund PD: Professional role(s) in the empowerment process: "working with" mental health consumers. *Psychosoc Rehab J* 16(3):65-73, 1993.
2. Rosenfield S: Factors contributing to the subjective quality of life of the chronically mentally ill. *J Health Soc Behav* 33:299-314, 1992.

Poster 34 **Saturday, October 7**
4:30 p.m.-6:00 p.m.

QUALITY OF LIFE IN SEVERE MENTAL ILLNESS: DOES DIAGNOSIS MATTER?

David P. Walling, Ph.D., *Research Scientist, University of Texas Medical Branch--Galveston, Mail Stop D-28, 301 University Boulevard, Galveston, TX 77555-0428;* Sharon G. Dott, M.D., Cheryl C. Folkes, B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the value of short-term treatment for improving quality of life and identify differences between diagnoses in improvements in quality of life.

SUMMARY:

Measures of quality of life provide one method of assessing the impact of treatment, either psychosocial or pharmacological, on the patient. The present study examined pre- and posttreatment quality of life in 104 individuals with severe mental illness. Through the use of the Quality of Life Enjoyment Scale, subjects were assessed at admission and at discharge from either a residential treatment facility or a psychiatric hospital. MANOVAs yielded significant differences in quality of life between admission and discharge, suggesting improvement in both groups. Post hoc analyses suggested that subjects diagnosed with major depression had significantly lower perceived quality of life at admission than at discharge. Additionally, those with bipolar disorder or major depression evidenced the greatest improvement on three of the five subscales.

This study suggests that short-term treatment improves quality of life regardless of diagnosis. Subjects with mood disorders experience greater improvement than those with psychotic disorders. Factors contributing to improvement in quality of life and implications for future studies will also be discussed.

REFERENCES:
1. Meltzer H, Burnett S, Bastani B, et al: Effects of six months of clozapine treatment on the quality of life of chronic schizophrenic patients. *Hosp Community Psychiatry* 41:892-897, 1990.
2. Awad G: Quality of life of schizophrenic patients on medications and implications for new drug trials. *Hosp Community Psychiatry* 43:262-265, 1992.

Poster 35 **Saturday, October 7**
4:30 p.m.-6:00 p.m.

ASSESSMENT IN MULTICULTURAL ENVIRONMENTS

Jonathan E. Morris, M.D., M.P.H., *Director, Division of Consultation-Liaison Psychiatry, Maine Medical Center, 22 Bramhall Street, Portland, ME 04102;* Pamina J. Hofer, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to critically discuss the variety of sociocultural issues that can influence qualitative and quantitative clinical measurements in psychopathology, using the Mini-Mental State examination as an example.

SUMMARY:

Most mental health care providers in the United States are trained to perform initial evaluations with a traditional procedure. This procedure generally involves a single examiner interviewing an individual patient in an office or hospital setting. Standardized questions are asked of the patient, and the patient's verbal responses and body language are used in formulating a diagnosis and laying a foundation for devising a treatment plan. Although this approach may be successfully applied when the examiner and the patient have similar expectations of the patient-provider relationship, problems develop when cultural differences exist.

The U.S. territory of Guam offers an exceptional environment in which to study these differences. A possession of the United States since 1898, Guam has been subject to U.S. influence for almost a century. However, the island population of 130,000 is composed of several ethnic groups, including 47% native Chamorro, 25% Filipino, 10% Caucasian, and 18% Oriental/others. Many of these individuals live within ethnic subcultures in which English is not the primary language and whose lifestyles are quite different from the U.S. norm. Specific examples of these assessment issues will be illustrated in applying the Guam multicultural perspective to the Mini-Mental State examination.

REFERENCES:
1. Ostrosky F et al: Sociocultural effects in neuropsychological assessment. *Int J Neurosci* 27:53-66, 1985.
2. Folstein MF, Folstein SE, McHugh PR: "Mini-Mental State": a practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res* 12:189-198, 1975.

Poster 36 **Saturday, October 7**
4:30 p.m.-6:00 p.m.

WOMEN IN PSYCHIATRIC INPATIENT UNITS IN MADRID AND SAN FRANCISCO: A TRANSCULTURAL POINT OF VIEW

Carmen Ibanez, M.D., *Psychiatrist, Hospital 12 Octubre, Kilometer 5.4, Andalucia Avenue, 25041 Madrid, Spain;* E. Garcia Bernardo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the roles of cultural and gender issues in psychiatry.

SUMMARY:

The presenters will profile the inpatient female patients at the Hospital 12 Octubre in Madrid and at San Francisco General Hospital. Sociodemographic, clinical, and therapeutic data on the two groups were compared, and gender and cultural characteristics were analyzed.

The study focused on women admitted between August and October 1994 to the two psychiatric units; 31 women were admitted to the Madrid hospital and 50 were admitted to the San Francisco hospital. A 22-item protocol was used to collect data.

Lengths of stay (15 days), age ranges (35-40 years), psychiatric diagnoses (affective disorder and psychosis), and rates of past psychiatric history (Madrid, 97%; San Francisco, 92%) were similar in the two locations. Differences included admission status (Madrid, 84% voluntary; San Francisco, 98% involuntary), personality disorders (Madrid, 10% histrionic; San Francisco, 10% borderline), family support (Madrid, 96%; San Francisco, 30%), homelessness (San Francisco, 28%), and admission to medium- or long-term facilities (San Francisco, 38%).

It appeared that differences between women diagnosed as having personality disorders (histrionic versus borderline) could be explained by cultural differences. Sociodemographic differences could reflect the importance of culture in the family support, education, and labor activities of women. Institutions are also influenced by culture. Rates of voluntary versus involuntary admissions and judicial versus medical discharge may be examples of such influence on institutions.

REFERENCES:
1. Sederer LI (ed): *Inpatient Psychiatry: Diagnosis and Treatment,* 2nd ed. Williams & Wilkins, Baltimore, 1986.
2. Stotland NL: Women and psychiatry. In Hales RE, Yudofsky SC, Talbot JA (eds): *Textbook of Psychiatry,* 2nd ed. American Psychiatric Press, Washington, DC, 1994, pp 1355-1377.

Poster 37 **Saturday, October 7**
4:30 p.m.-6:00 p.m.

PSYCHIATRIC INPATIENT UNITS IN MADRID AND SAN FRANCISCO: COMPARISON OF MENTAL HEALTH SYSTEMS AND CULTURES

E. Garcia Bernardo, M.D., *Psychiatrist, Hospital 12 Octubre, Kilometer 5.4, Andalucia Avenue, 25041 Madrid, Spain;* Carmen Ibanez, M.D., Miguel A. Jimenez, M.D., Jo Ellen Brainin-Rodriguez, M.D., Louis R. Alvarez, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the differences and similarities between psychiatric inpatient units in Madrid and San Francisco and discuss how culture and mental health systems modify the presentation of pathology and the implementation of treatment.

SUMMARY:

This poster will describe the psychiatric inpatient units in the Hospital 12 Octubre in Madrid and San Francisco General Hospital. The presenters will analyze the differences in the inpatient profiles, milieus, and treatments and will describe how culture and the mental health system are important in creating these differences.

Inpatients admitted to a psychiatric unit of the San Francisco General Hospital and a psychiatric unit of the Hospital 12 Octubre between August and October of 1994 were studied. Sociodemographic, clinical, and treatment data for the two hospitals were compared.

Seventy patients from each hospital were studied over 3 months. Preliminary results suggested important differences between the two populations. There was a strong correlation between length of stay and the availability of postdischarge facilities; the average length of stay was 15 days in San Francisco, where rehabilitation facilities were available, whereas the mean length of stay was 23 days in Madrid, which had no rehabilitation facilities. Mean ages, diagnoses, clinical profiles, and rates of employment were similar. A higher proportion of patients in Madrid were accompanied by their families.

These results indicate that culture is important in determining how mental illness appears, and for that reason it is crucial for the psychiatrist to be aware of the cultural background of the patient in order to make an accurate diagnosis and provide proper treatment. More differences were observed in postdischarge access to rehabilitation facilities than in clinical profiles. Families are a stronger cultural influence on patients' lives in Madrid than in San Francisco.

REFERENCES:
1. Sederer LI (ed): *Inpatient Psychiatry: Diagnosis and Treatment,* 2nd ed. Williams & Wilkins, Baltimore, 1986.
2. Griffith EEH, Gonzalez CA: Essentials of cultural psychiatry. In Hales RE, Yudofsky SC, Talbot JA (eds): *Textbook of Psychiatry,* 2nd ed. American Psychiatric Press, Washington, DC, 1994, pp 1379-1404.

Poster 38 **Saturday, October 7**
4:30 p.m.-6:00 p.m.

EFFECTIVE USE OF A BILINGUAL MENTAL HEALTH THERAPIST FOR SPANISH INTERPRETATION

Peggy E. Chatham-Showalter, M.D., *Staff Psychiatrist, Lehigh Valley Hospital, Suite 2800, 1243 South Cedar Crest Boulevard, Allentown, PA 18103-7982;* Diann D. Hasseman, M.Ed., Thomas E. Wasser, M.Ed.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify problems in providing language translation for psychiatric patients and describe a model that pairs an English-speaking psychiatrist with a bilingual mental health therapist for effective translation.

SUMMARY:

Many facilities lack bilingual psychiatrists for patients who do not speak English. Using interpreters often leads to assessment errors. This session will describe the experience over 2 years of a mental health clinic that has paired an English-speaking psychiatrist with a designated bilingual therapist to translate for patients who speak only Spanish, prefer Spanish, or lose their ability to speak English when they are distressed.

A group of 20 such Spanish-speaking patients jointly seen by a psychiatrist-therapist pair were compared with English-fluent Latino patients treated by the same psychiatrist. Demographic characteristics, years in the clinic, Global Assessment of Functioning ratings, and levels of patient satisfaction were similar in the two groups, as were percentages of schizophrenia, anxiety, and affective disorders.

If Latino patients experience similar psychiatric syndromes regardless of their language, then the use of a bilingual mental health professional to translate may help avoid the gross errors made by lay interpreters, but the risk of subtle errors exists. More research is necessary to better delineate diagnosis for Spanish-speaking patients and to determine the most effective means of providing interpretation.

REFERENCES:
1. Bamford K: Bilingual issues in mental health assessment and treatment. *Hispanic J Behav Sci* 377-390, 1991.
2. Vasquez C, Javier RA: The problem with interpreters: communicating with Spanish-speaking patients. *Hosp Community Psychiatry* 42:163-165, 1991.

Poster 39 **Saturday, October 7 4:30 p.m.-6:00 p.m.**

HIV RISK REDUCTION PROGRAM AND CURRICULUM FOR THE SEVERELY AND PERSISTENTLY MENTALLY ILL

Marlene J. Dunsmore, M.S.W., L.C.S.W., *HIV/AIDS Coordinator, Community Connections, 1512 Pennsylvania Avenue, S.E., Washington, DC 20003;* Margaret D. Hobbs, M.S.W., L.C.S.W., Catherine M. Anderson, M.Ed., Mirta K. Jones, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the development of an HIV risk reduction program and assess its effectiveness.

SUMMARY:

Community Connections is a private, nonprofit mental health agency that provides case management services for 307 severely and persistently mentally ill consumers. These consumers are sexually active, 50% are substance dependent, and 8% are seropositive for HIV. Psychiatric symptoms of poor impulse control and judgment, impaired cognitive ability, and delusional preoccupations inhibit the practice of safer sex. Living in Washington, D.C., which has the highest per capita rate of HIV infection in the nation, places these consumers at significant risk for contacting HIV.

In response to these risk factors, Community Connections developed a risk reduction curriculum to engage consumers in discussion and role playing concerning high-risk behaviors, modes of HIV transmission, and safer sex practices. This poster will present the curriculum, the use of consumers as co-leaders, anecdotal experiences of the leaders, and results of research interviews that tested the effectiveness of these teaching methods and materials.

REFERENCE:
1. Hanson M, Kramer TH, Gross W, et al: AIDS awareness and risk behaviors among dually disordered adults. *AIDS Educ Prev* 4:41-51, 1992.

Poster 40 **Saturday, October 7 4:30 p.m.-6:00 p.m.**

AIDS TREATMENT: WHO'S THE PATIENT?

Lawrence B. Jacobsberg, M.D., *Staff Psychiatrist, AIDS Mental Health Team, Visiting Nurse Service, Community Mental Health Services, 2170 McDonald Avenue, Brooklyn, NY 11223;* David C. Lindy, M.D., Neil Pessin, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the differing treatment and systems needs of different patient populations with AIDS, namely, men who have sex with men versus heterosexual risk groups.

SUMMARY:

The AIDS epidemic has shifted from the community of men having sex with men to heterosexuals, many of whom are members of minority groups. Mental health workers have found that the identified patient is often a member of a family with multiple psychosocial problems. These can include substance abuse, poverty, limited access to services, chaotic social systems, and other HIV-infected family members, especially children, who may be infected themselves and/or be in danger of becoming orphans. The Visiting Nurse Service of New York operates AIDS mental health teams to serve the mental health needs of patients with AIDS who receive home care. This poster will compare two populations: (a) men having sex with men and (b) heterosexuals. This comparison will look at these populations in terms of demographic profile, AIDS risk factors, patient psychiatric diagnosis, family composition and pathology, and mental health service needs of patient and family. The poster will also present case vignettes that highlight differences between the types of interventions required by these patient groups, with a focus on important needs of the children in AIDS families.

REFERENCE:
1. King MB: *AIDS, HIV and Mental Health.* Cambridge University Press, Cambridge, England, 1993.

Poster 41 **Saturday, October 7 4:30 p.m.-6:00 p.m.**

CONTRAST BETWEEN PHYSICIANS' ATTITUDES AND TREATMENT DECISIONS CONCERNING AIDS PATIENTS

Daniel P. Chapman, Ph.D., M.Sc., *Psychiatric Epidemiologist, Centers for Disease Control and Prevention, Mail Stop K-51, 4770 Buford Highway N.E., Atlanta, GA 30341-3724;* Irwin P. Levin, Ph.D., Mary Lynn E. Westemeier, David M. Rosenthal, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe physician attitudes toward AIDS patients and the relationship between attitudes and potential treatment decisions for this patient population.

SUMMARY:

Public opinion research has indicated that AIDS patients are a highly stigmatized population and that the public is concerned that these patients consume a disproportionately large percentage of medical care and research resources. This study investigated physicians' attitudes toward patients with AIDS. Physicians at a medical school hospital completed a survey including both measures of attitudes toward treatment of AIDS patients and a decision-making task assessing bias in the treatment of AIDS patients as compared with patients suffering from another chronic disease, leukemia. Although the physicians indicated that they were personally unbiased toward the treatment of AIDS patients, the decision-making task revealed that saving the lives of leukemia patients was viewed as significantly more important than saving the lives of AIDS patients ($p < 0.01$). These results suggest that although physicians may profess socially desirable attitudes toward AIDS patients, their decisions may be subject to biases similar to those observed among the public.

REFERENCES:

1. Levin IP, Chapman DP: Risk taking, frame of reference and characterization of victim groups in AIDS treatment decisions. *J Exp Soc Psychol* 26:421-434, 1990.
2. Levin IP, Chapman DP: Risky decision making and allocation of resources for leukemia and AIDS programs. *Health Psychol* 12:110-117, 1993.

Poster 42 — Sunday, October 8, 12 noon-1:30 p.m.

DYSPHAGIA IN PSYCHIATRIC PATIENTS

Patricia H. Bazemore, M.D., *Chief of Medicine, Worcester State Hospital, 305 Belmont Street, Worcester, MA 01604;* Rajoo R. Ananth, Ph.D., Joseph M. Tonkonogy, M.D., Ph.D., Kenneth L. Appelbaum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify six types of dysphagia in chronic psychiatric patients and describe the etiology and management of each; they should also be able to describe how to approach choking prevention in psychiatric settings by using screening and assessment tools, appropriate rehabilitative measures, and tailored emergency procedures.

SUMMARY:

Choking on food and aspiration pneumonia are two leading causes of death among psychiatric inpatients in the United States. These occurrences are often related to neuroleptic-induced bradykinesia, tardive dyskinesia, fast-eating syndrome, clozapine-induced salivary dysfunction, or neurologic disorders associated with severe mental illness. Clinical evaluation, often including videofluoroscopy, leads to both specific treatment and an evaluation of risks related to diet and unsupervised activity. Treatment and risk-benefit analysis of psychiatric patients with swallowing disorders may often avert serious choking incidents and deaths. Case histories of each type of dysphagia will be presented for analysis.

REFERENCES:

1. Bazemore PH, Tonkonogy J, Ananth R: Dysphagia in psychiatric patients: clinical and videofluoroscopy study. *Dysphagia* 6:2-5, 1991.
2. Appelbaum KL, Bazemore PH, Tonkonogy J, et al: Privilege and discharge decisions for psychiatric inpatients with dysphagia. *Hosp Community Psychiatry* 43:1023-1025, 1992.

Poster 43 — Sunday, October 8, 12 noon-1:30 p.m.

MEDICAL CLEARANCE: MAKING IT WORK

Robert C. Marks, M.D., *Associate Medical Coordinator for Mental Health Services, Illinois Department of Mental Health and Developmental Disabilities, 160 North LaSalle Street, Chicago, IL 60601;* Lesley M. Blake, M.D., Nada L. Stotland, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify the physical and mental status examinations essential to safe and appropriate transfer of patients from general hospital emergency departments to state psychiatric hospitals.

SUMMARY:

The interface between the general hospital emergency department and the state psychiatric hospital is often a troubled one. The emergency department physician attempting to transfer patients to the psychiatric hospital often experiences frustration. An array of expensive laboratory tests may be required. Beds may be limited. The staff at the state hospital may be difficult to reach and resistant to transfer. Meanwhile, the behaviorally disordered patient is creating havoc and is requiring inordinate resources in the emergency department. On the state hospital side, staff may find that patients are transferred without adequate physical or mental status examinations. Some transferred patients are simply acutely intoxicated on alcohol or other drugs, so that psychiatric hospitalization is not indicated. Others suffer from serious undiagnosed nonpsychiatric medical disorders that pose acute risks to patients' lives and that the state hospital is not equipped to handle.

In response to these problems, the presenters convened a

state-wide task force composed of psychiatrists from state and general hospitals, emergency physicians, legal experts, and representatives of community mental health centers. The task force produced a transfer protocol that has been effective in reducing tensions and improving care at the interface.

REFERENCE:

1. Hanneman PL, Mendoza R, Lewis R: Prospective evaluation of emergency department medical clearance. *Ann Emerg Med* 24:672-677, 1994.

Poster 44 **Sunday, October 8**
12 noon-1:30 p.m.

BRIEF NEUROPSYCHIATRIC COGNITIVE EXAMINATION IN DIAGNOSTIC EVALUATION OF CHRONIC PSYCHIATRIC PATIENTS

Joseph M. Tonkonogy, M.D., Ph.D., *Associate Professor, Department of Psychiatry, University of Massachusetts Medical Center, 55 Lake Avenue North, Worcester, MA 01655*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the role of standardized neuropsychiatric testing, based on comparisons with MRI and head CT scan data, in the diagnostic evaluation of chronic psychiatric patients.

SUMMARY:

The Brief Neuropsychiatric Cognitive Examination is the first standardized short cognitive test devised to reflect the severity of brain lesions as assessed by MRI and head CT scans in psychiatric patients. The major advantage of the test is the inclusion of subtests for evaluation of novel and incomplete information and the inclusion of more-sensitive subtests for examination of conventional information processing. The test shows excellent internal consistency and was found to be valid and reliable. The poster will compare the results of the Brief Neuropsychiatric Cognitive Examination with those of other tests for assessment of cognitive status as a reflection of the severity of brain lesions, and these results will be related to the course of disease progression and the functional status of state hospital patients.

Special attention will be given to the use of the Brief Neuropsychiatric Cognitive Examination in the forensic psychiatric evaluation, in early stages of dementia progression, and in the development of criteria for referral of patients for MRI and head CT scans.

REFERENCE:

1. Tonkonogy JM, Armstrong JR: Brief neuropsychiatric cognitive examination and head CT, MRI data. In *New Research Abstracts, 147th Annual Meeting of the American Psychiatric Association.* American Psychiatric Association, Washington, DC, 1994, p 145.

Poster 45 **Sunday, October 8**
12 noon-1:30 p.m.

CONSULTATION TO CULTURALLY DIVERSE MEDICAL CLINICS

Russell Lim, M.D., *Clinical Instructor, University of California at Los Angeles, Santa Monica West, 1525 Euclid Street, Santa Monica, CA 90404;* Ernesto Ferran, Jr., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to (a) identify and address the special needs of culturally diverse patients in their assessment, diagnosis, and treatment in community outpatient medical clinics, (b) describe training methods that are effective in these settings, and (c) identify salient characteristics of Native American, Latino, and Russian patients that influence their diagnosis and treatment.

SUMMARY:

With the increasing cultural diversity of the United States and the cost-effectiveness mandate of managed care, psychiatrists have the opportunity to create a new use for psychiatric skills by providing consultation to primary care sites, which may lower medical costs by decreasing the number of clinic visits. Community medical clinics with culturally diverse patients require special skills and knowledge so that these populations can be treated appropriately and effectively. This poster will contrast the outpatient psychiatric consultation programs in a refugee clinic at San Francisco General Hospital, which serves newly arrived Russians and other culturally diverse groups, with a medical clinic for Native Americans at a hospital in Albuquerque and with a medical clinic serving a predominantly Hispanic population in New York City. Examples of approaches to assessment, diagnosis, and treatment will be presented.

REFERENCES:

1. Epstein SA, Gonzales JJ: Outpatient consultation-liaison psychiatry: a valuable addition to the training of advanced psychiatry residents. *Gen Hosp Psychiatry* 15:369-374, 1993.
2. Lefley HP, Bestman EW: Public-academic linkages for culturally sensitive community mental health. *Community Ment Health J* 27:473-488, 1991.
3. Lu F, Lim RF, Mezzich J: Psychological issues in the assessment and diagnosis of culturally diverse individuals. In Oldham J, Riba M (eds): *American Psychiatric Press Review of Psychiatry,* Vol 14. American Psychiatric Press, Washington, DC, in press.

Poster 46 **Sunday, October 8**
12 noon-1:30 p.m.

EFFECT OF A PASSIVE BODY-HEATING PROCEDURE ON TENSION-ANXIETY IN DEPRESSIVE ILLNESS

John R. Meyers, M.D., *Resident, Cornell University Medical College, Payne Whitney Psychiatric Clinic, 525 East Sixty-Eighth Street, P.O. Box 140, New York, NY 10021;* Anne M. Miller, M.D., Dale A. D'Mello, M.D., Dominic Barbario, D.O., Meha Shah

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the efficacy of a warm-water bath as an adjunctive therapeutic strategy in the alleviation of anxiety in patients with major depressive disorder.

SUMMARY:

Passive body-heating procedures, such as a warm-water bath, have demonstrated efficacy in increasing the duration of slow-wave sleep in healthy volunteers. The clinical relevance of similar procedures in depressive illness has not been previously substantiated. A prospective study of 15 patients with major depression who were hospitalized on a psychiatric unit in a mid-Michigan general hospital examined the effect of a single 30-minute warm-water bath on subjective mood. The patients completed the Profile of Mood States (POMS) before and immediately after the bath. A substantial decline was observed in the mean tension-anxiety score (17.66 versus 12.90; $z = 1.96$, $p < 0.05$). A warm-water bath may be an effective, inexpensive, and practical means of managing anxiety and tension in patients with depressive illness.

REFERENCES:

1. Horne JA, Reid AJ: Night-time sleep EEG changes following body heating in a warm bath. *Electroencephalogr Clin Neurophysiol* 60:154-157, 1985.
2. Robiner WN: Psychological and physical reactions to whirlpool baths. *J Behav Med* 13:157-173, 1990.

Poster 47 **Sunday, October 8**
12 noon-1:30 p.m.

EPILEPSY AND REPORTED MORTALITY FROM SUICIDE: UNITED STATES, 1986-1990

Daniel P. Chapman, Ph.D., M.Sc., *Psychiatric Epidemiologist, Centers for Disease Control and Prevention, Mail Stop K-51, 4770 Buford Highway N.E., Atlanta, GA 30341-3724;* Russell Roegner, Ph.D., Elizabeth K. Lloyd, M.S., John R. Livengood, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the reported prevalence of epilepsy among persons committing suicide and to identify potential barriers to accurate reporting of suicide among persons with epilepsy.

SUMMARY:

Epilepsy has been associated with higher than average rates of mortality from various causes, including uncontrolled status epilepticus, drowning, and accidents. Mortality from suicide has also been reported to be greater among persons with epilepsy than among the general population. In this investigation the presenters used death certificate data from the National Center for Health Statistics to examine the cumulative prevalence of epilepsy reported among individuals whose underlying cause of death was suicide for the years 1986-1990 in the United States ($N = 153,475$). Overall, epilepsy was reported on the death certificates of persons committing suicide at a rate of 2.5 per 10,000 suicides. Among persons with epilepsy who were 55 years of age or younger, 3.1 per 10,000 deaths from suicide were reported; the rate was 1.1 per 10,000 for those over 55 years of age. Among persons younger than 25 years of age, 3.3 per 10,000 men who committed suicide and 2.1 per 10,000 women who committed suicide were reported to have had epilepsy. These data suggest, in contrast to results from some previous clinical investigations, that reported suicides among persons with epilepsy are few. This difference in findings may reflect problems in reporting epilepsy on the death certificates of persons who committed suicide.

REFERENCE:

1. U.S. Centers for Disease Control and Prevention: Prevalence of self-reported epilepsy--United States, 1986-1990. *MMWR* 43:810-811, 817-818, 1994.

Poster 48 **Sunday, October 8**
12 noon-1:30 p.m.

ABSENCE OF PARKINSONISM IN PATIENTS TAKING LONG-TERM NEUROLEPTICS WHO ABUSE COCAINE

Vasant P. Dhopesh, M.D., *Psychiatrist, Inpatient Detoxification Unit, Philadelphia Veterans Affairs Medical Center, 116/A, University and Woodland Avenues, Philadelphia, PA 19104;* Andrea M. Macfadden, M.S.N., R.N., C.S., I. Maany, M.D., G. Gamble, M.S.N., R.N., C.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to evaluate patients for signs of Parkinson's disease (parkinsonism) and describe the relationship of dopamine, parkinsonism, and cocaine use.

SUMMARY:

Long-term neuroleptic therapy can produce parkinsonism by altering central dopamine activity. Ongoing cocaine use leads to dopamine depletion. Significant numbers of patients with chronic schizophrenia abuse cocaine. The objective of this study, therefore, was to determine whether parkinsonism occurs in patients receiving long-term neuroleptic therapy who also abuse cocaine.

The subjects were 43 male patients receiving long-term depot neuroleptic therapy who were followed as outpatients at the Philadelphia Veterans Affairs Medical Center. They were examined with the 14-item United Parkinson's Disease Scale. Cocaine use histories were obtained, and urine samples were examined for a cocaine metabolite. All patients were receiving either fluphenazine or haloperidol.

Of the 43 patients, 19 had been abusing cocaine from 2 to 18 years; 24 were cocaine free. Urine was positive for a cocaine metabolite in 52.6% of the patients with histories of cocaine use. The urine samples of all cocaine-free patients were negative for cocaine. The mean total duration of neuroleptic treatment for the cocaine-abusing patients was 18.6 years (depot form, mean = 4 years). The mean duration of neuroleptic treatment for the cocaine-free patients was 22.0 • 8.4 years (depot form, mean = 6 years). The mean score on the United Parkinson's Disease Scale for the cocaine-abusing patients was 0.89 • 0.66, and the mean score of the cocaine-free patients was 1.5 • 1.4; the difference was not significant according to Student's *t* test.

These data suggest that cocaine abuse does not lead to parkinsonism in patients receiving long-term neuroleptic therapy.

REFERENCE:

1. Stone A, Greenstein RA, Gamble G, et al: Cocaine use in schizophrenic outpatients who receive depot neuroleptic medication. *Hosp Community Psychiatry* 44:176-177, 1993.

Poster 49 — **Sunday, October 8, 12 noon-1:30 p.m.**

PREVALENCE OF DISSOCIATIVE EXPERIENCES IN PSYCHIATRIC AND NONPSYCHIATRIC POPULATIONS IN AN INNER-CITY HOSPITAL

Madhumalti D. Bhavsar, M.D., *Resident, Department of Psychiatry, 4 South, Bronx-Lebanon Hospital Center, 1276 Fulton Avenue, Bronx, NY 10456;* Ali Khadivi, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the prevalence of dissociative symptoms in severely disadvantaged psychiatric and nonpsychiatric patients.

SUMMARY:

The presenters examined the hypothesis that severely disadvantaged psychiatric patients living in high-poverty areas are likely to have a high prevalence of dissociative symptoms.

Seventy-six psychiatric inpatients and 74 nonpsychiatric medical outpatients in an inner-city hospital were rated according to the Dissociative Experience Scale. The subjects were primarily African-American or Hispanic. Forty-eight percent were male, and 52% were female. All subjects were unemployed and were living in low-income, high-crime areas of the Bronx.

As predicted, the prevalence of dissociative symptoms in both populations was higher than reported in other settings. The average score on the Dissociative Experience Scale for the psychiatric inpatients was 23.4, which was significantly higher ($p = 0.001$) than the mean score of 12.1 for the nonpsychiatric patients. Of the psychiatric subjects, 38.2% scored at or above the cutoff of 20, which reflects prominent dissociative symptoms, as compared to only 16.4% of the nonpsychiatric subjects. In addition, 29.4% of the psychiatric patients and 10.5% of the nonpsychiatric patients had a score greater than 30, i.e., in a range consistent with posttraumatic stress disorder and dissociative disorder.

Dissociative experiences are prevalent in inner-city psychiatric and nonpsychiatric patients, reflecting the multiple stresses in their social environment. Routine screening for dissociative symptoms is needed in severely disadvantaged populations.

REFERENCE:

1. Saxe GN, Van der Kolk BA, Berkowitz R, et al: Dissociative disorders in psychiatric inpatients. *Am J Psychiatry* 150:1037-1042, 1993.

Poster 50 — **Sunday, October 8, 12 noon-1:30 p.m.**

THE ROLE OF ADVANCED-PRACTICE NURSES IN A PSYCHIATRIC PRIMARY CARE CLINIC

Jean G. Shelor, Ph.D., *Associate Chief of Nursing for Psychiatry, Veterans Affairs Medical Center, 1970 Boulevard, Salem, VA 24153*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to present the rationale for a psychiatric primary care clinic within a 500-bed medical/surgical/psychiatric Veterans Affairs medical center and to describe the roles of advanced-practice nurses and of continuous quality improvement monitors in a psychiatric primary care clinic.

SUMMARY:

Given the downsizing of inpatient psychiatric units and the increased emphasis on outpatient psychiatric care, the current shift to managed care is being met at the Salem, Virginia, Veterans Affairs Medical Center by a primary care team for psychiatric patients. The total spectrum of mental health care needs has expanded to include health promotion and disease prevention. For example, programs that address managing stress and learning adaptive coping skills enhance mental health and may prevent psychological trauma associated with family violence. The consumer's responsibility and involvement in self-care related to mental health are emphasized. The primary care team in psychiatry provides basic primary care for psychiatric outpatients. Primary care consists of triage within the outpatient department, crisis intervention, intake and initial assessments, and preventive health care services, such as referrals to psychoeducational groups, veterans' centers, or providers of medical/surgical interventions (e.g., ambulatory care units, day hospital, women's clinic), psychiatric assessment/intervention, community services, or psychometric testing. The emphasis of primary care in psychiatry is holistic care and the physiological and psychological wellness of the veteran.

Treatment is provided by an interdisciplinary team consisting of a psychiatrist, nurses in advanced practice, a licensed clinical social worker, a psychologist, and clerical support personnel. The nurses in advanced practice work with the physician and define primary care by the following tasks: (a) medical diagnosis and treatment; (b) psychological diagnosis and treatment; (c) personal support of patients of all backgrounds and in all stages of illness; (d) communication of information about diagnosis, treatment, prevention, and prognosis; and (e) detection, education, behavioral change, and preventive treatment.

REFERENCE:

1. Goroll AH, May LA, Mulley AG Jr (eds): *Primary Care Medicine.* JB Lippincott, Philadelphia, 1995.

Poster 51 — **Sunday, October 8, 12 noon-1:30 p.m.**

RELATIONSHIP BETWEEN CONCURRENT SECONDARY PSYCHIATRIC COMOR-BIDITY AND PROLONGED HOSPITAL LENGTH OF STAY

John T. Clarke, M.S.N., *Psychiatric Consultation-Liaison Nurse, Cleveland Veterans Affairs Medical Center, Mail Stop W118, 10701 East Boulevard, Cleveland, OH 44106*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe how variables affecting episodes of care influence diagnosis-related groups and hospital length of stay, to discuss the relationship between comorbid psychiatric conditions and length of stay, and to name five techniques for assisting with screening for comorbid conditions.

SUMMARY:

The relationship between concurrent secondary psychiatric comorbidity and length of hospital stay was examined in a retrospective study. Ten high-volume medical/surgical diagnostic-related groups (DRGs) were examined. Computerized chart abstracts for subjects admitted to an urban New England university-affiliated hospital in a 12-month period were reviewed ($N = 3,611$). Subjects in each DRG were divided into "comorbid" and "noncomorbid" groups on the basis of the presence of coded *ICD-9-CM* or *DSM-III-R* diagnoses of mental disorder. Health Care Financing Administration parameters for DRG-specific geometric-mean length of stay and outlier trim point were used. The rate of psychiatric comorbidity was 7%, although rates fluctuated by DRG. In 9 of the 10 DRGs, the mean length of stay for the group with comorbid conditions was greater than that of the subjects without noncomorbid conditions; in 4 DRGs the difference was statistically significant. Unspecified psychosis was the most frequently observed psychiatric diagnosis, whereas nondependent abuse of drugs was the predominant diagnostic spectrum. Limitations of the study and implications for research and practice will be presented.

REFERENCES:

1. Fulop G, Strain JJ, Fahs MC, et al: Medical disorders associated with psychiatric comorbidity and prolonged hospital stay. *Hosp Community Psychiatry* 40:80-82, 1989.
2. Fetter RB, Shin Y, Freeman JL, et al: Case mix definition by diagnosis-related groups. *Med Care* 18(2 suppl):iii, 1-53, 1980.

Poster 52 — **Sunday, October 8, 12 noon-1:30 p.m.**

ATYPICAL ANTIPSYCHOTICS: WEIGHT GAIN AND RELATED RISK OF HYPERGLYCEMIA IN AN OUTPATIENT SETTING

Marianne Emanuel, R.N., *Project Renewal, Manhattan Bowery Co., 448 West Forty-Eighth Street, New York, NY 10036;* Ralph Aquila, M.D., Sharon Goldfarb, R.N., M.S.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify psychiatric benefits and potential medical risks of atypical antipsychotic drugs in a supervised residence for mentally ill adults.

SUMMARY:

The presenters will describe efforts in their 57-bed supportive residence for formerly homeless mentally ill adults to identify medical pathology in persons who may not have had access to medical care or have avoided it because of their psychopathology. In this outpatient setting the psychological and physical responses of patients switched from standard neuroleptic therapy to atypical antipsychotic drugs can be observed. The atypical drugs, such as clozapine and risperidone, are useful in treating the acute phase of psychosis and in preventing relapse. They also seem to cause fewer extrapyramidal symptoms and lessen the risk of the development of tardive dyskinesia. For treating refractory schizophrenia, therefore, atypical antipsychotic drugs appear to be the drugs of choice.

The side effects of these drugs include weight gain and possible obesity. Although these effects may be viewed as less harmful than the proven benefits for a population with risk factors such as smoking, inactivity, and poor nutrition, adding the side effects of weight gain and obesity may compromise the patient's mental health by increasing the risk of the development of certain types of disease.

The presenters examined 22 patients switched to atypical antipsychotic drugs, tracking their weight gain and blood sugar levels. Evidence suggests that these medications, which may increase appetite and cause weight gain, may elevate blood sugar levels, thus increasing the risk of diabetes.

REFERENCES:

1. Marder SR, Meibach RC: Risperidone in the treatment of schizophrenia. *Am J Psychiatry* 151:825-835, 1994.
2. Aquila R, Emanuel M: Identification of medical pathology in a supportive residence for formerly homeless persons with serious and persistent mental illness. In *Syllabus, 46th Institute on Hospital & Community Psychiatry.* American Psychiatric Association, Washington, DC, 1994.

Poster 53 **Sunday, October 8**
12 noon-1:30 p.m.

LITHIUM CARBONATE IN THE TREATMENT OF AGGRESSIVE AND SELF-INJURIOUS BEHAVIOR IN TWO BRAIN-INJURED ADULTS IN A STATE PSYCHI-ATRIC HOSPITAL

Diane M. Stewart, M.D., *Psychiatrist, Buffalo Psychiatric Center, 400 Forest Avenue, Buffalo, NY 14213;* Stephen B. Bellus, Ph.D., Joseph G. Vergo, M.B.A., Peter P. Kost, Ph.D., Jeffrey Grace, M.D., Scott R. Barkstrom, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the use of lithium carbonate as a potential pharmacological intervention for improving self-control of aggressive and self-destructive behavior in brain-injured patients, regardless of the number of years since the injury or the setting of treatment.

SUMMARY:

Brain-injured individuals often experience problems with aggression, which can prevent full community reintegration. The presenters will demonstrate the efficacy of lithium carbonate in treating aggressive behaviors in two individuals who had been placed in a state psychiatric hospital because of dangerous and/or self-injurious behaviors (4 years and 17 years postinjury, respectively). Medication dosages and acuity indicators (seclusions, assaultive incidents, as-needed administration of drugs for agitation, and number of shifts under special observation) over a 2-year period were measured. Lithium, in concert with other medications, not only led to a decrease in the frequency of aggressive behaviors and to significant reductions in the use of behavior control techniques, but also allowed for a significant reduction in the use of neuroleptic medication in one case. The use of lithium may yield positive effects in the control of aggressive behavior, even in long-term cases.

REFERENCE:

1. Cassidy JW: Neuropharmacological management of destructive behavior after traumatic brain injury. *J Head Trauma Rehab* 9(3):43-60, 1994.

Poster 54 **Sunday, October 8**
12 noon-1:30 p.m.

TWO OPEN-LABEL, LONG-TERM SAFETY STUDIES OF SERTINDOLE

Linda G. Funderburg, M.D., *Physician, Clinical Research Unit, San Antonio State Hospital, 6711 South New Braunfels, San Antonio, TX 78223*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the use of sertindole in the treatment of schizophrenia and other psychotic disorders.

SUMMARY:

Sertindole is a potent antagonist of dopamine-2, serotonin-2, and alpha-1 adrenergic receptors that was discovered and patented by H. Lundbeck A/S (Copenhagen) and is currently being developed as an antipsychotic agent in the United States by the Psychopharmacology Venture of Abbott Laboratories. In *in vivo* electrophysiological experiments with rats, sertindole has demonstrated a selectivity for ventral tegmental dopaminergic neurons that is 100 times that for nigrostriatal dopaminergic neurons. Phase I studies with over 100 healthy

subjects have shown that sertindole is generally well tolerated, and phase II studies with over 300 patients have demonstrated minimal motor-system-related adverse effects.

Study M92-795 is a 2-year open-label investigation of sertindole in the treatment of schizophrenic patients who previously participated in a 6-8-week double-blind placebo-controlled trial of sertindole. Patients in M92-795 are assessed weekly for the first month and then monthly thereafter. Assessments include the Positive and Negative Syndrome Scale, Clinical Global Impression (CGI), routine laboratory tests, electrocardiograms, and objective rating scales for motor-system-related adverse effects (Simpson-Angus Scale for extrapyramidal symptoms, Barnes Akathisia Scale, and Abnormal Involuntary Movement Scale).

Study M93-061 is an open-label study of sertindole in the treatment of patients with schizophrenia and other psychotic disorders. Patients receive sertindole for up to 1 year and are assessed weekly for the first month and then monthly thereafter. Assessments include CGI, routine laboratory tests, and electrocardiograms.

Data from approximately 250 patients with at least 1 year of sertindole exposure will be presented. These data will include duration of participation, reasons for premature termination, scores on psychiatric rating scales, distribution of adverse events, frequency of motor-system-related adverse events, and use of anticholinergic agents.

Poster 55 **Sunday, October 8**
12 noon-1:30 p.m.

WHO, WHEN, AND HOW DOES CLOZAPINE HELP? A COMMUNITY MENTAL HEALTH CENTER EXPERIENCE

Rosalind M. Mance, M.B., B.S., *Medical Director, Community Outreach Services, Department of Psychiatry, Grady Memorial Hospital, 80 Butler Street S.E., Atlanta, GA 30335;* Geri Scheller-Gilkey, Ph.D., Cheryl Swofford, M.A., M.S., Monique Farrill, R.N., M.S., C.S., Nan B. Chadwick, R.N., M.S., C.S., Bobbi Woolwine, B.S., Andrew H. Miller, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the recent experience with clozapine of a community mental health center, including selection of patients, compliance, and regular evaluations of psychopathology, side effects, quality of life, and compliance.

SUMMARY:

Clozapine has been regarded by many as a breakthrough in the treatment of schizophrenia. Its major benefits for neuroleptic-resistant and neuroleptic-intolerant patients include improvement in positive symptoms, primary and secondary negative symptoms, disabling side effects, cognitive impairment, and quality of life. The major controversy over the use and efficacy of clozapine currently focuses on the validity, timing, and specificity of these benefits in comparison to those of other neuroleptics. In a resource-poor public mental health system, questions as to whether, when, and for whom clozapine is superior to typical neuroleptics have major implications for planning and implementing clozapine trials. Concern about the seriousness of potential side effects and the cost of the drug and the required weekly monitoring must be balanced by informed thinking about the type and timing of clinical improvement.

In an open outpatient trial of clozapine in an inner-city mental health center, 41 candidates were selected on the basis of persistent positive symptoms during treatment with typical neuroleptics, intolerance of neuroleptic side effects, or both. More than half of these patients took clozapine for at least 6 months, and a smaller group continued taking the drug for 2 years. Psychopathology, side effects, quality of life, and compliance were evaluated regularly.

For the study group who completed 6 or more months of clozapine treatment, improvements in ratings of positive symptoms, specifically the Brief Psychiatric Rating Scale (BPRS) thought disturbance and hostile-suspicious subscales, of extrapyramidal side effects, and of quality of life were seen within the first 6 months, and they continued up to and beyond the 12-month point. Improvements in ratings on the Scale for the Assessment of Negative Symptoms and the BPRS negative symptom subscale were not significant. Side effects were most commonly reported in the early months and were a significant reason for distress and early dropout, but they had been reduced dramatically by the end of the first year.

REFERENCES:

1. Carpenter WT, Conley RR, Buchanan RW, et al: Patient response and resource management: another view of clozapine treatment of schizophrenia. *Am J Psychiatry* 152:827-832, 1995.
2. Meltzer HY: Clozapine: is another view valid? (editorial). *Am J Psychiatry* 152:821-825, 1995.

Poster 56 **Sunday, October 8**
12 noon-1:30 p.m.

TREATMENT STRATEGIES IN THE PHARMACOLOGICAL MANAGEMENT OF ATTENTION DEFICIT HYPERACTIVITY DISORDER

Amar N. Bhandary, M.D., *Assistant Professor, Department of Psychiatry, School of Medicine, Louisiana State University, New Orleans, LA 70112;* Prakash S. Masand, M.D., Robert J. Gregory, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the neuropathogenesis and somatic disturbances of attention deficit hyperactivity disorder and to identify psychotropic and other treatments used in complicated cases.

SUMMARY:

Attention deficit (hyperactivity) disorder (ADHD) is a neuropsychiatric syndrome that affects 3-5% of children and persists chronically, although most adults have psychiatric comorbidity. The disorder's heterogenous nature and the paucity of a therapeutic database commonly hamper treatment of adult ADHD. Currently, pharmacotherapy relies on medications used for children. However, adulthood variables necessitate modified interventions. Currently, there is a pressing need for comprehensive research on this subject.

The subject literature and related pharmacotherapies will be reviewed, and ancillary literature germane to neuropharmacological mechanisms will be elaborated. Psychostimulants and nonstimulants will be discussed, along with commonly encountered difficulties. This overview will incorporate the existing and extrapolated databases, along with possible interventions for synthesizing this concise treatment algorithm.

Psychostimulants, particularly methylphenidate, retain the mainstay role; amphetamines often produce better outcomes. Psychostimulants treat neurobehavioral symptoms but sometimes only weakly control somatic symptoms, comorbid conditions, and hyperactivity, and they have a failure rate of 30-50%. Nonstimulants, such as antihypertensives, buspirone, and the newer psychotropics, are increasingly beneficial in primary or adjunctive roles. Tricyclic antidepressants and bupropion have established second-tier roles. Some combinations synergistically reduce comorbidity and adverse effects.

In conclusion, adulthood ADHD is a common, complex syndrome. Knowledge and proficiency in diagnosis and pharmacotherapy are critical. Treatment success is not assured with any specific agent, and polypharmacy is commonly required.

REFERENCES:

1. Weiss G, Hecktmann L, Milroy T, et al: Psychiatric status of hyperactives as adults: a controlled fifteen year followup of sixty-three hyperactive children. *J Am Acad Child Adolesc Psychiatry* 24:211-220, 1985.
2. Wender PH, Wood DR, Reimherr FW: Pharmacological treatment of attention deficit disorder: residual type in adults (ADD-RT). In Osman BB, Greenhill LL (eds): *Ritalin.* Mary Ann Liebert, New York, 1991, pp 25-34.

Poster 57 — **Sunday, October 8, 12 noon-1:30 p.m.**

RISPERIDONE FOR TREATING AGGRESSION ASSOCIATED WITH DEMENTIA

William D. Jeanblanc, M.D., *Medical Director, Senior Mental Health Center, Monadnock Community Hospital, Suite 309, 454 Old Street Road, Peterborough, NH 03458;* Yvonne B. Davis, M.S.N., M.S., R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the value of risperidone in the management of aggressive behavior associated with dementia in elderly patients.

SUMMARY:

Dementia is often associated with prolonged periods of agitated or violent behavior and refusal to follow directions or assist in activities of daily living. Drug treatment involves neuroleptics, benzodiazepines, anticonvulsants, estrogen, or psychotropic agents. However, neuroleptics are only modestly effective in controlling agitation, and other commonly used drugs do not benefit most patients or may cause sedation that leads to falls in the elderly or reduces the patient's ability to socialize with peers. The presenters report on five elderly patients in whom risperidone doses of 1.5 to 2.5 mg/day eliminated or markedly decreased dementia-related agitation or violent behavior and had no sedative side effect. Previous episodes of aggressive behavior in these patients were refractory to conventional antipsychotics and other commonly used drugs. Successful treatment without sedation allowed all patients to return to their nursing homes. On follow-up calls 4 to 12 weeks after the patients were discharged, nursing home staff reported that the patients had maintained significant improvement: few or no episodes of agitated or aggressive behavior, increased ability to participate in social activities and follow directions, and marked decreases in delusional speech. Further studies are needed to investigate the elective use of risperidone and other agents for treating dementia-related behavioral problems.

REFERENCES:

1. Schneider LS, Pollack VE, Lyness SA: A meta-analysis of controlled trials of neuroleptic treatment of dementia. *J Am Geriatr Soc* 38:553-563, 1990.
2. Marder SR, Meibach RC: Risperidone in the treatment of schizophrenia. *Am J Psychiatry* 151:825-835, 1994.

Poster 58 — **Sunday, October 8, 12 noon-1:30 p.m.**

RISPERIDONE IN THE TREATMENT OF TOURETTE'S SYNDROME

Michael R. Martinez, M.D., *Fellow, Child Psychiatry, Department of Psychiatry, University of Iowa Hospitals and Clinics, 200 Hawkins Drive, Iowa City, IA 52242*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify appropriate doses of risperidone and monitor risperidone therapy in patients with refractory Tourette's syndrome.

SUMMARY:

Risperidone is a potent serotonin-2 and dopamine-2 agonist indicated for the treatment of psychoses. However, recent reports suggest that risperidone is useful in treating Tourette's syndrome. This poster will describe four treatment-refractory patients with Tourette's syndrome (*DSM-III-R*) who were successfully treated with risperidone.

Patient 1 was a 17-year-old male with severe vocal tics that resulted in school refusal and motor tics severe enough to cause falls. Prior treatment had been only partly effective, and the medication was discontinued because of severe adverse drug reactions. Four months of treatment with risperidone at 1 to 3 mg/day was associated with decreases in tics, extrapyramidal symptoms, and stuttering and with a return to school.

Patient 2, a 28-year-old man, had frequent loud vocal tics and coprolalia for 15 years. Prior neuroleptic treatment had produced only minimal improvement and troublesome side effects. Risperidone, 1 mg every other day to 1 mg/day, resulted in moderate improvement in the patient's tics and mood.

Patient 3, a 7-year-old boy, had facial motor and vocal tics coexisting with diagnoses of Asperger's syndrome, attention deficit hyperactivity disorder, oppositional defiant disorder, enuresis, encopresis, and mixed seizure disorder. Replacement of 4 mg/day of haloperidol and 80 mg/day of paroxetine with risperidone, 0.5 to 2.5 mg/day for 3 weeks, and fluoxetine, 20 mg every other day, resulted in significant reduction of tics and aggressive behavior and in better classroom behavior.

Patient 4 was a 48-year-old man with motor and vocal tics and severe obsessive-compulsive disorder marked by perseverative behavior. The patient had responded only partially to pimozide, primarily because sedation had limited the dose. Risperidone was titrated to 4 mg/day over 4 weeks and then was maintained at this dose for 16 weeks. At follow-up the patient's tics were no longer obvious, the perseveration had decreased, and the obsessive-compulsive symptoms were much improved.

Among these patients, the only adverse drug reaction reported was dose-related drowsiness in patients 1 and 2. Risperidone was an effective and well-tolerated treatment for Tourette's syndrome. Currently, a 10-week parallel design trial comparing risperidone with clonidine is being conducted.

REFERENCES:

1. Stamenkovic M, Aschauer H, Kasper S: Risperidone for Tourette's syndrome. *Lancet* 344:1577-1578, 1994.
2. Van der Linden C, Bruggeman R, van Woerkom CAM: Serotonin-dopamine antagonist and Gilles de la Tourette's syndrome: an open pilot dose-titration study with risperidone. *Mov Disord* 9:687-688, 1994.

Poster 59 — **Sunday, October 8, 12 noon-1:30 p.m.**

RISPERIDONE FOR PATIENTS WITH DEVELOPMENTAL DISABILITIES

Theodore W. Wasserman, M.D., *Private Practice, 1345 South Fourth Street, Philadelphia, PA 19147*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the use of risperidone in place of conventional neuroleptics for treating developmentally disabled patients.

SUMMARY:

This poster will describe administration of risperidone to more than 100 developmentally disabled adults with a variety of axis I diagnoses over 6 or more months. Two thirds of the patients live in institutions, and one third live in the community. Epilepsy or a history of seizure disorder was diagnosed in one third of the patients; autistic disorder was diagnosed in 20%. Before starting treatment with risperidone, all patients were receiving neuroleptics (40% were receiving thioridazine). Transferring patients to risperidone was accomplished in less than 1 week with no untoward effects and no significant breakthrough behavior (severe breakthrough behavior is seen in many developmentally disabled patients when neuroleptic doses are reduced). The risperidone dose was 3 to 4 mg/day. Risperidone appeared to be effective and safe for this population. Aggression, the most common psychiatric symptom in developmentally disabled patients, was reduced, and the caregivers reported that the patients were more directable, less irritable, and more in touch with the environment. Dysphoric and aggressive features in the patients with autistic disorder were improved, and no increase in seizure frequency was experienced by patients with epilepsy. Risperidone was generally well tolerated, and fewer than 5% of the patients took antiparkinsonian medication.

REFERENCES:

1. Gilbert PL, Harris MJ, McAdams LA, et al: Neuroleptic withdrawal in schizophrenic patients: a review of the literature. *Arch Gen Psychiatry* 52:173-188, 1995.
2. Aman MG, Sarphare G, Burrow W: Psychotropic drugs in group homes: prevalence and relation to demographic/psychiatric variables. *Am J Ment Retard* 99:500-509, 1995.

Poster 60 — **Sunday, October 8, 12 noon-1:30 p.m.**

EFFICACY AND SAFETY OF SERTINDOLE IN TWO DOUBLE-BLIND, PLACEBO-CONTROLLED TRIALS FOR SCHIZOPHRENIC PATIENTS

S. Charles Schulz, M.D., *Chairman, Department of Psychiatry, Case Western Reserve University, 11100 Euclid Avenue, Cleveland, OH 44106;* Nigel M. Bark, M.D., Joanne Zborowski, Peter Schmitz, Terri Sebree, Bruce Wallin

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the pharmacological efficacy and safety of sertindole, a new antipsychotic medication currently under development.

SUMMARY:

Sertindole was discovered and patented by H. Lunbeck A/S (Copenhagen) and is being developed as an antipsychotic medication in the United States by the Psychopharmacology Venture of Abbott Laboratories. Sertindole is a potent antagonist with nanomolar affinities for dopamine D_2, serotonin 5-HT_2, and norepinephrine alpha-1 receptors. *In vivo* electrophysiological animal studies of sertindole have shown a selectivity for ventral tegmental dopaminergic neurons that is 100 times that for substantia nigra pars compacta neurons. Thus, it is hypothesized that sertindole will be an effective antipsychotic agent with minimal neurological side effects.

Sertindole study M92-762 was a phase II double-blind, placebo-controlled, fixed-dose, randomized 6-week trial of three doses of sertindole (8, 12, and 20 mg/day). Sixteen centers in the United States studied a random sample of 205 patients with schizophrenia. Study M93-098 was a larger, phase III trial of similar design that was conducted at 30 centers in the United States with a random sample of 461 patients. In contrast to M92-762, M93-098 used sertindole doses of 20 and 24 mg/day, a haloperidol reference (16 mg/day), and a treatment duration of 8 weeks. Both studies assessed efficacy by using the Brief Psychiatric Rating Scale, Positive and Negative Syndrome Scale, and Clinical Global Impression. Effects on motor function were assessed by the appearance of motor system adverse effects, the use of any medications for extrapyramidal side effects, and several specific rating scales (Simpson-Angus Scale, Barnes Akathisia Scale, and Abnormal Involuntary Movement Scale). Safety was assessed by adverse event monitoring, clinical laboratory analysis, and electrocardiograms. Data from M92-762 and M93-098 showed that patients treated with sertindole were significantly more improved, on all efficacy scales, than those treated with a placebo. The M93-098 patients receiving sertindole and haloperidol also showed significant reductions in total symptom scores on all efficacy scales. Only the sertindole-treated patients showed statistically significant improvement in negative symptoms. Both studies showed extrapyramidal side effects, and the amounts of medications for extrapyramidal symptoms were equivalent in the sertindole and placebo treatment arms. The haloperidol-treated patients experienced significantly more extrapyramidal side effects than did the sertindole-treated patients and were treated with significantly more medication for those symptoms.

REFERENCES:

1. Skarsfeldt T: Pharmacology of sertindole, a novel atypical neuroleptic. *Int Acad Biomed Drug Res* 4:62-66, 1993.
2. Kane JM, Freeman HL: Towards more effective antipsychotic treatment. *Br J Psychiatry* 165(suppl 25):22-31, 1994.

Poster 61 **Sunday, October 8**
12 noon-1:30 p.m.

RATIONAL USE OF ANTICHOLINERGIC MEDICATIONS FOR EXTRAPYRAMIDAL SIDE EFFECTS DURING TREATMENT OF SCHIZOPHRENIA

Rajiv Tandon, M.D., *Associate Professor of Psychiatry, University of Michigan Medical Center, 8D, Box 0116, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0116;* John R. DeQuardo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to (a) identify the possible effects of anticholinergic medications on schizophrenic symptoms and detect circumstances in which such effects are clinically meaningful, (b) discuss other beneficial and adverse effects of anticholinergic medications and differences among individual anticholinergic agents with regard to such effects, and (c) make better use of cholinergic medications during the treatment of schizophrenia.

SUMMARY:

Anticholinergic medications are widely used for the prevention and treatment of extrapyramidal side effects associated with antipsychotic treatment of schizophrenia. Different antipsychotic agents themselves have significant and variable amounts of anticholinergic activity. Although there continues to be some controversy about the prophylactic use of anticholinergics to prevent extrapyramidal side effects associated with antipsychotic drugs, such use is generally recommended. Anticholinergic agents are the mainstay for treating extrapyramidal side effects that occur during antipsychotic treatment. Anticholinergics, however, have a variety of side effects of their own. Different anticholinergics (with differing abilities to block various muscarinic and nicotinic receptor subtypes) differ in their profile of side effects. Furthermore, anticholinergics worsen certain motor side effects, such as tardive dyskinesia, in schizophrenia. Finally, anticholinergics have significant effects on positive and negative symptoms and may modify therapeutic effects of antipsychotics; in this regard, the unique therapeutic profile of clozapine has been related to its significant activity at the muscarinic M_1 cholinergic receptor. Although the effects of anticholinergics on schizophrenic symptoms are generally small and not of great clinical relevance, they can be very significant under certain circumstances. In treatment-refractory schizophrenic patients, for example, withdrawal from anticholinergic medications and the use of an antipsychotic medication with little anticholinergic activity are essential therapeutic interventions. Awareness of these issues will allow more rational use of anticholinergics during treatment of schizophrenia. Although clinical relevance will be emphasized, pathophysiological implications will also be summarized.

REFERENCES:
1. Tandon R, Greden J: Cholinergic hyperactivity and negative schizophrenic symptoms. *Arch Gen Psychiatry* 46:745-753, 1989.
2. Tandon R, DeQuardo J, Goodson J, et al: Effect of anticholinergics on positive and negative symptoms in schizophrenia. *Psychopharmacol Bull* 28:297-302, 1992.

Poster 62 **Sunday, October 8**
4:30 p.m.-6:00 p.m.

GEMINI HOUSE: A RESIDENTIAL TREATMENT MODEL FOR HOMELESS DUAL DIAGNOSIS CLIENTS

Timothy T. Hartnett, M.S.W., *Director, Drug and Alcohol Abuse Services, Mental Health Center of Greater Manchester, 175 River Road, Manchester, NH 03104*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe modification of a therapeutic community treatment model to meet the needs of a severely impaired population, describe development of a residential treatment program within a comprehensive mental health center, and identify three necessary elements of successful partial hospital programs for dual diagnosis clients.

SUMMARY:

Community mental health centers continue to struggle with treating clients who suffer from both severe, persistent mental illness and substance use disorders. This poster will describe a model residential treatment program for treating the dually diagnosed.

Gemini House integrates a residence using a modified therapeutic community approach with a partial hospital program. Clients and staff join in running and maintaining the home, creating a drug-free environment in which independent-living skills and healthy lifestyle change are cultivated. A partial hospital team of psychiatric and chemical dependency clinicians organize treatment, which targets psychiatric stability, relapse prevention, vocational rehabilitation, independent-living skills, and community integration.

Clients participate in a variety of interactive groups, individual therapy, and vocational and community-based activities that continually challenge them to make the lifestyle changes necessary for successful community living. As clients develop skills, they move through a series of levels with progressive independence.

The poster will also focus on many of the practical considerations in program design and development, e.g., admission and discharge criteria, relapse, self-help groups, and residential continua.

REFERENCE:
1. Minkoff K, Drake RE (eds): Dual Diagnosis of Major Mental Illness and Substance Disorder. *New Dir Ment Health Serv* 50, 1991.
2. Miller NS: Prevalence and treatment models for addiction in psychiatric populations. *Psychiatr Ann* 24(8), 1994.
3. Anthenelli RM: The initial evaluation of the dual diagnosis patient. *Psychiatr Ann* 24(8), 1994.
4. Minkoff K: An integrated treatment model for dual diagnosis of psychosis and addiction. *Hosp Community Psychiatry* 40:1031-1036, 1989.

Poster 63 **Sunday, October 8**
4:30 p.m.-6:00 p.m.

PROGRAM DEVELOPMENT FOR INTEGRATED TREATMENT AND SERVICES FOR PERSONS WHO HAVE MENTAL ILLNESS, DRUG ADDICTION, AND/OR 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*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the development and implementation of a dual/multiple-diagnosis program within an existing or new mental health or substance abuse agency; use program underpinnings such as screening, assessment, client readiness scales, and progress updates; and use a nonconfrontational treatment approach that includes interventions from "denial" to "abstinence."

SUMMARY:

This poster will teach participants to implement integrated treatment and services for persons who have drug addiction and/or alcoholism in addition to mental illness. Profiles of clients with multiple disorders, and considerations for services, will be outlined. Materials for screening, assessment, readiness measurement, progress updates, and networking will be described. A specific program of nonconfrontational treatment from "denial" to "abstinence," including phase-specific interventions, will be detailed. Participants will learn to use educational content and strategies within the treatment process. Dynamic treatment considerations, including developmental arrest and identity, will be included. Ancillary programs, such as "Helpful People in Touch," consumer-led self-help, and MICAA-NON, a program for families with dually diagnosed members, will be outlined.

REFERENCES:
1. Sciacca K: An integrated treatment approach for severely mentally ill individuals with substance disorders. New Dir Ment Health 50:69-84, 1991.
2. Sciacca K: *MIDAA Service Manual: A Step by Step Guide to Treatment and Program Implementation for Multiple Disorders.* Kathleen Sciacca, New York, 1994.
3. Sciacca K, Hatfield A: The family and the dually diagnosed patient. In Lehman A, Dixon L (eds): *Double Jeopardy: Chronic Mental Illness and Substance Use Disorders.* Gordon & Breach, New York, 1994.

Poster 64 **Sunday, October 8**
4:30 p.m.-6:00 p.m.

DOUBLE JEOPARDY: SCHIZOPHRENIA AND SUBSTANCE ABUSE

Geri Scheller-Gilkey, Ph.D., *Coordinator, Advanced Treatment Strategies Clinic, Department of Psychiatry, Grady Memorial Hospital, 80 Butler Street S.E., Atlanta, GA 30335;* Cheryl Swofford, M.A., M.S., Rosalind M. Mance, M.B., B.S., Monique Farrill, R.N., M.S., C.S., Bobbi Woolwine, B.S., Andrew H. Miller, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe factors associated with substance abuse and dependence in outpatients diagnosed with schizophrenia spectrum disorders.

SUMMARY:

Although the clinical reality of substance dependence and abuse among patients with schizophrenia is widely acknowledged, the interaction of these diagnoses is not well understood. Perhaps the largest study documenting the comorbidity of substance abuse is the Epidemiologic Catchment Area study, which found the rate to be 47% in patients with schizophrenia.

The present study examined substance dependence and abuse, schizophrenic symptoms, relapse, compliance, and demographic variables in a public inner-city mental health center. Data were collected from the charts of 251 patients who each had a schizophrenic spectrum disorder and had made at least 10 outpatient visits. Of these patients, 55% had a history of past or current substance abuse. Consistent with previous reports, the substance-abusing schizophrenia patients were more likely to be young and male. Moreover, there was a strong correlation between substance dependence or abuse and number of both lifetime hospitalizations (mean = 5.46, SD = 5.2, versus mean = 3.48, SD = 3.9; $p < 0.001$) and hospitalizations in the past 2 years (mean = 1.16, SD = 1.8, versus mean = 0.64, SD = 1.2; $p = 0.008$). There was also a higher rate of poor treatment adherence in the substance-abusing schizophrenia patients, as measured by missed appointments, and there was a significant positive correlation between missed appointments and hospitalizations.

These results extend the previous findings to a large inner-city sample of subjects and to a population that is at risk for relapse. Taken together, the data underline the need for further research into the nature and treatment of dual diagnosis patients.

REFERENCE:
1. Regier DA, Farmer ME, Rae DS, et al: Comorbidity of mental disorders with alcohol and other drug abuses. *JAMA* 264:2511-2518, 1990.

Poster 65 **Sunday, October 8**
4:30 p.m.-6:00 p.m.

IMPACT OF COMMUNITY SUPPORT SERVICES FOR PREGNANT ADDICTS

Mona G. Bastide, L.C.S.W., *Intensive Clinical Management Supervisor, MHMA, Inc., Suite 200, 100 Copley Place, Boston, MA 02118;* Christine A. Degan, R.N., M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss how client involvement in a community support program for pregnant addicts leads to better service linkage and utilization and describe how to measure outcomes for a population that is difficult to serve and track.

SUMMARY:

Identification, intervention, and advocacy are difficult with pregnant addicts because of a variety of psychosocial factors. Cooperation, coordination, and collaboration among multiple agencies and service providers are keys in developing a comprehensive service network for this population. Pregnant addicts enrolled in an intensive clinical management program served by the nation's first Medicaid managed care behavioral health carve-out are routinely offered community support services when they enter treatment.

The challenges of early identification, service connection, and measurement of outcomes, including birth outcomes, in a population with needs for multiple services and a reluctance to become engaged in treatment will be discussed. Strategies for overcoming these difficulties will be reviewed.

Pre- and postidentification measures will be displayed. These include cost, service utilization, functioning level, satisfaction, and birth outcomes. Implications for management actions and quality improvement will be outlined from the results obtained.

REFERENCE:
1. Jessup M: The treatment of perinatal addiction. *Addict Med* 152:553-558, 1990.

Poster 66 **Sunday, October 8**
4:30 p.m.-6:00 p.m.

DUAL DIAGNOSIS AND COMMUNITY VIOLENCE: THE ROLE OF EARLY AGE AT ONSET

Carl Fulwiler, M.D., *Co-Director, Bay Cove Community Treatment Team, Department of Psychiatry, Mail Stop 1007, New England Medical Center, 750 Washington Street, Boston, MA 02111;* Catherine Cooper Forbes, Hillel T. Grossman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify clinical and demographic variables associated with increased risk for acts of community violence by people with chronic mental illness.

SUMMARY:

Several different kinds of studies have shown higher than average rates of violent behavior in people with serious mental illness. In referrals to the urban Bay Cove Community Treatment Team, established by the department of mental health for patients who require frequent hospitalization or emergency services, a history of violence in the community is common (45%). Historical and clinical information on the patients has been systematically collected so that the factors associated with violence can be better understood.

As in other studies, alcohol and drug abuse were strongly correlated with violent behavior in these patients (chi-square analysis, $p < 0.0001$). In almost all cases, the substance abuse began at an early age, typically less than 15 years. Violence was also inversely associated with age at first diagnosis of mental illness (Mann-Whitney U test, Wilcoxon rank, two-tailed $p = 0.005$). In contrast, childhood behavioral and scholastic problems, including hyperactivity and learning disorder, were not associated with adult violence.

These findings suggest that the onset of alcohol or drug abuse during early adolescence is a significant risk factor for violent behavior in adulthood for people with chronic mental illness. Further statistical analysis will be performed to determine whether early onset of mental illness is a separate risk factor or is related to early substance abuse. Implications for violence prevention strategies will also be discussed.

REFERENCES:

1. Torrey EF: Violent behavior by individuals with serious mental illness. *Hosp Community Psychiatry* 45:653-662, 1994.
2. Lindqvist P, Allebeck P: Schizophrenia and assaultive behavior: the role of alcohol and drug abuse. *Acta Psychiatr Scand* 82:191-195, 1989.

Poster 67 **Sunday, October 8**
4:30 p.m.-6:00 p.m.

SUBSTANCE USE DISORDER AND EARLY COURSE OF ILLNESS IN SCHIZOPHRENIA AND AFFECTIVE PSYCHOSIS

Beatrice M. Kovasznay, M.D., Ph.D., *Chief of Psychiatry, Capital District Psychiatric Center, Third Floor, 75 New Scotland Avenue, Albany, NY 12208*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the relationship between a history of substance use disorders and both psychosocial functioning and treatment experience in the early course of illness in individuals with schizophrenia or affective psychosis.

SUMMARY:

The relationship between a history of substance use disorder and the early course of psychotic illness was examined in 96 subjects with schizophrenia and 106 subjects with affective psychosis followed in the Suffolk County Mental Health Project, a longitudinal study of first-admission psychosis. The subjects received a structured diagnostic interview and clinical ratings at baseline and 6 months later. Information about treatment received during the interval was included in the 6-month assessment. A lifetime history of substance use disorder was associated with worse clinical functioning and more positive psychotic symptoms at 6 months for schizophrenic subjects but not for those with affective psychosis. There were no differences associated with substance abuse in the number of outpatient visits or the proportion of subjects taking medication. Schizophrenic subjects were more likely to have cannabis use disorder and to be using cannabis during the interval.

REFERENCES:

1. Bromet EJ, Schwartz JE, Fennig S, et al: The epidemiology of psychosis (the Suffolk County Mental Health Project): rationale, methods and descriptive characteristics of the initial sample. *Schizophr Bull* 18:234-255, 1992.
2. Kovasznay B, Bromet E, Schwartz J, et al: Substance abuse and the onset of psychotic illness. *Hosp Community Psychiatry* 44:567-571, 1993.

Poster 68 **Sunday, October 8**
4:30 p.m.-6:00 p.m.

A MENTAL-HEALTH-BASED PRIMARY CARE MODEL FOR HIGH USERS OF PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES

Mort Rubinstein, M.D., *Director, General Psychiatry Division, New York Veterans Affairs Medical Center, Mail Stop 116A, 423 East Twenty-Third Street, New York, NY 10010*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify factors critical to developing a primary care model for high users of mental health services.

SUMMARY:

The presenters are developing a primary care model for patients with significant mental health and substance abuse problems. The proposed program will provide accessible, timely, coordinated, and comprehensive primary care focused on health care and biopsychosocial needs. Because these changes will affect a large, vulnerable patient population, a program evaluation component will be implemented simultaneously.

Patients and staff were surveyed about satisfaction with current care delivery and their perceptions and wishes. This information was used to obtain baseline measures against which to evaluate the success of the proposed program and to measure the changes over time.

The presenters will report sociodemographic, utilization, and preference-for-care findings from the initial survey of 140 patients. Patient preferences included the following: (a) 82% of the patients preferred care in one setting; (b) over 67% of the patients preferred the site of their care to be a mental health clinic; (c) over 40% of the patients preferred care that includes education about their problem, screening for other problems, reminder letters for appointments, and shorter waiting times; and (d) specific features ranked as having very much importance ranged from 89% for respect from caregivers to 48% for cost of care.

The utilization patterns of over 4,700 patients who had at least one visit to a mental health/substance abuse clinic during 1994 were reviewed. Of these, 2,200 patients were high users of mental health services and low users of other medical center services and were determined to be appropriate candidates for a mental-health-based primary care program.

As different primary care models for patients with varying mental health needs are implemented, data from later studies will focus on health outcome, cost of care, and patient and staff satisfaction.

REFERENCES:

1. Kassirer J: Access to specialty care. *N Engl J Med* 331:1151-1152, 1994.
2. Sturm R, Wells KB: How can care for depression become more cost-effective? *JAMA* 273:51-58, 1995.

Poster 69 **Sunday, October 8**
4:30 p.m.-6:00 p.m.

A PROPOSED PROGRESSIVE TREATMENT MODEL FOR DUAL DIAGNOSIS: A VIABLE PARADIGM FOR AN URBAN-RURAL COLLABORATIVE RELATIONSHIP?

Simon S. Chiu, M.D., Ph.D., *Clinical Director, Dual Diagnosis Program, Toledo Mental Health Center, Medical College of Ohio at Toledo, Toledo, OH 43699*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the issue of dual diagnosis in rural mental health and addiction services and identify essential elements in coordinating treatment services for dually diagnosed patients in the context of the rural-urban relationship.

SUMMARY:

Dual diagnosis research emphasizes integration of addiction and mental health treatment services in a continuum of care. The promising clinical research findings from New Hampshire provide support for the principles of continuity treatment teams, community linkage, and intensive case management, raising the issue of viable rural-urban collaboration for dual diagnosis.

The conceptual framework of the progressive treatment model presupposes that major mental illnesses and addiction disorders have to be treated concurrently. The acute-care unit in the urban mental health center is restructured to serve the dual functions of detoxification and psychiatric stabilization. The transition from the acute phase to the recovering phase is organized with the hybrid day hospital and community dual diagnosis residence. Multimodal treatment for dual diagnosis clients is the goal of the day hospital. Adaptive integration into the community is the objective of the dual diagnosis residence, derived from the therapeutic community model and the psychosocial rehabilitation paradigm.

The proposed program allows for flexible, creative, and positive collaboration between rural communities and an urban center. Policy for streamlining client referral and admission, establishing a community outreach team, cross-training, and staff sharing can be negotiated in addressing the special needs of the consumer.

The clinical, administrative, and financial implications of the proposed treatment model in an era of emerging managed care initiatives will be discussed.

REFERENCES:

1. Santos AB, Deci PA, Lachance KR, et al: Providing assertive community treatment for severely mentally ill patients in a rural area. *Hosp Community Psychiatry* 44:34-39, 1993.
2. Drake RE, Antosca LM, Noordsy DL, et al: New Hampshire's specialized services for the dually diagnosed. *New Dir Ment Health Serv* 50:57-67, 1991.

POSTER SESSIONS

Poster 70 **Sunday, October 8**
4:30 p.m.-6:00 p.m.

THE CULTURE OF CONTROL AND VIOLENCE IN PSYCHIATRIC SETTINGS

Eileen F. Morrison, Ph.D., R.N., *Director of Nursing Research, Medical College of Virginia Hospitals, P.O. Box 980073, Richmond, VA 23298-0073*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to (a) identify how a controlling organizational culture influences both staff and patients in psychiatric settings and increases violence and (b) describe how administrators can begin to address control and violence in psychiatric settings.

SUMMARY:

The results of two studies on aggression and violence will be presented to describe how an emphasis on control adversely influences patient behavior and increases violence in psychiatric settings. First, in a qualitative study, patients and staff reported a tradition of toughness and excessive control in staff behavior toward patients. The controlling ideology was converted into a rigid rule structure and preconceived staff roles that increased violence through provocation. Causal modeling methods were used in the second study to quantify the tradition of toughness. Organizations that emphasized control were predicted to have nursing staff with an overcontrolling approach to patient care and violence. The study results suggested that 10% of the violence was predicted by organizational and professional variables.

Although more research is needed in this area, the issue of staff control and its relationship to violence in health care settings must be addressed. This presentation will describe organizational issues related to violence, as well as interventions for decreasing staff control.

REFERENCES:

1. Morrison EF: The tradition of toughness: psychiatric nursing care by nonprofessionals in institutional settings. *Image* 20:222-234, 1990.
2. Johnson K, Morrison EF: Control or negotiation: a health care challenge. *Nurs Admin Q* 17(3):27-33, 1993.

Poster 71 **Sunday, October 8**
4:30 p.m.-6:00 p.m.

VIOLENCE AS A COERCIVE BEHAVIOR IN THE MENTALLY ILL

Eileen F. Morrison, Ph.D., R.N., *Director of Nursing Research, Medical College of Virginia Hospitals, P.O. Box 980073, Richmond, VA 23298-0073*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the interactional nature of aggression and violence in psychiatric settings and, by using this perspective, identify new techniques for preventing or minimizing aggression and violence.

SUMMARY:

Both qualitative and quantitative research methods have been used in studies on prediction of aggression and violence in psychiatric settings. The findings emphasize the interactional nature of aggression and violence and highlight the importance of violence as a coercive behavior used by many to maximize rewards. In fact, 60% of the aggression and violence was predicted by only three variables: coercion, history of violence, and length of hospitalization. The studies addressed one issue in the literature, the relative effect of personal versus environmental variables, by describing how violent individuals interacted with their environment in purposeful ways.

The implications of these findings for practice will be addressed. Common current interventions will be analyzed and critiqued from this perspective, and new interventions will be suggested. It is hoped that a synthesis of research findings will facilitate the application of research to practice settings and will ultimately decrease violence in psychiatric settings.

REFERENCES:

1. Morrison EF: The evolution of a concept: aggression and violence in psychiatric settings. *Arch Psychiatr Nurs* 8:245-263, 1994.
2. Morrison EF: Towards a better understanding of violence in psychiatric settings: debunking the myths. *Arch Psychiatr Nurs* 7:328-335, 1993.

Poster 72 **Sunday, October 8**
4:30 p.m.-6:00 p.m.

AN EDUCATIONAL PROGRAM ADDRESSING VIOLENCE IN THE WORKPLACE

John R. Kettley, M.S.W., A.C.S.W., B.C.D., *Social Work Specialist, University of Michigan Medical Center, B1 C204 UH, Box 0020, 1500 East Medical Center Drive, Ann Arbor, MI 48109;* Judith S. Rizzo, M.S., R.N., C.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe a program for de-escalating situations before they become violent, manage a violent situation, react appropriately in a weapons or hostage situation, assess their workplaces for violence potential, and develop a plan to counteract violence.

SUMMARY:

This poster will present a multidisciplinary program on managing escalating and violent behavior in the workplace and describe its implementation at the University of Michigan Medical Center for all staff. More than 4 years were spent planning the program because of the complexity of assimilating mental health approaches throughout the professional and the nonprofessional staff. The training package consists of a trigger-tape video, slides, and handouts. Discussions, lectures, and small-group interactions are the teaching modes. Tests before and after participation in the program were included to measure short-term effectiveness. Long-term evaluation is ongoing, with statistics and surveys now being compiled. The poster will provide an opportunity for focus groups to assess participants' own workplaces for violence potential and to plan for workplace safety.

REFERENCE:

1. National Institute for Occupational Safety and Health: *Proposed National Strategy for the Prevention of Severe Occupational Traumatic Injuries,* DHHS Publication 89-131. National Institute for Occupational Safety and Health Publications, U.S. Department of Health and Human Services, Cincinnati, 1993.

Poster 73 **Sunday, October 8**
4:30 p.m.-6:00 p.m.

MURDER IN A MEDICAL CENTER: ONE PSYCHIATRIC EMERGENCY SERVICE'S RESPONSE

Judith S. Rizzo, M.S., R.N., C.S., *Clinical Nurse Specialist, University of Michigan Medical Center, B1 C204 UH, Box 0020, 1500 East Medical Center Drive, Ann Arbor, MI 48109;* John R. Kettley, M.S.W., A.C.S.W., B.C.D., Rachel Lipson Glick, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to outline an emergency response plan for helping individuals manage the emotional impact of traumatic and violent events in organizations or businesses.

SUMMARY:

Two years ago, a faculty physician was shot to death by a deranged patient in one of the presenters' hospital clinics. This event had a tremendous emotional impact on the patients, staff, faculty, and all other members of the medical center community. This poster will describe the emergency team's immediate response and its role in developing an institution-wide internal disaster plan. This institutional disaster plan has led to significant collaborative relationships between the psychiatric emergency program and the hospital, medical school, and university. The team continues to expand its consultative and educational efforts to be proactive in helping staff manage and cope with the increasing risk of violence in the work setting.

REFERENCES:

1. Horowitz M: Stress response syndrome: a review of posttraumatic adjustment disorders. *Hosp Community Psychiatry* 37:241-249, 1986.
2. Monahan J, Steadman H: *Violence and Mental Disorder: Developments in Risk Assessment.* University of Chicago Press, Chicago, 1994.

Poster 74 **Sunday, October 8**
4:30 p.m.-6:00 p.m.

INTEGRATING HARM REDUCTION AND PSYCHIATRIC REHABILITATION ON AN ACUTE INPATIENT UNIT: PATIENT-CENTERED CARE FOR EVERYONE

Kathy Shook, M.S., R.N., *Associate Clinical Professor, University of California at San Francisco School of Nursing, San Francisco General Hospital, Room 7E27, 1001 Potrero Avenue, San Francisco, CA 94110;* Kathryn Ballou, B.S.N., R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify major principles of the harm reduction model and the psychiatric rehabilitation model and describe how integrating these models can positively affect dually diagnosed patients.

SUMMARY:

The harm reduction model and the psychiatric rehabilitation model are gaining prominence in the fields of substance abuse and psychiatry, respectively. Harm reduction, a public health model for drug users, focuses on reducing risk of disease and injury, rather than making demands on the client. The acute locked unit at San Francisco General Hospital has been using principles of psychiatric rehabilitation for over a year. However, patients with substance use problems are still treated as they always were, receiving treatment and trying to maintain abstinence.

This poster will describe efforts to introduce harm reduction into the unit and integrate it into the rehabilitation program. It is hoped that combining these patient-centered models will lead to better treatment alliances and improved outcomes for dually diagnosed patients. Helping all patients work toward their personal goals while they stay safe and healthy is indeed possible.

REFERENCES:
1. Springer E: Effective AIDS prevention with active drug users: the harm reduction model. *J Chem Depend Treat* 4:141-157, 1991.
2. Liberman RP: *Handbook of Psychiatric Rehabilitation.* Macmillan, New York, 1992.

Poster 75 **Sunday, October 8**
4:30 p.m.-6:00 p.m.

A COMPARATIVE STUDY OF VIOLENT BEHAVIOR ON AN ALL-FEMALE PSYCHIATRIC UNIT AND A MIXED-SEX UNIT

Ali Khadivi, Ph.D., *Associate Chief Psychologist, Inpatient Psychiatry Service, Bronx-Lebanon Hospital Center, 1276 Fulton Avenue, Bronx, NY 10456;* Raman C. Patel, M.D., Vinod R. Bhashyam, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the difference in the frequency of violent behavior between patients in a same-sex psychiatric unit and those in mixed-sex units.

SUMMARY:

To date, little is known about the effect of being in a same-sex psychiatric unit on the frequency of violent behavior. Depp, who conducted the only study, found that the assault rate for mixed-sex units was slightly greater than the rate for same-sex units. He hypothesized that a mixed-sex unit may produce "stimulus overload" for the psychiatric patients, which may lead to behavior that is more violent than that in same-sex units. The presenters tested this hypothesis by comparing the number of patients who engaged in violent behavior in two mixed-sex psychiatric units with the number of patients who engaged in violent behavior in an all-female psychiatric unit.

Patients involved in assaultive behavior were identified from retrospective review of all incident reports for 1994 in an inner-city hospital. Assaultive behavior was defined as physical contact with a patient, staff member, or property such that serious injury or damage occurred. A total of 81 inpatients (6.9% of all those admitted) were involved in assaultive behavior. The subjects were primarily African-American or Hispanic. Females accounted for 51.4%, and males accounted for 48.6%.

There were no significant differences in the numbers of patients who engaged in assaultive behavior between the two mixed-sex units and the all-female unit. The three units also did not differ in the types of assaults that occurred. The most frequent form of violent behavior was assault on a patient; this was followed in frequency by assault on staff and assault on property.

The results of this study do not support the stimulus-overload hypothesis and suggest that mixed-sex units have a frequency of violent behavior that is comparable to that in same-sex units.

REFERENCES:
1. Lion J, Reid W (eds): *Assaults Within Psychiatric Facilities.* Grune & Stratton, New York, 1983.
2. Davis S: Violence by psychiatric inpatients: a review. *Hosp Community Psychiatry* 42:585-590, 1991.

Poster 76 **Sunday, October 8**
4:30 p.m.-6:00 p.m.

THE ROLE OF TESTING IN MENTAL HEALTH JUSTICE TREATMENT PLANNING

des Anges Cruser, Ph.D. *Texas Tech University, Health Science Center, Montford Unit, 8602 Peach Street, Lubbock, TX 79409;* Ethel Perry, M.A., Chance Wooley, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the operation of an outpatient mental health forensics clinic, a testing battery for evaluating mentally ill offenders, the application of test results to psychiatric treatment, and the development of a multidisciplinary mental health justice treatment plan.

SUMMARY:

Appropriate treatment requires far more information than an accurate diagnosis. This poster will provide insights into the usefulness and limitations of a selected battery of psychological, psychosocial, and psychiatric tests in designing treatment plans for offenders with mental impairments. The presenters will describe the tests used, the rationale for their selection, and the ways in which the data can assist in development of an individualized mental health justice plan for each client. A multidisciplinary program involving specialists from both community- and jail-based treatment services in Harris County and Houston, Texas, will be described. The social and psychological usefulness of the data, corroboration between the test data and original clinical impressions, and modifications to the program and testing battery will be explored.

REFERENCES:
1. McFarland BH, Faulkner LR, Bloom JD, et al: Chronic mental illness and the criminal justice system. *Hosp Community Psychiatry* 40:718-723, 1989.
2. Anthenelli RM: The initial evaluation of the dual diagnosis patient. *Psychiatr Ann* 24:407-411, 1994.
3. Annis HM, Davis CS: Assessment of expectancies. In Donovan DM, Marlatt AG (eds): *Assessment of Addictive Behaviors.* Guilford Press, New York, 1988.

4. Baer JS, Lichtenstein E: Cognitive assessment. In Donovan DM, Marlatt AG (eds): *Assessment of Addictive Behaviors.* Guilford Press, New York, 1988.
5. Andrews DA, Bonta J: *The Psychology of Criminal Conduct.* Anderson, Cincinnati, 1994.
6. Jesness CF: The Jesness Inventory classification system. *Crim Justice Behav* 15:78-91, 1988.

Poster 77 **Sunday, October 8**
4:30 p.m.-6:00 p.m.

MANDATED TREATMENT: IT'S WORKING!

Daniel P. Potenza, M.D., *Clinical Director, Department of Supportive Services, Mental Health Center of Greater Manchester, 1555 Elm Street, Manchester, NH 03101;* Christopher O'Keefe, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe how court-mandated treatment enables patients to be maintained in the community rather than in a hospital.

SUMMARY:

One of the major dilemmas in providing service for patients with severe and persistent mental illness is dealing with those who are frequently hospitalized and who are uncooperative about taking prescribed medication and, as a result, are at risk in the community.

This poster will discuss the effectiveness of a state statutory authority that enables patients to be released from a facility during a period of court-ordered admission (up to 5 years) on the condition that they comply with specific provisions of community-based treatment or be subject to readmission to the facility. It will present specific conditional discharge plans for patients with severe mental illness, including those with co-occurring substance abuse. The implications of this imposed treatment approach over time will be described.

REFERENCES:

1. Geller J: Clinical guidelines for the use of involuntary outpatient treatment. *Hosp Community Psychiatry* 41:749-755, 1990.
2. Hiday V, Scheid-Cook T: A follow-up of chronic patients committed to outpatient treatment. *Hosp Community Psychiatry* 40:52-59, 1989.

Poster 78 **Sunday, October 8**
4:30 p.m.-6:00 p.m.

A FORENSIC SERVICES PROGRAM DESIGNED TO FACILITATE TREATMENT AND REFERRAL FOR MENTALLY ILL CLIENTS IN THE CRIMINAL JUSTICE SYSTEM

Michael H. Levinson, A.B.D., Clinical Psychology, *Director, Acute Services Division, Capitol Region Mental Health Center, 500 Vine Street, Hartford, CT 06112;* Brenda St. George, M.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the challenges in providing mental health services in a complex criminal justice system and identify the essential elements of a program that provides forensic and jail diversion services to seriously mentally ill persons.

SUMMARY:

The presenters will describe a program, developed over 2 years at Capitol Region Mental Health Center, designed to ensure that mentally ill persons involved in the criminal justice system could receive adequate evaluation, treatment, and referral. The impetus for the program was a series of meetings between the staff of the center and representatives from the criminal justice agencies to identify gaps in the system and to determine how to deliver services in jails and the court system. The program performs the following services: on-site evaluation of incarcerated people that exhibit signs of mental illness, identification of known mentally ill people arrested and being held for arraignment, evaluation and referral for inpatient treatment of mentally ill people in criminal justice facilities, assistance to families and significant others of mentally ill clients in the criminal justice system, coordination of outpatient and case management services for clients, referrals for other (e.g., substance abuse) services, on-site psychiatric and psychopharmacological services, consultation and education for criminal justice personnel, and outpatient restoration to competency. During the first 2 years of operation 400 clients were evaluated and provided with care, referrals for inpatient restoration to competency were reduced by 50%, and working relations between mental health providers and the criminal justice system were greatly improved.

REFERENCE:

1. Degen K, Cole N, Tamayo L, et al: Intensive case management for the seriously mentally ill. *Admin Policy Ment Health* 17(4), 1990.

Poster 79 **Sunday, October 8**
4:30 p.m.-6:00 p.m.

COURT-ORDERED ECT FOR INCOMPETENT PATIENTS IN ILLINOIS

Jagannathan Srinivasaraghavan, M.D., *Chief, Psychiatry Service, Canandaigua Veterans Affairs Medical Center, 400 Fort Hill Avenue, Canandaigua, NY 14424;* Richard Abrams, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the Illinois statute regarding the administration of ECT to incompetent patients and to identify demographic characteristics of patients affected by this statute.

SUMMARY:

Section 2-110 of the Illinois Mental Health and Developmental Disabilities Code requires that a guardian for an incompetent person obtain court approval before providing consent for participation of the ward in ECT. This study looked at the clinical impact of this statute on the incompetent patient.

All cases referred for court approval of ECT that were filed in the circuit court of Cook County in the calendar years 1991, 1992, and 1993 were examined. All relevant data regarding patient, originating hospital, and diagnosis were collected.

Court approval of ECT was sought in 33 cases, 14 in 1991, 9 in 1992, and 9 in 1993; one file was impounded. Of the patients for whom approval of ECT was sought, 27 were female and 20 were 65 years of age or older. There were 26 whites, 4 blacks, and 2 Hispanics. The primary diagnosis was major depression in 23 cases, mania in 3 cases, schizophrenia in 4 cases, and organic affective disorder in 2 cases. The mean time required for the court to reach a decision was 11 days. ECT was approved in 29 cases and was denied in 2 cases; 1 request was withdrawn. The cases involved 5 judges, 10 hospitals, and 19 physicians. All but 1 patient came from private hospitals, and only 6 came from nonteaching hospitals. Of the 26 patients who received ECT, 23 experienced complete remission or marked improvement.

In conclusion, 91% of court-referred cases were approved for ECT. The typical patient was an elderly white woman with a diagnosis of major depression coming from a private teaching hospital and attaining complete remission or marked improvement.

REFERENCES:

1. *Illinois Mental Health and Developmental Disabilities Code,* Section 2-110, 1992 revision.
2. Abrams R: *Electroconvulsive Therapy,* 2nd ed. Oxford University Press, New York, 1992.

Poster 80 **Sunday, October 8**
4:30 p.m.-6:00 p.m.

ILLINOIS EXPERIENCE WITH COURT-ORDERED PSYCHOTROPIC MEDICATION

Jagannathan Srinivasaraghavan, M.D., *Chief, Psychiatry Service, Canandaigua Veterans Affairs Medical Center, 400 Fort Hill Avenue, Canandaigua, NY 14424;* Atul Mahableshwarkar, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the Illinois statute regarding the administration of psychotropic medication to nonconsenting competent patients in nonemergency situations and to identify demographic characteristics of the patients affected by this statute.

SUMMARY:

Section 2-107.1 of the Illinois Mental Health and Developmental Disabilities Code, regarding administration of psychotropic medication upon application to a court, was enacted on August 13, 1991. This statute allows courts to order the administration of medications to patients in nonemergency situations without the patients being declared incompetent. The aim of this study was to determine the demographic characteristics of the affected patients and their originating hospitals.

All cases filed in the circuit court of Cook County, Illinois, from the enactment of the law in 1991 to December 31, 1993, were examined (of the 102 counties in Illinois, Cook County handles 60% of all mental health cases). All relevant data regarding patients and hospitals were collected from the files of the Cook County circuit court.

In 3 years, 200 cases were filed (91 for males and 109 for females). In the successive years 1991, 1992, and 1993 there were 12, 42, and 77 cases from public hospitals and 22, 21, and 25 cases from private hospitals, respectively. The mean time from the date of petition until the first court date was 10 days, with a range of 0-64 days, and the mean time to disposition was 19, with a range of 0-250 days.

Of the 200 cases, 79 were approved for administration of medication, 3 were denied, and 118 were dismissed without prejudice. Decisions were rendered by 6 judges, and 3 judges denied 1 case each. In 172 cases the physician was the petitioner.

Only 41% of the cases were tried. In 96% of the cases tried, the judges authorized approval of administration of psychotropic medication. In 3 years the burden of taking a patient to court was heavily shifted to public hospitals.

REFERENCE:

1. *Illinois Mental Health and Developmental Disabilities Code,* Section 2-107.1, 1992 revision.

Poster 81 **Sunday, October 8**
4:30 p.m.-6:00 p.m.

OUTPATIENT COMMITMENT: THE NEW YORK EXPERIENCE

Howard W. Telson, M.D., *Director, Bellevue Outpatient Commitment Program, Bellevue Hospital Center, Number 321, 215 East Twenty-Fourth Street, New York, NY 10010;* Joel J. Wallack, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the clinical and research goals of the New York State outpatient commitment legislation and describe Bellevue Hospital Center's implementation of a 3-year outpatient commitment pilot program.

SUMMARY:

In July 1995 the Bellevue Hospital Center Department of Psychiatry initiated a 3-year pilot program providing for "involuntary outpatient treatment of mentally ill persons." The 1994 New York State laws mandated this demonstration program on the basis of the legislature's findings that (a) other jurisdictions had laws allowing for court-ordered outpatient treatment and (b) some individuals who require psychiatric services to survive in the community "frequently reject the care and treatment offered to them on a voluntary basis and decompensate to the point of requiring repeated psychiatric hospitalizations." The legislation also called for an independently contracted research study to determine the pilot program's effectiveness "in assisting participants to live and function in the community, in preventing relapse or deterioration that may result in the need for hospitalization, and participant satisfaction."

This poster will highlight the main elements of Bellevue's clinical program, the legislation, and the research design.

REFERENCES:

1. Geller JL: Clinical guidelines for the use of involuntary outpatient treatment. *Hosp Community Psychiatry* 41:749-755, 1990.
2. Swartz MS, Burns BJ, Hiday VA, et al: New directions in research on involuntary outpatient commitment. *Psychiatr Serv* 46:381-385, 1995.

Poster 82 — **Sunday, October 8, 4:30 p.m.-6:00 p.m.**

EFFECTS OF RISPERIDONE ON AGGRESSION IN A MAXIMUM-SECURITY FORENSIC MENTAL HEALTH HOSPITAL

Fred Raleigh, Pharm.D., *Director, Pharmacy Services, Atascadero State Hospital, P.O. Box 7001, Atascadero, CA 93423*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to assess the effectiveness of risperidone in the management of aggression in a maximum-security mental health facility.

SUMMARY:

A treatment-outcome project was designed by the Atascadero State Hospital's Department of Psychiatry and Department of Pharmacy to evaluate the use of risperidone. The therapeutic effectiveness of risperidone, its production of adverse reactions over a 24-week treatment period, and its effects on psychopathology as shown by Brief Psychiatric Rating Scale (BPRS) scores were studied. Of the first 50 patients included in the project, 30 had a diagnosis of schizophrenia, 12 had a diagnosis of schizoaffective disorder, 4 had a diagnosis of affective disorder, 2 had a diagnosis of organic disorder, and 2 had other diagnoses. After 6 to 12 weeks of risperidone treatment, the 50 patients showed a clinically significant reduction in hostility (BPRS scores). Most of them (76%) had a history of assaultiveness, and 55% were also treatment refractory.

Case studies will be presented to illustrate how the incidence of assaults, number of employee injuries, and restraint and seclusion time were reduced in patients treated with risperidone. During this project risperidone had an unexpected and significant economic impact due to reduction of patient hostility and aggression, which in turn led to less use of restraints and seclusion and fewer assaults and employee injuries. Reduction in violence and staff injuries would have a significant impact on the operating expenses of a mental health facility.

REFERENCE:

1. Marder SR, Meibach RC: Risperidone in the treatment of schizophrenia. *Am J Psychiatry* 151:825-835, 1994.

Poster 83 — **Monday, October 9, 12 noon-1:30 p.m.**

OCCUPATIONAL THERAPY AND ACTIVITY THERAPY AS THEY RELATE TO PEDIATRIC PSYCHIATRIC PATIENTS AND THEIR FUNCTIONAL CAPACITY

Christine C. Hubbard, M.A., O.T.R./L., *Occupational Therapist, Acadia Hospital, 268 Stillwater Avenue, Bangor, ME 04401;* Suzanne Millett, M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the theoretical basis of pediatric psychiatric occupational and activity therapy and discuss how these treatment modalities are applied to improve the functional capacity of pediatric psychiatric patients.

SUMMARY:

Pediatric psychiatric patients have endured many insults to their normal development, including, but not limited to, abuse, neglect, and pre- and postnatal trauma. These insults affect children's ability to function in the everyday world of growing and maturing. Occupational therapy and life-studies therapy (activity therapy) have been combined in an inpatient setting to serve these children. This treatment is intended to promote a more successful and functional experience in the community after discharge.

Occupational therapists evaluate the children's sensory-perceptual, motor, and cognitive functioning to identify strengths and limitations in these areas. Activity therapists implement treatment programs that will match a child's areas of strength and provide the proper challenge to lessen the impact of his or her limitations. The treatment programs could include, but are not limited to, the improvement of social skills, sensory-perceptual skills, motor planning, gross and fine motor skills, and sensory integration. The treatment model to be outlined will address the functional capacity of the pediatric psychiatric patient. The patient, the family, and the treatment team benefit from understanding and affecting the child's ability to function while managing and treating broader psychiatric issues in the inpatient setting.

REFERENCES:

1. Fisher AG, Murray EA, Bundy AC (eds): *Sensory Integration: Theory and Practice.* Davis, Philadelphia, 1991.
2. King LJ: Toward a science of adaptive responses. *Am J Occup Ther* 32:429-437, 1979.

Poster 84 — **Monday, October 9, 12 noon-1:30 p.m.**

SENSORY INTEGRATION AS IT RELATES TO THE FUNCTIONAL PERFORMANCE OF PEDIATRIC PSYCHIATRIC PATIENTS

Christine C. Hubbard, M.A., O.T.R./L., *Occupational Therapist, Acadia Hospital, 268 Stillwater Avenue, Bangor, ME 04401;* Suzanne Millett, M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to relate the proprioception, kinesthetic/tactile, vestibular, gustatory, and visual sensory systems to functional performance and should be able to describe the functional impact of sensory integrative dysfunction in pediatric psychiatric patients.

SUMMARY:

Pediatric psychiatric patients have endured many insults to their normal development, including, but not limited to, abuse, neglect, and pre- and postnatal trauma. Because of this trauma, they may experience numerous areas of dysfunction, ranging from behavioral problems to neurological and sensory integrative deficits.

It is not uncommon for children with sensory integrative dysfunction to have behavior problems. These problems are in part due to difficulty in registering and modulating sensory information in the environment. Sensory input experienced through the muscles and joints, skin, eyes, ears, nose, mouth, and inner ear is critical for supporting successful task performance.

When sensory integrative dysfunction is identified and treated, children are better able to maintain and manage their behavior. By engaging in sensory integration activities that provide the necessary sensory input, children are able to organize and focus their energy and attention. As children learn to regulate sensory input and behavioral output, they are able to experience more success in performing functional tasks in school, self-care, play, and self-management.

REFERENCES:

1. Fisher AG, Murray EA, Bundy AC (eds): *Sensory Integration: Theory and Practice.* Davis, Philadelphia, 1991.
2. King LJ: Toward a science of adaptive responses. *Am J Occup Ther* 32:429-437, 1979.

Poster 85 — **Monday, October 9, 12 noon-1:30 p.m.**

SERVICES AND PROGRAMS FOR PARENTS WITH MENTAL ILLNESS AND THEIR FAMILIES

Joanne Nicholson, Ph.D., *Assistant Professor, Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify and discuss current approaches to the organization of services, program design, and implementation for parents with mental illness and their offspring.

SUMMARY:

In a 1990 national survey, state mental health authority managers identified only nine programs that specifically focused on the needs of parents with mental illness and their offspring. This lack of services contrasts with the relative flurry of activity regarding these needs documented in the early 1980s by Cohler and Musick. Recent authors have pointed to the dearth of activity in the rehabilitation field, for example, and have suggested ways in which professionals could contribute to enhanced outcomes for these families.

An overview of information about current programs and service initiatives across the country will be presented. Descriptions of programs were obtained in the initial 1990 survey and in telephone interviews with providers conducted in 1993. This poster will provide an opportunity for professionals to identify further service needs of parents with mental illness and their families, to describe their current program efforts, and to discuss intervention opportunities.

REFERENCES:
1. Nicholson J, Geller JL, Fisher WH, et al: State policies and programs that address the needs of mentally ill mothers in the public sector. *Hosp Community Psychiatry* 44:484-489, 1993.
2. Cohler BJ, Musick J (eds): Intervention Among Psychiatrically Impaired Parents and Their Young Children. *New Dir Ment Health Serv* 24, 1984.
3. Nicholson J, Blanch A: Rehabilitation for parenting roles for people with serious mental illness. *Psychosoc Rehab J* 18:109-119, 1994.

Poster 86 **Monday, October 9**
12 noon-1:30 p.m.

PSYCHIATRIC RESIDENTIAL TREATMENT FOR SEVERELY DISTURBED ADOLESCENTS

Michael J. Lustick, M.D., *Clinical Director, High Meadows, 825 Hartford Turnpike, Hamden, CT 06517*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to develop a risk assessment program with a treatment team framework that provides graduated autonomy for each adolescent in residential treatment and to describe a comprehensive milieu program for providing continual feedback to residents in a respectful adolescent environment.

SUMMARY:

Effective residential treatment of adolescents must diminish the influence of psychiatric disturbance while simultaneously augmenting adaptive capacities. This poster will describe a state-sponsored residential adolescent treatment program that provides for individual treatment and risk assessment and is complemented by a milieu therapy system. The individual treatment approach is monitored by a mobility status system, whereas the milieu therapy approach uses a level system. The dual systems allow and facilitate more specific focus on the nature of problem or dysfunctional behavior. Individual issues are to be separately acknowledged. The result has been a substantial long-term decrease in the need for restraints and seclusions and an increased ability of residents to engage in more autonomous age-appropriate activities. The child psychiatrist or clinical director has a key role in helping to define a treatment philosophy and then vigorously pursuing opportunities to support, elaborate, and clarify it.

REFERENCES:
1. Rose M: Leaping in the dark: the fear of transition. *Residential Treatment Child Youth* 11:67-79, 1994.
2. Schimmer R: Dangerous development: considerations concerning the governance of sexual behavior in residential treatment centers. *Residential Treatment Child Youth* 11:23-35, 1993.

Poster 87 **Monday, October 9**
12 noon-1:30 p.m.

EARLY SEXUAL ABUSE AS A RISK FACTOR FOR BEHAVIORAL PATHOLOGY AMONG MENTALLY ILL FEMALE INPATIENTS WITH CHEMICAL ABUSE

Helen G. Muhlbauer, M.D., *Director, Comprehensive Psychiatric Emergency Program, Inpatient Psychiatry Service, Bronx-Lebanon Hospital Center, 6th Floor, 1276 Fulton Avenue, Bronx, NY 10456;* Ali Khadivi, Ph.D., Marjorie Waldbaum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the risks posed by early sexual abuse in severely disadvantaged mentally ill female patients with chemical abuse.

SUMMARY:

The presenters sought to demonstrate that mentally ill, chemical-abusing female patients with histories of early sexual abuse have higher levels of psychopathology and more family history of drug abuse than do such patients without histories of early sexual abuse.

In the investigation 124 mentally ill, chemical-abusing female patients were identified from a retrospective chart review of all admissions in 1994 to an all-female unit. These patients each had a substance-related disorder plus at least one comorbid axis I condition. Seventy-one patients who described a history of sexual abuse before age 18 were compared to 53 patients who denied any early sexual abuse.

As predicted, the substance-abusing patients with a history of early sexual abuse had a significantly lower age at first psychiatric hospitalization ($p < 0.01$), more suicide attempts ($p < 0.02$), more arrests ($p < 0.04$), and more family members with histories of substance abuse ($p < 0.004$) than did the control group. The two groups did not differ on axis I diagnostic subgroups or in frequency of axis II and axis III subgroups, including HIV status.

In conclusion, a history of early sexual abuse is associated with more severe psychopathology in an already high-risk group. This suggests a need for routine screening for sexual abuse among mentally ill female patients with substance abuse.

REFERENCE:
1. Brown RG, Bradley A: Psychiatric morbidity in adult inpatients with childhood histories of sexual and physical abuse. *Am J Psychiatry* 148:55-61, 1991.

Poster 88 — **Monday, October 9, 12 noon-1:30 p.m.**

USE OF A VIDEO-BASED EDUCATIONAL PACKAGE IN HIGH SCHOOLS

Heather Milliken, M.D., F.R.C.P.(C.), *Clinical Director, Schizophrenia Service, Royal Ottawa Hospital, Second Floor, Whitney Building, 1145 Carling Avenue, Ottawa, Ontario K1Z 7K4, Canada;* Lyn Williams-Keeler, M.A., L. Stinson, B.Sc.N., B. Jones, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe how high school students' knowledge of schizophrenia can be improved and how students' attitudes toward the illness can be shaped by the viewing and discussion of a videotape about schizophrenia in which their peers portray people afflicted with and affected by the illness.

SUMMARY:

This poster will review the effect of the videotape "Surviving Schizophrenia: Portraits on Film" on high school students, for whom it was produced. The videotape showcases the talents of sensitive young improvisational actors, who created a compelling statement about a complex illness that affects their peer group. It is hoped that if the actors are convincing in their portrayal of the sadness and loss produced by this disease, their peer group will respond with sympathy and understanding of this illness, which is often referred to as "youth's greatest disabler."

Two groups of approximately 165 high school seniors were involved; one group only watched the videotape, and the other group watched the videotape and participated in a discussion. Both groups were tested before and after viewing to determine whether there were increases in accurate information and in positive attitudes relating to persons afflicted by schizophrenia. The results clearly indicated that the videotape has merit as an educational and destigmatizing tool with this age group.

REFERENCE:

1. Lieberman J, Jody D, Geisler S, et al: Time course and biologic correlates of treatment response in first-episode schizophrenia. *Arch Gen Psychiatry* 50:369-376, 1993.

Poster 89--Withdrawn

Poster 90 — **Monday, October 9, 12 noon-1:30 p.m.**

A MENTAL HEALTH CAPITATION PROGRAM: AN UPDATE

Gerard Gallucci, M.D., M.H.S., *Medical Director, Adult Outpatient Program, Johns Hopkins Bayview Medical Center, B-3 South, 4940 Eastern Avenue, Baltimore, MD 21224;* Deborah Agas, J.D., Tom Marshall, L.C.S.W., Wayne Swartz, L.C.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the unique features of a mental health capitation program, discuss some of the administrative and clinical issues related to a capitated program, and assess the effectiveness of the program on the basis of a preliminary analysis of various outcome measures.

SUMMARY:

This poster will provide an update on a capitated mental health project in Baltimore, Maryland. It will describe some of the challenges faced in the design and operation of the project. Client vignettes illustrating the clinical, administrative, and financial issues involved in a capitated mental health project for clients with severe and persistent mental illness will be presented.

REFERENCE:

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

Poster 91 — **Monday, October 9, 12 noon-1:30 p.m.**

EMPOWERING CONSUMERS, FAMILIES, AND COMMUNITIES: GEORGIA'S MODEL FOR MENTAL HEALTH CARE REFORM

Thomas W. Hester, M.D., *Medical Director and Director for Substance Abuse Services, Division of Mental Health, Mental Retardation, and Substance Abuse, DHR, Fourth Floor Annex, Two Peachtree Street, Atlanta, GA 30303;* Claire Griffin-Francell, M.S., R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the historical context, the structure, and the function of the Georgia model for mental health care reform and discuss progress in its implementation.

SUMMARY:

This poster will present Georgia's new model for delivery of mental health services; this model establishes a new benchmark in empowering recipients of care. The unrelenting political forces that drove this historical change will be described. A governor-appointed task force held state-wide meetings to seek input from families, consumers, advocates, public and private

providers, public managers, and community leaders. The task force developed legislation that mandated the radical system change that was overwhelmingly passed in 1992.

A model of 19 regional boards, each required by law to have 51% consumer membership, has decision-making power for planning, funding, and evaluation of services. Control of all mental health care institutions in the community, including hospitals, resides with these citizens. Progress in implementing this state law, along with the struggles and surprises that accompanied it, will be described.

Poster 92 **Monday, October 9**
12 noon-1:30 p.m.

TRANSFORMATIONS: THE ROLE OF THE AREA MEDICAL DIRECTOR WITHIN PUBLIC MANAGED CARE

Barbara L. Fenby, D.S.W., L.C.S.W., *Deputy Area Director, Massachusetts Department of Mental Health, Box 288, Lyman Street, Westborough, MA 01581;* William S. James, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe how the area medical director is integral to the success of public managed care.

SUMMARY:

The role of the medical director of the state hospital is changing as a result of the transformation of public sector mental health into public managed care, which includes downsizing of institutions, an increase in consumer voice, and broadening of the services available in the community. This poster will explore the continuing need for medical/clinical leadership, which can be met through the emerging role of area medical director of the combined hospital-community geographically based service system. By using sample job descriptions from the Joint Commission on Accreditation of Healthcare Organizations, universities, states, and private organizations, the poster will examine how such roles are embedded in complex systems with matrixed leadership. The development of clear organizational missions and visions is essential to resolving conflicting ideologies, clarifying roles, and establishing an organizational culture. The area medical director is reframed as one of many organizational leaders who, guided by utilization management and total quality improvement, are able to create a cost-effective, consumer-centered, dynamic service that retains its clinical mission.

REFERENCES:

1. Baudrillard J: Selections from illusions of the end. *Can J Political Soc Theory* 17(1-2), 1994.
2. Thompson J: Trends in the development of psychiatric services. *Hosp Community Psychiatry* 45:987-992, 1994.

Poster 93 **Monday, October 9**
12 noon-1:30 p.m.

THE SYNERGIZING SYSTEM: THE NEW PSYCHIATRIST'S ROLE IN SYSTEMS MANAGEMENT

Theodore E. Kirousis, M.S.S.W., *Metro West Area Director, Department of Mental Health, P.O. Box 288, Lyman Street, Westborough, MA 01581;* Barbara L. Fenby, D.S.W., L.C.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the changes in roles for psychiatrists and other professionals in managing systems and patients in a managed care environment.

SUMMARY:

The new managed care environment compels an organizational transformation from an emphasis on clinical products that are developed and delivered by individual practitioners to a behavior-management outcome that is shaped and delivered by teams. This context requires that the psychiatrist have broadened leadership, skills, and education and that the larger mental health team have an expanded understanding of how to effectively use the psychiatrist. The goal is a team-based organization poised to respond to the needs of consumers with serious mental illness and their families by making use of its capability for increased learning, self-management, and innovative practice. This process will be illustrated by a description of changes in a regional mental health system. The differentiation of professional roles and complex learning within increasingly large organizations will be addressed. Professionals will develop extended understanding through presentation of specific examples of how they might implement similar changes and processes in their own environments.

REFERENCES:

1. Hassard J, Parker M: *Postmodernism and Organizations.* Sage Publications, Newbury Park, CA, 1993.
2. Ray C, Oss M: Community mental health and managed care. *New Dir Ment Health Serv* 59:89-98, 1993.

Poster 94 **Monday, October 9**
12 noon-1:30 p.m.

PUBLIC MANAGED CARE: A BLENDING OF COMPREHENSIVE MENTAL HEALTH SERVICES AND FISCAL RESPONSIBILITY

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

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe managed health care in the public sector, discuss the current issues that must be addressed, and review in depth the current model in western Massachusetts.

SUMMARY:

This poster will review the process of managed care, with particular application to public sector psychiatry. The dilemma of providing a comprehensive, coordinated, and clinically appropriate system of care in a cost-effective manner will be reviewed. The issues covered will include managing the interface between public and private care, dealing with government regulations and cost shifting, contracting for services (including performance indicators), managing utilization, making use of total quality improvement, and involving and empowering consumers.

The current model in western Massachusetts consists of a balanced program of (a) a central authority (the Department of Mental Health area office) that is responsible for the overall coordination of services in the area and (b) comprehensive community support systems that are locally based within natural service areas and have a mandate to assess the needs and preferences of consumers. The poster will review how this system functions, including specific programs, management techniques, and outcome data, in the context of good clinical care and cost containment.

REFERENCE:

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

Poster 95 **Monday, October 9**
12 noon-1:30 p.m.

ACADEMIC URBAN PSYCHIATRY: REPORT FROM THE FRONT

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;* Wesley E. Sowers, M.D., Kenneth S. Thompson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the urban health crisis and possible ways academic departments of psychiatry can address the crisis.

SUMMARY:

The urban poor find themselves in a socioeconomic disaster. Entwined with this catastrophe is a public health crisis that is reflected in the high morbidity and mortality rates of this population. It can be seen particularly in high infant mortality rates and in the epidemics of crack cocaine use, AIDS, tuberculosis, violence, and trauma. It is likely that there has also been an increase in the prevalence of social psychological problems, such as loneliness and grief, and of psychiatric disorders, such as depression, posttraumatic stress disorder, and psychosis.

Urban academic medical centers have historically provided care for the impoverished people living in their shadows. As the urban crisis has deepened, academia has been uncertain how to proceed. This poster will describe the experiences encountered by a department of psychiatry attempting to strengthen its inner-city mental health care services and reinvent inner-city community psychiatry.

REFERENCES:

1. Braithwaite RL, Taylor SE (eds): *Health Issues in the Black Community.* Jossey-Bass, San Francisco, 1992.
2. Foreman S: Social responsibility and the academic medical center: building community-based systems for the nation's health. *J Acad Med* 69:97-102, 1994.

Poster 96 **Monday, October 9**
12 noon-1:30 p.m.

THE POSTMODERN WORLD AND PSYCHIATRY

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.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe forces operating in the postmodern world that are likely to shape mental health care in the future.

SUMMARY:

The United States is entering an era of tremendous social change as the productive forces shift from manufacturing to information-driven, knowledge-based service organizations. The extent and scale of the changes may come to approach those that occurred a century ago in the move from the farm and the village to the factory and the city. These changes have unsettled notions of how society views itself, most notably in the appearance of postmodern thought. At present, the full implications across society of this shift are not clear, but trends are emerging. Among these trends are deurbanization, increasing unemployment, and decreasing senses of community and social solidarity. The potential impacts of all these changes on psychiatry will be explored in this poster. Particular emphasis will be placed on examining the movement to create a postinstitutional system of mental health care.

REFERENCES:
1. Drucker PF: *Post-Capitalist Society.* HarperCollins, New York, 1993.
2. Wallace R, Fullilove MT, Wallace D: Family systems and deurbanization: implications for substance abuse. In Lowinson JH, Ruiz P, Mullman RB (eds): *Substance Abuse: A Comprehensive Textbook,* 2nd ed. Williams & Wilkins, Baltimore, 1992.

Poster 97--Withdrawn

Poster 98 — Monday, October 9, 12 noon-1:30 p.m.

MEASURING OUTCOMES IN A HIGH-UTILIZATION, HIGH-RISK MEDICAID POPULATION

Christine A. Degan, R.N., M.A., *Intensive Clinical Management Program Manager, MHMA, Inc., Suite 200, I Copley Place, Boston, MA 02116;* Deborah Nelson, Ph.D., Marsha Wilens, Ed.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe how to measure outcomes for a high-utilization, high-risk Medicaid population and discuss how measurement activity leads to improvements in service delivery for this population.

SUMMARY:

A sample of clients enrolled in an intensive clinical management program served by the nation's first Medicaid managed care behavioral health carve-out was assessed with functional status and satisfaction measures at three points. Three functional status measures were used: (a) the SF-36, developed by Ware and Sherbourne; (b) the Consumer Reported Outcomes and Satisfaction Survey, developed by Mason; and (c) a customized functional status tool that uses the best elements of the preceding two measures.

Aspects of measuring functional status in a poorly functioning, multiply stressed population will be discussed. Such issues include challenges in measuring outcomes for this population by using tools developed for better-functioning populations and implications for management action and quality improvement stemming from results.

REFERENCES:
1. Nelson DC, Hartman E, Ojeman PG, et al: Outcomes measurement and management with a large Medicaid population: a public/private collaboration. *Behav Healthcare Tomorrow* 4(3):31-37, 1995.
2. Ware JE Jr, Sherbourne CD: The MOS 36-item short-form health survey (SF-36), I: conceptual framework and item selection. *Med Care* 30:473-483, 1992.
3. Mason JH: *The Consumer Reported Outcomes and Satisfaction Survey (CROSS).* Blue Cross/Blue Shield of Massachusetts, North Quincy, MA, 1994.

Poster 99 — Monday, October 9, 12 noon-1:30 p.m.

LAYOFFS, REDUCTIONS IN FORCE, DOWNSIZING, RIGHTSIZING: UNCERTAINTY IN THE WORKPLACE

Leslie L. Citrome, M.D., *Clinical Assistant Professor of Psychiatry, New York University, Nathan Kline Institute for Psychiatric Research, Orangeburg, NY 10962*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the importance of a comprehensive plan for managing a layoff and describe the possible adverse impact on survivors of the layoff and on corporate organization.

SUMMARY:

Reductions in force, or layoffs, have become more common in recent years. No industry, public or private, appears to be immune. The layoff process will be described in a case example of a state-operated psychiatric hospital whose downsizing is occurring in the context of a steady contraction of services by the parent agency of the past 40 years. A review of the available literature on layoffs will be presented, with emphasis on (a) the effects of layoffs on the employees who lose their jobs, the survivors, and the corporate organization and (b) the impact of unions and the federal WARN act. The case example will be discussed by using concepts developed in the literature review. The adverse impact of workers being displaced by colleagues (bumping) will be described. Emphasis will be placed on clear communication.

REFERENCES:
1. Morton GL: Helping managers and employees cope with work-force cutbacks. *Training Develop J* 37(9):50-54, 1983.
2. Farley JE: Response of mental health professionals to layoffs. *Hosp Community Psychiatry* 42:624-627, 1991.

Poster 100 — Monday, October 9, 12 noon-1:30 p.m.

A STATEWIDE PUBLIC MENTAL HEALTH OUTCOMES PROJECT

James A. Clardy, M.D., *Assistant Professor of Psychiatry, University of Arkansas for Medical Sciences, Slot 554, Little Rock, AR 72205;* Brenda Booth, Ph.D., Richard Smith, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe an example of outcomes research implemented in routine clinical settings, discuss the use of tracer conditions to measure the process and outcomes of care, and describe the importance of measuring disease-specific versus generic symptoms or disabilities associated with psychiatric illnesses.

SUMMARY:

This poster will present a project for measuring clinical outcomes and assessing the process of care for public mental health patients in Arkansas who are at risk for hospital admission. All 14 Arkansas community mental health centers (CMHCs) are involved in this 2-year project to examine patients covered by Medicaid. Major depression and schizophrenia serve as tracer conditions to represent the effectiveness and value of the process of mental health care. The project is measuring prospectively CMHC alternatives to hospitalization and longitudinal outcomes of care. Regular data on outcomes and process of care will be provided to CMHC decision makers.

Instruments that measure disease-specific and more generic psychiatric symptoms and outcomes will be highlighted. The presenters will emphasize how research-designed and -validated tools, the Depression and Schizophrenia Outcomes Modules, can be used to measure outcomes in routine clinical settings in order to provide information for policy and continuous quality improvement, ultimately improving care for patients and increasing value for the public.

Poster 101 — Monday, October 9, 12 noon-1:30 p.m.

CONSUMER-DRIVEN CAPITATION MODEL FOR PERSONS WITH SEVERE MENTAL ILLNESS: IS IT POSSIBLE?

Diana M. McIntosh, R.N., M.S.N., C.S., *Director, Supportive Treatment Service, Central Psychiatric Clinic, 3259 Elland Avenue, Cincinnati, OH 45229;* Steven A. Fekete, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe a consumer-driven capitation model of care for persons with severe mental illness.

SUMMARY:

This poster will describe a consumer-driven capitation pilot project, called Phase I, whose overall objective was to promote community integration of persons with severe mental illness. In Phase I, fiscal responsibility for care was assigned to the mental health providers. Money was attached to individual consumers rather than to units of services, thus promoting flexibility and creativity in developing treatment strategies. Funds were committed for multiple purposes and were used in nontraditional ways. Consumers who volunteered to take part in Phase I were initially inpatients at a state mental hospital. At discharge, each received a comprehensive assessment by a multidisciplinary team and then participated with a treatment team to identify the patient's needs and the best approaches to meet them. A quality assurance component and a formal evaluation of cost-effectiveness were attached to the project. Consumer outcomes in housing, education and vocation, and satisfaction were also measured.

REFERENCES:

1. Christianson JB, Gray DR: What CMHC's can learn from two states' efforts to capitate Medicaid benefits. *Hosp Community Psychiatry* 45:777-781, 1994.
2. Reed SK, Habigian H: Postmortem of the Rochester capitation experiment. *Hosp Community Psychiatry* 45:761-764, 1994.

Poster 102 — Monday, October 9, 12 noon-1:30 p.m.

COMMUNITY-ORIENTED ACCELERATED CARE: CAN REENGINEERED HOSPITAL CARE REDUCE STAYS?

Steven A. Fekete, M.D., *Medical Director, Community-Oriented Accelerated Care, University of Cincinnati Hospital, 3259 Elland Avenue, Cincinnati, OH 45229*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to (a) identify program differences between a short-term, crisis-focused inpatient unit and longer-term inpatient treatment and (b) describe clinical, ethical, and financial implications associated with programming of this type.

SUMMARY:

This poster will present an innovative model for inpatient psychiatric treatment of the severely mentally disabled: the Community-Oriented Accelerated Care program, a pilot project initiated by the University of Cincinnati in collaboration with the local mental health board to explore alternatives to traditional longer-term inpatient treatment. The program offers stabilization and community reintegration. It is consumer driven, with daily evaluations of its effectiveness and patient response. The patients' demographic characteristics and diagnostic categories are typical for a community-based inpatient unit. Although the average length of stay has decreased from 13 days to approximately 5.5 days, the recidivism rate remains at 10%. Further outcome data demonstrate overall consumer satisfaction and symptom reduction in addition to a favorable cost analysis, which support the universal application of this model. This program will be compared with traditional programs.

REFERENCES:
1. Breslow RE, Klinger BI, Erickson BJ: Crisis hospitalization on a psychiatric emergency service. *Gen Hosp Psychiatry* 5:307-315, 1993.
2. Bergman R: Reengineering healthcare. *Hosp Health Networks*, Feb 1994, pp 28-36.

Poster 103 **Monday, October 9**
12 noon-1:30 p.m.

IMPLEMENTING CONTINUOUS QUALITY IMPROVEMENT TO INCREASE ORGANIZATIONAL PERFORMANCE IN A STATE PSYCHIATRIC HOSPITAL

Ronald C. Comer, D.S.W., *Instructor in Psychiatric Social Work, Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia, PA 19129;* Amy T. Henasey, R.N., Laura Molnar, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify key challenges in and benefits of employing continuous quality improvement (CQI) principles within state psychiatric hospitals and list essential steps in initiating a hospital-wide CQI process.

SUMMARY:

One of the more powerful forces for organizational change that has emerged over the past 5 years in health care quality assessment and assurance is the philosophy of continuous quality improvement (CQI). Challenges in implementing CQI principles in any health care organization are significant. However, in many state hospitals, which continue to be plagued by downsizing and threats of closure, creating an organizational climate that encourages CQI principles, such as experimentation, risk taking, change, empowerment, and teamwork, can be formidable.

This poster will show how top-down leadership initiatives to move from a static paradigm of quality assurance and utilization review to CQI process-focused methods have been implemented in one prototypic state psychiatric hospital. Particular attention will be paid to steps for redefining the hospital's mission, vision, and values and for breaking down traditional organizational barriers to interdisciplinary communication and improving the collaboration and continuity between the hospital and community-based mental health services.

REFERENCES:
1. Elliott RL: Applying quality improvement principles and techniques in public mental health systems. *Hosp Community Psychiatry* 45:439-444, 1994.
2. Vermillion JM, Pfeiffer SI: Treatment outcome and continuous quality improvement: two aspects of program evaluation. *Psychiatr Hosp* 24:9-14, 1993.

Poster 104 **Monday, October 9**
12 noon-1:30 p.m.

EVOLUTION OF CONTINUOUS QUALITY IMPROVEMENT IN A UNIVERSITY-PUBLIC PSYCHIATRIC HOSPITAL SYSTEM

Nelson P. Gruber, M.D., *President, Medical Staff Organization, Harris County Psychiatric Center, Room 2D08, 2800 South MacGregor Way, Houston, TX 77021;* Robert W. Guynn, M.D., Roy V. Varner, M.D., Dorothy Matthews, Ph.D., David R. Small, M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe how continuous quality improvement (CQI) can be implemented in a university-public psychiatric system with multiple missions; to identify some of the benefits, problems, and limitations of CQI in such a system; to evaluate how CQI could work in their own institutions; and to identify future issues involving CQI in health care.

SUMMARY:

The Joint Commission on Accreditation of Healthcare Organizations prescribes that quality management strategies, such as continuous quality improvement (CQI), be used in the organizations it surveys. This poster will evaluate the implementation of CQI in a 250-bed university-public psychiatric hospital. Academic-public system collaboration at the University of Texas at Houston and the advent of CQI at the Harris County Psychiatric Center will be presented. Introduction and development will be traced from early false starts through currently successful process teams and councils to the upcoming system-wide shift in the quality management program. Attention will be focused on the inclusion of various clinical services in this effort and on the pitfalls encountered so far. The challenges and obstacles met by the medical staff will be highlighted. The successes (improved teamwork, communication, and internal processes), unexpected uses of CQI principles (bridging interagency differences), and future refinements (more time-effective use of CQI) will be summarized. One hospital's experience can be used to help delineate developing attitudes and perspectives on CQI activities in psychiatry.

REFERENCES:
1. Wakefield BJ: Overcoming the barriers to implementation of TQM/CQI in hospitals: myths and realities. *QRB Qual Rev Bull* 19:83-88, 1993.
2. McCabe WJ: Total quality management in a hospital. *QRB Qual Rev Bull* 18:134-140, 1992.
3. Ernst DF: Total quality management in the hospital setting. *J Nurs Care Qual* 8(2):1-8.

Poster 105--Withdrawn

Poster 106 **Monday, October 9**
12 noon-1:30 p.m.

CONTINUOUS PATIENT IMPROVEMENT: APPLICATION OF A QUALITY IMPROVEMENT MODEL TO INPATIENT PSYCHIATRIC TREATMENT

Steven D. Newman, Psy.D., *Clinical Psychologist, United Samaritans Medical Center, 600 Sagar Avenue, Danville, IL 61832*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to (a) describe the rationale for and basic concepts of continuous quality improvement as applied to inpatient psychiatric treatment, (b) identify the advantages to the patient of involvement as a member of the treatment team, and (c) explain the relationship of continuous quality improvement to treatment planning, outcome measurement, patient satisfaction, and quality assurance.

SUMMARY:

This poster will describe the extension of continuous quality improvement principles (decision making in teams, reliance on data, continuous feedback, and goal setting) to the treatment of patients on an acute psychiatric unit within a general medical center. Patients are members of the treatment team; they perform self-assessments, set goals, plan interventions, and collect information on progress toward goals in a continuous cycle. Particular emphasis is placed on team building and feedback to the patient. This model is viewed within the context of current pressures on acute psychiatric treatment, including demands for evidence of therapeutic efficacy and efficiency, requirements for briefer hospitalizations, and concern for patient satisfaction. Particular advantages of this approach include the consistent use of a problem-solving method that is widely applicable; the potential to improve patient involvement, program structure and clarity, and staff cohesion; and a conceptual basis for integrating the diverse requirements of patients, staff, third-party payers, physicians, and hospital administrators.

REFERENCE:

1. Berwick DS: Continuous improvement as an ideal in health care. *N Engl J Med* 320:53-56, 1989.

SYMPOSIA

Symposium 1 — Friday, October 6, 8:30 a.m.-10:00 a.m.

HEALTH CARE REFORM: DEATH AND TRANSFORMATION--PSYCHIATRIC PROSPECTS FOR THE MILLENNIUM

Steffi Woolhandler, M.D., *Associate Professor of Medicine, Harvard Medical School and Cambridge Hospital, 1493 Cambridge Street, Cambridge, MA 02139;* Howard F. Stock, M.D., Herbert S. Sacks, M.D., Norman A. Clemens, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to (a) identify developing financial mechanisms to which psychiatry must adapt in order to survive and thrive in a new environment, (b) describe proposed schemes for providing health care in the millennium, and (c) discuss psychiatrists' adaptations to sweeping change.

SUMMARY:

Huge investor-owned companies dominate health care delivery throughout the nation. Academic health centers scramble to survive with mergers and acquisitions of other institutions and downsizing of services, research, and beds. Market-driven reform has invaded the trust relationship of doctors and patients, modifying psychiatrists' roles as healers, care givers, helpers, and advocates for the sick. The new reform has increased the population without health coverage. Psychiatrists are having to choose between quality patient care and their own economic survival. Rationing, "cherry picking," and denial of care are the hallmarks of the most abusive managed care practices.

On the basis of deterioration of quality of care and profit degradation, pundits forecast further expansion of organized care systems, emergent forms of "corporization," and the ultimate failure of managed Medicaid and Medicare. The next evolution may be quasi-public utilities to govern health care delivery. How can psychiatry and good patient care survive these revolutionary changes?

REFERENCES:

1. Iglehart J: Health policy report: Medicaid and managed care. *N Engl J Med* 332:1727-1731, 1995.
2. Kassiner J: Managed care and the morality of the marketplace. *N Engl J Med* 333:50-52, 1995.

Symposium 2 — Friday, October 6, 10:30 a.m.-12 noon

PERSPECTIVES ON BOUNDARY VIOLATION: VIEWS OF A VICTIM AND OF A CLINICIAN

Kathleen M. Mogul, M.D., *Associate Clinical Professor of Psychiatry, Tufts University;* Janet W. Wohlberg, A.B.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify and discuss boundary issues and their impact on treatment and patients.

SUMMARY:

Boundary violations that may lead to and/or be a part of the exploitation of patients may be unrecognizable or difficult to recognize by clinicians, patients, and third-party observers. Exploitation of a patient by a therapist creates a dilemma in which the abusing therapist's victims and colleagues share many common feelings, e.g., a sense of betrayal and an undermining of trust, anger, confusion, and a sense of helplessness about how to proceed. Victims and clinicians have much to learn from each other about what happens, how it happens, and what actions to take in the face of exploitative boundary violations. This symposium will consider the slippery slope toward exploitation and how it is perceived by a victim who has experienced exploitation in a therapeutic setting and by a clinician who has treated victims of previous exploitation. It will also explore the impact of boundary violations on treatment, dealing with abusive colleagues, and subsequent treatment concerns.

REFERENCES:

1. Gonsioreek JC (ed): *Breach of Trust: Sexual Exploitation by Health Care Professionals and Clergy.* Sage Publications, Thousand Oaks, CA, 1995.
2. Herman JL: *Trauma and Recovery.* Basic Books, New York, 1992.
3. Gabbard GO: *Sexual Exploitation in Professional Relationships.* American Psychiatric Press, Washington, DC, 1989.

Symposium 3 — Saturday, October 7, 3:30 p.m.-5:00 p.m.

OUTCOMES MANAGEMENT: USE OF OUTCOMES MANAGEMENT RESEARCH TO IMPROVE QUALITY OF CARE

Clarissa C. Marques, Ph.D., *Senior Vice President and Chief Clinical Officer, Green Spring Health Services, Suite 500, Clark Building, 5565 Sterrett Place, Columbia, MD 21044;* Jonathan D. Book, M.D., Mary Shorter-Fahimi, L.C.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the key issues in Green Spring Health Services' outcomes measurement strategies, tools used in these efforts, findings to date, and directions for the future.

SUMMARY:

Green Spring Health Services has addressed the need to examine patient treatment outcomes by instituting routine measurement of outcomes within its care-management operation by means of validated, nationally recognized instruments and carefully designed protocols for administration.

Green Spring is currently able to report findings from a number of areas of outcomes management: patient satisfaction, general outcomes as measured by change in psychiatric symptoms and health status, condition-specific outcomes for patients diagnosed as having major depression, and patient readmissions. The specific instruments used to measure these outcomes include the Health Status Questionnaire, the Brief Symptom Inventory, the Depression Technology of Patient Experience module, Basis 32, and modifications of the Group Health Association of America's Consumer Satisfaction Surveys. Analysis of information collected through these instruments is used to modify care delivery design, provider network education efforts, and network composition.

REFERENCES:

1. Derogatis LR, Melisaratos N: The Brief Symptom Inventory: an introductory report. *Psychol Med* 12:595-605, 1983.
2. Eisen SV, Dill DL, Grob MC: Reliability and validity of a brief patient-report instrument for psychiatric outcome evaluation. *Hosp Community Psychiatry* 45:242-247, 1994.
3. Rost K, Smith GR, Burnam MA, et al: Measuring the outcomes of care for mental health problems. *Med Care* 30:MS266-MS273, 1992.

Symposium 4 — Sunday, October 8 8:30 a.m.-10:00 a.m.

THE CASE MANAGEMENT RELATIONSHIP: RESEARCH FINDINGS AND CLINICAL IMPLICATIONS

Roger D. Fallot, Ph.D., *Co-Director, Community Connections, 1512 Pennsylvania Ave., S.E., Washington, DC 20003;* Hans Kroon, Sc.D., Gregory B. Teague, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to recognize and discuss key findings in recent research on the relationship between consumers and case managers and should be able to apply these findings to clinical service delivery.

SUMMARY:

Over the past 15 years, case management has become a central component of services for people with severe mental disorders. A critical feature in virtually all case management models is the development of a collaborative relationship between consumer and case manager. The specific nature of this relationship and the key elements in a working case alliance, however, have not been adequately studied. This symposium presents findings from several projects examining the case management relationship.

First, the presenters will outline the results of a systematic effort to articulate a conceptual framework for the case management alliance. Next, the quality of the relationship between the consumer and the case manager will be examined in connection with treatment planning models. Finally, predictors of consumer satisfaction with the case management relationship will be explored. Since these studies involve sites in the United States and Europe, there will be opportunities to discuss cross-cultural issues as well as clinical implications.

REFERENCES:

1. Goering PN, Stylianos SK: Exploring the helping relationship between the schizophrenic client and rehabilitation therapist. *Am J Orthopsychiatry* 58:271-278, 1988.
2. Harris M, Bergman H (eds): *Case Management for Mentally Ill Patients.* Harwood Academic, New York, 1993.

Symposium 5 — Sunday, October 8 8:30 a.m.-10:00 a.m.

OUTCOME RESEARCH IN PRIVATE PSYCHIATRIC HOSPITALS: MOVING FROM ADVERTISEMENT TO ACCOUNTABILITY

Philip D. Harvey, Ph.D., *Associate Professor of Psychiatry, Mount Sinai School of Medicine, One Gustave Levy Place, New York, NY 10029;* John F. Clarkin, Ph.D., Steven S. Sharfstein, M.D., David L. Pogge, Ph.D., Lolafaye Coyne, Ph.D., Ronald D. Geraty, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the major requirements in developing scientific outcome studies for psychiatric hospitals and describe the concerns of third-party payers regarding demonstration of treatment efficacy.

SUMMARY:

Changes in the reimbursement system for mental health have demanded greater accountability on the part of providers, including hospitals. Historically, providers of psychiatric treatment, including inpatient treatment, could be justifiably criticized regarding their lack of concern about the effectiveness of treatment and the most appropriate treatment modalities to be

employed. In an effort to demonstrate that they are delivering care that is effective and worth the cost, many hospitals that depend on third-party payers have recently instituted programs of outcome research. Research on the outcome of mental health treatment has proven to be one of the most difficult areas in psychiatry. Not the least of the difficulties is the balance between research that is so methodologically weak that it is no more than an advertisement and research that is so methodologically rigorous that it fails the test of generalizability to real-world situations.

This workshop will bridge the gap between methodological rigor and pragmatic usefulness in outcome research in psychiatric hospitals. Experienced researchers who are attempting to balance NIMH-quality research and usefulness to managed care evaluation will present their ideas and data, covering populations that are served in current inpatient modalities: adolescents, acutely ill adults, and special long-stay populations. Managed care representatives will present their requirements for outcome research, including their own standards for methodological competence. Researchers who have performed longitudinal studies of the natural course of illness in psychiatric disorders will provide guidelines for distinguishing between the effects of treatment and natural fluctuations in the course of the illness. Finally, a distinguished clinician and commentator in the area of managed care and effective psychiatric treatment will provide perspectives on the importance of outcomes research in contemporary psychiatric care. Information on the optimal strategy for developing outcome studies will be provided.

REFERENCES:

1. Wells KB, Rogers WH, Davis LM, et al: Quality of care for hospitalized depressed elderly patients before and after implementation of the Medicare prospective payment system. *Am J Psychiatry* 150:1799-1805, 1993.
2. Sharfstein SS: Quality improvement (editorial). *Am J Psychiatry* 150:1767-1768, 1993.

Symposium 6 — Sunday, October 8, 10:30 a.m.-12 noon

MENTAL HEALTH CARE IN AN INTEGRATED DELIVERY SYSTEM

Steven M. Mirin, M.D., *Chief Executive Officer and Psychiatrist in Chief, McLean Hospital, 115 Mill Street, Belmont, MA 02178-1048;* Paul Summergrad, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to anticipate the impediments to developing mental health services within a larger integrated health care delivery system and should be able to identify the personal and professional steps necessary to accomplish this goal.

SUMMARY:

Growing pressure to contain costs and manage the delivery of mental health care is reshaping the role of clinicians practicing in both community-based and institutional settings. At the same time, the national trend toward the development of integrated health care delivery systems poses new challenges and opportunities for psychiatrists and other mental health care professionals. This symposium will focus on the development of an integrated system of psychiatric services in the context of a larger general health care delivery system. The process of removing impediments to integration, defining appropriate roles for mental health care providers within the larger system, and tracking the costs, development, and outcomes of care across multiple sites of service will be discussed.

REFERENCES:

1. Mirin SM, Sederer LI: Mental health care: current realities, future directions. *Psychiatr Q* 65:161-175, 1994.
2. Sederer LI, Mirin SM: The impact of managed care on clinical practice. *Psychiatr Q* 65:177-188, 1994.

Symposium 7 — Sunday, October 8, 3:30 p.m.-5:00 p.m.

ACADEMIC PSYCHIATRY IN A MANAGED CARE ENVIRONMENT

James M. Schuster, M.D., M.B.A., *Director of Psychiatry Managed Services and Emergency Psychiatry Services, Allegheny General Hospital, 320 East North Avenue, Pittsburgh, PA 15212-4772;* Stuart M. Sotsky, M.D., Sheldon I. Miller, M.D., Ole J. Thienhaus, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the problems that managed care poses for academic departments of psychiatry and the wide variety of available responses that may lead to successful adaptation.

SUMMARY:

Managed behavioral health care poses especially difficult problems for academic departments. These issues include reduced use of doctorate-level providers, a focus on short-term therapies, and lack of funding for educational activities. Many departments are developing strategies to cope with these issues, including reorganizing departments, decreasing costs, establishing partnerships with other providers, and accepting capitation. First, Dr. Schuster will review the effect of managed care on academic departments, problems faced by academic departments, potential solutions to these problems, and contracting with managed care organizations. Dr. Sotsky will discuss the development of a medical management system,

quality monitoring, and implementation of treatment approaches (e.g., short-term psychotherapy) that are not often used in many departments. Dr. Miller will outline the development of a regional network of providers connected to a university and the implications of accepting capitation. Dr. Thienhaus will conclude with an evaluation of the impact of managed care on educational and research activities.

Symposium 8 — Monday, October 9, 8:30 a.m.-10:00 a.m.

HOW LONG SHOULD SOMEONE REMAIN IN ASSERTIVE COMMUNITY TREATMENT? TWO VIEWS

Leonard I. Stein, M.D., *Professor Emeritus, University of Wisconsin Medical School, Madison, WI;* William Knoedler, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the Program for Assertive Community Treatment, how a variety of models can be integrated into a system of care for persons with serious and persistent mental illness, and the advantages and disadvantages of having clients remain in assertive community treatment indefinitely.

SUMMARY:

The Program for Assertive Community Treatment is an intensive program operating 7 days a week with a high staff-to-patient ratio that has proven to be very effective in helping persons with serious and persistent mental illness to maintain stability in the community and to achieve a decent quality of life. This symposium will explore whether clients in such treatment should generally remain in the program indefinitely or should be gradually transferred to a less intensive program once their clinical conditions have become well stabilized. The presenters will call on their experience and knowledge of the field to discuss the potential advantages and disadvantages of such a move. There will be ample time for audience participation.

REFERENCES:

1. Stein LI, Test MA: An alternative to mental hospital treatment. *Arch Gen Psychiatry* 37:409-412, 1980.
2. Stein LI, Diamond RG, Factor RM: A system approach to the care of persons with schizophrenia. In Herz MI et al (eds): *Psychosocial Treatment of Schizophrenia,* vol 4. Elsevier, New York, 1990.

Symposium 9 — Monday, October 9, 10:30 a.m.-12 noon

SERVING HOMELESS MENTALLY ILL INDIVIDUALS: THE MCKINNEY PROJECTS

Stephen M. Goldfinger, M.D., *Assistant Professor of Psychiatry, Harvard Medical School, 74 Fenwood Road, Boston, MA 02115-6106;* Anthony F. Lehman, M.D., Richard Hough, Ph.D., Elie Valencia, M.A., J.D., David L. Shern, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the most recent findings from randomized controlled trials of case management, housing, empowerment, and consumer-oriented day programs with populations of seriously and persistently mentally ill homeless individuals.

SUMMARY:

In 1990, five research demonstration projects for homeless adults with severe mental illness were funded by the McKinney Act through the Center for Mental Health Services. These projects are among the first longitudinal experimental studies of housing and service interventions for homeless people with severe mental illnesses. The goal of these projects was to generate knowledge of how to improve mental health and functional status, residential stability, and quality of life. Through random assignment of project participants to control and experimental groups, the investigators are evaluating the effectiveness of the following conditions and interventions: independent living versus living in consumer-run group homes, comprehensive support services with and without subsidized independent housing, an assertive community treatment program, on-site psychiatric rehabilitation and stable long-term housing, and intensive transitional services for homeless men with schizophrenia living in shelters. By the use of a common set of measures, these projects also address the nature and characteristics of the mental health treatment services and housing provided. In this presentation the principal investigators in each of these projects will share follow-up data and will address the process issues in designing, implementing, and analyzing control studies for this population.

REFERENCE:

1. Center for Mental Health Services: *Making a Difference: Interim Status of the McKinney Research Demonstration Project for Homeless Mentally Ill Adults.* Available from Deborah Dennis, Project Director, Policy Research Associates, 262 Delaware Avenue, Delmar, NY 12054.

SYMPOSIA

Symposium 10 **Monday, October 9**
1:30 p.m.-3:00 p.m.

MODELS FOR THE FUTURE OF PUBLIC PSYCHIATRY

Paul D. Peterson, Ph.D., *Director, Western Branch, Washington Institute for Mental Illness Research and Training, 9601 Steilacoom Boulevard, S.W., Tacoma, WA 98498;* Cornelia A. Ragiel, R.N., Ed.D., M. Annette Hanson, M.D., Robert J. Ronis, M.D., Michael F. Hogan, Ph.D., Shirley D. Furtick, M.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify characteristics of successful collaborations between public psychiatry training programs and public mental health service delivery services that enhance education, research, and service delivery, and they should be able to describe strategies for supporting and expanding public-academic collaborations in mental health and forensic programs.

SUMMARY:

Rapid changes are occurring in public mental health service delivery and in the financing, training, and support components of public psychiatry programs. Successful collaborations between public psychiatry programs and public mental health and correctional programs in four states will be discussed as examples of the partnerships necessary for maintaining and expanding the relevance and viability of public psychiatry in the future. Elements that encourage and impede effective partnerships, including multidisciplinary training, system design, financing, human resource development, communication, and consumer and family involvement, will be discussed. Time will be provided for discussion with the audience.

REFERENCES:

1. Bevilacqua JJ: The NIMH Public-Academic Liaison (PAL) research initiative: an update. *Hosp Community Psychiatry* 42:71, 1991.
2. Peterson PD: Merging cultures: academic/public mental health collaboration. *Admin Policy Ment Health* 20:411-419, 1993.

TABLE TOPICS

Table Topic 1

Saturday, October 7
1:30 p.m.-3:00 p.m.

CLINICAL APPLICATIONS OF AN EMPOWERMENT MODEL OF RECOVERY FROM PSYCHIATRIC DISABILITIES

Daniel B. Fisher, M.D., Ph.D., *Director, National Empowerment Center, 25 Bigelow Street, Cambridge, MA 02139-2301;* Patricia Deegan, Ph.D., Peter Stastny, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to enumerate the important principles of the empowerment model of recovery and discuss examples of the application of these principles in clinical work.

SUMMARY:

Clinicians often ask how they can use an empowerment approach in their clinical practices. As a first step, clinicians can examine the empowerment model of recovery for people with psychiatric disabilities, which emphasizes the dignity of each person and the importance of hope, consumer-defined problems and goals, liberty, self-control of symptoms, peer support, and provision of essential materials and social supports. Clinical application of this model involves learning from consumer/survivors that the majority of people recover; using consumer/survivors to train mental health professionals; encouraging consumer/survivors to work as providers; validating people's own narrative descriptions of their problems and their involvement in their own treatment planning; providing an informed choice of medications; offering real alternatives to involuntary interventions in the name of treatment, such as prior directives; permitting consumer/survivors to participate in total quality improvement; and developing cultural competence. Each of these activities requires a shift in the relationship of the professional to the service recipient, from mistrust to trust. The provider's trust in the consumer can nurture the consumer's trust in him- or herself, which serves as the basis for healing.

REFERENCES:

1. Deegan P: The independent living movement and people with psychiatric disabilities: taking back control over our lives. *Psychosocial Rehab J* 15:3-19, 1992.
2. Fisher D: Health care reform based on an empowerment model of recovery for people with psychiatric disabilities. *Hosp Community Psychiatry* 45:913-915, 1994.

Table Topic 2

Saturday, October 7
3:30 p.m.-5:00 p.m.

PSYCHIATRIC EMPLOYMENT: FINDING POSITIONS, FINDING PHYSICIANS

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

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss current job opportunities in the field of psychiatry and ways in which psychiatrists and facilities can best present themselves to achieve their goals.

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 may include, but are not limited to, steps in the recruitment process (for both physician applicants and employers), how to best present yourself or your facility, creating a win/win situation, information on current job opportunities, and resources available to psychiatrists and mental health employers. In addition, information will be shared about current trends in employment as seen through the operation of APA's year-round physician placement program.

REFERENCE:

1. Kronhaus A: *Choosing Your Practice.* Springer-Verlag, New York, 1990.

Table Topic 3

Monday, October 9
10:30 a.m.-12 noon

HIRING THE PATIENT IN MENTAL HEALTH SERVICES: VARIED PERSPECTIVES

Kenneth K. Miya, Ph.D., *Program Director, Los Angeles County Department of Mental Health, Room 150, Graduate Hall, 1937 Hospital Place, Los Angeles, CA 90033;* Suzane E. Wilbur, M.S.N., Benjamin Crocker, M.D., Frank Compton, B.S.

TABLE TOPICS

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss mental health programs that have employed seriously mentally ill patients and describe the vicissitudes of hiring such patients.

SUMMARY:

The Los Angeles County Department of Mental Health is strongly encouraging its directly operated and contracted services to employ persons with serious mental illnesses. Such action has necessitated several paradigm changes to enable examination of stigma, prejudice, fear and defensiveness, and resistance within the mental health system itself. Mental health professionals will share their professional experiences with hiring and working with people who have a diagnosis of schizophrenia as staff and co-worker. Staff are confronted with new boundary issues, new concepts of confidentiality, and the reconfiguration of ideas about how to relate to and treat a former patient (who is now a colleague). A former patient who is now an employee will share his experience of becoming a mental health service provider alongside those who were formerly his treatment team. Perspectives will be shared by the clinic manager, the physician, and the former consumer--now employee.

REFERENCE:

1. Sherman PS, Porter R: Mental health consumers as case management aides. *Hosp Community Psychiatry* 42:494-498, 1991.

Table Topic 4 — Monday, October 9, 1:30 p.m.-3:00 p.m.

ETHICAL ISSUES IN THE CLINICAL CARE OF THE HOMELESS MENTALLY ILL

Richard C. Christensen, M.D., *Assistant Professor of Psychiatry, University of Florida College of Medicine, 6704 Northwest Thirty-Third Street, Gainesville, FL 32606*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify many of the most common ethical issues related to the engagement, assessment, and treatment of the homeless mentally ill and provide alternative resolutions to ethical dilemmas confronted by providers of care to this population.

SUMMARY:

Although much has been written about the clinical care of the homeless mentally ill in the past 10 years, very little in the literature addresses the unique ethical issues engendered when clinicians attempt to engage, assess, and treat this population. Moreover, since a great deal of psychiatric care of the homeless is delivered in unconventional treatment settings (e.g., shelters, drop-in centers, and city parks), distinctive ethical tensions emerge that are grounded in the more traditional concerns of valid consent, treatment refusal, coerced compliance, involuntary hospitalization, and clinician-client confidentiality.

This table topic will present a brief overview of the most common categories of ethical conflict in psychiatry and will provide a framework for addressing ethical dilemmas in the clinical setting. These aspects of practical medical ethics will then be applied to the unique ethical issues that arise when providers attempt to engage, assess, and treat the homeless mentally ill in traditional and nontraditional clinical settings. Case studies will be presented and used to facilitate an interactive ethical analysis of common issues confronted by clinicians providing care to the homeless mentally ill.

REFERENCES:

1. Christensen R: Treating the homeless mentally ill: an ethical perspective. *Psychiatr Times* 10(6):27-29, 1993.
2. Lamb R, Bachrach R, Kass F: *Treating the Homeless Mentally Ill: A Task Force Report of the American Psychiatric Association.* American Psychiatric Press, Washington, DC, 1992.

Table Topic 5 — Monday, October 9, 3:30 p.m.-5:00 p.m.

PET THERAPY: COMPANION ANIMALS IN OUR PROFESSIONAL AND PRIVATE LIVES

Robin L.Z. Rosner, L.S.W., *Homemaker Program Coordinator, Tri-City Consortium on Aging, 1874 Aldersgate Drive, Cleveland, OH 44124;* Barbara J. Wood, Ph.D., Mary B. Brown, R.N., M.S., C.S., Ann M. Childers, M.D., Mary D. Moller, M.S.N., A.R.N.P.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify settings and circumstances in which the presence of a companion animal can contribute to improved mental health and/or facilitate a therapeutic relationship, describe both the benefits and the challenges of working with companion animals, and discuss how the human-animal bond can improve mental health through the supportive nature of the relationship.

SUMMARY:

The effectiveness or positive outcome of a treatment is often associated with the actual relationship that develops between a therapist and his or her patient/client. Pet-facilitated therapy has

the ability to encourage communication between therapists and patients/clients who are frightened, withdrawn, or depressed. The unconditional positive regard shown by animals enables patients/clients to feel accepted and comforted, if not loved. The presence of an animal can be normalizing in an otherwise frightening or institutional setting. The spontaneous behavior exhibited by animals can serve as a distraction from psychological pain.

Faculty will share professional and personal impressions of the contributions that companion animals can make to the lives of patients/clients, as well as their own. Participants are encouraged to describe their own experiences of being accompanied or assisted by animals in the course of their work and private lives and to share in a discussion of the benefits and challenges involved.

REFERENCES:

1. Cusek O: *Pets and Mental Health.* Haworth Press, New York, 1988.
2. Wood B: Is Holly working today? In Corrigan T, Hoppe S (eds): *And a Deer's Ear, Eagle's Song and Bear's Grace: Animals and Women.* Cleis Press, Pittsburgh, 1990.
3. Berg JS: Acknowledging losses in ourselves and our patients (Residents' Forum). *Psychiatr News,* August 20, 1993.

WORKSHOPS

Workshop 1 — Saturday, October 7, 1:30 p.m.-3:00 p.m.

ALGORITHMS FOR THE PHARMACOTHERAPY OF SCHIZOPHRENIA AND FOR THE USE OF MEDICATION IN DEPRESSION AND DYSTHYMIA

David N. Osser, M.D., *Assistant Professor of Psychiatry, Harvard Medical School, 150 Winding River Road, Needham, MA 02192;* Carlos A. Zarate, Jr., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to implement an efficient but comprehensive strategy for using pharmacologic agents to treat depression and schizophrenia.

SUMMARY:

Depressive and dysthymic states are divided into two categories: nonreactive (autonomous) and reactive. After family and past history of response, medical history, and cost are considered, tricyclic antidepressants are usually selected for patients with autonomous depression (about 10% of patients with depressed symptoms) and a serotonin reuptake inhibitor is usually selected for patients with reactive mood. After adequate trials, nonresponders from either category are changed to the alternative medication or have it added to their first drug. Nonresponders to these procedures who meet the *DSM-IV* criteria for atypical features may receive a monoamine oxidase inhibitor. Proposals for the role of bupropion and venlafaxine will be offered. Persistently depressed patients are assessed for the presence of characterologic syndromes and other comorbid problems. These determine appropriate additional steps and the prognosis. Specific recommendations will be given for various situations.

Strategies for optimizing the outcome of medication treatment in schizophrenia and related psychoses will be proposed. This part of the session will begin with a diagnostic and treatment algorithm for first-onset psychoses based on naturalistic outcome data from the McLean First-Episode Psychosis Project. Next, acute exacerbations will be considered. These most commonly result from noncompliance, stress, or substance abuse. Issues in speeding onset of benefits while minimizing side effects will be outlined. Indications for the use of depot medications versus alternatives for maintenance treatment will be presented. For the suboptimally responsive patient, it is recommended that at least two adequate trials of neuroleptics be given before clozapine is used. Factors in determining adequacy include the bioavailability of the drug, the duration of the trial, management of benefit-reducing side effects, selection of possibly more effective neuroleptics, and use of adjunctive medications. The potential role of electroconvulsive therapy will be discussed. The presentation will conclude with suggestions for ensuring an adequate clozapine trial.

REFERENCES:

1. Osser DN: A systematic approach to the classification and pharmacotherapy of nonpsychotic major depression and dysthymia. *J Clin Psychopharmacol* 13:133-144, 1993.
2. Zarate CA Jr, Cole JO: An algorithm for the pharmacological treatment of schizophrenia. *Psychiatr Ann* 24:333-340, 1994.
3. Osser DN, Patterson RD: Pharmacotherapy of schizophrenia II: an algorithm for neuroleptic-resistant patients. In Soreff S (ed): *The Seriously and Persistently Mentally Ill: The State of the Art Treatment Handbook.* Hogrefe and Huber, Toronto, in press.

Workshop 2 — Saturday, October 7, 1:30 p.m.-3:00 p.m.

NONTRADITIONAL APPROACHES TO NONCOMPLIANT BEHAVIOR

Margaret J. Allende, M.S.N., *Clinical Coordinator, Assertive Community Treatment Team, Connecticut Mental Health Center, 566 Whalley Avenue, New Haven, CT 06519;* Margaret Bailey, M.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to define noncompliance in at least two ways, describe five motivational interviewing principles, identify three general principles of brief treatment, and describe how these combined principles have contributed to the development of nontraditional treatment approaches to noncompliant behavior.

SUMMARY:

The noncompliant behaviors most often described in community and mental health literature have been the failure to keep appointments, remain in treatment, and/or take medication as prescribed. Assertive community treatment teams were developed in response to an increasing prevalence of relapse and recidivism that seemed directly related to noncompliant behaviors. In the context of this nontraditional outreach treatment approach, efforts were made by the presenters' team staff to discover ways to engage these noncompliant clients, who were predominantly dually diagnosed (major mental illness and substance abuse). Interventions borrowed from motivational interviewing and brief treatment theories led to engagement and more positive treatment experiences. This workshop will attempt to heighten awareness about what may be meant by the term "noncompliance," identify the therapeutic ingredients that have contributed to the presenters' treatment approach, and describe specific nontraditional approaches and client responses.

REFERENCE:

1. Miller WR, Rollnick S: *Motivational Interviewing.* Guilford Press, New York, 1991.

WORKSHOPS

Workshop 3 — **Saturday, October 7, 1:30 p.m.-3:00 p.m.**

THE INVISIBLE LESBIAN: DEMYSTIFYING LESBIAN RELATIONSHIPS AND SEXUALITY

1994-1995 APA/Mead Johnson Fellows Workshop

Mary E. Barber, M.D., *1994-1995 APA/Mead Johnson Fellow and Psychiatry Resident, New York Hospital-Payne Whitney Clinic, Suite 71, 435 East Seventieth Street, New York, NY 10021;* Karine J. Igartua, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss issues in lesbian sexuality and relationships and to more effectively relate to lesbian patients and peers.

SUMMARY:

Women's issues in medicine have only recently begun to be discussed, and even now they are only a special-interest topic. Women's sexuality is usually left out of even these discussions and remains a mysterious black box in the medical school curriculum. Given these limitations, the topic of lesbian sexuality and lesbian relationships has been all but invisible.

In an effort to emphasize the normality of lesbian relationships, many professionals have taken the position that lesbian relationships are the same as heterosexual relationships. Recently, evidence that this is not the whole story has grown--in fact, there are many issues specific to lesbian relationships. Another tendency has been to lump lesbian sexuality with gay male sexuality, as if all homosexuals have the same developmental issues, behaviors, and fantasy lives. This is also an overgeneralization, because it is known that sexual expression and identification differ between lesbians and gay men. These differences have direct relevance to clinicians treating lesbian patients. The speakers will discuss issues specific to lesbian relationships and lesbian sexual development and will describe ways in which lesbian sexuality differs from that of gay men.

REFERENCES:

1. Barron-Barret M: *Invisible Lives.* Harper & Row, New York, 1990.
2. Marmor J (ed): *Homosexual Behavior.* Basic Books, New York, 1980.
3. Roth S: Psychotherapy with lesbian couples. *J Marital Fam Ther* 3:273-286, 1985.

Workshop 4 — **Saturday, October 7, 3:30 p.m.-5:00 p.m.**

MENTAL HEALTH INTERVENTIONS IN PRIMARY CARE MEDICAL SETTINGS/MEDICAL CLEARANCE: FACT OR FICTION IN THE PSYCHIATRIC PATIENT?

1994-1995 APA/Mead Johnson Fellows Workshop

Barbara J. Cannon, M.D., *1994-1995 APA/Mead Johnson Fellow and Resident, Department of Psychiatry, Harvard Medical School and Massachusetts General Hospital, Bulfinch 3, 32 Fruit Street, Boston, MA 02114-2698;* Kathleen A. Moreno, M.D., *1994-1995 APA/Mead Johnson Fellow and Child Psychiatry Fellow, UCLA-Neuropsychiatric Institute, Los Angeles, CA;* Patrice A. Harris, M.D., Laura A. Roebuck, M.D., Maria A. Sullivan, M.D., Ph.D., Kaycia L. Vansickle, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the current limitations of medical care for psychiatric patients, determine an appropriate medical evaluation for psychiatric patients, describe a system that would facilitate access to medical records for noncompliant psychiatric patients with serious medical problems, discuss the benefits of consultation/liaison interventions in primary medical settings, describe integrated programs in which mental health services are provided in primary care settings, and identify the benefits of expanded training in mental health for nonpsychiatric physicians.

SUMMARY:

The medical care that psychiatric patients receive varies by region and by socioeconomic class. Both psychiatric and nonpsychiatric physicians often fail to diagnose medical illness in psychiatric patients. It is therefore vital that psychiatrists maintain a medical orientation to advocate proper triage for this vulnerable population.

It is well known that medical morbidity in psychiatric patients far surpasses that in the general population. Patients treated in public sector mental health facilities should receive careful, regular medical evaluation. We should implement systems to make available pertinent medical and psychiatric histories for this high-risk population.

Drs. Moreno, Sullivan, and Vansickle will describe several current models of medical care for psychiatric patients in emergency rooms, outpatient treatment centers, and freestanding psychiatric hospitals. They will use case presentations to illustrate existing problems, and they will present ideas for improvement.

Persons with mental and addictive disorders more often seek care in general medical settings than in specialty mental health settings. Persons with medical illness often have significant psychiatric comorbidity, which may increase the use of medical care and worsen medical outcome.

Dr. Cannon will review studies of general medical practitioners' diagnosis and treatment of mental illness in ambulatory medical settings. She will discuss trials of mental health interventions in these settings.

Dr. Roebuck will describe clinical programs that provide integrated mental health services in primary care settings. She will discuss how to apply these models to develop mental health programs in rural areas with few psychiatric services.

Dr. Harris will review a pilot program in which primary care medical residents rotate through an outpatient psychiatric clinic. She will discuss the impact of this model on patient care.

REFERENCES:

1. Katon W, Gonzalez J: A review of randomized trials of psychiatric consultation-liaison studies in primary care. *Psychosomatics* 35:268-278, 1994.
2. Regier D, Narrow WE, Rae DS, et al: The de facto U.S. mental and addictive disorders service system: epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. *Arch Gen Psychiatry* 50:85-94, 1993.
3. Riba M, Hale M: Medical clearance: fact or fiction in the hospital emergency room. *Psychosomatics* 31:400-404, 1990.
4. Tintinalli JE, Peacock FW 4th, Wright MA: Emergency medical evaluation of psychiatric patients. *Ann Emerg Med* 23:859-862, 1994.

Workshop 5 — Saturday, October 7, 3:30 p.m.-5:00 p.m.

A DOUBLE-EDGED SWORD: THE PROFESSIONAL AS FAMILY MEMBER OF A PERSON WITH MENTAL ILLNESS

Daniel Dubovsky, M.S.W., *Assistant Instructor, Medical College of Pennsylvania, 3200 Henry Avenue, Philadelphia, PA 19129*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the struggles that arise for the professional who is also involved in obtaining services from the mental health system for a loved one.

SUMMARY:

Being a professional in the field of mental health can be emotionally difficult at times. Having a family member with a mental illness can also be exceedingly taxing. Coping with either of these circumstances by itself can be a challenge, but being both a professional in the field and a family member of a person who has a mental illness raises some unique issues. This interactive workshop will present some of the experiences of loss and grieving that family members of people with mental illness confront throughout their lives. How family members' lives are affected by their encounters with their loved ones and with the mental health system will be considered. The presentation will also address the issues that professionals face in managing the dualities of their professional lives and their personal experiences with loved ones and the mental health system, as well as methods of juxtaposing these in a positive manner.

REFERENCES:

1. Kubler-Ross E: *On Death and Dying.* Macmillan, New York, 1969.
2. Schiller L, Bennett A: *The Quiet Room.* Warner Books, New York, 1994.

Workshop 6 — Sunday, October 8, 8:30 a.m.-10:00 a.m.

TEACHING RESIDENTS TO WORK WITH THE HOMELESS IN COMMUNITY SETTINGS

Kenneth S. Duckworth, M.D., *Medical Director, Continuing Care Service, Massachusetts Mental Health Center, 74 Fenwood Road, Boston, MA 02115;* Stephen M. Goldfinger, M.D., Mark Cattalani, M.D., Donna Nickerson-Reti, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe clinical opportunities and pitfalls in developing a training program for working with the homeless, identify systemic/political issues involved in organizing such a program, and discuss trainees' perspectives on street- and shelter-based work.

SUMMARY:

Despite the growing number of homeless individuals with severe mental illness, there are inadequate numbers of psychiatrists with interest and experience in working with this population. Recently, the Center for Mental Health Services sponsored two workshops to expose trainees to psychiatrists involved with the homeless mentally ill and to provide examples of how involvement with homeless populations can be a satisfying and rewarding career.

At the new Harvard-Longwood residency, one 6-month rotation, psychiatry in primary care, was envisioned to take place in traditional hospital-based medical clinics. However, recognizing the need to integrate medical and psychiatric care,

the Massachusetts Mental Health Center faculty developed a community-based program that works closely with medical care providers who work with homeless men and women. Working in these nonpsychiatric settings and services, residents provide evaluation, ongoing treatment, and liaison to medical providers, such as Health Care for the Homeless, who care for this population. In addition to drawing on their psychiatric skills, residents in this rotation have developed relationships with shelters, staff and clients of drop-in centers, outreach teams, and a medical step-down unit in a homeless nursing home.

Massachusetts Mental Health Center residents and the faculty with whom they work will present this workshop. It will illustrate the teaching and clinical opportunities in these atypical settings in an effort to foster development of similar training experiences in other cities.

REFERENCE:

1. Susser E, Goldfinger SM, White A: Some clinical approaches to work with the homeless mentally ill. *Community Ment Health J* 26:468-480, 1990.

Workshop 7 — Sunday, October 8 8:30 a.m.-10:00 a.m.

THE PROFESSIONAL SATISFACTION OF PSYCHIATRISTS IN A MANAGED CARE ENVIRONMENT

Lloyd I. Sederer, M.D., *Senior Vice President for Clinical Services, McLean Hospital, 115 Mill Street, Belmont, MA 02178-1048*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss findings from studies on the professional satisfaction of physicians, describe empirically derived predictors of psychiatrist satisfaction, and identify ways to enhance psychiatrist satisfaction in managed care environments.

SUMMARY:

Empirical studies on the professional satisfaction of physicians will be discussed, with an emphasis on the impact of physician satisfaction on patient satisfaction and clinical outcome. An empirical study on predictors of professional satisfaction of psychiatrists in managed care environments will be presented. The professional satisfaction of physicians in general, and psychiatrists in particular, is an important, often overlooked aspect of clinical services and health care reform that can be quantitatively assessed and influenced.

REFERENCES:

1. Sederer LI, Lee MT, et al: The professional satisfaction of psychiatrists in a managed care environment. Submitted for publication.
2. Stamps PL, Cruz NTB: *Issues in Physician Satisfaction: New Perspectives.* Health Administration Press, Ann Arbor, MI, 1994.

Workshop 8 — Sunday, October 8 8:30 a.m.-10:00 a.m.

ASSERTIVE COMMUNITY TREATMENT AND PATIENTS' RIGHTS

Michael A. Hoge, Ph.D., *Associate Professor of Psychology, Department of Psychiatry, Yale University, 34 Park Street, New Haven, CT 06519;* Howard V. Zonana, M.D., Elizabeth Grottole, M.S.W., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to (a) identify the potential conflicts between current assertive community treatment practices and patients' legal rights and (b) identify a series of clinical strategies for maximizing the effectiveness of assertive community treatment while practicing within the bounds of ethical standards and the law.

SUMMARY:

Historically, severely disabled psychiatric patients, particularly those prone to violence, were treated involuntarily through long-term inpatient hospitalization. With the advent of deinstitutionalization and the closure of state hospitals, these individuals are now routinely living in the community. Assertive community treatment is currently the treatment of choice for such patients, involving intensive outreach to provide support and direction, monitor clinical status, and ensure medication compliance. The assertive and, at times, intrusive nature of such interventions often appears clinically necessary given the level of impairment among the patients served. However, these interventions may severely stretch, if not violate, the laws in many states involving patients' rights. Potentially infringed are patients' rights to (a) refuse treatment, (b) maintain confidentiality in communications with their treaters, and (c) exercise independence in choosing where to live and how to manage their daily lives.

This workshop will use a case similar to the now-famous Larry Hogue case in New York to highlight the ethical and legal dilemmas involved in providing assertive community treatment to individuals who repeatedly refuse treatment, decompensate, and engage in destructive behavior. Specific strategies will be recommended for managing such situations within legal and ethical bounds. In this context, the trends toward the liberalization of commitment statutes and the passage of outpatient commitment laws will be reviewed.

REFERENCES:
1. Thompson KS, Griffith EHH, Leaf PJ: A historical review of the Madison model of community care. *Hosp Community Psychiatry* 41:625-634, 1990.
2. Parry J: Involuntary civil commitment in the 90s: a constitutional perspective. *Ment Physical Disabil Law Reporter* 18:320-328, 1994.

Workshop 9 — Sunday, October 8 8:30 a.m.-10:00 a.m.

QUALITY OF LIFE IN MENTAL HEALTH: DIFFERENT VIEWS OF THE ELEPHANT

Marion A. Becker, R.N., Ph.D., *Assistant Professor, Department of Health and Human Issues, University of Wisconsin at Madison, Clinical Science Center, 600 Highland Avenue, Madison, WI 53792;* Ronald J. Diamond, M.D., Anthony F. Lehman, M.D., Alan Rosen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the complexities of measuring quality of life and the importance of consumer and family perspectives.

SUMMARY:

Mental health programs have the goal of increasing the quality of life. Unfortunately, there is confusion about what this means and how it can be assessed. Quality of life includes ability to function, satisfaction with one's life, and objective indicators of material well-being. It is not a single measure but is made up of a number of independent domains, from physical health to interpersonal relationships. This workshop will compare quality of life from provider, consumer, and family points of view. Different assessment approaches will be presented, and clinical implications will be discussed.

REFERENCES:
1. Becker M, Diamond R, Sainfort F: A new patient focused index for measuring quality of life in persons with severe and persistent mental illness. *Qual Life Res* 2:239-251, 1993.
2. Revicki DA, Murray M: Assessing health-related quality of life outcomes of drug treatments for psychiatric disorders. *Clin Concepts* 1:465-475, 1994.

Workshop 10 — Sunday, October 8 10:30 a.m.-12 noon

COMPREHENSIVE CARE FOR CHRONIC MENTAL ILLNESS: WHAT'S AVAILABLE? WHAT'S BEST? WHAT'S WORKING?

1994-1995 APA/Mead Johnson Fellows Workshop

Sandra Freeman, M.D., *1994-1995 APA/Mead Johnson Fellow and Resident in Psychiatry, University of North Carolina at Chapel Hill, 101 Manning Drive, Chapel Hill, NC 27514;* Francisco A. Moreno, M.D., William A. Price, M.D., M.P.H., Katherine E. Watkins, M.D., Kevin W. Young, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify the strengths and weaknesses of mainstream and nontraditional methods of service delivery to the chronically mentally ill in the United States and discuss the relevant findings of a retrospective cohort study of treatment outcomes for an intensively managed schizophrenia clinic.

SUMMARY:

Four brief presentations relevant to the care of patients with chronic mental illness will be presented. Dr. Watkins will present the case of a patient with schizophrenia and will compare the different resources available to that person under different health care delivery systems.

Dr. Moreno will review our understanding of the comprehensive delivery of care. The managed care principles that are applied to most health care systems evolved from the need to contain cost while maintaining quality. One important evaluation strategy is an ongoing assessment of how much is too little and how much is too much. Experiences with a managed care model in Arizona will be shared.

Dr. Young will review historical forces leading to a grassroots movement to provide outreach and other innovative programs using continuous treatment teams composed of health care professionals from all disciplines.

Drs. Freeman and Price will present the results of a retrospective cohort study of treatment outcomes for an intensively managed schizophrenia clinic population.

REFERENCES:
1. Lurie N, Moscovice IS, Finch M, et al: Does capitation affect the health of the chronically mentally ill? results from a randomized trial. *JAMA* 267:3300-3304, 1992.
2. Hennekens CH, Buring JE: *Epidemiology in Medicine.* Little, Brown, Boston, 1987.

Workshop 11 — Sunday, October 8 10:30 a.m.-12 noon

HOW WELL DOES TREATMENT WORK? OUTCOMES MEASUREMENT STRATEGIES

David A. Adler, M.D., *Senior Psychiatrist, New England Medical Center, NEMC Box 1007, 750 Washington Street, Boston, MA 02111;* Kathleen M. Bungay, Pharm.D.

WORKSHOPS

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to distinguish between the outcomes shown by patient-based health assessment and by traditional evaluations, discuss application of health-related quality-of-life assessments in clinical practice, identify potential and actual benefits of and barriers to the use of such measures, and identify potential uses of patient-based outcomes assessments in managing and monitoring patients' care.

SUMMARY:

Assessing the outcomes of treatments will inevitably play a major role in mental health care in the future. Traditional clinical assessments of health/mental health must be integrated with broader perspectives, including patient-based assessments, patient satisfaction, and the cost-effectiveness of health care.

The specific goals of this workshop are to introduce (a) the use of measurement techniques, including patient self-administered questionnaires, in monitoring and managing patients' care; (b) the basic concepts and scientific techniques employed in measuring health-related quality of life; and (c) the application of these techniques in routine patient care to monitor the effects of therapy. The scientific approach to patient self-assessment will be illustrated by examples of selected general and disease-specific instruments. Suggestions for clinicians' future involvement in measuring and monitoring health-related quality of life and managing patients' care by using the results will be proposed. The use of these measures with patients in an outpatient psychiatry clinic and an outpatient general medical clinic will be described.

REFERENCES:

1. Stewart AL, Ware JE: *Measuring Functioning and Well-Being: The Medical Outcomes Study Approach.* Duke University Press, Durham, NC, 1992.
2. Bungay KM, Ware JE: *Measuring and Monitoring Health-Related Quality of Life.* Upjohn, Kalamazoo, MI, April 1993.

Workshop 12

Sunday, October 8
10:30 a.m.-12 noon

ROLES FOR PSYCHIATRISTS IN COMMUNITY MENTAL HEALTH PROGRAMS: UNDERSTANDING INTERFACES AND OVERCOMING BARRIERS

Charles R. Goldman, M.D., *Professor and Director, Public Psychiatry Training Program, Department of Neuropsychiatry and Behavioral Science, Suite 104A, 3555 Harden Street Extension, Columbia, SC 29203;* Paul S. Links, M.D., Robert J. Breen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe a method for determining psychiatrists' roles and realistic work expectations, identify key interfaces in various clinical settings, and discuss how to overcome common barriers to redesigning the role of the psychiatrist.

SUMMARY:

As mental health systems continue to evolve toward community-based programs serving very ill clients and emphasizing cost controls, psychiatrists may feel extreme pressure and role strain. This often leads to burnout and costly turnover, and ultimately to declining quality of care. Trained in a comprehensive biopsychosocial model, many psychiatrists nevertheless become isolated from other treatment team members and from program managers, thus suffering from the giant-in-the-closet syndrome. This workshop will focus on practical ways for psychiatrists, and those who employ them, to create satisfying and productive roles for psychiatrists in various clinical settings. One method involves a participatory process for determining roles and reasonable caseloads in specific mental health programs. Another involves understanding the critical interfaces between psychiatric assessment/management, therapy, and rehabilitation for various patient groups and clinical settings. Ways to overcome roadblocks to successful implementation of these redesigned roles will be discussed.

REFERENCES:

1. Goldman CR, Faulkner LR, Breeding KA: Estimating psychiatrist staffing needs in community mental health programs. *Hosp Community Psychiatry* 45:333-337, 1994.
2. Links PS, Kirkpatrick H, Whelton C: Psychosocial rehabilitation and the role of the psychiatrist. *Psychosoc Rehab J* 18:121-129, 1994.

Workshop 13

Sunday, October 8
10:30 a.m.-12 noon

A CONCEPTUAL FRAMEWORK FOR DEALING WITH DIFFICULT PATIENTS

Linda S. Godleski, M.D., *Medical Director, Connecticut Mental Health Center, 34 Park Street, New Haven, CT 06519;* Kenneth N. Luke, M.D., Janet E. DiPreta, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to develop a conceptual framework for identifying and treating their difficult patients, especially those with severe axis I diagnoses complicated by complicated axis II features.

SUMMARY:

Mental health clinicians soon learn that difficult patients frequently use the majority of mental health resources. In addition to having severe axis I pathology, these individuals often have compounding axis II features. This diagnostic combination adversely influences treatment team management, patient compliance and social adjustment, and ultimate placement.

This workshop will identify various types of difficult patients with personality traits/disorders corresponding to *DSM-IV* clusters. The session will include discussion of specific characteristics that can frustrate the clinician, such as dependent, hostile, manipulative, demanding, passive-aggressive, attention-seeking, entitled, and inflexible behaviors.

The participants will be invited to examine their own personality styles to understand how they affect their interactions with these difficult chronic patients. Clinicians will learn to use their negative feelings about their patients as important clinical data in defining diagnosis and treatment, rather than denying or disowning these feelings.

Finally, the workshop will focus on various treatment strategies to improve care and decrease clinician frustration when working with these difficult patients. Participants will be encouraged to discuss their own such experiences.

REFERENCES:

1. Gallop R, Lancee W, Shugar G: Residents' and nurses' perceptions of difficult-to-treat short-stay patients. *Hosp Community Psychiatry* 44:352-357, 1993.
2. Colson D: Difficult patients in extended psychiatric hospitalization: a research perspective on the patient, staff, and team. *Psychiatry* 53:369-382, 1990.

Workshop 14 — Sunday, October 8 1:30 p.m.-3:00 p.m.

POLITICS AND PSYCHIATRY: THE DYNAMIC INTERFACE

1994-1995 APA/Mead Johnson Fellows Workshop

Rael D. Strous, M.D., *1994-1995 APA/Mead Johnson Fellow and Resident in Psychiatry, Albert Einstein College of Medicine, Apt. 3B, 1540 Pelham Parkway South, Bronx, NY 10461;* Mary E. Barber, M.D., Francisco A. Moreno, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify ways in which psychiatry can contribute to a healthier understanding and resolution of political dilemmas.

SUMMARY:

For better or for worse, politics and mental health have been closely intertwined since the time of Sigmund Freud. *Civilization and Its Discontents* was Freud's attempt to delineate the psychology of government systems. Some, in fact, would argue that the role of a psychiatrist does not merely refer to managing the individual or small groups but extends to community, society, and international relations. This may entail significant responsibility and use of skills and techniques acquired, developed, and practiced during standard psychiatric treatment. It may be impossible for us as psychiatrists to avoid politics today, because of the very alive relationship between the two areas, and this has implications for both our clinical work and our personal lives. Psychiatrists are often challenged as to which level to pitch their involvement, fully realizing the ethical dilemmas that may be confronted during such a process.

Issues to be explored in depth will include (a) the role of psychiatrists in international affairs, conflict resolution, and analysis of leaders' personalities; (b) political activism by psychiatrists; and (c) implications for mental health workers treating illegal aliens.

REFERENCES:

1. Dominquez F: Determinants of health care utilization in the Chicano and Mexican immigrant populations: a review of the literature. *Border Health* 3:2-15, 1987.
2. Freud S: *Civilization and Its Discontents.* Authorized translation by Riviere J. J Cope & H Smith, New York, 1930.
3. Post JM: Narcissism and the charismatic leader-follower relationship. *Political Psychol* 7:675-688, 1986.

Workshop 15 — Sunday, October 8 1:30 p.m.-3:00 p.m.

PSYCHIATRIC CLINICAL NURSE SPECIALIST: COLLABORATIVE PRACTICE MODEL IN AN OUTPATIENT SETTING

Nancy P. Hanrahan, M.S., R.N., *Psychiatric Clinical Nurse Specialist and Director, Psychopharmacology Program, Acadia Hospital, 268 Stillwater Avenue, Bangor, ME 04401;* Nadeen Bonica, M.S., R.N., C.S., Paul W. Tisher, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to explain the collaborative practice model for clinical nurse specialists working with physicians, describe the contract between the clinical nurse specialist and the physician and how it relates to assessment and treatment, and explain the nuts and bolts of financing the service, including staffing, funding, budgeting, and growth.

SUMMARY:

The collaborative practice model for collaboration between physicians and clinical nurse specialists provides psychopharmacology and psychotherapy services to a large population of children, adolescents, and adults. The presentation will focus

on the nurse-physician contract and how it relates to assessment and treatment. Cost-effectiveness, funding, budgeting, and growth of the service will be described such that participants can use the information to set up similar psychopharmacology services.

REFERENCE:

1. Talley S, Brooke P: Prescriptive authority for the psychiatric clinical specialist: framing the issues. *Arch Psychiatr Nurs* 6(2):71-82, 1992.

Workshop 16 — Sunday, October 8 1:30 p.m.-3:00 p.m.

COMMUNITY PSYCHIATRY: TREATMENT PROTOCOLS IN AN INNER-CITY ENVIRONMENT

Benjamin Crocker, M.D., *Mental Health Psychiatrist, Los Angeles County Department of Mental Health, P.O. Box 0956, South Pasadena, CA 91031-0956;* Reta D. Floyd, M.D., Jack M. Barbour, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify barriers, satisfactions, efficiencies, and inefficiencies involved in treating inner-city patients and discuss role flexibility and institutional and architectural cuing of physician, patient, and family behaviors.

SUMMARY:

This workshop will consist of three community psychiatrists sharing their experiences of working with high-utilizing patients in the downtown and South Central areas of Los Angeles. The resistance of these patients to using traditional services and the techniques used in confronting this resistance will be explored. The journey of becoming caregivers in the homes and streets of these communities and experiences in bridging different institutions in an era of service system reorganization will be discussed. Such issues are important because of the advent of managed care and reconfiguration of the service delivery system. Many once-enthusiastic psychiatrists have deserted the community; it is time for them to find the way home.

REFERENCE:

1. Hu T, Jerrell J: Cost-effectiveness of alternative approaches in treating severely mentally ill in California. *Schizophr Bull* 17:461-468, 1991.

Workshop 17 — Sunday, October 8 1:30 p.m.-3:00 p.m.

BRAIN SPECT IMAGING IN CLINICAL NEUROPSYCHIATRY

Sheldon Benjamin, M.D., *Associate Professor of Psychiatry and Neurology, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655-0001*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to list the clinical conditions in which single photon emission computed tomography (SPECT) imaging of the brain is most useful and discuss the differential diagnosis of the most common SPECT abnormalities.

SUMMARY:

Brain SPECT imaging is readily available in many general hospitals. Apart from its frequent use in neuropsychiatric research, it is used clinically in the evaluation of dementia, seizures, vascular disease, head injury, and focal neurobehavioral syndromes. Although this modality is sometimes criticized as having a high sensitivity but low specificity, brain SPECT can be a valuable diagnostic tool when the differential diagnostic referral question is properly framed. The major clinical uses for brain SPECT imaging in neuropsychiatry and the differential diagnosis of commonly reported abnormalities will be reviewed, and then a series of brief clinical cases will be presented for discussion. SPECT images will be correlated with images and clinical findings from magnetic resonance imaging and computed tomography. Emphasis will be placed on the integration of brain SPECT imaging into clinical decision making and the provision of practical tips on SPECT use.

REFERENCE:

1. Holman BL, Devous MD: Functional brain SPECT: the emergence of a powerful clinical method. *J Nucl Med* 33:1888-1902, 1992.

Workshop 18 — Sunday, October 8 1:30 p.m.-3:00 p.m.

DEVELOPMENT OF A TRAINING GUIDE FOR PSYCHIATRIC RESIDENTS: TREATING PEOPLE WITH CHRONIC MENTAL ILLNESS

Joint Session with Group for the Advancement of Psychiatry

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

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to list residents' most common questions about treating people with chronic mental illness, describe a theoretical framework for training residents in this area, and describe how to use clinical case vignettes to enhance residents' skills in individual, family, and systems work.

SUMMARY:

The presenter, representing the Group for the Advancement of Psychiatry's Committee on Community Psychiatry, will describe the development of a clinical case-oriented training guide for psychiatric residents and other beginning clinicians treating people with chronic mental illness. The need for this type of training material will be reviewed in the context of the history of resistance of professionals to working with this population. The methods for assessing residents' needs and involving them in the process will be described.

The theoretical framework of the manual will be outlined, and, through specific case vignettes, the use of the manual will be illustrated in the areas of individual, family, and systems assessment, treatment planning, medicating, individual treatment, family involvement in treatment, use of system resources, dual diagnosis (substance abuse), and homelessness.

REFERENCE:

1. Group for the Advancement of Psychiatry: *Resident's Guide to the Treatment of People with Chronic Mental Illness,* GAP Report 136. American Psychiatric Press, Washington, DC, 1993.

Workshop 19 — Sunday, October 8 3:30 p.m.-5:00 p.m.

CAN DIALECTICAL BEHAVIOR THERAPY WORK IN COMMUNITY MENTAL HEALTH CENTERS?

J. Lindsey Tweed, M.D., *Clinical Associate, Box 3516, Duke University Medical Center, Durham, NC 27710*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to (a) describe three attempts by community mental health centers to implement dialectical behavior therapy programs for persons with borderline personality disorder and (b) identify three factors that may affect the success of the dialectical behavior therapy program in a community mental health center.

SUMMARY:

Dialectical behavior therapy has been shown to be effective for persons with borderline personality disorder. It appears to be a promising intervention for persons with borderline personality disorder in community mental health centers (CMHCs), but there are practical problems in implementing it in CMHCs. Dialectical behavior therapy is also labor intensive and involves individual psychotherapy, group skills training, peer supervision, and between-session patient contact.

In the first part of the workshop the presenter will describe attempts to implement dialectical behavior therapy in a number of different CMHCs. Examples in both resource-rich and resource-poor CMHCs will be included. Attempts to implement both a full dialectical behavior therapy model and scaled-down versions will be described. Programs that have been more and less successful will be included, and the presenter will speculate on factors affecting success.

In the second half of the workshop participants will be invited to share their views on how dialectical behavior therapy might best be implemented in CMHCs.

REFERENCE:

1. Linehan MM, Armstrong HE, Suarez A, et al: Cognitive-behavioral treatment of chronically parasuicidal patients. *Arch Gen Psychiatry* 48:1060-1064, 1991.

Workshop 20 — Sunday, October 8 3:30 p.m.-5:00 p.m.

MANAGED MENTAL HEALTH CARE FOR HIGH UTILIZERS

Jack M. Barbour, M.D., *Co-Director, Barbour and Floyd Partners Program, Suite A, 2610 Industrial Way, Lynwood, CA 90262;* Reta D. Floyd, M.D., Linda Connery, L.C.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to (a) design a program that changes utilization patterns of high utilizers of mental health services so that the annual cost of such services is reduced by 75% and (b) develop a plan for changing the locus of service delivery from institutional settings to community-based programs.

SUMMARY:

This workshop will demonstrate how a newly formed grass-roots agency changed the service utilization pattern of the highest utilizers in the public mental health system from emergency room, inpatient, and crisis evaluation services to intensive case management, outpatient services, and medication support services.

The workshop will include graphics with accompanying explanations of the flow of this challenging population from assignment to this agency by the department of mental health; quality-of-life outcomes will be included. The role of the psychiatrist in a program for high utilizers that combines the medical model with the psychiatric rehabilitation model will be described. The presentation will include the use of capitation as an innovative tool for cutting-edge practices in working with this historically treatment-resistant population.

The methods for gathering data for each member about services and costs in the year before he or she was in this program will be described, and these data will be compared with data from the first year's experience.

This presentation is important because little has been written

or presented about capitation, managed mental health care, or the application of either of these to a population of high utilizers. The workshop will demonstrate the dramatic change in utilization of services, and the major cost savings.

REFERENCES:

1. Hargreaves WA: A capitation model for providing mental health services in California. *Hosp Community Psychiatry* 43:275-276, 1992.
2. Koyanagi C: The quiet success of the national plan for the chronically mentally ill. *Hosp Community Psychiatry* 42:681-683, 1991.

Workshop 21 — Sunday, October 8, 3:30 p.m.-5:00 p.m.

TEACHING PROFESSIONAL BOUNDARIES TO TRAINEES IN A DEVELOPMENTAL CONTEXT

Kenneth S. Duckworth, M.D., *Medical Director, Continuing Care Service, Massachusetts Mental Health Center, 74 Fenwood Road, Boston, MA 02115*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe a framework for identifying developmental aspects of professional barriers and identify risk factors for possible boundary violations in trainees.

SUMMARY:

Managing the boundaries between mental health professionals and those they serve is a task that all clinicians must master. Boundary violations are a not infrequent source of negative publicity for the profession and are a focus of media sensationalism. However, few training programs provide the opportunity for a focused discussion of appropriate professional behavior and the context in which to understand the rationale for, and challenges to, maintaining appropriate boundaries between doctors and patients.

This workshop will provide an empirical framework for identifying and organizing developmentally expectable tensions for trainees in developing professional boundaries. Extensive clinical vignettes from work with multidisciplinary trainees, psychiatric residents, and psychology fellows at the Massachusetts Mental Health Center will provide illustrations of this framework for understanding boundary issues. The presenter's own thoughts and experiences will be used to work with the audience to develop a model for using supervision to teach residents and students how to understand, monitor, and respect professional boundaries in their clinical work.

REFERENCE:

1. Durkworth KS, Kahn MW, Gutheil TG: Roles, quandaries, and remedies: teaching professional boundaries to medical students. *Harvard Rev Psychiatry* 1:266-270, 1994.

Workshop 22 — Monday, October 9, 8:30 a.m.-10:00 a.m.

USE OF COMPUTERS IN A COMMUNITY MENTAL HEALTH SETTING: A PRACTICAL WORKSHOP FOR GUIDANCE AND DISCUSSION

H. Rowland Pearsall, M.D., *Director of Inpatient Services, Connecticut Mental Health Center, 34 Park Street, New Haven, CT 06519;* Michael J. Sernyak, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify possible uses of computers in clinical settings, describe the advantages of a network over independent desktop computers, and describe how off-the-shelf computer programs can be used to create clinically useful applications without extensive additional programming.

SUMMARY:

This discussion will present examples of how computers can be used to assist in clinical work in community mental health centers, will specify technical considerations, including the pros and cons of setting up a network of computers, and will describe how commercially available computer programs can be used to create applications for specific tasks, such as discharge summaries, treatment plans, and patient databases. The presenters will demonstrate sample applications and will invite discussion of other clinicians' experiences in developing practical, cost-effective uses of the computer. This workshop is intended to provide practical guidance to professionals who are slightly to moderately computer literate and to stimulate ideas that can be implemented with equipment and programs that institutions likely already possess, with minimal investment in new equipment or programs.

REFERENCE:

1. Modai I, Rabinowitz J: Why and how to establish a computerized system for psychiatric case records. *Hosp Community Psychiatry* 44:1091-1095, 1993.

Workshop 23 — Monday, October 9, 8:30 a.m.-10:00 a.m.

PSYCHIATRY AND THE SEX OFFENDER: ARE WE AFRAID TO LOOK?

1994-1995 APA/Mead Johnson Fellows Workshop

John K. Heussy, M.D., *1994-1995 APA/Mead Johnson Fellow and Resident in Psychiatry, New York University Medical Center, Room NB20n11, 550 First Avenue, New York, NY 10016;* Joe N. Sangster, Sr., M.D., Kaycia L. Vansickle, M.D.

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EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the characterological traits, life experiences, and familial and societal influences that may contribute to the commission of sexual offenses; the modalities of treatment currently available before, during, and after incarceration; and the challenges facing the psychiatric community in providing treatment.

SUMMARY:

Without treatment, sex offenders are more likely than any other criminals to repeat their offenses, and yet surprisingly few receive adequate treatment. Multiple modalities of treatment, including organic treatments aimed at reducing testosterone levels, behavioral reconditioning to alter the patterns of sexual arousal, and group therapies to confront and extinguish criminal behaviors, have been employed in an attempt to reduce recidivism. Such treatment most often begins after incarceration, where the potential for intensive intervention in a structured, inpatient environment has been impeded by several factors. These include offenders' reluctance to confront their crimes and risk disclosure among the inmate population, sentences that are too short to allow completion of lengthy treatment protocols, the lack of adequate incentives for offenders on probation to continue their treatment, and hesitancy on the part of an overburdened legal system to identify and prosecute juvenile offenders, who receive a lot of leeway because of our discomfort in saying that such behavior starts early.

Prevention, the cornerstone of any effective treatment, requires early detection and intervention, thereby expanding the role of the psychiatric community in treating sex offenders. A better understanding of the character structure of the offender and his position in a cycle of behavior supported by familial and societal influences may enhance such interventions. At present, few treatment options are available to the sexual offender before criminal charges or legal involvement. Some rare examples of such treatment, along with ideas for potential enhancement of treatment delivery, will be explored in this session.

REFERENCE:

1. Schwartz BK (ed): *A Practitioner's Guide to Treating the Incarcerated Male Sex Offender: Breaking the Cycle of Sexual Abuse.* U.S. Government Printing Office, Washington, DC, 1988.

Workshop 24 — **Monday, October 9**
8:30 a.m.-10:00 a.m.

PREPARING FOR THE JOINT COMMISSION SURVEY

Roger L. Coleman, M.D., *Chief of Professional Services, Cedar Crest Regional Hospital, Newington, CT, and Surveyor, Joint Commission on Accreditation of Healthcare Organizations;* Richard L. Elliott, M.D., Leo E. Kirven, Jr., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify Joint Commission on Accreditation of Healthcare Organizations standards for psychiatric services, describe the quality assessment and quality improvement processes, implement programs for improving the quality and performance of the medical staff and overall organization, and prepare for successful and meaningful completion of Joint Commission accreditation.

SUMMARY:

This is an updated session about preparing for the Joint Commission on Accreditation of Healthcare Organizations survey. The focus will be on the content and processes of the Joint Commission survey and how facilities can meaningfully prepare for the event. Major standards will be emphasized, particularly those most essential for psychiatrists and members of the medical staff. The faculty, composed of Joint Commission surveyors and medical administrators, will present approaches to the Joint Commission survey from both perspectives. For example, the rather broad topics of quality assurance and performance improvement will be presented from the dual focuses of how the surveyor approaches the subjects and how the hospital can develop a program that meets Joint Commission standards. The faculty will present a practical, rather than theoretical, approach in this session. The presentation will stress Joint Commission standards relating to clinical administration, including leadership, credentialing, quality, performance, and functional activities.

REFERENCES:

1. Coleman R: Hospital quality assurance and risk management. In Tasman A (ed): *American Psychiatric Press Review of Psychiatry,* vol. 11. American Psychiatric Press, Washington, DC, 1992.
2. Elliott R: Applying quality improvement principles and techniques in public mental health systems. *Hosp Community Psychiatry* 45:439-444, 1994.

Workshop 25 — **Monday, October 9**
8:30 a.m.-10:00 a.m.

VOICE AND CHOICE: ENHANCING THE THERAPEUTIC ALLIANCE THROUGH PSYCHIATRIC ADVANCE DIRECTIVES

Constance M. Kalinowski, M.D., *Director, Kuyichagulia Project, Unit 6B, San Francisco General Hospital, 1001 Potrero Avenue, San Francisco, CA 94110;* Daniel A. Pone, J.D., Lori
Shepherd, M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the clinical benefits of advance directives and health care policies in psychiatric treatment, the legal bases for the use of advance directives and health care proxies in psychiatric treatment, and strategies for enhancing the therapeutic alliance through development of advance directives and health care proxies in partnership with mental health consumers.

SUMMARY:

Advance directives and health care proxies are becoming widely used in general health care settings in the wake of the Cruzan case. Congress passed the Federal Patient Self-Determination Act as a means of promoting the use of advance directives across the country in direct response to cases like that of Cruzan. Mental health consumers, like other citizens, are beginning to take advantage of advance directives to express their wishes about their health care, including mental health treatment. Psychiatrists and other clinicians have an important role in assisting clients in making these critical decisions about their care and treatment. Collaborating with patients in developing advance directives will not only yield valuable clinical information but will also help strengthen the therapeutic alliance. This presentation will include a review of the legal bases for using advance directives in psychiatric care, case examples of clinicians working with mental health clients in developing advance directives, and consumer perspectives on the importance of advance directives in empowering clients.

REFERENCES:

1. Appelbaum PS: Advance directives for psychiatric treatment. *Hosp Community Psychiatry* 42:983-984, 1991.
2. American Psychiatric Association Council on Psychiatry and Law: *The Patient Self-Determination Act: What Every Psychiatrist Should Know.* American Psychiatric Association, Washington, DC, December 1992.

Workshop 26

Monday, October 9
10:30 a.m-12 noon

TRAINING IN CROSS-CULTURAL PSYCHIATRY: THREE RESIDENTS' EXPERIENCE WITH NOVEL TRAINING APPROACHES FROM ACROSS THE COUNTRY

Russell Lim, M.D., *Clinical Instructor, University of California at Los Angeles, Santa Monica West, 1525 Euclid Street, Santa Monica, CA 90404;* Joy T. Hiramoto, M.D., Carlos Ruiz, M.D., Francis G. Lu, M.D., Arthur M. Kleinman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to perform culturally competent evaluations of ethnically diverse patients, discuss transference and countertransference issues in work with such patients, describe use of nonverbal cues in these situations, describe how a culturally competent inpatient unit provides education about culture's impact on the diagnosis and treatment of culturally diverse individuals, and describe how a didactic program including history, cultural traditions, values, and family structure can increase understanding of patients in specific ethnic groups.

SUMMARY:

The publication of *DSM-IV,* with its newly devised cultural formulation and culture, age, and gender considerations in the narrative sections, reflects the growing minority populations in the United States. Psychiatrists need to be more aware of cultural issues in clinician-patient interactions. The residents will present three different training approaches in cross-cultural psychiatry from the University of California at San Francisco, Columbia University, and the University of Hawaii.

At the University of California at San Francisco, residents learn cross-cultural psychiatry by experiential learning and culture-sensitivity training. The audience will participate in a cultural-awareness exercise, will view a videotape showing how to use an interpreter, and will be instructed in the use of a cultural consultant. At Columbia University, lecturers present background information on Hispanic patients, including their history, cultural values, and family structure, and show how these factors influence evaluation and treatment. At the University of Hawaii, videotape vignettes are used to teach sensitivity to nonverbal communication from patients, and these videotapes will be shown to the audience.

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, Jacobsen FM: Ethnocultural transference and countertransference in the therapeutic dyad. *Am J Orthopsychiatry* 61:392-402, 1991.
3. Lee E (exec producer): Working with Interpreters: The Therapeutic Triad (videotape). Calman Video Productions, San Francisco, 1987.
4. Lu F, Lim R, Mezzich J: Psychological issues in the assessment and diagnosis of culturally diverse patients. In Riba M, Oldham J (eds): *American Psychiatric Press Review of Psychiatry,* vol. 14, American Psychiatric Press, Washington, DC, 1995.
5. Pinderhughes E: *Understanding Race, Ethnicity, and Power.* Free Press, New York, 1989.
6. Zatzick D, Lu FG: The ethnic/minority unit as a training site in transcultural psychiatry. *Acad Psychiatry* 15:218-225, 1991.

WORKSHOPS

Workshop 27

Monday, October 9
10:30 a.m.-12 noon

ACCESS TO INPATIENT TREATMENT IN THE AGE OF MANAGED MENTAL HEALTH SERVICES

Anne L. Bateman, Ed.D., R.N., C.S., *Clinical Director, Emergency Mental Health Service, University of Massachusetts Medical Center, Worcester, MA 01655*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify variables that affect access to inpatient treatment in a managed mental health care system and describe client-focused issues involved in obtaining psychiatric inpatient care.

SUMMARY:

In October 1992 the Commonwealth of Massachusetts moved to a system of managed mental health and substance abuse services for certain categories of Medicaid. Research from the initial period of this process in central Massachusetts will be compared with the experience 2 years later. Case examples and service delivery descriptors will be provided. Data will be compared for two time periods before and after initiation of managed care, and outcomes will be discussed.

REFERENCES:

1. Thompson J, Burns B, Goldman H, et al: Initial level of care and clinical status in a managed mental health program. *Hosp Community Psychiatry* 43:599-603, 1992.
2. Dorwart RA: Managed mental health care: myths and realities for the 1990s. *Hosp Community Psychiatry* 41:1087-1091, 1990.

Workshop 28

Monday, October 9
10:30 a.m.-12 noon

PSYCHIATRY AND PRIMARY CARE: CAN WE TALK?

Robert W. Hierholzer, M.D., *Assistant Chief, Department of Psychiatry, Valley Medical Center, 445 South Cedar Avenue, Fresno, CA 93702;* David Nowlis, Ph.D., Jean Crane, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the range of psychiatric problems seen in primary care settings, the training of family practice physicians in psychiatric and psychological issues, and how to effectively provide psychiatric consultation to primary care physicians.

SUMMARY:

Given the current emphasis on primary care in medicine, there has been concern among specialists about the future of their specialties. Psychiatry is no exception, as exemplified by discussions at last year's Institute about the need for psychiatrists to serve as consultants to primary care physicians.

The goal in this workshop will be to examine the collaboration between primary care and psychiatry from the perspectives of both psychiatry and family practice, with emphasis on residency training issues. For psychiatrists to adapt well in medical systems with gatekeepers they must understand the training and consultative needs of primary care physicians.

This presentation will cover (a) the range of psychiatric issues seen in primary care, (b) current training for family practice residents in psychiatric and psychological issues, and (c) the consultative needs of primary care physicians and implications for psychiatry residency training.

REFERENCES:

1. Weiner JM, Dickstein LJ, Stein SP, et al: The future of the psychiatric workforce in the era of health system reform (abstract). In *Syllabus, 46th Institute on Hospital & Community Psychiatry.* American Psychiatric Association, Washington, DC, 1994, pp 25-26.
2. Longlett S, Kruse J: Behavioral science education in family medicine: a survey of behavioral science educators and family physicians. *Fam Med* 24:28-35, 1992.

Workshop 29

Monday, October 9
10:30 a.m.-12 noon

TREATING SURVIVORS OF TRAUMA IN AN ACUTE-CARE DAY HOSPITAL

Jeanne L. Steiner, D.O., *Associate Professor, Department of Psychiatry, Yale University School of Medicine, New Haven, CT;* Robert G. Lussier, M.D., Linda M. DiPalma, M.S.N., R.N., C.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss assessment of symptoms and syndromes associated with the sequelae of severe trauma and discuss strategies that can be used in acute care settings.

SUMMARY:

The panel will present diagnostic and treatment concerns relevant to the treatment of survivors of severe trauma. Emphasis will be placed on clinical issues related to care in acute treatment day hospitals. Specific symptoms and syndromes that result from trauma will be described, including dissociative symptoms and disorders, posttraumatic stress disorder, and borderline personality disorder. Diagnostic strategies that can assist with rapid assessment will be presented, and use of

standardized instruments will be described. Therapist reactions to working with patients who have experienced severe trauma will be discussed. Treatment strategies that can be used in a partial hospital program will be addressed; these include psychoeducation, methods of maintaining safety, pharmacological interventions, and techniques to improve dissociative symptoms. Case vignettes will be used to illustrate the material.

REFERENCES:
1. Bryer JB, Nelson BA, Miller JB, et al: Childhood sexual and physical abuse as factors in adult psychiatric illness. *Am J Psychiatry* 144:1426-1430, 1987.
2. Herman JL: *Trauma and Recovery.* Basic Books, New York, 1992.

Workshop 30 — Monday, October 9 1:30 p.m.-3:00 p.m.

FOUNTAIN HOUSE AND THE PSYCHIATRIST

Ralph Aquila, M.D., *Attending Psychiatrist, St. Luke's/ Roosevelt Hospital Center, 448 West Forty-Eighth Street, New York, NY 10036;* Thomas J. Malamud, C.R.C., Stephen M. Theccanat, M.D., Kenneth Steele

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the interaction between psychiatrists and the Fountain House model and how club members and psychiatrists can learn from each other for a better working relationship.

SUMMARY:

Fountain House is an intentional community that provides a restorative environment for individuals who have been socially and vocationally disabled by mental illness. It focuses on the strengths of the person, as do all psychosocial rehabilitation models. It differs from other programs in that Fountain House does not provide treatment. Psychiatry, on the other hand, as a medical model, focuses on the illness of the person. Although there have been some attempts to define the role of the psychiatrist in psychosocial rehabilitation models, there has been no literature defining the role of the psychiatrist or psychiatry with the Fountain House model. In the last few years, Fountain House has subcontracted with a teaching hospital to provide psychiatric services for its homeless members. The relationship has grown beyond the original mandate but has not been without difficulties. One key issue has been maintaining the autonomy of Fountain House from the psychiatrists. A series of vignettes will describe this relationship among psychiatrists from a teaching hospital, clubhouse members, and the staff of Fountain House.

REFERENCES:
1. Beard JH, Propst RN, Malamud TJ: The Fountain House model of psychiatric rehabilitation. *Psychosoc Rehab J* 5(1), 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* 18:121-130, 1994.

Workshop 31 — Monday, October 9 1:30 p.m.-3:00 p.m.

IMPROVING TRIAGE DECISIONS ON THE INITIAL VISIT

Mary L. Turner, Ph.D., *Psychology Fellow, Yale University/ Connecticut Mental Health Center, 34 Park Street, New Haven, CT 06508;* Linda S. Godleski, M.D., Jaak Rakfeldt, M.S.W., Ph.D., Gail M. Simonson, A.P.R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to develop optimal triage strategies by targeting patients for conventional and innovative modalities.

SUMMARY:

Decisions at the initial visit are often the most crucial in determining the course and success of each patient's treatment. These decisions are especially important in view of cost containment and the need to adapt treatment modalities to the needs of health maintenance organizations. This workshop will focus on how multidisciplinary treaters can develop effective, efficient treatment strategies beginning with the patient's first visit.

On the basis of their experience at Yale University and in the Connecticut Mental Health Center Acute Service Unit, the presenters will discuss innovative triage strategies, including single-session treatment, brief intermittent psychotherapy, holding techniques designed to determine engagabilty, and triage/emergency room early-intervention connections that minimize dropouts. In addition, the successful application of short-term approaches that are used primarily with high-functioning patients will be demonstrated with the chronically mentally ill population.

Participants will be encouraged to share their triage strategies and to discuss difficulties they have encountered.

REFERENCES:
1. Hoge MA, Davidson L, Griffith EEH, et al: Defining managed care in public sector psychiatry. *Hosp Community Psychiatry* 45:1085-1089, 1994.
2. Bachrach LL: Continuity of care and approaches to case management for long-term mentally ill patients. *Hosp Community Psychiatry* 44:465-468, 1993.

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Workshop 32 — Monday, October 9, 1:30 p.m.-3:00 p.m.

TOWARD IMPROVED RISK ASSESSMENT AND QUALITY CARE IN MANAGED CARE

Marten W. deVries, M.D., *Section Chairman, Department of Psychiatry and Neuropsychology, University of Limburg, P.O. Box 616, 6200 MD Maastricht 00220, The Netherlands;* Harry B. Pomerantz, M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe (a) how existing health care utilization data can be supplemented with systematic and person-based research to result in better risk assessment and quality care and (b) a multimethod research strategy and its health care and economic consequences.

SUMMARY:

In this workshop the problem of combining population and individual morbidity data with the planning of services stands central. The dynamics of morbidity and health care availability have always made the vital relationship between science and health care planners difficult. This is even more true in today's cost-constrained environment. From the managerial point of view, the reliability, validity, and relevance of epidemiologic data for service implementation have always left room for doubt. Often gathered in large cross-sectional samples, such data do not reflect the dynamic processes of service, demand, and health policy decision making.

To alleviate the inherent tension among supply, need, and demand, the presenters propose a multimethod epidemiologic design for planning cost containment and quality care. The methods are driven by the fact that illness is not randomly distributed in a population, nor is it persistently active in the lives of individuals. Data must therefore be gathered not only on populations but also on social networks, neighborhoods, and the personal experience of illness. For example, at the population level illness tends to cluster in groups residing in specific social settings or neighborhoods with definable risk and protective factors of interest to service planning. Similarly, the individual experience of psychopathology takes place within definable social networks and fluctuates dynamically in relation to time of day and sociocultural settings. These data are of value in planning treatment. The multistage design uses patient registration statistics and social network sampling, as well as snowball sampling and intensive time sampling, to bridge the gap between the population and individual data points. Such reliable measures of population and illness dynamics help assess risk and guide the implementation of detailed data on cost-effectiveness and quality of care, which are particularly important for the ethical allocation of scarce resources.

In this workshop the multimethod research approach will be demonstrated by drawing examples from a number of social settings and various mental disorders. Application in risk assessment and service planning, and eventually in the evaluation of care, prevention, and realistic cost containment, will be described.

REFERENCES:

1. deVries MW (ed): *The Experience of Psychopathology: Investigating Mental Disorders in Their Natural Settings.* Cambridge University Press, Cambridge, England, 1992.
2. Kaplan CD, Korf D, Sterk C: Temporal and social contexts of heroin-using populations: an illustration of the snowball sampling technique. *J Nerv Ment Dis* 175:566-574, 1987.

Workshop 33 — Monday, October 9, 3:30 p.m.-5:00 p.m.

CONSUMER SELF-DISCLOSURE, BOUNDARY VIOLATIONS, AND THE AMERICANS WITH DISABILITIES ACT

Larry Davidson, Ph.D., *Assistant Director for Program Development, Division of Outpatient Services, Connecticut Mental Health Center, 34 Park Street, New Haven, CT 06519;* Richard Weingarten, M.A., Karen A. Kangas, Ed.D., Ezra E.H. Griffith, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify the complex range of issues that should inform a mental health provider's decisions about whether to disclose information about his or her personal history of psychiatric disability, what to disclose, to whom, at what points in time, in what situations, at what risk, and to what end.

SUMMARY:

The Americans with Disabilities Act has sent conflicting messages to mental health consumers and providers. By prohibiting employers from asking about a person's history of disability, the Americans with Disabilities Act safeguards a consumer's right to confidentiality. By mandating the provision of reasonable accommodations, however, it also encourages individuals to disclose information about their disabilities and their specific needs to their employers. This legislation has further assisted consumers in their acquisition of provider positions in mental health settings in which the desire to serve as visible role models requires disclosure of their personal histories to their clients.

This workshop will facilitate discussion of issues involved in decisions to disclose information about oneself to both employers and clients and the potential consequences of these decisions from the perspectives of an employer of consumer providers, a consumer provider, a state mental health authority representative responsible for consumer employment initiatives, and a forensic psychiatrist experienced in litigation concerning self-disclosure as a boundary violation.

REFERENCES:
1. Dixon L, Krauss N, Lehman AL: Consumers as service providers: the promise and challenge. *Community Ment Health J* 30:615-625, 1994.
2. Stephens CL, Belisle KC: The "consumer-as-provider" initiative. *J Ment Health Admin* 20:178-182, 1993.

Workshop 34 — Monday, October 9, 3:30 p.m.-5:00 p.m.

THE PSYCHIATRIST IN THE PUBLIC SECTOR: INTERLOPER OR MESSIAH?

Nada L. Stotland, M.D., *Medical Coordinator for Mental Health Services, Illinois Department of Mental Health and Developmental Disabilities*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to anticipate and deal with the wide range of roles for psychiatrists in publicly funded mental health systems.

SUMMARY:

The history and realities of health care in community mental health centers, state hospitals, and other publicly funded settings often result in psychiatrists having a lesser administrative and clinical role in private and academic systems. At worst, psychiatrists, seen as greedy physicians and pill pushers more interested in social control, personal power, and wealth than in the compassionate understanding and care of patients, are actively excluded from policy-making positions. The psychiatrist's hours and functions are sharply restricted and marginalized within the system. Even in more receptive public environments, funding, location, and working conditions may hamper psychiatric recruitment and participation. When a psychiatrist comes into such a setting, the pent-up expectations can be overwhelming. These issues will be discussed by psychiatrists in a newly created administrative position, taking over a troubled state hospital, and running a Veterans Affairs hospital and by a psychologist running a state mental health system.

REFERENCE:

1. Yank GR, Lindsay RJ, Barber JW, et al: Ethical issues for academic participants in state-university collaboration programs. *Hosp Community Psychiatry* 43:1213-1217, 1992.

Workshop 35 — Monday, October 9, 3:30 p.m.-5:00 p.m.

TELEPSYCHIATRY AND RURAL MENTAL HEALTH

M. Anthony Graham, M.D., *Medical Director, Southwestern Virginia Mental Health Institute, 502 East Main Street, Marion, VA 24354;* Henry A. Smith, M.S.W., Richard Mears, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the use of telecommunications linkage for improving rural mental health care and summarize outcome data from the Telepsychiatry Project in southwest Virginia.

SUMMARY:

The Southwestern Virginia Telepsychiatry Project seeks to provide integrated mental health services within a 2000-square-mile region of rural southwest Virginia by using state-of-the-art interactive telecommunications technology. There will be four participants in the consortium: the Southwestern Virginia Mental Health Institute, Cumberland Mountain Community Services, New River Valley Community Services, and Dickenson County Community Services.

This Appalachian section of Virginia has traditionally found it virtually impossible to recruit and retain medical specialists, particularly psychiatrists. Because of the lack of sufficient psychiatric manpower resources at the rural community service board sites, after discharge many patients are seen for short times and after long intervals (2-3 months between psychiatrist appointments is not uncommon). This unfortunate lack of psychiatric manpower contributes significantly to many of these patients falling through the cracks, with subsequent deterioration and frequent relapses and rehospitalizations.

Primary services will include outpatient psychiatric clinics supported by psychiatrists at the Southwestern Virginia Mental Health Institute and the community service boards. In addition, the project will allow for family and consumer interaction with the institute's staff, participation in commitment hearings, discharge planning, and an array of ongoing supports and services. The target population for this project consists of individuals with serious and persistent mental illness who are treated by public sector providers and who, because of the nature of their illness and the unavailability of psychiatric support, are caught in the revolving door between acute hospitalization and life in the community.

The faculty will present information and outcomes collected by the Southwestern Virginia Telepsychiatry Project during its first month of operation.

REFERENCES:

1. Preston J, Brown F, Hartley B: Using telemedicine to improve health care in distant areas. *Hosp Community Psychiatry* 43:25-32, 1992.
2. Grigsby J, Kaehny M, et al: *Analysis of Expansion of Access to Care Through Use of Telemedicine.* Center for Health Policy Research, 1993.

WORKSHOPS

Workshop 36 **Monday, October 9**
3:30 p.m.-5:00 p.m.

THE ROLE OF PSYCHIATRY IN A PUBLIC MENTAL HEALTH SYSTEM

M. Annette Hanson, M.D., *Deputy Commissioner, Clinical/ Professional Services, Massachusetts Department of Mental Health, 25 Staniford Street, Boston, MA 02114;* Walter W. Shervington, M.D., Stuart B. Silver, M.D., Richard C. Lippincott, M.D., Thomas S. Fox, M.D., David M. Gottesman, M.D., William H. Reid, M.D., M.P.H., Ted Lawlor, M.D., Irma J. Bland, M.D., William S. James, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the changing role of psychiatry in a public mental health system, identify problems that affect successful integration of psychiatry into the public mental health system, and discuss potential solutions.

SUMMARY:

Historically, psychiatrists have been leaders in public mental health systems and have been regarded as the principal treating authorities. More recently their roles have changed. However, the need for their unique skills may be more important than ever, because public systems are caring for sicker populations, are involved with managed mental health care, and have increasingly sophisticated treatment tools.

At present there is a lack of clarity about what the role of a psychiatrist is or should be. Systems have moved from a traditional hospital-based medical model to a community-based model that stresses rehabilitation. In the process, tension has developed between psychiatrists and other clinical and administrative staff involved in the care, treatment, and rehabilitation of people with serious mental illness. Psychiatrists have withdrawn from the leadership and administrative functions and have resisted group-process decision making.

This workshop will examine the role of psychiatrists as managers in public sector behavioral health care systems. The various roles required of these highly trained professionals at all levels of a public mental health system will be described, including the clinical and managerial skills they need to function effectively in a complex, changing health care environment. Typically, psychiatrists occupy managerial positions at three levels of the public mental health system--as commissioners, medical directors/deputy commissioners, and area/regional medical directors.

The presentation will begin with a brief examination of these and other major issues. One representative from each managerial level will then discuss his or her role and experience. The workshop will end with a panel discussion with audience participation.

REFERENCES:

1. Levinson D, Klerman G: *The Clinician Executive: Some Problematic Issues for the Psychiatrist in Mental Health Organizations.* Department of Psychiatry, Yale University, New Haven, CT.
2. *The Psychiatrist's Role in the North Carolina Community Mental Health Program.* Community Mental Health Psychiatry Committee, North Carolina Psychiatric Association, March 1992.

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