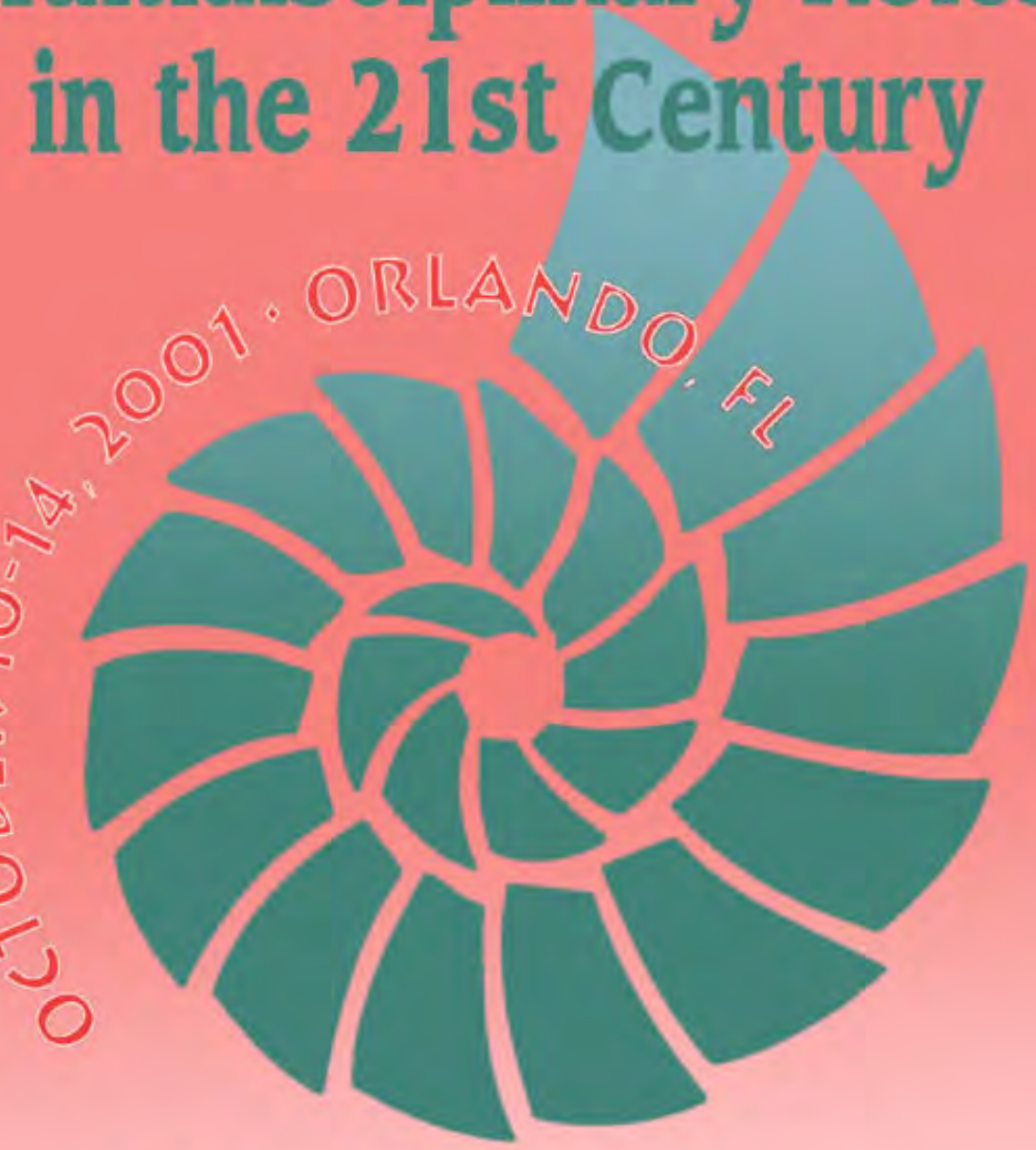
CME SYLLABUS AND PROCEEDINGS SUMMARY

Multidisciplinary Roles in the 21st Century



53rd Institute on Psychiatric Services

American Psychiatric Association

CERTIFICATE OF ATTENDANCE

This certificate provides verification of your completion of educational activities at the 2001 Institute on Psychiatric Services.

This is to certify that

_____

Attended the 2001 Institute on Psychiatric Services of the
American Psychiatric Association
October 10-14, 2001
Orlando, FL

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

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

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

DAILY LOG FOR ATTENDANCE AT CME FUNCTIONS AT THE 53rd INSTITUTE ON PSYCHIATRIC SERVICES OCTOBER 10-14 • ORLANDO, FL

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

DAY	TITLE OF SESSION	NUMBER OF HOURS	CME CATEGORY
	TOTAL		

HOW TO OBTAIN CME CREDIT

FOR THE

2001 INSTITUTE ON PSYCHIATRIC SERVICES

The American Psychiatric Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education (CME) for physicians. The APA certifies that the continuing medical education activities designated as category 1 for the 2001 Institute sessions meet the criteria for category 1 of the Physician's Recognition Award of the American Medical Association and for the CME requirements of the APA.

The scientific program at the Institute offers a broad range of sessions designated for CME credit. The sessions that meet the criteria for category 1 credit include CME Courses, Full-Day Sessions, Industry-Supported Symposia, Innovative Programs, Leadership and Career Development Seminars, Lectures, Medical Updates, Multimedia Sessions, Psychiatric Services Achievement Awards Session, Symposia and Workshops. Other sessions may be considered category 2 credit. These include Caucuses, Clinical Consultations, Debates, Discussion Groups, Forums and Posters.

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

RECORDING CME CREDIT THROUGH THE *CME RECORDER*

APA members can record the number of Category 1 hours they earn at the Institute on Psychiatric Services (and at the APA Annual Meeting) by completing the Computerized Evaluation Program onsite and entering their CME hours. The hours entered onsite through the computerized evaluation are maintained for APA members in the personal CME Recorder section of the APA website.

The CME Recorder (for APA members) maintains a record of CME credits earned at APA annual meetings and entered through the Computerized Evauation, and also records CME credits earned online through the APA CME website. APA members may view and print these records from their personal computers. Members also have the capability to enter hours earned at other CME activities.

APA members log in though the "Members Only" section of the APA website or through **http://www.psych.org/cme/apacme**. Select the *CME Recorder*, access your personal record and view the hours you have earned through APA activities; see your APA CME certificate expiration date; learn about state CME requirements; and find direct links to state relicensing boards.

CME REQUIREMENTS FOR APA MEMBERS

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

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

(continued on next page)

CME REQUIREMENTS FOR APA MEMBERS
(Cont'd.)

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

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

HOW TO EARN A CERTIFICATE FOR CME COMPLIANCE

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

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

HOW TO FULFILL THE CME REQUIREMENTS OF THE APA

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

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

You may also **report your CME activities directly to the APA,** using the official APA report form. This form may be obtained from the APA Office of Education, 1400 K Street, N.W., Washington, DC 20015, or call (202) 682-6179 or filed electronically via the APA Home Page at http:/www@psych.org.

EXEMPTIONS

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

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

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

CONTINUING MEDICAL EDUCATION

SYLLABUS AND PROCEEDINGS SUMMARY

FOR THE

53rd
INSTITUTE ON PSYCHIATRIC SERVICES

October 10–14, 2001

Orlando, FL

The American Psychiatric Association
Institute on Psychiatric Services
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Course 1 **Wednesday, October 10**
9:00 a.m.-4:00 p.m.

MANAGEMENT AND TREATMENT OF THE VIOLENT PATIENT

Gary J. Maier, M.D., *301 Troy Drive, Madison, WI 53704-1521*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) describe a comprehensive model for managing and treating the violent patient; 2) describe techniques for controlling the acutely violent patient using verbal, physical, and pharmacologic techniques; 3) describe state-of-the-art psychopharmacologic approaches to the violent inpatient/outpatient; 4) describe the legal issues specific to the commitment, release, and prosecution of violent inpatients in light of the HCFA regulations; and 5) describe methods of identifying and working through the countertransference feelings of fear, anger, and helplessness that frequently arise when working with violent patients.

SUMMARY:

This course will present a comprehensive model for the management and treatment of the acute and chronic violent patient in both inpatient and outpatient settings. The need for clinicians to provide safe working conditions will be outlined. Architectural issues that need to be considered when working in a setting with a high incidence of violent patients will be reviewed. Management of the prodromal syndrome that precedes physical violence will be described, including talking-down techniques for de-escalating a potentially violent patient. Alternatives to the use of seclusion and restraint will be described. Medical/psychiatric diagnostic procedures leading to medical and psychopharmacological 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 the Tarasoff decision, will be described. Building a case that will result in successful prosecution of a willfully violent patient will be presented. The pattern of "aggression cycles" that results from repetitive violence will be presented from the perspective of both the staff and the violent patient. Finally, but most important, countertransference reactions will be identified. The forums in which clinicians' feelings should be resolved and the process of resolution will also be identified.

REFERENCES:

1. Flannery RB, Fischer W, Walker A, Kolodziej K, Splain MJ: Assaults on staff by psychiatric patients and community residents. Psychiatric Services 2000; 51(1):111–113.
2. Mammen OK, Shear MK, Pilkonis PA, Kolkodj, Thase ME, Greeno CG: Anger attacks: correlates in significance of an unrecognized symptom. Journal of Clinical Psychiatry 1999; 60(9):633–642.

Course 2 **Wednesday, October 10**
1:00 p.m.-5:00 p.m.

LIMIT SETTING WITH PSYCHIATRIC PATIENTS

Donald A. Misch, M.D., *Associate Professor of Psychiatry, Medical College of Georgia, 1515 Pope Avenue, Augusta, GA 30912*; Lydia E. Weisser, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) identify rationales for setting limits; 2) recognize the utility of the parent-child analogy in setting limits; 3) summarize and employ proper rules and techniques for limit setting; and 4) understand and take into account the factors that interfere with effective limit setting.

SUMMARY:

Limit setting is a necessary and frequent element of every psychiatrist's clinical work, but it is a subject in which most psychiatrists receive little formal training. This course will review the fundamental knowledge base and the specific techniques necessary to set limits successfully in clinical psychiatry. Topics that will be covered include the rationales for psychiatric limit setting, the value of the parent-child analogy, key strategies and techniques, and the factors that interfere with appropriate limit setting. Both theoretical and practical aspects of these subjects will be addressed, giving participants relevant and immediately useful information that can be applied in their clinical work. In addition to didactic presentations, the course will consist of faculty-facilitated large- and small-group exercises involving limit setting with particular patients in specific situations. Participants will be introduced to a structured worksheet designed to foster effective limit setting. Course participants are also encouraged to present their own clinical vignettes. The course is designed primarily for beginning and intermediate level clinicians.

REFERENCES:

1. Pam A: Limit setting: theory, techniques, and risks. American Journal of Psychotherapy 1994; 48(3):432–440.
2. Welch HG, Bernat JL, Mogielnicki RP: Who's in charge here? Maximizing patient benefits and professional authority by physician limit setting. J Gen Intern Med 1994; 9(8):450–454.

Course 3 **Wednesday, October 10**
1:00 p.m.-5:00 p.m.

HELP! I'VE BEEN PROMOTED: INTRODUCTION TO ADMINISTRATION AND MANAGEMENT

Mark L. Russakoff, M.D., *Director of Psychiatry, Phelps Memorial Hospital, 701 North Broadway, Sleepy Hollow, NY 10591*; Philip E. Veenhuis, M.D., *325 North Salisbury Street, Raleigh, NC 27603-1388*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) articulate fundamental concepts of organizational structure, process, and functions; 2) describe parameters of leadership; 3) understand differing and complementary models of human motivation in the work place; and 4) appreciate the inevitable conflicts that evolve within organizations and describe methods to resolve them.

SUMMARY:

It is common for clinicians to be promoted to managerial positions in mental health organizations without being provided with the knowledge of administrative issues needed to facilitate their functioning in their new roles. Being an administrator draws on knowledge and skill sets that are distinct from being a good clinician, although many people rise to the occasion. There is substantial literature on administration and management that is pertinent to work as a clinical administrator. This course will provide those who are interested in clinical administrative positions, recently promoted to such positions, and those who are open to new information and have been in such positions but never understood quite what they do, with the basic concepts central to understanding organizations, organizational processes, and the management of personnel. The purpose of an organization, its structure, and issues of planning and leadership will be discussed from the perspective of the clinical administrator. Various approaches that have been promulgated to understand motivation of employees and the relationship of employees to managers will be described. The course will be interactive, with the faculty offering anecdotes to illustrate the administrative issues and the participants invited to experiment with the concepts in the analysis of their particular situations.

REFERENCES:

1. Baker JG, Baker DF: Perceived ideological differences, job satisfaction and organizational commitment among psychiatrists in a community mental health center. Community Mental Health Journal 1999; 35(1):85–95.
2. Rodenhauser P, ed.: Mental Health Care Administration: A Guide for Practitioners. Ann Arbor, University of Michigan Press, 2000.

Course 4 **Thursday, October 11**
9:00 a.m.-4:00 p.m.

SUBJECTIVITY: CRUCIAL KEY TO THERAPY AND TO THE UNIQUENESS OF THE HUMAN MIND

Vincenzo R. Sanguineti, M.D., *Associate Professor of Psychiatry, Jefferson Medical College, 1015 Chestnut Street, Suite 825, Philadelphia, PA 19107-5567*; Alwyn Scott, Sc.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) better understand the structure of the subjective experience and the sources of contributing data; 2) grasp the unique character of each individual mental state; and 3) use such information to gain deeper understanding and empathy in relating to patients.

SUMMARY:

Defined by philosopher D. Chalmers as "the hard problem of consciousness," subjectivity has traditionally been an exceedingly difficult topic. The course will start with a brief historical review and discussion with the participants of an operational definition of subjectivity. The definition will include the extremely intricate and individualized nonconscious and conscious activities (activation of memories, meanings, values, intentional states, and emotional correlates) that accompany each perception and that are accessible only from the first-person perspective. Such a theoretical viewpoint is necessary for linking investigations of the replicable, algorithmic workings of neural circuitry—accessed only from an objective, third-person perspective—with the continuously updated interpretation of the world that surrounds us, of ourselves, and of the interactive processes between the two levels of psychic reality. The faculty will compare sets of physical laws and how they may best apply to this extreme intricacy of mental operations. The participants will be guided to a group dialogue on the concept of consciousness and will discuss a graphic model depicting the architecture of the subjective. The general role of emotions and specific emotional states will be explored, and several clinical vignettes will illustrate the application of subjectivity to therapy.

TARGET AUDIENCE:

Psychiatrists, psychologists, and other psychotherapists dealing with the subjective mental process.

REFERENCES:

1. Greenfield S: The Private Life of the Brain: Emotions, Consciousness and the Secret of the Self. John Wiley and Sons, 2000.
2. Edelman GM, Tononi G: A Universe of Consciousness: How Matter Becomes Imagination. New York, Basic Books, 2000.

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

DEALING WITH RESISTANCE IN ADDICTION PATIENTS

David Mee-Lee, M.D., *Assistant Clinical Professor of Psychiatry, University of California, Davis, 4228 Boxelder Place, Davis, CA 95616*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) identify ways for clinicians to better deal with resistance in addiction; 2) demonstrate new skills in assessing readiness to change; and 3) recognize ways to develop different clinical tracks for patients at different stages of change.

SUMMARY:

Denial and resistance are expected parts of many addiction patients' presentation. Yet the strategies to deal with resistance have traditionally been education, confrontation, and intensive and often inpatient services. The training of mental health professionals frequently neglects strategies on how to engage addiction patients into participatory treatment planning. Addiction treatment professionals often lack psychotherapy training to finesse counseling skills. This course is designed to help participants improve assessment and treatment of resistance in addiction patients and become better acquainted with how people change. It will teach skills that can help retain patients in treatment and encourage honesty, not game playing; accountability, not arguing; and confrontation. Besides improving clinical approaches, this course will discuss the changes needed to reconfigure treatment services to better match patients' readiness to change. The format of the course will provide the opportunity to build skills around the assessment, engagement, and treatment of patients who are at varying stages of readiness to change. Videotaped interviews, role play, participant exercises, and case consultation will be the methods used along with didactic presentation.

TARGET AUDIENCE:

Psychiatrists, other mental health and addiction clinicians, clinical supervisors, residents, and students.

REFERENCES:

1. Baier JS, Kivlahan DR, Donovan DM: Integrating skills training and motivational therapies—implications for treatment of substance dependence. Journal of Substance Abuse Treatment 1999; 17:15–23.
2. Brown VB, Melchoir LA, Panter AT, et al: Women's steps to change and entry into drug abuse treatment—a multidimensional stage of change model. Journal of Substance Abuse Treatment 2000; 18(3):231–240.

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

THE CLINICAL IMPACT OF DOING TIME: MENTAL ILLNESS AND INCARCERATION

Merrill R. Rotter, M.D., *Director, Division of Law and Psychiatry, Albert Einstein College of Medicine, and Bronx Psychiatric Center, 1500 Waters Place, Bronx, NY 1046*; Michael F. Steinbacher, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) identify and assess corrections-related behavior in psychiatric settings; 2) differentiate patient care issues pertaining to correctional environments and patient attributes; and 3) reduce assault risk within the treatment setting through early intervention.

SUMMARY:

An increasing number of individuals in the mental health treatment system have a history of criminal incarceration. They arrive in mental health treatment facilities with needs and expectations quite different from those persons without experience in correctional settings. Many have acquired a spectrum of beliefs and behaviors that, while adaptive in prison and jail, impede their success in treatment settings. Staff who are unaware of the impact of incarceration can misread early warning signs of difficult adjustment to place, program, and treatment. They may even inadvertently escalate potentially dangerous situations, increasing risk to both staff and clients. Based on research initiated by the New York State Office of Mental Health, New York State Department of Labor, and the Albert Einstein College of Medicine, this course will provide essential information and skills training for providers through enhancing their understanding of the experience of correctional incarceration, its particular impact on individuals suffering from mental illness, and its enduring effects on their attitudes, beliefs, and behaviors after release. In order to enhance treatment and maintain safety, it is important for providers to approach this population with "cultural compe-

tence''—an understanding of the culture of jail and prison and its impact on current behavior.

TARGET AUDIENCE:

Mental health providers of all disciplines.

REFERENCES:

1. Lamb HR, Weinberger LE, Gross BH: Community treatment of severely mentally ill offenders under the jurisdiction of criminal justice system: a review. Psychiatric Services 1999; 50:907–915.
2. Rotter MR, Larkin S, Schare ML, Massaro J, Steinbacher MF: The Clinical Impact of Doing Time: Mental Illness and Incarceration. New York State Office of Mental Health, 1999.

Course 7 **Friday, October 12**
9:00 a.m.-4:00 p.m.

ROLES OF THE PSYCHIATRIST ON AN ASSERTIVE COMMUNITY TREATMENT TEAM

Joan E. Bishop, M.D., *Department of Psychiatry, University of Western Ontario, 388 Dundas Street, Suite 100, London, ON Canada N6B 1V7*; Lisa A. Bogue, M.D.; Gayle C. Parker, B.S.N.; Tony M. Scott, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) identify and assess corrections related behavior in psychiatric settings; 2) differentiate patient care issues pertaining to correctional environments and patient attributes; and 3) reduce assault risk within the treatment setting through early intervention.

SUMMARY:

Assertive community treatment (ACT) is an evidence-based ''mini-system'' for delivering comprehensive care to severely mentally ill (SMI) persons who are living in the community. Many randomized controlled trials have demonstrated its effectiveness. The literature describes the critical ingredients (including a psychiatrist on the team) that are necessary for achieving good outcomes for ACT clients, but there is very little written specifically on the role of the ACT psychiatrist. This course will describe the psychiatrist's role as practiced by two academically based urban ACT teams, which have been implemented according to the ''NAMI/PACT'' standards. Faculty will describe the many roles of the ACT psychiatrist and facilitate discussion of how psychiatrists can facilitate (or conversely hinder) teamwork. Faculty will also present detailed information about three specific components of the psychiatrist role: 1) risk assessment for suicide and violence; 2) comorbid conditions; and 3) intergration of a relational/psychodynamic approach into treatment of persons with SMI within the ACT.

TARGET AUDIENCE:

Psychiatrists or senior psychiatric residents who already know the basics of the ACT model and are either planning to join or have recently joined ACT teams or ACT team coordinators and psychiatrists who wish more in-depth clinical knowledge about potential roles of ACT psychiatrist.

REFERENCES:

1. Appelbaum PS, Robbins PC, Monahan J: Violence and delusions: data from the MacArthur violence risk assessment study. American Journal of Psychiatry 2000; 157:566–572.
2. Arsenault L, Moffitt TE, Caspri A, Taylor PJ, Silva PA: Mental disorders and violence in a total birth cohort: results from the Dunedin study. Archives of General Psychiatry 2000; 57:979–986.

Course 8 **Friday, October 12**
1:00 p.m.-5:00 p.m.

INTEGRATED MODEL FOR TREATMENT OF CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS

Kenneth M. Minkoff, M.D., *Medical Director, Choate Health Management, and Consultant and Trainer, Integrated Treatment Systems and Interventions for Co-Occurring Disorders, 500 West Cummings Park, Suite 3900, Woburn, MA 01801*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) identify five philosophical/clinical barriers to integrated treatment and describe how to resolve them; 2) describe the four phases of treatment/recovery in an integrated disease and recovery model for mental illness and addiction; 3) describe and implement a protocol for diagnosing psychiatric illness in the presence of substance use disorder and vice versa; and 4) describe integrated program models for treatment of dual diagnosis and specific populations addressed by each model.

SUMMARY:

This course provides a basic introduction to the complex topic of co-occuring psychiatric and substance disorders, with the goal of assisting the practitioner to develop a systematic, integrated conceptual framework that facilitates rational treatment planning and treatment matching, and permits the design of a comprehensive, continuous, integrated system of care. The course will

begin with a brief overview of the problem of dual diagnosis and the difficulties practitioners encounter in providing successful treatment. Using national consensus best-practice models based on available research, subtypes of the dual-diagnosis population and basic principles of successful intervention will be identified. These principles will emphasize the importance of empathic, hopeful, continuous, integrated treatment relationships, integrated dual primary phase-specific treatment matching, and appropriate balance of case management/care with empathic detachment and confrontation. Barriers to integrated treatment will be identified, and an integrated parallel disease and recovery model will be used as a mechanism to address those barriers. This model will then be used to illustrate the process of integrated assessment, treatment matching (including motivational enhancement interventions), and strategies for psychopharmacologic intervention. Participants are encouraged to bring clinical and programmatic problems and scenarios to the course for discussion.

REFERENCES:

1. Barreira P, Espey B, Fishbein R, et al: Linking substance abuse and serious mental illness service delivery systems: initiating a statewide collaborative. Behavioral Health Services and Research 2000; 27(1):107–113.
2. Drake RE, et al: Treatment of substance abuse disorders in seriously mentally ill patients. Nervous and Mental Disease 1993; 181:606–611.

Course 9 **Friday, October 12**
1:00 p.m.-5:00 p.m.

ASSESSING AND TREATING GAMBLING DISORDERS IN PATIENTS WITH CHRONIC MENTAL ILLNESS

James R. Westphal, M.D., *1001 Potrero, Suite 7M8, San Francisco, CA 94110-0852*; Lee Stevens, M.D., *Department of Psychiatry, Louisiana State University Health Science Center, 1501 Kings Highway, Shreveport, LA 71130-3932*; James C. Patterson II, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) determine the risk of comorbid gambling disorders in their treatment population; 2) select screening and diagnostic instruments for gambling disorders appropriate for their treatment population; and 3) understand prevention and psychotherapeutic/pharmacological treatment approaches to gambling disorders.

SUMMARY:

With the rapid expansion of legalized gambling in the United States in the past 20 years, the number of patients with gambling disorders has increased. Psychiatry patients are more likely to develop gambling disorders than an adult without a psychiatric disorder. Often gambling disorders are not recognized and contribute to treatment resistance in patients with chronic mental illness. This course will review pertinent and clinical information on gambling disorders including diagnostic definitions, epidemiology, screening instruments, and treatment and prevention approaches. The efficient gambling disorder screeners will be demonstrated and scored by the participants. Cognitive-behavioral approaches to treatment suitable for patients with chronic mental illness will be emphasized. Cases of patients with chronic mental illness and gambling disorders will be presented to illustrate clinical principles. Facilitation of 12-step programs will also be discussed. The relevant neurobiology of gambling disorders will be reviewed as a basis for discussion of pharmacological treatments. Public health approaches focused on harm reduction will conclude the course.

TARGET AUDIENCE:

General psychiatrists and mental health practitioners.

REFERENCES:

1. Kim S: Opioid antagonists in the treatment of impulse-control disorders. Journal of Clinical Psychology 1998; 56(4):7–12.
2. National Research Council: Pathological Gambling: A Critical Review. Washington, DC, National Academy Press, 1999.

Course 10 **Saturday, October 13**
8:00 a.m.-12 noon

PRACTICING REWARDING PSYCHIATRY IN JAILS AND PRISONS

Henry C. Weinstein, M.D., *Clinical Professor of Psychiatry, New York University Medical Center, 1111 Park Avenue, New York, NY 10128*; Kathryn A. Burns, M.D.; Kenneth G. Gilbert, M.D.; Annette L. Hanson, M.D.; Cassandra F. Newkirk, M.D.; John S. Zil, M.D.

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

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

TARGET AUDIENCE:

Mental health care providers, especially psychiatrists.

REFERENCES:

1. Kates N, Craven M, Crustolo A, Nikolaou L, Allen C: Integrating mental health services into primary care. Gen Hosp Psych 1997; 19:324–337.
2. Rand EH, Thompson TL: Using successful models of care to guide the teaching of psychiatry in primary care. Psychosomat 1997; 38:140–147.

Course 11 **Saturday, October 13**
8:00 a.m.-12 noon

PSYCHIATRY AND PRIMARY CARE: SHARING CARE

Nick S. Kates, M.B., *Associate Professor, 43 Charleton Avenue, East, Hamilton, ON Canada L8N 1Y3*; Jonathan S. Davine, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) understand the basic principles of the practice of correctional psychiatry and 2) become familiar with additional advanced issues and topics.

SUMMARY:

This course in correctional psychiatry is a presentation of the APA Caucus of Psychiatrists Practicing in Criminal Justice Settings. To meet the needs of a varied audience—with different levels of training and/or experience—this course will cover both basic and several advanced topics. Basic topics will include careers in correctional psychiatry, the legal context of correctional psychiatry, including the major cases, psychopharmacology in correctional settings, and basic ethics issues as well as the "rules of engagement," i.e., the rules and routines of a correctional environment and how the correctional psychiatrist can work within such constraints. Some additional advanced topics will include integrating medical and mental health services, systems approaches, managed care issues, cross-training with security personnel, and special populations. The faculty for this course are members of the executive board of the caucus and task force that revised the APA guidelines.

TARGET AUDIENCE:

All psychiatrists and mental health professionals.

REFERENCES:

1. American Psychiatric Association: Psychiatric Services in Jails and Prisons, Second Edition. Washington DC, American Psychiatric Press, 2000.
2. Conover T, Newjack: Guarding Sing Sing. New York, Random House, 2000.

Course 12 **Saturday, October 13**
8:00 a.m.-5:00 p.m.

OFFICE-BASED BUPRENORPHINE TREATMENT

APA Council on Addiction Psychiatry and American Academy of Addiction Psychiatry

Thomas R. Kosten, M.D., *950 Campbell Avenue, Building 35, 151D, West Haven, CT 06516*; Eric C. Strain, M.D., *5510 Nathan Shock Drive, Baltimore, MD 21224*; Laura McNicholas, M.D.; Herbert D. Kleber, M.D.; Joseph Liberto, M.D.; David Fiellin, M.D.; H. Westley Clark, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) identify clinically relevant pharmacological characteristics of buprenorphine; 2) describe resources needed to set up office-based treatment with buprenorphine for patients with opioid dependence; 3) list at least five factors to consider in determining if a patient is an appropriate candidate for office-based treatment with buprenorphine; and 4) list at least three situations in

which patient information can be shared under current laws protecting patients' confidentiality.

SUMMARY:

This course is offered as a collaboration between the APA Council on Addiction Psychiatry and the American Academy of Addiction Psychiatry for physicians with a range of levels of experience and expertise in the treatment of patients with substance use disorders. The purpose of the course is to provide information to participants related to office-based prescribing of the medication buprenorphine for the treatment of opioid dependence. General aspects of opioid pharmacology will be reviewed; buprenoprphine's pharmacological profile will be described to facilitate an understanding of its clinical use in the treatment of opioid dependence. Treatment with medications such as buprenorphine provide an important mechanism for achieving and maintaining abstinence. However, nonpharmacological interventions are nearly always necessary to achieve treatment stability. Therefore, different levels of treatment services will be reviewed. The types of treatments that may be used in the different levels of services will be discussed, and guidance will be provided to participants regarding general principles for the office-based physician when treating this patient population. Psychiatric and medical comorbidities that the treating physician must be aware of will be discussed, as well as patient assessment and selection for office-based opiate dependence treatment, clinical management, confidentiality, and office management issues.

The Drug Addiction Act of 2000, Public Law 106-310, provides a waiver from the requirements of the Narcotic Addict Treatment Act and permits qualified physicians to dispense (including prescribe) schedule III, IV, or V narcotic drugs or combinations of such drugs approved by the FDA for the treatment of a heroin addiction. A physician is deemed qualified if he/she completes not less than eight hours of training provided by selected organizations, including APA, or currently holds subspecialty certification in addiction psychiatry, or is certified in addiction medicine by the American Society of Addiction Medicine or the American Osteopathic Association. **Participation in this course enables physicians to meet the federal requirement to complete eight hours of specialized training.**

TARGET AUDIENCE:

Physicians and other clinicians who are interested in learning about office-based prescribing of buprenorphine for the treatment of opioid dependence.

REFERENCES:

1. O'Connor PG, Oliveto A, Shi JM, Triffleman EG, Carroll KM, Kosten TR, Rounsaville BJ, Pakes JA, Schottenfield RS: A randomized trial of buprenorphine maintenance for heroin dependence in a primary care clinic for substance users versus a methadone clinic. American Journal of Medicine 1998; 105:100–105.
2. Rounsaville BJ, Kosten TR: Treatment of opioid dependence: quality and access. JAMA 2000; 283(10):1337–1339.

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

BUILD YOUR OWN RELATIONAL DATABASE ELECTRONIC MEDICAL RECORD

Daniel A. Deutschman, M.D., *Department of Psychiatry, Case Western Reserve University, 18051 Jefferson Park Road, Middleburg Heights, OH 44130*

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, the participant should be able to: 1) build a basic electronic medical record (EMR) for use with their patients to capture medication data; 2) understand the value of EMRs in providing quality of care and office efficiency; 3) obtain assistance in further development of EMRs; and 4) recognize the added value of having the psychiatrist as the programmer.

SUMMARY:

This course, designed for clinicians at all levels of computer sophistication, will enable clinicians to understand the essential design and structure of EMRs. Clinicians will at the conclusion of the course be in a position to begin to build such systems for use with their own patients to capture medication data. Clinicians will learn the role of fields, primary keys, tables, normalization of tables, table relationships, queries, click lists, data entry forms, and reports. There will be discussion of automatic data entry using look-up tables and value lists. These will serve as the source for medication names, doses, directions, etc. Medication trial reports will be demonstrated. The format will be interactive and practice oriented with an opportunity for questions and answers. When clinicians take the time to program the software, they will be in a position to continually upgrade and strengthen the system as they grow in experience and sophistication. EMRs enhance quality and thereby have the potential to significantly enhance public health. They speed data entry, improve office efficiency, improve productivity, and pay for themselves many times over.

TARGET AUDIENCE:

Practicing, research, and administrative psychiatrists/ administrators.

REFERENCES:

1. McDonald CJ: The barriers to electronic medical record systems and how to overcome them. Journal of the American Medical Informatics Assoc 1997; 4:213–221.
2. Tang PC, LaRosa MP, Gorden SM: Use of computer-based records, completeness of documentation and appropriateness of documented clinical decisions. Journal of the American Medical Informatics Association 1999; 6:245–251.

Course 14 **Saturday, October 13**
1:00 p.m.-5:00 p.m.

HOW TO MEASURE OUTCOMES WITHOUT BREAKING THE BANK

Gabriel Kaplan, M.D., Chairman, *Department of Psychiatry, Franciscan Health, 25 McWilliams Place, Suite 606, Jersey City, NJ 07302-0000*; James R. Westphal, M.D., *1001 Potrero, Suite 7M8, San Francisco, CA 94110-0852*

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

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

TARGET AUDIENCE:

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

REFERENCES:

1. Hunkeler EM, Westphal JR, Williams M: Computer assisted patient evaluation systems: advice from the trenches. Behavior Health Tomorrow 1996; 5:73–75.
2. Micklitsch CN, Ryan-Mitlying AR: Physician performance for survival and success. Medical Group Management Association, COR Healthcare Resources, November 1997.

Debate 1 **Thursday, October 11**
1:30 p.m.-3:00 p.m.

PRESIDENT-ELECT CANDIDATES, APA BOARD OF TRUSTEES

Candidates for President-Elect, APA Board of Trustees, in the year 2002 will debate issues of interest to the membership and to psychiatry in general. Attendees will gain first-hand knowledge of each candidate's platform and agenda prior to the election of APA officers.

Debate 2 **Friday, October 12**
1:30 p.m.-3:00 p.m.

RESOLVED: FAITH-BASED MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES SHOULD HAVE LIBERALIZED ACCESS TO FEDERAL FUNDING

American Association of Community Psychiatrists

Andrés J. Pumariega, M.D., *Professor and Director, Child and Adolescent Psychiatry, James H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70567, Hillrise Hall, Johnson City, TN 37614-9567*; Anita S. Everett, M.D., *Inspector General, Virginia Department of Mental Health and Mental Retardation and Substance Abuse Services, 37 Canterbury Road, Charlottesville, VA 22903*; David A. Pollack, M.D., *Associate Professor of Psychiatry, and Associate Director, Public Psychiatry Training Program, Oregon Health Sciences University, 3181 S.W. Sam Jackson Park Road, Portland, OR 97201*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the policy ramifications involved in President Bush's initiatives; understand the role that psychiatrists could play as experts in the guidance of policy development.

AFFIRMATIVE SUMMARY:

In January 2001, President Bush announced an initiative to reduce barriers to federal funding for faith-based communities. This has resulted in a national debate. President Bush asserts that: "The indispensable and transforming work of faith-based and other charitable service groups must be encouraged. Government cannot be replaced by charities, but it can and should welcome them as partners." According to a recent survey conducted by the Pew Forum on Religion and Public Life, the majority of Americans support increased access to federal funding for social services provided by faith-based communities. A common goal of community mental health is the promotion of successful integration in a natural community setting. This initiative presents a wonderful opportunity to enhance natural community supports for the persons served by our professions. Perhaps even more important is the opportunity for increased access for those who are currently not able to be served due to inadequate resources in our public mental health service systems. It should become our role as professionals to assert that our expertise regarding principles of empiric evidence-based medicine and demonstrated best practices be applied to any program development or new initiatives, regardless of who provides the actual services.

NEGATIVE SUMMARY:

The question of whether to provide federal funds to faith-based organizations, which use religious activities as part of their therapeutic methodology, raises serious concerns, which relate to the constitutional protections associated with the separation of church and state. These concerns can be reduced to four main questions:

1) Would protecting faith-based providers from having to "compromise their religious character" lead to unfair advantage in relation to other competitors for grants? Without scientific support for faith-based treatment effectiveness, how can we allow government funds to be used without specific clinical standards?

2) How do we protect the rights of witting or unwitting patients who might object to being required to participate in religiously oriented clinical services. How do we prevent inappropriate proselytization?

3) What happens to the rights of the current or potential employees when faith-based organizations discriminate in hiring or firing on the basis of demanding that employees adhere to the tenets of a particular religion?

4) When we allow faith-based treatments to be supported by government funds, how do we determine which religions are acceptable and which ones are antithetical to the government's clinical and "moral" principles?

These questions cannot be satisfactorily resolved to assure that serious constitutional violations would not be committed.

REFERENCES:

1. NPR Transcript April 10, 2001, from "All Things Considered."
2. Speech by President Bush: January 30, 2001. (Transcript available at *www.whitehouse.gov/news/reports/faithbased.html*).
3. NY Times.com article: Faith-Based Discrimination: The Case of Alicia Pedreira.

Full-Day Session 1 **Thursday, October 11**
8:30 a.m.-5:00 p.m.

DAVANLOO'S INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY IN CLINICAL PRACTICE

James Q. Schubmehl, M.D., *Clinical Associate Professor of Psychiatry, University of Rochester, 2541 Monroe Avenue, #B-7, Rochester, NY 14618-3123*; Alan R. Beeber, M.D.; Deborah Lebeaux, M.S.W.; Tewfik Said, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: describe main elements of Davanloo's technique, and should find many aspects of the presentation useful to his/her own clinical practice.

SUMMARY:

Highly resistant, poorly motivated patients are a major challenge to every clinician, especially when the clinical picture includes a complex mixture of character pathology and symptom disturbances. Davanloo's intensive short-term dynamic psychotherapy has shown rapid effectiveness with difficult-to-treat conditions, including functional disorders, depression, panic, and other anxiety disorders. This workshop, for those who practice or make referrals to psychotherapy, will demonstrate the range of applications of this technique, with specific technical interventions for particular conditions. There will be extensive use of videotapes to demonstrate the innovative techniques and metapsychology underlying the activation of the therapeutic alliance even with hard-to-engage patients. As well, the catalytic role of the "unlocking of the unconscious" in freeing the patient from the destructive forces of the punitive superego will be clearly shown. There will be periodic blocks of time for discussion. The session will provide participants with an overview of this uniquely powerful way of understanding human psychic functioning. It will further demonstrate how these techniques are used to help individuals free themselves from the crippling effects of their psychopathology.

TARGET AUDIENCE:

All clinicians who work with nonpsychotic people.

REFERENCES:

1. Davanloo H: Unlocking the Unconscious. West Sussex, England, John Wiley and Sons Ltd., 1990.
2. Beeber A: The perpetrator of the unconscious in Davanloo's new metapsychology, parts I–III. International Journal of Intensive Short-Term Dynamic Psychotherapy 1999; 13:151–189.
3. Lebeaux D: The rise in the transference in Davanloo's intensive short-term dynamic psychotherapy: principles, technique and issues for training. International Journal of Intensive Short-Term Dynamic Psychotherapy 1999; 13:3–16.
4. Said T: Current status of criteria for selection for patients for short-term dynamic psychotherapy. International Journal of Short-Term Psychotherapy 1996; 11:99–127.
5. Schubmehl JQ: Technique and metapsychology of the early working through phase of Davanloo's intensive short-term dynamic psychotherapy. International Journal of Short-Term Psychotherapy 1996; 11:225–251.

Full-Day Session 2 **Friday, October 12**
8:30 a.m.-5:00 p.m.

TREATMENT AND CARE IN THE THIRD DECADE OF AIDS

APA AIDS Education Project and Columbia University HIV Mental Health Training Project

Marshall Forstein, M.D., *Medical Director, HIV/Mental Health and Addiction Services, Department of Psychiatry, Fenway Community Health Center, and Assistant Professor of Clinical Psychiatry, Harvard University, 24 Olmstead Street, Jamaica Plain, MA 02130*; Francine Cournos, M.D.; Meg Kaplan, Ph.D.; Richard Herman, M.A.; Milton L. Wainberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this training, participants are expected to be able to: be familiar with the most recent HIV medical developments and treatments; recognize the psychiatric and psychosocial dimensions of HIV disease; understand the skills that can help patients reduce their risk behaviors for HIV infection; identify patient issues related to substance use, pain, and sleep.

SUMMARY:

HIV continues to spread at alarming rates throughout the world, having already claimed more than 16 million lives. While great strides have been made in understanding the natural history of the disease, much is still unknown, and treatments remain complex and unavailable to more than 95% of those infected throughout the world. Rates of infections continue to rise in the young, sexually active population, for injecting drug users, and among people of color. Those most vulnerable in our society—because of mental illness, poverty, homelessness, and substance abuse—increasingly bear the burden of HIV.

HIV both causes and exacerbates psychiatric disorders, affecting clinical assessment and treatment throughout the spectrum of psychiatric patients. This

symposium will focus on information that psychiatrists and other mental health professionals can use to more effectively address current and future HIV mental health challenges. Faculty will present updated information on new diagnostic tools and treatments, clinical assessment and treatment of neuropsychiatric disorders, psychosocial issues, risk-reduction strategies, and the complex relationships between substance use, pain, sleep, and adherence. Clinical cases and discussion with the audience will allow for exploration of those issues most pressing to participants.

REFERENCES:

1. American Psychiatric Association: Practice Guideline for the Treatment of Patients with HIV/AIDS. Washington, DC, APA 2000.
2. Cournos F, Forstein M (eds.): New Directions for Mental Health Services: What Mental Health Practitioners Need to Know About HIV and AIDS. American Journal of Psychiatry 2000 Fall;(87).
3. Krebs FC, Ross H, McAllister J, Wigdahl B: HIV-1-associated central nervous system dysfunction. Adv Pharmacol. 2000;49:315–85.
4. LoPiccolo CJ, Goodkin K: The role of precise conceptualization in the treatment of a complicated HIV-1-infected neuropsychiatric patient. J Neuropsychiatry Clin Neurosci 1999;11:234–40.

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

AVOIDING MEDICAL MORBIDITIES IN THE PATHWAY OF CARE FOR SCHIZOPHRENIA

Supported by AstraZeneca Pharmaceuticals

Henry A. Nasrallah, M.D., *Professor of Psychiatry and Neurology, University of Mississippi Medical Center, 1500 East Woodrow Wilson Drive, Jackson, MS 39216*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize several medical morbidities that may occur secondary to antipsychotic pharmacotheraphy including neurological, neuroendocrine metabolic, and cardiovascular syndromes.

SUMMARY:

Persons suffering from schizophrenia are often significantly disabled by this brain disease socially and vocationally. In addition, schizophrenia has been shown to have higher morbidity and mortality compared with non-psychiatric matched controls. While some of the morbidities that afflict schizophrenic patients are possibly co-morbid medical conditions (e.g. diabetes), the result of unhealthy lifestyle (e.g. smoking) or self-neglect, other medical morbidities have been linked to the pharmacotherapeutic interventions. Antipsychotic medications are a vital and indispensable component of managing psychotic and other psychopathological domains of schizophrenia, especially the second generation of atypical antipsychotics, which have improved the clinical and functional outcomes of schizophrenia. However, while the new generation antipsychotics have better tolerability, some of them may induce or exacerbate certain medical morbidities in persons with schizophrenia.

In this symposium, several medical disorders (neurologic, neuroendocrine, cardiovascular, and metabolic) that may emerge in the course of antipsychotic pharmacotherapy, will be discussed. Dr. Tandon will start by describing iatrogenic neurological disorders both acute and delayed, followed by Dr. Cutler who will review the spectrum of neuroendocrine complications of some antipsychotics. Dr. Perkins will then discuss the multiple medical complications of obesity and dyslipidemias that may occur with the maintenance therapy of some medications. Finally, Dr. Nasrallah will describe hyperglycemia, type II diabetes mellitus, and acute ketoacidosis that have recently been observed and reported with some atypical antipsychotics. All speakers will focus on ways to minimize or prevent the occurrence of these medical morbidities in the path of care for schizophrenia.

TARGET AUDIENCE(S):

Psychiatrists, neurologists, primary care physicians, nurses, pharmacists, physician assistants, case managers.

No. 1A
ANTIPSYCHOTIC TREATMENT AND NEUROLOGIC HEALTH: EPS, TD, AND COGNITION

Rajiv Tandon, M.D., *Professor of Psychiatry, and Director, Schizophrenia Program, University of Michigan Medical Center, 1500 East Medical Center Drive, UH 9C-9150, Ann Arbor, MI 48109*

SUMMARY:

Schizophrenia is characterized by significant cognitive dysfunction and "soft" neurological deficits, which contribute significantly to the debilitation of the illness. While conventional antipsychotic medications are effective in reducing psychopathology, they are relatively ineffective in ameliorating neuropsychological deficits and their use is associated with a whole range of neurological adverse effects that compromise quality of life. Extrapyramidal side effects (EPS) and the risk of tardive dyskinesia (TD) are two important adverse effects associated with conventional antipsychotic treatment. Atypical antipsychotics are significantly better than conventional antipsychotics with regard to these side effects. By definition, all atypical antipsychotics are associated with a lower risk of EPS than conventional antipsychotics; there are, however, individual differences between different atypical antipsychotics with regard to this EPS advantage. This EPS advantage of atypical antipsychotics translates into several important "secondary" benefits, including better negative symptom efficacy, lesser dysphoria, less impaired cognition, and a lower risk of TD. Atypical antipsychotics are consistently found to be more beneficial than conventional agents in improving cognitive function in psychotic patients. The nature of neurological dysfunction in schizophrenia and its impact on the course of illness will be discussed. Differences between conventional and atypical antipsychotics and between different atypical antipsychotics with regard to impact on cognitive function and neurological side-effect profiles will be reviewed. Clinical implications of these differences will be summarized.

No. 1B
IMPACT OF ANTIPSYCHOTICS ON THE NEUROENDOCRINE SYSTEM: SEXUAL ISSUES AND SCHIZOPHRENIA

Peter J. Weiden, M.D., *Professor of Psychiatry, State University of New York Health Sciences Center at Brook-*

lyn, 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11201

SUMMARY:

The goal of this presentation is to discuss the evaluation of sexuality in schizophrenia, with particular attention to how to distinguish sexual difficulties that are a direct result of the illness with those that are induced by public health treatment. The topic of sexuality and sexual functioning in schizophrenia has been relatively neglected in research, but is of considerable interest to our patients. For example, satisfaction surveys show that schizophrenia patients frequently report that their antipsychotics are causing sexual dysfunction, and, not surprisingly, that they are very distressed by this. Further, as patients regain their lives more often nowadays because of the newer medications, clinicians will have to be able to respond to the concerns about the impact of antipsychotics on sexuality.

The neurobiology of normal sexual functioning is a prerequisite to better understanding of sexual issues in schizophrenia. Normal sexual functioning has been divided into desire, arousal, and orgasm. Some of the neurotransmitter and neuroendocrine pathways identified in these responses are affected by schizophrenia, or are disrupted by pharmacologic treatment of schizophrenia. The most salient pathways are dopamine, serotonin, and prolactin. This presentation will review the mechanism of action of dopamine, serotonin, and prolactin on normal sexual functioning and review the literature on the clinical effects of disrupting these systems. Then, these disruptions will be discussed in the context of the diagnosis of schizophrenia, the different antipsychotic medications, and the types of presentations of sexual problems often seen in patients with schizophrenia.

No. 1C
THE LINK BETWEEN OBESITY, DYSLIPIDEMIA, AND ATYPICAL ANTIPSYCHOTIC TREATMENT

Diana O. Perkins, M.D., *Associate Professor, Department of Psychiatry, University of North Carolina, Chapel Hill, CB7160, Neurosciences Hospital, Chapel Hill, NC 27599*

SUMMARY:

The atypical antipsychotic medications, including risperidone, olanzapine, quetiapine, and clozapine offer important advantages over older antipsychotic medications, particularly improved effectiveness and a decreased liability to extrapyramidal side effects. Weight gain, however, has emerged as a troublesome and potentially serious side effect of the atypical antipsychotics, with clozapine and olanzapine apparently having the greatest weight gain liability. In addition, alterations in lipid metabolism, especially serum triglyceride levels, have recently been reported with clozapine and olanzapine. Weight gain and lipid abnormalities are associated with health risks (e.g., heart disease, joint disease, sleep apnea), and weight gain may impact on a patient's quality of life and willingness to take antipsychotics. The presentation will summarize the impact of atypical antipsychotics on weight change and serum lipid profiles, and the potential health consequences of these side effects. The potential mechanism that may underlie antipsychotic-related weight gain is reviewed. Finally, nonpharmacological and pharmacological interventions to minimize weight gain and adverse effects on lipid metabolism will be briefly discussed.

No. 1D
ANTIPSYCHOTIC-INDUCED HYPERGLYCEMIA AND DIABETES

Henry A. Nasrallah, M.D., *Professor of Psychiatry and Neurology, University of Mississippi Medical Center, 1500 East Woodrow Wilson Drive, Jackson, MS 39216*

SUMMARY:

There is substantial evidence that patients with schizophrenia are at high risk for diabetes and that some of the older conventional antipsychotics as well as some of the new atypical antipsychotics may exacerbate preexisting diabetes in schizophrenia or may induce new cases (Nasrallah et al, 2000). The introduction of chlorpromazine in the 1950s was reported to increase the prevalence of diabetes from 4.2% to 17.2% (Thornard-Neumann, 1968). With the widespread use of atypical antipsychotics in the 1990s, many researchers have reported a high incidence of new cases of diabetes with clozapine and olanzapine, and to a much lesser degree in risperidone and quetiapine (Wirshing et al., 1998). Some of the cases of type II diabetes are associated with weight gain and obesity (which are higher with clozapine and olanzapine than other atypical antipsychotics). However, there are many cases of diabetes, and even acute ketoacidosis, that are emerging in patients in the early stages of olanzapine or clozapine treatment and who had not yet gained any significant amount of weight.

Further, conversion of patients from normoglycemia to hyperglycemia in about 40% of clozapine patients and 20% of olanzapine patients has been reported (Casey et al., 2000). It is thus vital that the management of schizophrenia patients receiving antipychotic medications include pre-identification of high-risk patients by (1) screening patients prior to selection of an antipsychotic for a personal history or a first-degree family history of diabetes, which significantly increases risk for antipsychotic-induced diabetic exacerbation;

(2) measuring the patient's weight for obesity (≥ 120% ideal body weight or ≥ 27 kg/m^2 BMI; (3) exercising caution in treating high-risk ethnic populations (African Americans, Native Americans, and Hispanic Americans); (4) identifying a past diagnosis of gestational diabetes in female patients; (5) conducting weekly FBS measures in all at-risk patients, especially those receiving olanzapine and clozapine; (6) alerting the patients and staff for early symptoms of diabetes in schizophrenic patients receiving atypical antipsychotics.

REFERENCES:

1. Tandon R, Milner K, Jibson M: Antipsychotics from theory to practice: Integrating clinical and basic data. Journal of Clinical Psychiatry 1999; 60 [Suppl 8]: 21–28.
2. Meston C, Frohlich P: The neurobiology of sexual functioning. Arch Gen Psychiatry 2000;57: 1012–1030.
3. Weiden P, Mackell J: Differing side effect burdens between newer and older antipsychotic medications. Presented to NCDEU, Boca Raton, FL, June, 1999.
4. Devlin MJ, Ynaovski SZ, Wilson GT: Obesity: what mental health professionals need to know. Am J Psychiatry 2000;157:854–866.
5. Allison DB, Mentore JL, Heo M, Chandler LP, et al: Antipsychotic-induced weight gain: a comprehensive research synthesis. Am J Psychiatry 1999; 156(11):1686–1696.
6. Goldstein LE, et al: New-onset diabetes mellitus and diabetic ketoacidosis associated with olanzapine treatment. Psychosomatics 1999; 40: 438–443.
7. Schultz SK, et al: Impaired glucose tolerance and abnormal movements in patients with schizophrenia. Am J Psychiat 1999; 156: 640–642.

Industry-Supported Symposium 2 **Wednesday, October 10 6:30 p.m.-9:30 p.m.**

RAISING EXPECTATIONS IN SCHIZOPHRENIA: ENHANCING LONG-TERM OUTCOMES

Supported by Pfizer Inc.

Daniel E. Casey, M.D., *Chief, Psychiatric Research and Psychopharmacology, VA Medical Center, Portland, 3710 S.W. US Veterans Hospital Road, Portland, OR 97201*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify risk factors for the onset of psychosis, understand new treatment options for acute psychosis, recognize the role atypical antipsychotics play in improving patient's quality of life, compare and contrast the side-effect profiles between typical and atypical antipsychotics.

SUMMARY:

Schizophrenia is a lifelong illness for most patients, with the prognosis being poor. The traditional neuroleptics provide only partial symptomatic control and add a substantial burden of side effects. The novel or atypical antipsychotics, which are quickly replacing the conventional antipsychotics, have provided advantages in symptom control and are much better tolerated medicines. Although these advancements have led to a higher quality of life for patients, there are still questions regarding differential efficacy and side-effect profiles. Therefore, it is necessary to review new findings in the field of managing psychosis with these atypical antipsychotic agents. Dr. Alan J. Mendelowitz will discuss the importance of recognizing prodromal symptoms of psychosis and assessing risk factors for onset of psychosis, as well as the outcome of treatment in the first psychotic episode and implications for further care. Dr. Rajiv Tandon will review new treatment options and considerations for managing acute psychosis. Atypical agents offer the potential to use fewer drug combinations and increase the control of acute psychotic symptoms. He will also discuss maximizing the therapeutic benefits of the new antipsychotics across the spectrum of psychotic, affective, and cognitive symptoms. Dr. Daniel E. Casey will review how the atypical antipsychotics greatly improve the benefit/risk ratio by decreasing side effects and increasing efficacy. Overall, this symposium will address how atypical antipsychotics can raise the standard of care by helping patients to become more productive members of society.

TARGET AUDIENCE(S):

Mental health professionals.

No. 2A
THE IMPORTANCE OF EARLY INTERVENTION IN SCHIZOPHRENIA

Alan J. Mendelowitz, M.D., *Unit Chief for Psychiatric Services, Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004*

SUMMARY:

Psychotic disorders are unique and include a wide spectrum of psychotic, affective, and cognitive symptoms. Recently, there has been an increasing focus on the early stages of schizophrenia. It has been known for many years that many patients suffering from psychosis may exhibit certain prodromal symptoms. These symptoms are subtle but may aid physicians in the early detection of schizophrenia. Early detection of patients

with schizophrenia will allow for earlier treatment interventions. It is hoped that intervening in the illness at an early time period will allow for improving the long-term outcome of this devastating illness. This presentation will discuss new strategies for the identification of prodromal symptoms and review data that indicate that the use of second-generation antipsychotics are the treatment of choice at the early stage of the illness. The presentation will also review some of the current research aimed at early intervention as well as preventing and reducing the severity of psychosis.

No. 2B
BRIDGING THE GAP: FROM ACUTE PSYCHOSIS TO IMPROVING FUNCTIONAL OUTCOMES

Rajiv Tandon, M.D., *Professor of Psychiatry, and Director, Schizophrenia Program, University of Michigan Medical Center, 1500 East Medical Center Drive, UH 9C-9150, Ann Arbor, MI 48109*

SUMMARY:

The treatment of acute psychotic episodes continues to remain a challenge and although management strategies are different among clinicians, the overall goal is the same. For example, the treatment of psychosis is an urgent situation that must be handled quickly and safely. Assessment of the patient must be conducted immediately in order to minimize danger to the patient as well as to the staff. Physicians must make timely decisions on the best treatment for the patient. Current options include utilization of conventional antipsychotics, such as haloperidol, or the utilization of benzodiazapines, such as lorazapam. In this presentation, we will discuss the role of intramuscular formulation (IM) treatment in the clinical setting. In addition, the treatment of the spectrum of nonpsychotic symptoms of schizophrenia will be examined, including negative, cognitive, and depressive symptoms. The atypical antipsychotics are capable of treating these dimensions of psychotic illness. Although the atypical antipsychotics share many clinical attributes, their different pharmacological profiles will be considered.

No. 2C
IMPROVING HEALTHY OUTCOMES WITH ATYPICAL ANTIPSYCHOTICS: FOCUSING ON CARDIOVASCULAR ISSUES

Daniel E. Casey, M.D., *Chief, Psychiatric Research and Psychopharmacology, VA Medical Center, Portland, 3710 S.W. US Veterans Hospital Road, Portland, OR 97201*

SUMMARY:

Until recently the traditional or typical neuroleptics have been the mainstay of treating acute and chronic psychosis. However, these drugs have limited efficacy, particularly in the domains of negative symptoms and affective disturbances. Also, a wide range of adverse effects imposed additional physical burdens on patients who were trying to overcome the impairments induced by psychosis. The new atypical antipsychotics have greatly improved the benefit/risk ratio by enhancing efficacy and substantially reducing the side-effect liabilities. Recent studies with the new agents have shown improvement in negative and depressive symptoms associated with acute psychosis as well as a decrease in suicide. In terms of adverse effects, most of the atypical drugs have eliminated the troublesome acute extrapyramidal syndromes so that akathisia, dystonia, and parkinsonism occur at rates that are not significantly different from placebo. New data also indicate that the vexing problem of tardive dyskinesia may be greatly reduced or eliminated by using the atypical agents. Similarly, most atypical antipsychotics do not raise prolactin, leading to restoration of normal endocrine and sexual function. However, weight gain with some of the atypical drugs is of growing concern as this increases the risk of comorbid medical illnesses such as diabetes and cardiovascular diseases. Recent long-term studies support the concept of an enhanced benefit/risk ratio with lower relapse rates. This is due, at least in part, to improved compliance with better medications. Overall the atypical antipsychotic medications have greatly improved the chances for patients to more fully achieve their potential for healthy outcomes in everyday life and reduce the stigma of serious mental illness.

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Industry-Supported Symposium 3 **Thursday, October 11 12 noon-1:30 p.m.**

RECONCEPTUALIZING BIPOLAR DISORDER IN 2001

Supported by GlaxoSmithKline

Robert M.A. Hirschfeld, M.D., *Department of Psychiatry, University of Texas Medical Branch, 301 University Boulevard, Galveston, TX 77555-0188*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have a better understanding of the medical management of bipolar disorders in children and adolescents.

SUMMARY:

To date, educational activities on bipolar disorder have focused on bipolar I disorder and on the acute treatment of mania. This symposium will discuss the need to reconceptualize the treatment for bipolar disorder. It will first overview bipolar spectrum disorders, in which there are abnormalities of mood regulation and destructive mood swings. Bipolar spectrum disorders are often unrecognized and misdiagnosed; most cases initially present as depression. Clinicians must be aware that treatment of bipolar depression differs substantially from that of unipolar depression.

Next, symposium faculty will propose a paradigm shift in the management of bipolar disorder in which mania is treated with agents that stabilize mood from "above" baseline and depression is treated with agents that stabilize mood from "below" baseline, and without causing switches into mania or cycle acceleration. The most recent data on recognition of the condition and diagnostic aid tools, as well as treatment of bipolar depression, including detailed strategies for its management, will be presented.

Finally, bipolar disorder often starts in childhood and adolescence. However, young children often show less discrete episodes of mania or depression than youth. Relatively little is known about the prevalence and treatment of this condition in younger age groups. It may often be mistaken for attention deficient hyperactivity disorder, conduct disorder, and other problems of childhood and adolescence. This symposium will provide an update on current knowledge on the diagnosis and treatment of bipolar disorder in children and adolescents, including its recognition. The current status of pharmacotherapy of bipolar disorder in this younger age group will be presented and medication strategies will be discussed.

TARGET AUDIENCE(S):

Psychiatrists, psychologists.

No. 3A
DIAGNOSIS OF BIPOLAR SPECTRUM DISORDER

Robert M.A. Hirschfeld, M.D., *Department of Psychiatry, University of Texas Medical Branch, 301 University Boulevard, Galveston, TX 77555-0188*

SUMMARY:

In the minds of many clinicians, bipolar disorder is synonymous with bipolar I disorder (requiring episodes of mania), with a lifetime prevalence of 1% in the general population. In fact, bipolar spectrum disorder includes a range of disorders, from bipolar I to bipolar II (hypomanic, but not manic episodes), cyclothymia, and hyperthymic temperament. The population prevalence of bipolar spectrum disorder approaches 5% of the general population. Because bipolar spectrum disorder usually presents to the clinician as depression, it is often misdiagnosed as unipolar depression. This can have serious adverse consequences if traditional antidepressant treatment is utilized. This presentation will overview the recognition and diagnosis of bipolar spectrum disorder, and will present ways to screen for it.

No. 3B
RECONCEPTUALIZING THE TREATMENT OF BIPOLAR DISORDER

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

SUMMARY:

There exists a need to reconceptualize the treatment of bipolar disorder. The most commonly used medications during hospitalization (divalproex, lithium, and the atypical antipsychotic medications) tend to stabilize mood from "above" baseline. These medications have primarily been developed for use in the treatment of mania and psychosis. The most commonly used medications in the outpatient setting tend to be antidepressants and placebo-controlled data suggest some of these medications destabilize mood; this is especially so in rapid cycling. Several large datasets now suggest that depressive symptoms are more common than hypomanic/manic symptoms in outpatient settings. Antidepressants have primarily been developed for use in the treatment of unipolar depression, but very little placebo-controlled data exist to inform their use in bipolar depression. We propose a paradigm shift in the outpatient management

of bipolar disorder. There is reason to believe that medications should be developed for use in the outpatient setting that possess the capacity to stabilize mood from "below" baseline and without causing switches into mania or cycle induction. A clear and substantial unmet need exists in this area. This presentation will review novel treatment for patients presenting with bipolar depression and/or rapid cycling bipolar disorder with special emphasis on their ability to stabilize mood from "below" baseline.

No. 3C
DIAGNOSIS AND TREATMENT OF BIPOLAR DISORDER IN CHILDREN AND ADOLESCENTS

Karen D. Wagner, M.D., *Division of Child and Adolescent Psychiatry, University of Texas, 301 University Boulevard, Galveston, TX 77555*

SUMMARY:

Bipolar disorder in youth is diagnosed by using DSM-IV criteria. However, young children often show less discrete episodes of mania or depression than youth. They tend to be irritable across episodes and emotionally labile. Bipolar disorder in children and adolescents is a serious disorder and has a significant adverse impact on a child's social, academic, and family functioning. There is a high rate of relapse and risk for suicide with this disorder in youth. It is essential to identify effective treatments for childhood bipolar disorder. Currently, there are little controlled data available regarding the efficacy and safety of medications for treatment of this disorder in youth. Mood stabilizers remain the mainstay of treatment, although there is increasing interest in the newer anticonvulsant medications and antipsychotic medications for the treatment of this disorder. The current status of pharmacotherapy of bipolar disorder in children and adolescents will be presented and medication strategies will be discussed.

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Industry-Supported Symposium 4 **Thursday, October 11 12 noon-1:30 p.m.**

REALITY CHECK: REAL WORLD CONSIDERATIONS IN THE TREATMENT OF MOOD AND ANXIETY DISORDERS

Supported by Pfizer Inc.

Martin B. Keller, M.D., *Mary E. Zucker Professor and Chairman, Department of Psychiatry and Human Behavior, Brown University and Butler Hospital, 700 Butler Drive, Providence RI 02906*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the importance of recognizing comorbid depression and anxiety disorders and identify treatment implications, review the clinical pharmacology of antidepressants and how this may affect antidepressant selection, discuss the limitations and applications of treatment outcome studies.

SUMMARY:

Though effective pharmacotherapy treatments are readily available, mood and anxiety disorders continue to be underdiagnosed and undertreated. This may be the result of incorrect diagnosis, incomplete diagnosis, or inadequate treatment regimens, as these disorders rarely exist in isolation. Clinicians must be able to look beyond immediate symptom relief and identify the proper course of treatment for each patient. This symposium will examine the use of antidepressants in primary care and psychiatry and how patients present in a clinical setting as compared with controlled trials. Real-world treatment considerations for mood and anxiety disorders will be reviewed as well as the importance of appropriate antidepressant selection. This symposium will begin with a presentation on comorbid mood and anxiety symptoms, specifically, the effects of panic-agoraphobic spectrum symptoms on course and outcome in mood disorders. The next presentation will review the impact of pharmacology on antidepressant selection and the importance of selecting the appropriate antidepressant to improve clinical outcomes. This symposium will conclude with a presentation on the impact of outcomes studies on the treatment of mood and anxiety disorders and the clues they may provide for future treatment recommendations.

TARGET AUDIENCE(S):

Psychiatrists.

No. 4A
EFFECT OF PANIC-AGORAPHOBIC SPECTRUM ON MOOD DISORDERS TREATMENT

M. Katherine Shear, M.D., *Director, Anxiety Disorders Prevention, University of Pittsburgh, 100 North Bellfield Avenue, Room 768, Pittsburgh, PA 15213*

SUMMARY:

Method: Panic disorder is a negative predictor of course and outcome in mood disorders. We present data from the literature and from several studies documenting this. In addition, a self-report measure of panic agoraphobic spectrum was administered to women participating in a study of recurrent depression, and to patients in a study of bipolar disorder. Effects of PAS on symptoms and treatment outcome were assessed by comparing patients with and without criterion-level spectrum symptoms.

Results: Panic disorder is a negative predictor of outcome in the treatment of depression. Panic-agoraphobic spectrum symptoms are more common than panic disorder and are stronger predictors of severity and poorer outcome. This is true for bipolar as well.

Conclusion: Both panic disorder and panic-agoraphobic spectrum are prevalent in unipolar and bipolar depression. Those with PAS symptoms had a higher risk of suicidality and required more than six months longer to respond to treatment. Knowledge of patients' lifetime panic spectrum status can aid the clinician in treatment planning and in the optimal monitoring of patients' course of illness.

No. 4B
THE ANTIDEPRESSANT SELECTION PROCESS

Sheldon H. Preskorn, M.D., *Psychiatric Research Institute, University of Kansas, 1100 North St. Francis, Suite 200, Wichita, KS 67214*

SUMMARY:

Despite significant advances in treatment choice, the use of antidepressants in clinical practice remains far from optimal. Initial antidepressant selection is the most immediate influential way to improve clinical outcomes. Improving outcomes for patients with depression and/or anxiety disorders involves selecting the best possible drug therapy for each individual patient. Considerations relevant to antidepressant selection include pharmacokinetic issues, pharmacodynamic drug-drug interactions, and drug metabolism-related drug interaction. This presentation will review the clinical pharmacology of the available antidepressants to assist clinicians in anticipating and predicting the effects of different antidepressants on patients. This discussion will include choosing a specific antidepressant for the patient who has not benefited from a trial of a specific type of antidepressant, either because of inadequate effect or treatment-limiting adverse effects; and avoiding adverse drug interactions when choosing an antidepressant.

No. 4C
THE REAL WORLD SIGNIFICANCE OF TREATMENT OUTCOME STUDIES

Peter P. Roy-Byrne, M.D., *Chief of Psychiatry, Harborview Medical Center, 325 9th Avenue, Suite 359911, Seattle, WA 98104*

SUMMARY:

Because untreated mood and anxiety disorders can cause severe social and economic consequences due to absenteeism, lost worker productivity, and overutilization of health care services, it is generally important for clinicians to be able to recognize and appropriately treat these serious conditions. However, in order to appreciate the implications of a given study for the treatment and long-term prognosis of the patients seen in their day-to-day practice, clinicians need an understanding of the different kinds of treatment outcome studies and their limitations (i.e., efficacy versus effectiveness), the implications of type of outcome measured for various stakeholders (patient, clinician, employer, insurer, "society"), and appreciation of the importance of patient treatment preference. This presentation will review these concepts in the context of several recent treatment outcome studies.

REFERENCES:

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2. Reich J, Warshaw M, Peterson LG, White K, et al: Comorbidity of panic and major depressive disorder. J Psychiatr Res 1993;27 Suppl 1:23–33.
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Industry-Supported Symposium 5 — **Thursday, October 11 6:00 p.m.-9:00 p.m.**

CONTROVERSY IN PSYCHIATRY: SOLUTIONS FOR RECOVERY AND WELLNESS

Supported by Eli Lilly and Company

Gerald A. Maguire, M.D., *Assistant Clinical Professor of Psychiatry, University of California at Irvine, 101 City Drive, Route 88, Building 3, Orange, CA 92868*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the rational treatment plans for optimizing wellness and maximizing recovery in psychotic and mood disorders.

SUMMARY:

The understanding of the treatment of psychotic and mood disorders is ever expanding. Often, the treatment of psychosis is complicated by comorbid mood disorders. Solutions will be presented outlining rationales in the treatment of psychotic and mood disorders. With emerging treatments, patients are no longer relegated to live sub-standard lifestyles. Treatment is no longer focused on just the mangement of acute symptoms, but on maximizing recovery in an overall wellness model.

TARGET AUDIENCE(S):

Clinicians working in the mental health field.

No. 5A
STRATEGIES FOR RAPID STABILIZATION IN THE ACUTE CARE SETTING

Jay D. Fawver, M.D., *Associate Clinical Professor, Parkview Health Systems, 5220 Wyndemere Court, Fort Wayne, IN 46835*

SUMMARY:

Obtaining a prompt response in the treatment of the acutely agitated patient is ideal treatment. A rapid onset of antipsychotic or antimanic efficacy not only shortens lengths of hospital stays, but also diminishes the likelihood of the patient harming himself/herself and others. This presentation will review current strategies for optimizing the onsets of action of pharmacological tools used for the treatment of acute psychosis and mania. Dosing strategies, combination therapies, and augmen-

tation approaches will be discussed. Available data supporting treatment approaches will be examined, although successful anecdotal strategies will also be reviewed. Additionally, applicable uses of newer formulations of medications will be identified. Case studies will be presented to practically demonstrate the use of these treatment approaches in the inpatient and outpatient settings.

No. 5B
MINIMIZING RELAPSE AND MAXIMIZING RECOVERY

Gerald A. Maguire, M.D., *Assistant Clinical Professor of Psychiatry, University of California at Irvine, 101 City Drive, Route 88, Building 3, Orange, CA 92868*

SUMMARY:

The treatment of mood disorders is often complicated by coexistant mood disorders. Depression is a leading cause of disability among individuals with schizophrenia. It is estimated that over half the patients with schizophrenia attempt suicide and approximately 15% complete suicide. Conventional antipsychotic agents not only do not improve depression in schizophrenia, but they may actually exacerbate the condition. The treatment of schizophrenia, with the availability of the broad-spectrum antipsychotics, allows for improvement not only in the quality of life, but perhaps the quantity of life as well. Data will be presented outlining the optimal treatment strategies at improving comorbid depression in schizophrenia with improved chances of recovery and overall wellness.

No. 5C
NEW APPROACHES IN MANAGING THE MULTIPHASES OF BIPOLAR DISORDER

Lesley M. Arnold, M.D., *University of Cincinnati College of Medicine, 231 Albert Sabin Way, P.O. Box 670559, Cincinnati, OH 45267-0559*

SUMMARY:

Bipolar disorder is characterized by disturbances in mood, cognition, perception, and behavior. Conceptualizations of mood-stabilizing medications have typically focused on the efficacy of these agents in treating acute mood symptoms and preventing mood episodes. However, a growing body of data suggests that there are important clinical differenced among new and established agents used to treat bipolar disorder in the degree to which these agents affect the full gamit of symptoms associated with the illness. For example, patients with mixed episodes appear to have a greater likelihood of response to divalproex and olanzapine than to lithium. In this presentation, we review the scientific evidence supporting the efficacy of lithium, divalproex, olanzapine, carbamazepine, and new antiepileptic and atypical antipsycotic agents in the treatment of the syndromic components of bipolar illness. These data include randomized, double-blind, controlled studies in the treatment of acute mood episodes as well as emerging comparison trials and long-term studies.

No. 5D
ENHANCING WELLNESS IN PSYCHIATRY AND PRIMARY CARE

Ralph Aquila, M.D., *Director, Residential Community Services, Project Renewal, and Department of Psychiatry, St. Luke's/Roosevelt Hospital Center, 167 Upper Mountain Avenue, Montclair, NJ 07042*

SUMMARY:

Over the years, people with serious and persistent mental illness have actually received worse care or worse access to care than the average population. People with a mental illness are three to four times more likely than the general population to have serious medical problems that coexist with their psychological problems. These diseases include hypertension, cardiovascular disease, obesity, diabetes, and hepatitis B and C. Treatment for these patients has tended to focus primarily on the symptoms of their mental disorder rather than their physical well being. Because psychiatrists often are the primary caregiver for patients with mental illness, they must become advocates for basic medical follow-up and patients' overall health and well-being. Additionally, primary care physicians who encounter such patients must pay closer attention to the impact of atypical antipsychotics, as well as address the side-effect profiles. Together, psychiatrists and primary care physicians can help patients with mental illness toward reintegration—toward employment, independent living, and personal fulfillment.

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

INTEGRATED TREATMENT OF BIPOLAR DISORDER

Supported by GlaxoSmithKline

Frederick K. Goodwin, M.D., *Director, Psychopharmacology Research Center, George Washington University Medical Center, 2150 Pennsylvania Avenue, NW, Washington, DC 20037*

EDUCATIONAL OBJECTIVES:

To appraise the data on lithium's role in the treatment of bipolar disorder today, including its impact on suicide, and the role of compliance in its effectiveness.

No. 6A
THE COMPARATIVE EFFICACY OF LITHIUM AND THE ANTICONVOLSANTS

Frederick K. Goodwin, M.D., *Director, Psychopharmacology Research Center, George Washington University Medical Center, 2150 Pennsylvania Avenue, NW, Washington, DC 20037*

SUMMARY:

This presentation will compare the efficacy of lithium to that of the anticonvulsants in acute mania and bipolar depression (generally "breakthrough" depression during maintenance treatment); and as maintenance treatment for the prevention of future episodes. For acute mania, characterized by typical features (euphoria, grandiosity) lithium is generally the treatment of first choice, while anticonvulsants are more effective in mixed states. For bipolar depression there are a number of controlled studies supporting the efficacy of lithium. Among the anticonvulsants, lamotrigine is the only one that has established antidepressant efficacy in placebo-controlled studies. For prevention of recurrent episodes (prophylaxis) lithium is the only agent whose efficacy has been established by placebo-controlled trials. Reasons for the apparent decline in the effectiveness of lithium in recent U.S. studies, as well as reasons why these U.S. data are in sharp contrast to those from most other countries, will be discussed. Finally, evidence for the advantages of drug combinations, particularly lithium combined with anticonvulsants, will be reviewed.

No. 6B
SUICIDE AND PSYCHOLOGICAL ASPECTS IN MANIC-DEPRESSIVE ILLNESS

Kay R. Jamison, Ph.D., *2745 Brandywine Street, NW, Washington, DC 20008*

SUMMARY:

At least 25% to 50% of patients with bipolar manic-depression attempt suicide at least once. With the exception of lithium, which is the most demonstrably effective treatment against suicide, remarkably little is known about specific contributions of mood-altering treatments to minimizing mortality rates in persons with major mood disorders in general and bipolar illness in particular. Suicide is usually a manifestation of severe psychiatric distress that is often associated with a diagnosable and treatable form of depression or other mental illness. In a clinical setting, an assessment of suicidal risk must precede any attempt to treat psychiatric illness. Dr. Jamison will describe psychological aspects of manic-depressive illness. The uses of psychotherapy will be discussed, along with challenges such as medication noncompliance and suicide in bipolar illness.

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

THERAPEUTIC CHALLENGES IN MANAGING DEPRESSION AND ANXIETY

Supported by Wyeth-Ayerst Laboratories

David V. Sheehan, M.D., *3515 East Fletcher Avenue, Tampa, FL 33613-4706*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have an increased understanding of the need to treat anxiety and depression beyond remission to response in patients of all ages and should be able to make more informed decisions about treatment.

No. 7A
ACHIEVING REMISSION IN DEPRESSION AND GAD

David V. Sheehan, M.D., *3515 East Fletcher Avenue, Tampa, FL 33613-4706*

SUMMARY:

Depression and anxiety are frequently comorbid. Untreated generalized anxiety disorder (GAD) may, in fact, lead to depression. The objective of treating both depression and GAD is to complete symptom remission, as well as complete restoration of daily functioning, with as few medication side effects as possible. While various medications are effective for many patients, too often even positive outcomes of pharmacotherapy result in a response, but fall short of remission. Failure to achieve remission results in a poorer long-term prognosis. It is generally held that all FDA-approved antidepressant medications are equally effective in major depressive disorder. Data show, however, that certain patients are more responsive to, and thus more likely to achieve remission with, particular products, e.g., severely ill hospitalized patients may be more responsive to tertiary TCAs than to SSRIs. Older, nonselective MAOIs are more effective for certain outpatients than are TCAs, but not SSRIs. Newer data show that among more recently available antidepressants, only high-dose venlafaxine is more effective than SSRIs. Patients with GAD are less likely to make a satisfactory recovery at six-month, two-year, and five-year follow up than are patients with major depression. Rickels et al., showed in 1993 that imipramine was more effective in GAD than diazepam. Subsequently, antidepressants have increasingly become first-line treatment for GAD. Four short-term and two long-term, double-blind, placebo-controlled studies support the short-term and long-term efficacy of venlafaxine XR in treatment of GAD. Persistence over a long time frame is critical in achieving optimal results.

No. 7B
EFFECTIVE AND EFFICIENT TREATMENT OF COMORBID DEPRESSION AND ANXIETY IN THE ELDERLY

P. Murali Doraiswamy, M.D., *Department of Psychiatry, Duke University Medical Center, Room 3547 South Hospital Box 3018, Durham, NC 27710*

SUMMARY:

Anxiety disorders affect about 10% of the elderly population, with comorbid anxiety and depression being the most common presentation of anxiety in late life. GAD is one of the most prevalent anxiety disorders in the elderly, with rates of approximately 3%–5%. Anxiety disorders in the elderly tend to be chronic with average duration of 10 years or longer. Untreated comorbid depression and anxiety are associated with reduced quality of life, increased health care utilization, and increased morbidity. Treatment challenges include the failure to diagnose and overutilization of benzodiazepines. In addition to their lack of antidepressant efficacy, benzodiazepines can produce unwanted consequences, such as cognitive impairment and ataxia, in the elderly. There are several randomized trials of SSRIs and venlafaxine in geriatric depression. However, there are currently no randomized trials of any SRRI in elderly GAD subjects. In a recent posthoc analysis of five trials, venlafaxine was more effective than placebo in reducing GAD symptoms in a sample of 1,845 elderly subjects. Newer antidepressants thus provide the most optimal choice for effective long-term treatment of anxious depression in the elderly. This presentation will review these data and provide practical tips for evaluation and treatment selection.

No. 7C
MAINTAINING REMISSION OVER THE LONG HAUL

Prakash S. Masand, M.D., *Director, Psychiatric Consultation Services, State University of New York Health Sciences Center, 750 East Adams Street, Syracuse, NY 13210*

SUMMARY:

Depression is a chronic medical illness. Relapse and recurrence is the rule rather than the exception in most patients. Up to 80% of patients will have a recurrence within 15 years of the index episode. Remission rather than improvement should be the long-term goal of treatment. The talk will address the efficacy of the antidepressants in achieving remission over the long term. Impediments to maintaining remission, including noncompliance, stressors, substance abuse, and side effects, will be explored. Pharmacokinetic interactions involving the antidepressants will also be discussed.

REFERENCES:

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Industry-Supported Symposium 8 **Friday, October 12 12 noon-1:30 p.m.**

EXPANDING HORIZONS: CHOLINESTERASE INHIBITION IN ALZHEIMER'S DISEASE AND BEYOND

Supported by Easai Inc., and Pfizer Inc.

Pierre N. Tariot, M.D., *Department of Psychiatry, University of Rochester Medical Center, 435 East Henrietta Road, Rochester, NY 14620*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to assess the data on cholinesterase inhibitor use in early and prolonged treatment of Alzheimer's disease (AD); recognize the potential neuroprotective effects of cholinesterase inhibitors; understand the role cholinergic mechanisms may play in improving behavior and neuropsychiatric symptoms in AD patients; assess the potential expanded use of cholinesterase inhibitors in non-AD diagnoses.

No. 8A
CHOLINERGIC TREATMENT OF ALZHEIMER'S DISEASE: ASSESSING THE DATA

Pierre N. Tariot, M.D., *Department of Psychiatry, University of Rochester Medical Center, 435 East Henrietta Road, Rochester, NY 14620*

SUMMARY:

Basic science studies suggest the possibility of neuroprotective effects in cholinesterase inhibitor use in Alzheimer's disease (AD), including amelioration of amyloid precursor protein (APP) processing, favorable effects on amyloid beta (AB) fibril aggregation, reduction of AB toxicity, antiexcitotoxic effects, neurotrophic effects, and even favorable effects on cerebral blood flow and immune function. These kinds of findings would suggest the possibility that cholinergic therapy may alter the course of AD. The clinical evidence will be reviewed, including data from prolonged placebo-controlled trials of donepezil; prolonged open experience trials with tacrine, physostigmine, donepezil, rivastigmine, and galantamine; the effects of withdrawal of therapy; effects of delayed start of therapy; and new data regarding effects later in the course of illness. Taken together these clinical findings are consistent with basic science studies suggesting that there may be cholinoprotective or even neuroprotective effects of chronic therapy, and that early and prolonged therapy may be rational.

No. 8B
CHOLINERGIC TREATMENT OF BEHAVIORAL AND PSYCHIATRIC SYMPTOMS IN DEMENTIA

David C. Steffens, M.D., *Assistant Professor of Psychiatry, Duke University, DUMC Box 3903, Durham, NC 27707-5378*

SUMMARY:

Acetylcholine is commonly perceived as being the "memory neurotransmitter." Indeed, several studies have shown that memory is mediated through cholinergic pathways. Anticholinergic drugs have long been known to have serious cognitive effects in both clinical settings and research studies. These observations led to the development of cholinesterase inhibitors such as tacrine, donepezil, and reminyl. These drugs have shown efficacy in treating cognitive symptoms of dementia.

However, what is now being recognized clinically and in recent studies is that these agents also have powerful effects on noncognitive symptoms of dementia. Reports are emerging of improvement in both behavioral and psychiatric symptoms in demented patients treated with cholinesterase inhibitors.

Several basic neuroscience studies support this observation. We will review the cholinergic pathways that have been elucidated so far that are implicated in behavior. Also, we will revisit the "cholinergic hypothesis" of depression. Thus, this review will summarize the recent studies of behavioral change in dementia using these drugs and will provide an overview of cholinergic mechanisms that may underlie the observation that cholinesterase inhibitors improve both behavior and neuropsychiatric symptoms in demented individuals.

No. 8C
USE OF CHOLINESTERASE INHIBITORS BEYOND ALZHEIMER'S DISEASE

Gary J. Kennedy, M.D., *Professor of Psychiatry, Montefiore Medical Center, 446 E. 86th, Apt. 11-C, New York, NY 10028*

SUMMARY:

The Food and Drug Administration has approved cholinesterase inhibitors only for use in mild to moderate Alzheimer's disease. However, data from placebo-controlled randomized trials, open-label studies, and case reports document the broader application of these agents beyond their ability to boost the cholinergic signal and

improve cognition. Evidence from imaging studies suggests that the cholinesterase inhibitors provide a neuroprotective effect that may involve muscarinic and nicotinic properties that are not disease specific. In addition, there are hypothetical arguments for the expanded use of cholinesterase inhibitors. First is the prevalence of impaired cognition across the spectrum of central nervous system disorders. Second is their safety and tolerability. This favorable risk/benefit ratio is amplified by the devastating potential of neurodegenerative disease. As a result clinicians are using cholinesterase inhibitors for late-stage Alzheimer's disease, as well as Lewy body, vascular, and HIV dementia, age-associated memory impairment, mild cognitive impairment, traumatic brain injury, Down's syndrome, Huntington's disease, multiple sclerosis, and delirium.

Eric Kandel argues that the explosion in neuroscience will bring about a new nosology in psychiatry based on behavioral genomics and neurotransmitter profiling. The widening use of cholinesterase inhibitors like the expanded indications for serotonergic agents suggests Kandel's prediction is coming true.

REFERENCES:

1. Tariot PN, et al: The pharmacological wager: prospects for delaying the onset or modifying the progression of Alzheimer's disease. In Fosette F, ed. La Maladie d' Alzheimers: Prediction, Prevention. Fondation Nationale de Gerontalogie, Paris, 61–83, 1999.
2. Tariot PN, Solomon PR, Morris JC, et al: A 5-month, randomized, placebo-controlled trial of galantamine in Alzheimer's disease. Neurology, 2000;54:2269–2276.
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4. Fernandez HH, Friedman JH, Grace J, et al: Mov Disord 2000;15:173–176.
5. Greene YM, Tariot PN, Wishart H, et al: J Clin Psychopharmacol 2000;20:350–356.

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

OPTIMIZING PSYCHOSIS MANAGEMENT: TREATMENT FOR THE FUTURE

Supported by Janssen Pharmaceutica

Prakash S. Masand, M.D., *Director, Psychiatric Consultation Services, State University of New York Health Sciences Center, 750 East Adams Street, Syracuse, NY 13210*

EDUCATIONAL OBJECTIVES:

Upon completion of this activity, participants should be able to: describe the factors that influence the management of psychosis across a spectrum of care settings; select optimal approaches to the management of psychosis in acute care, the long-term setting, and in the elderly patient population; and review the data from clinical trials that may impact treatment practices.

No. 9A
APPROACHES, BEST PRACTICES, AND CONSIDERATIONS: THE ABC'S OF ACUTE PSYCHOSIS

Douglas H. Hughes, M.D., *University of Boston, 78 Monmouth Street, Brookline, MA 02446*

SUMMARY:

The primary goal in treating acutely psychotic patients is two-fold: to reduce agitation and aggression and to minimize psychotic symptoms. Beyond the acute phase, treatment should maximize functioning and prevent relapse. In the emergency setting, rapid tranquilization to minimize patient distress and potential for violence has been the gold standard for more than a decade. Evidence shows that, when indicated, immediate initiation of antipsychotic therapy is also imperative, as delays in active treatment of psychosis are associated with increased negative symptoms and reduced psychosocial functioning. Oral administration of antipsychotic medication in the emergency room offers similar speed of onset to intramuscular administration and may be associated with greater patient cooperation. Atypical antipsychotics have shown great promise in rapidly reducing psychotic symptoms and are associated with improvements in negative symptoms, compliance, and relapse rates compared with conventional agents such as haloperidol. The selection of an antipsychotic in the acute setting should, therefore, be optimized for the long-term needs of the individual patient, as this medication is likely to be continued upon discharge.

This presentation will focus on current and emerging approaches to the management of the acutely psychotic patient in the emergency setting, emphasizing the critical role of emergency care in optimizing long-term outcomes.

No. 9B
MANAGEMENT OF ADULT PSYCHOSIS: LONG-TERM IMPLICATIONS OF SHORT-TERM CHOICES

Samuel J. Keith, M.D., *Professor and Chairman of Medicine, Department of Psychiatry, University of New Mex-*

ico, 2400 Tucker Avenue, N.E., Room 404, Albuquerque, NM 87131; John M. Kane, M.D., Marielle Eerdekens, M.D., Michael D. Lesem, M.D., Keith Karcher; Jean-Pierre Lindenmayer, M.D.

SUMMARY:

For over three decades beginning in the mid 1950s, the pharmacologic treatment of psychosis consisted of the pharmacologic blockade of the dopamine D_2 receptor in all areas of the brain. This "dopamine hypothesis" of schizophrenia resulted in reduction in psychosis, but along with this therapeutic benefit came side effects like extrapyramidal symptoms, a potential worsening of negative symptoms, and patient rejection of the medications that led to discontinuation of treatment. When we examine side effects there are a number of principles that we must take under consideration. Is the side effect permanent or likely to go away? Will adherence be affected? What are the health risks? What is the psychological impact to the patient, and how do we assess this? Are alternative treatments available?

It is now possible to understand which side effects hold significance for patients in terms of whether they are reluctant to take medications. Noncompliance with psychotropic medications is a primary reason for recidivism to inpatient hospitalization and a great contributor to the "revolving-door syndrome" affecting psychiatric patients. The novel antipsychotic medications offer us advantages over conventional antipsychotic medications. We will examine, in depth, the side-effect profiles of the novel antipsychotics in terms of the real choices a clinician and a patient now have. There are differences between the novel antipsychotic medications that make informed choices possible. Though the number of studies is limited, the use of depot medications has been shown to improve compliance, empower the patient, prevent relapse, and positively impact caregiver staff. Finally, we need to have an understanding of the cost of our treatments if we wish to remain in control of our profession and the patients it benefits so much.

No. 9C
PSYCHOSIS IN THE ELDERLY: CONSENSUS AND CONTROVERSY

P. Murali Doraiswamy, M.D., *Department of Psychiatry, Duke University Medical Center, Duke South Hospital, Room 3550 Trent Drive, Durham, NC 27710*

SUMMARY:

Psychotic symptoms in older adults may arise from a variety of psychiatric and medical conditions. Thus the diagnosis and treatment of the psychotic elderly are challenging and often complicated by a high frequency of comorbid medical illnesses and the potential for a higher risk of side effects and age-related changes in drug pharmacokinetics. The treatment of psychosis in older populations requires careful consideration of potential causes and complications. In the context of dementia, patients have been shown to benefit from cholinergic augmentation, which reduces behavioral disturbances.

Conventional antipsychotics, at usual doses, may be poorly tolerated, especially in elderly patients. Side effects of particular concern include extrapyramidal symptoms, tardive dyskinesia (TD), cognitive dulling and other anticholinergic effects, and potentially, cardiovascular effects and metabolic abnormalities. The atypical antipsychotics offer several advantages over conventional antipsychotics in terms of effects on negative and cognitive symptoms and tolerability. They are less likely to cause EPS and TD, although these side effects may manifest at higher medication dosages in the geriatric population—in general, dosing requirements for elderly patients tend to be much lower than those for younger adults.

This presentation will present practical tips on the clinical evaluation and appropriate use of newer antipsychotics in treatment of elderly psychotic patients and touch upon the use of cholinergic augmentation in cases of dementia. Emerging data from clinical trials in older populations will allow clinicians to distinguish among the atypical antpsychotics and incorporate them into the overall management of elderly patients with psychosis.

REFERENCES:

1. McElroy SL, Keck PE, et al: A randomized comparison of divalproex oral loading versus haloperidol in the initial treatment of acute psychotic mania. J Clin Psychiatry. 1996;57:142–146.
2. Hughes DH: Acute psychopharmacological management of the aggressively psychotic patient. Psychiatr Serv. 1999;50:1135–1137.
3. Hughes D: Management of suicidal and aggressive patients in the medical setting. In: Psychiatric Care of the Medical Patient 2nd ed., edited by Stoudemire A, Fogel BS, Greenberg D, Oxford Press, 1998.
4. Katz I, Goff DC Shader RI: Non-neurological side effects of antipsychotic agents. In: Schizophrenia, edited by Hirsch SR, Weinberger DR. Oxford, England, Blackwell Science, 1995, pp. 566–584.
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Industry-Supported Symposium 10 **Saturday, October 13 6:30 a.m.-8:00 a.m.**

SCHIZOPHRENIA: EVOLVING THERAPEUTIC CONCEPTS

Supported by Bristol-Myers Squibb

Stephen R. Marder, M.D., *Director VA Desert Pacific Mental Health, West Los Angeles VA Health, 11301 Wilshire Boulevard, Los Angeles, CA 90073*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: assess prodromal symptoms of schizophrenia and evaluate and institute early intervention, have a better understanding of issues and options in maintenance therapy of chronic schizophrenia, recognize and treat the prodromal stages of schizophrenia, and optimize long-term management of schizophrenia using new pharmacologic and nonpharmacologic intervention.

No. 10A
CAN SCHIZOPHRENIA BE DIAGNOSED EARLY

Barbara Cornblatt, Ph.D., *Director, RAP Program and Clinic, Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004*

SUMMARY:

The schizophrenia prodrome begins with the first noticeable change in behavior and lasts until the onset of frank psychosis. Recent evidence suggests that treatment initiated during this stage might stop progression to psychosis. The prodrome is characterized by a cluster of nonspecific (e.g., decline in school functioning, increasing social withdrawal) and schizophrenia-like (e.g., odd behaviors, unusual perceptions) disturbances and by a profile of neurocognitive abnormalities (e.g., deficits in attention).

The Recognition and Prevention (RAP) Program of Hillside Hospital focuses on research and early intervention in adolescents in the prodromal stages of schizophrenia. A major goal of this program is establishing an accurate prodromal screening battery to permit the earliest possible treatment initiation. A broad range of intervention strategies are also being evaluated within the RAP clinic, including pharmacologic, psychoeducational, and individual, family and group therapies.

More than 80 patients have completed the RAP protocol and received at least one year of treatment. Findings from the naturalistic treatment phase indicate: 1) the majority of youngsters have improved clinically; 2) antipsychotics become the medication of choice as attenuated positive symptoms increase; and 3) the primary predictor of conversion to schizophrenia is noncompliance with medication. Additionally, cognitive improvement is a major consideration for prodromal treatment.

No. 10B
LONG-TERM MANAGEMENT OF SCHIZOPHRENIA

Stephen R. Marder, M.D., *Director VA Desert Pacific Mental Health, West Los Angeles VA Health, 11301 Wilshire Boulevard, Los Angeles, CA 90073*

SUMMARY:

Treatment guidelines from the American Psychiatric Association, Patient Outcomes Research Team (PORT), and other sources concur that optimal, long-term treatment for patients with schizophrenia should include antipsychotic medications, case management strategies, and psychosocial rehabilitation. Substantial evidence also supports the effectiveness of patient and family education programs that focus on the nature of schizophrenia and its treatment.

Newer antipsychotics introduced in the 1990s raised expectations for improving functional outcomes of individuals with schizophrenia. The hope was that agents with fewer neurologic side effects and improved effectiveness for neurocognitive and mood symptoms would promote improved social and vocational outcomes. Recent studies combining newer antipsychotics with behavioral skills training, such as the VA Cooperative Study, will be reviewed. Strategies combining optimal medication with psychosocial treatments can be effective in improving treatment adherence, important causes of psychotic relapse, and poor outcome.

Important unmet needs still abound in the long-term management of schizophrenia. Although second generation antipsychotics represent a major advance in pharmacotherapy, they are still associated with side effects such as weight gain and have limited effects on negative symptoms and cognition. New strategies for addressing these limitations will be discussed, including antipsychotics in development and strategies for enhancing efficacy of available agents.

REFERENCES:

1. Drake RE, Becker DR: The individual placement and support model of supported employment. Psychiatric Services 1996;47:473–475.
2. Lehman AF: Vocational rehabilitation in schizophrenia. Schizophrenia Bulletin. 1994;645–656.
3. Haas GL, Garratt LS, Sweeny JA: Delay of first antipsychotic medication in schizophrenia: impact on symptomatology and clinical course of illness. J Psychiatry Res 1998;13(suppl 13):31–34.
4. Herz M: Early intervention in different phases of schizophrenia. J Pract Psychiatry Behav Health 1999;197–208.
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Industry-Supported Symposium 11 — **Saturday, October 13 12 noon-1:30 p.m.**

INDIVIDUALIZING MANAGEMENT OF DEPRESSIVE DISORDERS

Supported by Organon Inc.

Norman Sussman, M.D., *NYU School of Medicine, 550 First Avenue, New York, NY 10016*

SUMMARY:

The heterogeneity of clinical symptoms and the diversity of patient populations characterize the management of depression. An essential aspect of depression management is the need to individualize treatment. Patients differ in their response to treatment and in their ability to tolerate various interventions. The success or failure of treatment thus depends on matching the known properties of an antidepressant drug to the known clinical profile of the individual patient. It is important to consider how a drug will impact on the lifestyle and physical well-being of the patient. For many patients, preservation or restoration of normal sexual functioning is an important consideration in antidepressant therapy. Abundant evidence shows that there are differences among antidepressants with respect to their impact on sexual functioning. Maintenance of desired body weight is another major goal of drug therapy. Unwanted weight gain can interfere with compliance and lead to secondary medical problems. Antidepressant drugs carry markedly different risks with regard to effects on body weight. These considerations, coupled with knowledge of drug effects in special populations, such as the elderly, and the management of treatment resistance, all represent part of the process of individualized treatment. The goal of this symposium is to review antidepressant tolerability, treatment of the medically ill elderly, and the management of treatment resistance so that individual patients may have an improved outcome.

No. 11A
WEIGHT GAIN ASSOCIATED WITH LONG-TERM ANTIDEPRESSANT THERAPY

Norman Sussman, M.D., *NYU School of Medicine, 550 First Avenue, New York, NY 10016*

SUMMARY:

It is increasingly evident that the short-term effects of antidepressant drugs on body weight may be different from those seen during chronic therapy. SSRIs typically produce weight loss early in treatment, but this effect is transient. During ongoing therapy, some patients gain substantial weight. While most placebo-controlled studies do not show weight gain to be a frequent long-term side effect of SSRIs, anecdotal reports and nonplacebo controlled studies do suggest that this is common. Mirtazapine causes significant weight gain early in treatment. This effect plateaus, and patients may lose the added weight over time. Nefazodone appears to be weight neutral, while bupropion causes more weight loss than weight gain. The clinical and methodological issues that are involved in understanding the weight effects of antidepressant drugs will be reviewed.

No. 11B
MANAGEMENT OF ANTIDEPRESSANT NONRESPONDERS

Jerrold F. Rosenbaum, M.D., *Massachusetts General Hospital, 15 Parkman Street WACC 812, Boston, MA 02114*

SUMMARY:

The goal of antidepressant treatment is remission of depression, which implies full symptom reduction, relapse and recurrence prevention, and functional restoration. The majority of patients who merit antidepressant treatment fall short of this goal. For acute treatments,

those who do not remit are either partial responders or nonresponders. The therapeutic strategies employed are different for these two groups. Recent surveys of practitioners reveal the approaches they are most likely to take to address this clinical challenge. Although controlled data are also available to assess some clinical options, many preferred strategies are driven primarily by clinical consensus. Therapeutic options can generally be classified in the categories of optimization, augmentation, combination, or switching. Popular, novel, and promising strategies for antidepressant partial responders and nonresponders will be presented.

No. 11C
SEXUAL DYSFUNCTION WITH TREATMENT OF MAJOR DEPRESSION

David Lloyd Ginsberg, M.D., *150 East 58th Street, 27th Floor, New York, NY 10155*

SUMMARY:

Although sexual dysfunction in depressed patients can have many causes antidepressant administration is one of the most important. Nearly all of the antidepressants available today can cause sexual dysfunction in some area of the sexual response cycle. The more recently developed agents, including the selective serotonin reuptake inhibitors (SSRIs) and the norepinephrine/serotonin reuptake inhibitor (NSRI) venlafaxine, are associated with inhibited desire and delay or absence of orgasm. In fact, only three agents available today, bupropion, mirtacapine, and nefazodone, are not associated with significant sexual dysfunction.

Because most patients will not spontaneously broach the subject of sexual dysfunction, it is vital that clinicians specifically inquire about it in those being treated with antidepressants. Sexual functioning is an integral part of self-concept and well being; furthermore, antidepressant-induced sexual dysfunction is a frequent source of patient dissatisfaction and noncompliance with medication. Fortunately, several strategies for management of antidepressant-related sexual adverse effects are available. Given the incomplete nature of our understanding of both the neurophysiology of the sexual response and and the mechanisms of medication-induced sexual adverse effects, the choice of a management strategy is still largely empirical. Emerging data, however, indicate that antidote and substitution strategies may offer the most favorable benefit-to-risk ratio. For those patients who are suitable, initial selection of an antidepressant not associated with sexual side effects may represent the optimum strategy.

REFERENCES:

1. Sussman N, Ginsberg D: Rethinking side effects of the selective serotonin reuptake inhibitors: sexual dysfunction and weight gain. Psychiatr Annals 1998;28:89–97.
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Industry-Supported Symposium 12 **Saturday, October 13 6:00 p.m.-9:00 p.m.**

COGNITION IN SCHIZOPHRENIA: RESTORING FUNCTIONS

Supported by Pfizer Inc.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the nature and severity of cognitive dysfunction in schizophrenia; recognize the functional significance of cognitive impairment; assess treatment approaches with novel antipsychotic medications; and discuss methods for rehabilitation.

SUMMARY:

Cognitive impairment is an independent feature of schizophrenia that in recent years has been found to be even more important than positive and negative symptoms in determining functional outcome in schizophrenia. The cognitive impairment in schizophrenia affects attention, long-term and short-term memory and learning, executive function (decision making and abstraction), and fine motor performance. This impairment is present at the first episode of psychosis and generally worsens slightly during the course of illness. The severity of impairment does not correlate with psychosis, is weakly related to negative symptoms, and is a strong predictor of global function, work status, and social skills. Typical neuroleptic drugs have not been found to improve cognition. The use of anticholinergic drugs to treat EPS may worsen memory. Recent studies with the new medications, i.e. ziprasidone, clozapine, quetiapine, olanzapine, and risperidone, indicate this class of agents is able to improve many domains of cognition. The pattern varies across drugs to some extent. Strategies to pharmacologically enhance their efficacy in cognition are being developed. Further, new techniques of cognitive rehabilitation may augment the effects of the atypical antipsychotic drugs. The goals of reintegration of

patients into the community and restoration of work and social function are more likely to be accomplished by focusing on improving cognition.

TARGET AUDIENCE(S):

Mental health professionals.

No. 12A
IMPROVING COGNITIVE IMPAIRMENT IN SCHIZOPHRENIA

Stephen R. Marder, M.D., *Professor and Vice Chairman, Department of Psychiatry, UCLA School of Medicine, 11301 Wilshire Boulevard, Los Angeles, CA 90073*

SUMMARY:

Cognitive dysfunction in schizophrenia is present before, during, and after psychotic episodes. Different domains of cognitive functioning are impaired in schizophrenia. The more severe deficits are in the areas of memory and include memory span, serial learning, and delayed recall. There is also a gradient of impairment across cognitive function, with aspects of long-term memory often unimpaired. On average, the impairment level is 1–2 standard deviations below normal. Patients who develop schizophrenia usually perform more poorly in childhood than their siblings and peers. In the first episode of illness, patients have impairments that are only slightly less severe than patients with chronic illness. Patients with a poor overall outcome are consistently more impaired in cognitive function. The overall severity of cognitive impairment is found to be related to the severity of negative symptoms but not positive symptoms. Improving cognitive impairment is essential for a good outcome in schizophrenia. Treatment with atypical antipsychotic medication can improve some components of cognitive impairment, leading to better work and social outcome. The major targets of atypical antipsychotics are dopamine, acetylcholine, glutamate, serotonin, and GABA, which are the key neurotransmitters involved in the cognitive deficit in schizophrenia.

No. 12B
SCHIZOPHRENIA: IDENTIFYING LINKS AMID COGNITIVE IMPAIRMENT AND FUNCTIONAL OUTCOMES

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

SUMMARY:

The cumulative published literature on neurocognition and functional outcome in schizophrenia has doubled in the last few years. Meta-analysis has revealed that the relationships between key neurocognitive constructs (secondary verbal memory, immediate memory, vigilance, and executive functions) and the outcome domains are highly significant (all P values <.0001). The effect sizes were in the medium range for the individual neurocognitive constructs. If composite indices were used instead of individual constructs, the relationships were much stronger (typically 20%–60% of the variance in functional outcome explained). It appears that certain neurocognitive capacities are necessary for adequate functional outcome of patients and that deficits in these areas may restrict the patient from adapting well. The mechanisms for these relationships are not understood, and the next step is to identify mediators that can account for these relationships. Social cognition and learning potential are two possible mediators that are related to basic neurocognition and functional outcome.

No. 12C
COGNITION IN SCHIZOPHRENIA: THE EFFECTS OF ANTIPSYCHOTIC MEDICATION

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

SUMMARY:

Cognitive impairment is an important predictor of functional outcome in patients with schizophrenia. This is true especially of memory, attention, and executive function. These deficits have received relatively little attention as targets of pharmacological treatment. Recent studies of agents that regulate memory and other elements of cognitive function in humans suggest a number of promising targets for cognition-enhancing treatments. While antipsychotic medications are used primarily to treat psychotic symptoms, newer antipsychotic medications offer a number of cognitive advantages over the older medications. Studies of the cognitive effects of atypical antipsychotic medications will be reviewed with an emphasis on opportunities to reduce adverse cognitive events associated with older drugs and the increasing evidence for treatment-induced improvements in cognitive functions. The cognitive profiles of action of the newer agents will also be reviewed. Pharmacologic strategies to improve the ability of the new antipsychotic drugs to enhance cognition will be discussed.

REFERENCES:

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and strategies, Schizophrenia Bulletin 1999; 25:257–74.
2. Green MF, Kern RS, Braff DL, Mintz J: Neurocognitive deficits and functional outcome in schizophrenia: are we measuring the "right stuff"? Schizophrenia Bulletin 2000; 26:119–136.
3. Meltzer HY, McGurk SR: The effects of clozapine, risperidone, and olanzapine on cognitive function in schizophrenia. Schizophrenia Bulletin 1999; 25: 223–257.
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INNOVATIVE PROGRAMS: SESSION 1 SYSTEM DELIVERY

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

EMOTIONAL WELL-BEING IN THE U.S. AIR FORCE

Steven E. Pflanz, M.D., *Chief, Mental Health Services, F.E. Warren Air Force Base, U.S. Air Force, 408 West First Avenue, Cheyenne, WY 82001*

EDUCATIONAL OBJECTIVES:

To understand one community's approach towards the primary prevention of mental illness and the importance of implementing mental health community outreach programs.

SUMMARY:

It has become increasingly clear that the medical establishment will need to dedicate a much greater share of its resources towards the prevention of illness and shift its focus away from the treatment of existing illnesses. Given the widespread prevalence of and tremendous costs associated with mental illness, the reduction of mental illness and stress is clearly critical to any effort aimed at fostering population health. Forty-eight percent of the U.S. population suffers from a mental illness during their lifetime. In addition to the terrible personal toll exacted by emotional distress, individuals suffering from psychiatric illness exhibit decreased work productivity, increased workforce turnover, greater absenteeism, and higher medical costs. Efforts to reduce the incidence of psychiatric illness will likely lower the costs associated with mental illness and enhance the emotional well-being of our communities.

Our mental health service has implemented a comprehensive mental health promotion campaign for our community. The cornerstone of this effort is an educational program that offers basic health education on five mental health topics to enhance the emotional health of U.S.A.F personnel: stress management, suicide prevention, emotional response to trauma, alcohol and drug abuse prevention, and violence awareness education. This is the first community outreach program we are aware of that offers this broad mental health education to an entire population.

TARGET AUDIENCE:

General psychiatry, social & community psychiatry, primary prevention.

REFERENCES:

1. Pflanz SE: Psychiatric illness & the workplace. Milit Med 1999; 164:401–6.
2. Sauter SL, Murphy LR, Hurrell JJ: Prevention of work-related disorders. Am Psych 1990; 45:1146–58.

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

MENTAL HEALTH ACCESS POINT: MANAGED CARE IN THE PUBLIC SECTOR

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

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

A coalition of community mental health agencies in Hamilton County, Ohio, in an effort to manage local mental health services in a more efficient and effective manner, formed a partnership with the county mental health board to create Mental Health Access Point (MHAP), an innovative, managed care endeavor in a public mental health system. MHAP is the front door to community mental health services for the county. It contains a clinical arm administratively under the umbrella of Central Clinic, Cincinnati, Ohio. Like most managed care systems it has three functions: 1) assessment/evaluation; 2) authorization of services; 3) utilization review and monitoring. Recognizing recent advancements in private sector managed care, MHAP attempts to combine the best practices of the public sector with some of the successes of the private sector.

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

chronic and dually diagnosed mental illness and children.

REFERENCES:

1. Mental Health in the Public Sector, edited by Minkoff K, 1997.
2. Starling G: Managing the Public Sector, Wadsworth Publishing Company, 1993.

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

TRAINING COMMUNITY GATEKEEPERS TO RECOGNIZE MENTAL HEALTH CRISES

Linda Sacco, A.C.S.W., *Program Director, Community Mental Health Services, Visiting Nurse Service of New York, 1601 Bronxdale Avenue, Bronx, NY 10462*; Christine MacNaughton, C.S.W., *Program Coordinator, Visiting Nurse Service of New York, 1601 Bronxdale Avenue, Bronx, NY 10462*

EDUCATIONAL OBJECTIVES:

To develop an outreach model for training community gatekeepers in recognizing mental health needs and how to access crisis services.

SUMMARY:

Community mental health outreach programs, such as mobile crisis services, are dependent upon people in the community to recognize mental health needs and to make referrals for intervention. While mental health providers are generally aware of the services available for those in crisis, they are often not the first to come into contact with an individual in distress. It is the non-mental health providers that are usually the first to become aware of the need for intervention. These "gatekeepers" to the mental health system may be law enforcement personnel, clergy, court personnel, housing management, medical professionals, or community leaders. Each has a different role in the lives of people in acute distress and is in a unique position to identify mental health needs.

The Visiting Nurse Service of New York administers mobile crisis services in three boroughs of New York City. In response to the concern that community gatekeepers were not aware of the availability of crisis intervention services in their community, VNS conducted an aggressive outreach campaign in the borough of the Bronx to educate the community about these services. The outreach targeted non-mental health professionals and community providers who had not traditionally referred clients to the mobile crisis service. Once identified, agencies were sent an outreach letter and program literature with an offer of a staff and/or client presentation. Follow-up calls revealed that there was a lack of knowledge about mental health issues and how and when to access the services being offered. Each group of gatekeepers was provided with training to teach them to identify when an individual is in need of mental health intervention and how and when to access crisis services. Each training was tailored to the specific population served and the level of knowledge of the group.

This program has been successful in increasing awareness of mental health issues, knowledge of crisis intervention, and the ability to access services as evidenced by the increase in referrals to the mobile crisis service following each training. This presentation will focus on developing an outreach strategy, gaining the trust and cooperation of community providers, and developing a curriculum tailored to each group. Problems and successes in implementing the program will be discussed.

TARGET AUDIENCE:

Mental health/crisis program administrators.

REFERENCES:

1. Zealberg J: Comprehensive Emergency Mental Health Care. New York, WW Norton and Company, 1996.
2. Slaikeu C: Crisis Intervention. Boston, Allyn and Bacon, 1990.

INNOVATIVE PROGRAMS: SESSION 2 CRISIS RISK REDUCTION

Innovative Program 4 Wednesday, October 10 3:30 p.m.-5:00 p.m.

INTENSIVE CASE MANAGEMENT AND KENDRA'S LAW: A COMPARISON OF MANDATED AND NONMANDATED CLIENTS

Wanda Rodríguez, *Program Coordinator, Community Mental Health Services, Visiting Nurse Service of New York, 1601 Bronxdale Avenue, Bronx, NY 10462*; Luis Vega, *Supervisor, Visiting Nurse Service of New York, 1601 Bronxdale Avenue, Bronx, NY 10462*

EDUCATIONAL OBJECTIVES:

To demonstrate knowledge of ICM services and Kendra's law and to understand the impact of involuntary outpatient commitment on ICM service delivery.

SUMMARY:

New York State's assisted outpatient treatment (AOT) statute commonly known as Kendra's Law allows for the utilization of legal intervention to compel patients

to accept mental health services in the community. In addition, all patients must have intensive case management (ICM) services for which they might not have been previously eligible. This potential change in case mix may have implications for ICM service providers in terms of staff training, safety, and outcomes.

Visiting Nurse Service of New York Community Mental Health Division has administered two ICM programs in New York City since 1988. As one of the mandated providers of ICM services, VNS works in collaboration with the AOT program and treatment providers to ensure that clients comply with the mandated treatment.

In order to plan for any changes indicated in the provision of ICM services, a study was conducted to determine if the AOT clients were different from the usual ICM clients. The first 50 AOT cases were compared with a random sample of 50 non-AOT cases in terms of demographics, psychiatric history, service utilization, engagement, treatment compliance, and outcomes. Preliminary findings suggest that the AOT clients are younger, more volatile, more difficult to engage, and more treatment resistant. This means that the ICM program will have to implement more intensive training of staff in new techniques of engaging, assessing, and working with this very difficult, involuntary population.

This presentation will provide an overview of the AOT statute and ICM services. The results of the study and the implications for ICM service providers will be discussed as a framework for developing a service delivery model that can accommodate the special needs of this population.

TARGET AUDIENCE:

Mental health providers and administrators.

REFERENCES:

1. Policy Research Associates: Final Report of the NYC Outpatient Commitment Program. Delmar, NY, 1999.
2. Lidz C: Coercion in psychiatric care: what have we learned from the research? J Am Acad Psychiatry Law, 1999; 26:631–637.

Innovative Program 5 Wednesday, October 10 3:30 p.m.-5:00 p.m.

DOES A TEAM APPROACH IMPROVE CRISIS INTERVENTION OUTCOMES?

Katherine G. Levine, M.S.W., *Program Director, Community Mental Health Services, Visiting Nurse Service of New York, 450 East 149th Street, 3rd Floor, Bronx, NY 10455*; Lori Rodríguez, *Program Coordinator, Community Mental Health Services, Visiting Nurse Service of New York, 1601 Broxdale Avenue, Bronx, NY 10462*

EDUCATIONAL OBJECTIVES:

To describe an expanded home-based crisis program and the duties of its members, and to describe outcome data comparing the expanded team to a traditional home-based crisis program.

SUMMARY:

This program describes the difference in outcomes between a traditional home-based crisis program and an expanded multidisciplinary program. Both programs operate in the Bronx, N.Y. and serve similar populations—children and youth at risk of psychiatric hospitalization. The traditional team consists of an MSW supervisor, four bachelor-level service providers, and four hours a week of psychiatric consultation. The expanded team makes use of a varied group of service providers including natural supports, respite workers, parent advocates, case aides, and social work assistants, as well as master-level social workers, a community mental health nurse, and 21 hours a week of psychiatric consultation. The teams will be described, and outcome data presented. Levels of risks will be compared as will outcome data. Outcome data will compare each team's drop-out rate, consumer satisfaction, reduction of risk rate, hospitalization rates, length of service, and success of linkage to follow-up services.

TARGET AUDIENCE:

Child and adolescent psychiatrists, residents, crisis teams.

REFERENCES:

1. James B: Treating Traumatized Children. Lexington, MA, Lexington Press, 1989.
2. Madsen WC: Collaborative Therapy With Multistressed Families. New York, Guilford Press, 1999.

Innovative Program 6 Wednesday, October 10 3:30 p.m.-5:00 p.m.

A MODEL OF MOBILE CRISIS SERVICE EFFECTIVE IN ROUTINE CLINICAL PRACTICE

John Hoult, M.B., *Psychiatry Consultant, Waterlow Unit, Highgate Hill, England N19 5NX*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the principles of care and the structure and function of the model of crisis resolution.

SUMMARY:

Joy et al, (1998) in a review for the Cochrane Library of mobile crisis services have shown that in randomized, controlled trials they produce fewer admissions and re-admissions, improved patient and career satisfaction, and increased retention of patients in care. However, Geller et al (1995) wrote that mobile crisis services had not demonstrated their effectiveness in routine clinical practice. Over a period of 20 years, a model of mobile crisis resolution service has developed, based on work done in Denver, Colorado and Madison, Wisconsin in the 1970s, which has been shown to be successful in Australia and England. Hospital admissions have been reduced by up to 30% in inner-city areas and by up to 46% in suburban areas; bed use has decreased; patient and career satisfaction is high. The model will be described, and data will be presented from evaluations of teams in Sydney, Australia, and from Birmingham and London in England.

TARGET AUDIENCE:

Clinicians, directors of mental health services.

REFERENCES:

1. Joy CB, Adams CE, Rice K: Crisis intervention for severe mental illness. The Cochrane Library, 1998.
2. Geller JL, Fisher WH, Mc Dermott M: A national survey of mobile crisis services and their evaluation. Psych Services 1995; 46: 893–897.

INNOVATIVE PROGRAMS: SESSION 3 UNIQUE PROGRAMS FOR SPECIAL POPULATIONS

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

LABYRINTH USE IN A COMMUNITY MENTAL HEALTH PROGRAM

Katherine G. Levine, M.S.W., *Program Director, Community Mental Health Services, Visiting Nurse Service of New York, 450 East 149th Street, 3rd Floor, Bronx, NY 10455*; Paul Gray, *A.A., Respite Worker, Community Mental Health Services, Visiting Nurse Service of New York, 450 East 149th Street, 3rd Floor, Bronx, NY 10455*

EDUCATIONAL OBJECTIVES:

To know the difference between a maze and a labyrinth and to know how to use a labyrinth as a self soothing device.

SUMMARY:

The Visiting Nurse Service of New York's Community Mental Health Service operates a respite and recreation program in the Mott Haven Section of the South Bronx. This program serves seriously emotionally disturbed children. The Camino de Paz Labyrinth project started when a labyrinth was introduced to the children as part of a self-soothing program. The project expanded to include the construction of several labyrinths within the community and the holding of a Labyrinth Festival. Both the children and their families were active participants in constructing the various labyrinths and organizing the festival. This program will describe the project. A videotape of a labyrinth being walked by children, families, and community members will be shown. A self-report, self-soothing scale completed by youth who learned to self-sooth using the labyrinth will be contrasted with completion of the same scale by youth who were taught more traditional self-soothing skills. This will be followed by a brief discussion of outcome data comparing 20 cases using this approach with 20 cases drawn from another home-based crisis team serving similar youngsters but using the more traditional treatment-team approach. Outcomes to be examined will include dropout rate, consumer satisfaction, reduction of risk rate, hospitalization rates, length of service, and success of linkage to follow-up services. This will be followed by a case presentation and discussion.

TARGET AUDIENCE:

Psychiatrists, crisis team members.

REFERENCES:

1. James B: Treating Traumatized Children. Lexington, MA, Lexington Press, 1989.
2. Madsen WC. Collaborative Therapy With Multi-stressed Families. New York, Guilford Press, 1999.

Innovative Program 8 Thursday, October 11 8:00 a.m.-9:30 a.m.

BORDERLINE PERSONALITY DISORDER: AN ACADEMIC AND COMMUNITY COLLABORATION

Joann Heap, A.C.S.W., *Senior Clinical Social Worker, Department of Psychiatry, University of Michigan Health System, 900 Wall Street, Box 0722, Ann Arbor, MI 48109-0722*; Kenneth R. Silk, M.D., *Associate Professor and Associate Chairman, Department of Psychiatry, University of Michigan Health System, 1500 East Medical Center Drive, CFOB Box 0704, Ann Arbor, MI 48109-0704*

EDUCATIONAL OBJECTIVES:

To appreciate the benefit of as well as the complexities involved in establishing a collaborative treatment pro-

gram between an academic health system and a community mental health system.

SUMMARY:

Patients with borderline personality disorder (BPD) are high utilizers of all types of mental health services. The development of a cooperative program, combining two very different systems, an academic health system and a community mental health system, allows each system to allocate and use resources in the most cost-effective manner while providing effective, informed, "cutting-edge" treatment to these high-utilizing patients. The similarities and differences of the two systems show points of consistency that allow varied disciplines from each system to treat this Axis II disorder and comorbid Axis I disorders while offering case management and behavioral treatment appropriate to level of severity of illness. Since instability and impulsivity are the key symptoms of BPD, the disorder is by definition "difficult to treat." The current treatment approach is a cognitive-behavioral model that combines group skills training and individual dialectical behavior therapy (DBT). The treatment for BPD described in this presentation combines resources, shares medical expertise, and delivers level of care according to criteria rather than membership in a specific service delivery site. Efficiency of delivery and appropriateness of treatment can reduce high-risk/high-cost behaviors in persons with BPD. The combination of both systems allows for consistency in treatment method within a larger framework of options while facilitating efficient communication across service sites and decreasing clinician alienation and burn-out.

TARGET AUDIENCE:

Case managers, CMH workers, psychiatrists, faculty of academic health centers.

REFERENCES:

1. Linehan MM: Cognitive Behavioral Treatment of Borderline Personality Disorder. New York, Guilford, 1993.
2. Silk KR, Eisner W, Allport C, et al: Focused time-limited inpatient treatment of borderline personality disorder. J Personality Dis 1994; 8:268–278.

Innovative Program 9 Thursday, October 11 8:00 a.m.-9:30 a.m.

CONSULTATION TO HOMEBOUND AIDS PATIENTS

Lawrence B. Jacobsberg, M.D., Ph.D., *Team Psychiatrist, Community Mental Health Services, Visiting Nurse Service of New York, 220 East 63rd Street, New York, NY 10021*; Thomas Laverack, M.S.W., *Program Coordinator, Community Mental Health Service, Visiting Nurse Service of New York, 2170 McDonald Avenue, Brooklyn, NY 11223*; David C. Lindy, M.D.; Neil Pessin, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to recognize symptoms of psychological distress in AIDS patients and plan effective treatment strategies for the home care setting.

SUMMARY:

Patients with HIV/AIDS are often homebound as a result of their illness. The Visiting Nurse Service of New York supports HIV-Mental Health Consultation Teams to provide consultation and liaison to the medical home care services of these patients.

Reason for referral varies, but includes acute stress of medical illness as well as chronic psychosocial problems. Each necessitates different modifications to the patient's treatment plan. Psychotropic medications are sometimes prescribed, but in the bulk of cases the focus is on psychosocial interventions.

At intake, the degree of cognitive impairment of each patient is assessed with the Folstein Mini-Mental State Exam. The psychological distress of referred patients is evaluated both at intake and following intervention using the Brief Symptom Inventory. Quantitative assessment of more than 850 patents over the program's 10-year span has allowed assessment of changing patterns of referred patients, including an increase in HIV-associated dementia rates, as would have been expected given the overall longer survival time of AIDS patients. In addition, the effects of intervention, antiretroviral therapy, psychosocial support, and constitutional vulnerability were assessed.

By engaging a varied audience of caregivers, each of whom has unique clinical experiences, the presentation will expand the treatment repertoires of all participants.

TARGET AUDIENCE:

Psychiatrists, psychiatric nurses, and clinical social workers.

REFERENCES:

1. Clark BR, Everall IP: What is the role of the HIV liaison psychiatrist? Genitourin Med 1997; 73:568–70.
2. Ellis D, Collis I, King M: A controlled comparison of HIV and general medical referrals to a liaison psychiatry service. AIDS Care 1994;6:69–76.

INNOVATIVE PROGRAMS: SESSION 4 FAMILY AND CULTURE

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

THE EARLY DETECTION, INTERVENTION, AND PREVENTION OF PSYCHOSIS PROGRAM

William R. McFarlane, M.D., *Chairman, Department of Psychiatry, Maine Medical Center, 22 Bramhall Street, Portland, ME 04102-3134*; Douglas R. Robbins, M.D.; William L. Cook, Ph.D.

EDUCATIONAL OBJECTIVES:

Attendees will understand the evidence for early intervention in psychotic disorders and its effect on outcomes, will be able to identify key characteristics of international early intervention programs, understand the core components of the program, and identify the key indicators of risk for psychosis as manifested during the prodromal phase.

SUMMARY:

The purpose of the EDIP program is to lower the incidence in Portland, Maine, of schizophrenia and other psychotic disorders by intervening during the late prodromal phase of these disorders, leading to secondary prevention of the psychosis itself. It is based on the growing evidence that early intervention reduces severity and duration of psychosis and short- and long-term disability. Building upon programs in the U.K., Norway, and Australia, it includes three core components: (1) outreach and training for professionals in frequent contact with young persons at risk, ages 12–30; (2) public education; and (3) comprehensive psychosocial and pharmacological treatment for those found to be likely to go on to a psychotic episode. The outreach is focused on general and family practitioners and on teachers and guidance counselors in high schools and colleges. The public education uses commercial media to reduce stigma and disseminate information about mental illness in general, specific prodromal signs and symptoms, and means for contacting the clinical team. Treatment emphasizes family psychoeducation and cognitive therapy; low-dose drug treatment is used if psychosocial approaches are failing. Program management includes a wide spectrum of community, consumer, and family representation. Pilot outcomes, including a very low rate of conversion to psychosis, are promising.

TARGET AUDIENCE:

Mental health practitioners, public health officials.

REFERENCES:

1. Falloon IRH: Early intervention for first episodes of schizophrenia: a preliminary exploration. Psychiatry 1992; 55:4–15.
2. Loebel AD, et al.: Duration of psychosis and outcome in first-episode schizophrenia. American Journal of Psychiatry 1992; 149:1183–1188.

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

SIMULTANEOUS CONSUMER-FAMILY-PROVIDER PSYCHIATRIC EDUCATION: THE PEBBLES IN THE POND EXPERIENCE

Karen A. Landwehr, M.C., *Clinician and Educator, Comprehensive Mental Health Partnership, 1201 South Proctor Street, Tacoma, WA 98405*; Larry S. Baker, M.Div., *Director of Training, Comprehensive Mental Health Partnership, 1201 South Proctor Street, Tacoma, WA 98405*

EDUCATIONAL OBJECTIVES:

To recognize the need for a multidisciplinary approach for psychiatric education; to identify disciplines outside of psychiatry that can enhance the effectiveness of psychiatric education programs.

SUMMARY:

This presentation will provide participants an example of how an interdisciplinary approach to psychiatric education can increase the effectiveness of educational endeavors aimed at improving treatment results. An overview of the Pebbles in the Pond: Living with Chronic Neurobiological Disorders program, a 12-week, 36-hour, psychiatric education program for mentally ill consumers, their family members, human service workers, and other interested persons will be given. The Pebbles in the Pond program draws on the fields of psychiatry, social psychology, sociology, developmental psychology, adult education, neurobiology, theology, neurolinguistics, and pharmacology to help participants understand those major mental disorders with the potential for psychosis. By integrating material from each discipline, the program seeks to help participants use up-to-date information about mental illness to develop insight into their own experiences of mental illness, take responsibility for symptom management, and identify strategies for coping with the psychiatric conditions that touch their lives. In the process, participants develop support networks, familial conflict is often reduced, and the

animosity that frequently exists between consumers, family members, and psychiatrists and mental health professionals is lessened. Results of pre- and post-class knowledge assessments demonstrating the effectiveness of this approach will be provided.

TARGET AUDIENCE:

Clinicians, therapeutic educators, and individuals who train and supervise clinical staff.

REFERENCES:

1. Lehman AF, Steinwachs DM: Translating research into practice: the schizophrenia patient outcomes research team (PORT) treatment recommendations. Schizophrenia Bulletin, 1998; NIMH, 24:1.
2. Yalom ID: The theory and practice of group psychotherapy. Basic Books, 1985.

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

WHAT IS "CULTURE" IN CULTURAL COMPETENT CARE?

Albert C. Gaw, M.D., *Speaker-Elect, APA Assembly; Medical Director, San Francisco Mental Health Rehabilitation Facility; and Medical Director for Long-Term Care, Community Mental Health Services, San Francisco Department of Public Health, 887 Potrero Avenue, San Francisco, CA 94110*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the concept of culture as it applies to clinical care.

SUMMARY:

In an effort to promote access to mental health services to all sectors of the population, the concept of cultural competency has been adopted by the federal government and many state agencies as a way to bridge the linguistic and cultural gaps that stand between many ethnic patients and their mainstream U.S. providers. For example, provision of culturally competent service at the emergency room of general hospitals is now required through statutory mandate in Massachusetts and some other states. Increasingly, delivery of culturally competent care is now becoming a standard of care in many sectors of the U.S. health care delivery system.

But what is "culture" in culturally competent care? How does a clinician incorporate the concept of culture into clinical practice?

This presentation will trace the evolution of the concept of culture in anthropological literature to the current definition adopted by the DSM-IV task force. Its use in the DSM-IV cultural formulation and clinical assessment will be highlighted.

TARGET AUDIENCE:

Interdisciplinary clinicians.

REFERENCES:

1. Gaw AC: Concise Guide to Cross-Cultural Psychiatry. Washington, DC, Am Psychiatric Press, 2001.
2. Mezzich JE, Kleinman A, Fabrega Jr H, et al (eds): Culture and Psychiatric Diagnosis: A DSM-IV Prespective. Washington, DC, American Psychiatric Press, 1996.

INNOVATIVE PROGRAMS: SESSION 5 TEACHING AND TRAINING

Innovative Program 13 Friday, October 12 10:00 a.m.-11:30 a.m.

"BEING" AND "PAYING": USING METAPHOR TO TEACH RESIDENTS HOW TO STAFF CASES

Rodney J.S. Deaton, M.D., J.D., *Clinical Assistant Professor, Department of Psychiatry, Indiana University, 333 North Pennsylvania Street, Suite 612, Indianapolis, IN 46204-1828*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) identify common English metaphors for location and exchange; (2) begin to use these metaphors to explain common interpersonal problems in intuitive, "experience-near" terms.

SUMMARY:

In both public and private settings, most psychiatrists now work closely with mental health professionals of all disciplines. Although psychiatrists generally provide psychopharmacologic treatment, many psychiatrists in these settings are also asked to "staff" and to oversee the psychosocial treatment of patients as well. Because different professionals usually use different vocabulary to describe their psychological work, misunderstandings and confusion often result. In this presentation, I will describe an educational program designed to teach psychiatric residents to "staff" complex cases more effectively. In the program, I teach residents to use two common metaphor systems—metaphors of location and of exchange—to explain complex interpersonal relationships. Examples include whether a patient is "present" or "absent" in a relationship, or whether (and how) a patient is "paying life's emotional bills." Because these metaphors are deeply rooted in our common physical

and interpersonal experiences, they have strong, intuitive meanings that bypass the need for more arcane vocabulary. They therefore provide an experience-near language that residents may easily use with other professionals to formulate patients' interpersonal problems and to implement interpersonal treatments that will account for patients' "presence" in treatment and that will promote more "free exchange" in patients' relationships with others.

TARGET AUDIENCE:

Psychiatry residents, training directors, psychotherapy teachers.

REFERENCES:

1. Lakoff G, Johnson M: Philosophy in the Flesh: The Embodied Mind and Its Challenge to Western Thought. New York, NY, Basic Books, 1999.
2. Johnson M: Moral Imagination: Implications of Cognitive Science for Ethics. Chicago, IL, University of Chicago Press, 1993.

Innovative Program 14 **Friday, October 12**
10:00 a.m.-11:30 a.m.

RESIDENT EDUCATION IN COMMUNITY PSYCHIATRY: THE ROLE OF SERVICE LEARNING

Richard C. Christensen, M.D., *Senior Physician, Northeast Florida Hospital, Florida Department of Children and Families, and Former APA/Bristol-Myers Squibb Fellow, 280 19th Avenue, South, Jacksonville Beach, FL 32250*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have an understanding of the educational role service-learning can play in the development and implementation of clinical opportunities for residents in community psychiatry.

SUMMARY:

In 1995 the Health Professions Schools in Service to the Nation launched a program of community-based education called service-learning (SL). The foundation of this innovative form of education is a balanced partnership between communities and health professions schools resulting in a reciprocity between serving the identified needs of the community and meeting defined educational objectives. At the University of Florida, under the auspices of the community psychiatry program, upper level psychiatry residents have a unique opportunity to engage in a service-learning experience through an inner-city, shelter-based psychiatry clinic for the homeless mentally ill located in Jacksonville, Florida. This one-day-a-week clinic received funding through the Northeast Florida Area Health Education Center in order to train psychiatry residents on how to best meet the clinical needs of an extremely underserved population.

The presentation will describe how and why this innovative educational model has been implemented by explicating the following aspects of SL in this particular community psychiatry initiative: responding to identified community and agency needs in treating the homeless mentally ill, providing needed service while simultaneously achieving clearly defined educational objectives in residency training, cultivating community partnerships to meet clearly identified health care needs, emphasizing reciprocal learning between the residents and informal "teachers" in the community and the agency, supporting the values of volunteerism and service among physicians in training.

REFERENCES:

1. Seifer SD: Service-learning: community-campus partnerships for health professions education. Academic Medicine 1998; 73:3 273–277.
2. Christensen RC: Service-Learning in Medical Education: Teaching Psychiatry Residents to Work with the Homeless Mentally Ill. Service Learning in Medical Education (Monograph of American Association of Higher Education). In press.

Innovative Program 15 **Friday, October 12**
10:00 a.m.-11:30 a.m.

TEACHING BEHAVIORAL SCIENCES TO FAMILY DOCTORS

Jonathan S. Davine, M.D., *Assistant Professor of Psychiatry, 2757 King Street, East, Hamilton, ON, Canada L8G 5E4*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand (1) a longitudinal method of teaching behavioral sciences to family medicine residents, and (2) CME initiatives in a shared-care family medicine/psychiatry program.

SUMMARY:

In this presentation, we describe the approach to the teaching of behavioral sciences to family medicine residents at McMaster University in Hamilton, Ontario. Instead of a block placement in the psychiatric unit, teaching takes place on a weekly half day, devoted to behavioral sciences, for the entire duration of the two-year residency. During this time, a psychiatric consultant is present on-site in the family medicine unit. The training is problem based, usually within small groups, and

utilizes examples from cases residents are seeing in their practice. A videotape showing part of a session will be aired.

In addition, we discuss a new program at McMaster, the Hamilton-Wentworth HSO Mental Health Program, whereby psychiatrists work directly with family doctors in the community. Psychiatrists go to the family doctor's office on a weekly or biweekly basis, and work on-site. This type of work affords many opportunities for educational activities with family doctors already established in the community. Different approaches to CME in this setting are discussed.

TARGET AUDIENCE:

Psychiatrists, family physicians and mental health specialists.

REFERENCES:

1. Kates N, et al: Psychiatry and family medicine: the McMaster approach. Can J Psychiatry 1987:32(6).
2. Stram J, et al: The role of psychiatry in the training of primary care physicians. General Hospital Psychiatry 1986; 8.

INNOVATIVE PROGRAMS: SESSION 6 MEASURING OUTCOMES

Innovative Program 16 **Friday, October 12 1:30 p.m.-3:00 p.m.**

AN ACUTE INPATIENT ALTERNATIVE: RESULTS FROM A RANDOMIZED TRIAL

William B. Hawthorne, Ph.D., *Executive Director, Community Research Foundation, 1202 Morena Boulevard, Suite 300, San Diego, CA 92110*; James B. Lohr, M.D., *Chief, Department of Psychiatry, Veterans Hospital, 3350 La Jolla Village Drive, Code 116-A, San Diego, CA 92161-0002*; Elizabeth E. Green, Ph.D.; Brian S. Mittman, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) identify characteristics of an innovative alternative to acute psychiatric hospitalization with a patient-centered and psychosocial rehabilitation focus, (2) understand findings comparing the alternative program with a Veterans Hospital inpatient unit on multiple measures.

SUMMARY:

The innovative program to be presented is a well-established alternative to acute psychiatric inpatient treatment known as Short-Term Acute Residential Treatment (START) located in San Diego, Ca. Founded 20 years ago, there are now six START facilities providing an inpatient alternative for up to 75 voluntary adult patients each day. The programs have a patient-centered and psychosocial rehabilitation focus. Staffing is multidisciplinary and includes registered psychiatric rehabilitation providers, mental health rehabilitation specialists, psychiatrists, psychologists, social workers, and nurses. The average length of stay at a START program is about 10 days. Findings from a randomized clinical trial comparing outcomes for veterans receiving treatment either at START or the VA hospital inpatient unit will be presented. Patients are assessed at admission, discharge, and two, six, and 12 months after discharge. Instruments include SCID diagnostic data, Alcohol Severity Index, SCI-PANSS (Structured Clinical Interview for Positive and Negative Syndrome Scale), SF-36V (Short-Form-36 for Veterans), and the QWB (Quality of Well-Being). Assessment of patient satisfaction and patients' perspectives on their care will be based on the Perceptions of Care and the Ward Atmosphere Scale.

TARGET AUDIENCE:

Health services researchers; community, public mental health, and Veterans Administration psychiatrists and administrators; outcomes researchers.

REFERENCES:

1. Hawthorne WB, Green EE, Lohr JB, Hough R, Smith PG: Comparison of outcomes of acute care in short-term residential treatment and psychiatric hospital settings. Psychiatric Services 1999; 50(3): 401–406.

Innovative Program 17 **Friday, October 12 1:30 p.m.-3:00 p.m.**

THE KENNEDY AXIS V AS AN OUTCOME MEASURE IN A FORENSIC HOSPITAL PROGRAM

Michael T. Jumes, Ph.D., *Chief Psychologist, Competency Program, North Texas State Hospital at Vernon, P.O. Box 2231, Vernon, TX 76384*; Joseph L. Black, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate basic understanding of the K-Axis tool, and to consider its efficacy as a measure of hospital treatment outcome.

SUMMARY:

The purpose of this presentation is to describe the Kennedy Axis V (K-Axis V) and review a study of its predictive validity in an inpatient setting. It is intended for the multidisciplinary hospital treatment team member, as well as the researcher or hospital administrator

interested in multidimensional clinical outcomes measurement. A clinician-rated measure of patient function, the K-Axis provides behavioral anchors for the rating of eight functional domains (psychological skills, social skills, violence, ADLs, substance abuse, medical impairment, ancillary problems, and global functioning (GAF-Equivalent). Data were collected on a coed, adult, pretrial forensic hospital unit using a repeated measures design. As anticipated, analyses revealed moderate, negative correlations between certain subscale scores and hospital length of stay. Moreover, the K-Axis scores at hospital admission help predict which patients will be discharged with recommendations they be found competent, and which patients will be discharged with recommendations for further hospital treatment. In sum, the K-Axis V appears to provide a straightforward, clinically relevant, multidimensional description of patient functioning well suited for tracking inpatient treatment progress and outcome.

TARGET AUDIENCE:

Multidisciplinary psychiatric hospital team members; outcomes measure researchers; hospital administrators.

REFERENCES:

1. Higgins J, Purvis K: A comparison of the Kennedy Axis V and the Global Assessment of Functioning Scale. J of Psychiatric Practice 2000; 6: 84–90.
2. Kennedy JA: Fundamentals of psychiatric treatment planning. Washington, DC, American Psychiatric Press, 1992.

Innovative Program 18 **Friday, October 12**
1:30 p.m.-3:00 p.m.

INPATIENT TREATMENT PLAN BASED ON FUNCTIONAL OUTCOMES MEASUREMENT

Joseph L. Black, M.D., *Chief Psychiatrist, Competency Program, North Texas State Hospital at Vernon, 4730 College Drive, Vernon, TX 76384*; Michael T. Jumes, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to create clinically relevant treatment plans with measureable outcomes by using the Kennedy Axis V subscales as parameters.

SUMMARY:

This presentation reviews an innovative multidisciplinary treatment plan process. Multidisciplinary treatment teams require a method of inpatient treatment planning that will (1) be clinically relevant to staff and patients, (2) offer clear focus of treatment, (3) provide outcome-oriented goals, (4) facilitate continuity of care, (5) facilitate risk-management plan development, and (6) provide measureable treatment outcomes. To meet these needs, a method was developed using the Kennedy Axis V (I-Axis) subscales to organize identified problems. First, an Overall Rehabilitation Goal (ORG) is identified. This short or long-term goal denotes functional improvement as a response to treatment. Next, the K-Axis subscales are utilized as an organizational tool, categorizing and describing the functional barriers to attaining the ORG. In this model, multidisciplinary treatment teams members have collective responsibility for assessing the patient and developing an appropriate ORG, identifying the barriers to attaining the ORG and moving to the next level of care, developing a health maintenance goal, developing a risk-management plan, providing intervention, and tracking progress toward attaining the ORG. This utilization of the K-Axis subscales allows treatment progress and outcome to be not only functionally described, but measured as well.

TARGET AUDIENCE:

Multidisciplinary psychiatric hospital team members; outcomes measure researchers; hospital administrators.

REFERENCES:

1. Higgins J, Purvis K: A comparison of the Kennedy Axis V and the Global Assessment of Functioning Scale. J of Psychiatric Practice 2000; 6: 84–90.
2. Kennedy JA: Fundamentals of Psychiatric Treatment Planning. Washington, DC, American Psychiatric Press, 1992.

INNOVATIVE PROGRAMS: SESSION 7 TELEMEDICINE AND TECHNOLOGY

Innovative Program 19 **Saturday, October 13**
8:00 a.m.-9:30 a.m.

TELEPSYCHIATRY IN GEORGIA

Lydia E. Weisser, D.O., *Assistant Professor of Psychiatry, Medical College of Georgia, 1120 15th Street, BAA-330, Augusta, GA 30912*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) demonstrate an understanding of the definition of "telemedicine," (2) recognize the potential for telemedicine's application to psychiatry as a clinical tool, (3) recognize the potential for telemedicine's application to psychiatry as a teaching.

SUMMARY:

The overall objective of this program is to introduce participants to the telepsychiatry program at the Medical College of Georgia (MCG). Telepsychiatry's goal is to develop a system of health care to serve individuals with mental illness who reside in underserved areas of the state. Since its inception in July 1995, over 1,350 telepsychiatry patient encounters have occurred. Due to the serious shortage of mental health services in Georgia, approximately 40% of patients referred to telepsychiatry have never been seen by a psychiatrist. Currently, active clinics are held in Athens, Waycross, Warrenton, and Wrightsville, with plans for expansion to include residents of a nursing home in Johnson County, juvenile offenders in Sandersville, and the opening of a new site in north Georgia. The program content will include a description of the equipment, costs, and reimbursement issues, as well as a discussion of telepsychiatry's use as a teaching tool for residents and medical students. This program is intended for anyone with an interest in learning about current technological advances in health care delivery.

TARGET AUDIENCE:

General.

REFERENCES:

1. Vought, G, Adams S: Telepsychiatry: addressing mental health needs in Georgia. Community Mental Health Journal, 2000; 36: 525–533.
2. Lee, Grigsby, et al:The Georgia Mental Health Network—a web-based supplement to telepsychiatry in Georgia. Telemedicine Journal 2000; 4:104.

Innovative Program 20 Saturday, October 13 8:00 a.m.-9:30 a.m.

THE USEFULNESS OF HANDHELD PERSONAL COMPUTERS IN PSYCHIATRY RESIDENCY

David C. Belmonte, M.D., *Resident, Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109*; Abigail B. Schlesinger, M.D., *Resident, Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109*; Teri L. Wolfe, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize areas of utility of handheld personal computers, when provided for use by psychiatry residents.

SUMMARY:

Finding ways to improve the efficiency and overall satisfaction of hospital housestaff is important because improvements in resident workload, efficiency, and overall job satisfaction result in ultimate benefits to all members of the health care community. Handheld computers have been introduced to medical students and residents in the last three years as a way to communicate feedback to administrators, and to keep track of patient records, billing information, and procedures. With the advent and growth of the Internet, additional medical information is now available through a myriad of Web-based programs such as MDConsult, and through informal peer consultation and electronic mail communication. There is a new tool that has been recently introduced on the market that is capable of integrating all of the above functions, including the ability to access Internet information as needed. This is the "Pocket PC," or, a full personal computer that is fully transportable, lightweight, and wireless. We have explored the use of such a computer in a psychiatry residency program, where descriptive and often lengthy notes are common. We will review and describe the specific areas of utility of these computers in such a residency program, including details of the resident experience in the following areas: recording, editing, and transferring detailed histories and notes; completing and transferring patient logs; retrieving timely and relevant information from software and/or Internet sources; steamlining personal time commitments via personal planning and scheduling programs; and improving communication between residents, the psychiatry department, and the international medical community.

TARGET AUDIENCE:

Hospital housestaff and administrators, educators with an interest in implementing handheld computers to their programs.

REFERENCES:

1. Malan T et al: Hand-held computer operating system program for collection of resident experience data. Obstatrics and Gynecology. 2000; 96 (5):792–4.
2. Blackman et al: The usefulness of handheld computers in a surgical group practice. Proceedings, AIMA Annual Symposium. 1999; 686–690.

Innovative Program 21 Saturday, October 13 8:00 a.m.-9:30 a.m.

ESTABLISHING A VIABLE TELEMEDICINE CLINIC FOR FORENSIC PSYCHIATRY PATIENTS

Tracy D. Gunter-Justice, M.D., *Director, Forensic Evaluation Service, Hall Institute, 10 Harvest Ridge Drive,*

Columbia, SC 29229; William Quirk, L.S.W., *Director of Social Work, Hall Institute, 1800 Colonial Drive, Columbia, SC 29202*; R. Gregory Lande, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate a basic understanding of the use of telepsychiatry in the practice psychiatry and recognize the complexities of setting up a viable telemedicine program.

SUMMARY:

Over the last 30 years, the use of telemedicine has grown dramatically. The available technology has become less expensive, more reliable, and of better resolution, allowing for more applications in forensic psychiatry. The research done by the Association of Telemedicine Service Providers estimated that corrections medicine alone comprises 20% of all clinical telemedicine. The application of telemedicine has resulted in easier access to expertise and cost reduction while maintaining high-quality patient assessment and care of incarcerated persons. This innovative program will focus on the process of setting up and using a telemedicine site from a maximum security psychiatric hospital providing pre-trial evaluations, case consultation, clinical assessments, and educational opportunities to the state detention centers and mental health centers. The target audience for this presentation includes anyone interested in telepsychiatry. There are no specific background requirements for participants. A basic understanding of the nature of a psychiatric evaluation and experience with telephone and fax machine technology is preferable.

REFERENCES:

1. Bear D, Jacobson G, Aaronson S, et al: Telemedicine in psychiatry: making the dream a reality. Am J Psychiatry 1997; 154:885.
2. Brodley B, Claypoole K, et al: Satisfaction of forensic psychiatric patients with remote telepsychiatric evaluation. Psychiatr Serv 2000; 51:1305–1307.

INNOVATIVE PROGRAMS: SESSION 8 RECOVERY AND REHABILITATION

Innovative Program 22 Saturday, October 13 3:30 p.m.-5:00 p.m.

MULTIDISCIPLINARY APPROACH TO RECOVERY SPIRITUALITY IN DETOXIFICATION

Camilo A. Martin, M.D., *Department of Psychiatry, VA Medical Center, Gainesville, 1610 S.W. Archer Road, Gainesville, FL 32608*; Charlie A. Gass, D.Min., *Pastoral Psychotherapist, VA Medical Center, 1601 S.W. Archer Road, Gainesville, FL 32608*; Alice T. Allen, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand a concrete and practical approach to recovery spirituality and recognize the connection between spirituality and internal values that affect recovery.

SUMMARY:

Introduction: A new multidisciplinary program in substance abuse detoxification introduces recovery spirituality into comprehensive addictions treatment for a diverse population treated at a VA hospital.

Rationale: Spirituality is integral to substance abuse treatment (e.g., 12-step model). Yet medical literature on detoxification—the initial step in recovery—rarely mentions spirituality playing any part in its management. This is surprising since (1) crises are fertile ground for spiritual awakening and (2) peri-detoxification events—social, medical, legal—reveal detoxification to be crisis intervention at its best. A program to facilitate the vital incorporation of spirituality in subsequent recovery phases has been developed.

Program Description: All team professionals (psychiatrist, resident, pastoral psychotherapist-chaplain, nurse, social worker) integrate spirituality into the recovery process, traditionally only the chaplain's responsibility. Each presents spirituality as an important dimension of treatment, i.e., emphasis on hope. In the first week, patients attend a small group (3 to 10 patients) where a triangular conceptual model that distinguishes spirituality from religion is presented. Larger, weekly didactic sessions (15–30 patients) cover spirituality dimensions, e.g., relationships, accountability, trust, tolerance, discipline, shame, grief, forgiveness. Pre/post-treatment spiritual assessment inventories are administered by structured interviews to evaluate how patients rate the importance of specific spiritual dimensions in their lives. Program evaluation research on the program's first two years will be presented.

TARGET AUDIENCE:

Psychiatrists, psychiatric residents, psychologists, nurses, social workers, pastoral psychotherapists, chaplains, other professionals involved in addictions treatment.

REFERENCES:

1. National Institute on Drug Abuse, National Institutes of Health: Principles of Drug Addiction Treatment. Bethesda, MD, NIH Publication, 1999.
2. Lerner WD, Barr MA, (ed): Hospital-Based Substance Abuse Treatment. New York, Pergammon Press, 1990.

Innovative Program 23 Saturday, October 13 3:30 p.m.-5:00 p.m.

SUPPORTED EMPLOYMENT FOR HOMELESS PEOPLE: HOW IS IT DONE?

Michele M. Fontaine, M.A., C.R.C., *Coordinator, Job Links Supported Employment Program, Project Renewal, Inc., 200 Varick Street, 9th Floor, New York, NY 10014*; Hunter L. McQuistion, M.D., *Medical Director, Project Renewal, Inc., National Development and Research Institutes, and Former APA/Bristol-Myers Squibb Fellow, 200 Varick Street, 9th Floor, New York, NY 10014*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand what supported employment is and that it is a viable form of psychiatric rehabilitation.

SUMMARY:

Vocational approaches are assuming a central role in the treatment and rehabilitation of severe psychiatric disorders, and supported employment is one approach that has been shown to be effective. Project Renewal, an agency serving New York City's homeless population, has initiated a novel program adapting the supported employment model specifically to homeless clientele with severe mental illness.

This initiative presents both special opportunities and challenges, such as breaking the cycle of homelessness and demoralization and sensitizing clinicians to their clients' vocational potential. A key challenge this program faces is destigmatizing both mental illness and homelessness.

This presentation will explore the issues of creating meaningful vocational rehabilitation for mentally ill people with present and past histories of homelessness. While describing the program, the presenters will present illustrative case material and formative outcome data concerning this unique intervention, focusing on the challenges of overcoming stigma.

REFERENCES:

1. Becker DR, Drake RE: A Working Life: The Individual Placement and Support Program. Concord NH, Dartmouth Psychiatric Research Center, 1993.
2. Clark RE: Creating work opportunities for people with severe mental illness. Community Mental Health Journal 1995; 31:397–407.

Innovative Program 24 Saturday, October 13 3:30 p.m.-5:00 p.m.

MANAGING RISK IN PSYCHIATRIC REHABILITATION: A PATIENT-DRIVEN APPROACH

Peggy A. Wilson, D.N.S., *Clinical Nurse Specialist, San Francisco Mental Health Rehabilitation Facility, 887 Potrero Avenue, San Francisco, CA 94110*; Albert C. Gaw, M.D., *Speaker-Elect, APA Assembly; Medical Director, San Francisco Mental Health Rehabilitation Facility; and Medical Director for Long-Term Care, Community Mental Health Services, San Francisco Department of Public Health, 887 Potrero Avenue, San Francisco, CA 94110*; Mozettia Henley, D.N.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand an innovative, psychiatric treatment plan for high-risk patients.

SUMMARY:

The recent U.S. Surgeon General's report on mental health and mental illness identified the organization of services as the linchpin of effective treatment for adults with severe mental disorders. With psychiatric hospitals continuing to close, the number of severely mentally ill clients receiving community-based treatment has increased, and the intensity of service demands has also increased. New, innovative approaches to the marketplace are required. High-risk clients with complex histories are frequently both difficult to treat and difficult to place. There are conflicting societal demands for the prevention of violence while providing the least restrictive care, and this conflict is occurring during a time of significant downsizing and restructuring of health care systems. These clients challenge our current service systems to ameliorate the risk of danger to self and others while simultaneously providing adequate, appropriate, and effective psychosocial services.

This presentation will use a case study approach to illustrate how multidisciplinary services can be used to plan and implement comprehensive treatment plans for high-risk clients. With a case of a young man with a history of maternal neglect, amphetamine psychosis, violence toward others, and court-ordered psychiatric hospitalization, we will highlight the issues raised by the difficult-to-treat and difficult-to-place psychiatric patient, and present a model of service delivery that is driven by client needs, integrating the principles of psychiatric rehabilitation, least-restrictive care, prevention of violence, and shared risk.

TARGET AUDIENCE:

Direct service providers of all disciplines, administrators, and program directors.

REFERENCES:

1. Luettgen J, Chrapko WE, Reddon JR: Preventing violent re-offending in not criminally responsible patients. International J Law and Psychiatry 1998; 21:89–98.
2. Lansing AE, Lyons JS, Martens LC, O'Mahoney MT, Miller SI, Obolsky A: The treatment of dangerous patients in managed care: psychiatric hospital utilization and outcome. Gen Hosp Psychiatry 1997; 19:112–118.

Leadership and Career Development Seminar 1 **Friday, October 12 10:00 a.m.-11:30 a.m.**

THE OTHER SIDE OF THE MOUNTAIN: FROM RESIDENCY TO REALITY

Stephen M. Goldfinger, M.D., *Liaison, APA Institute Scientific Program Committee, and Professor and Vice Chair, Department of Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, Brooklyn, NY 11203*; Deborah Hales, M.D.; Ronald C. Albucher, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this program, the participant will be able to describe the differences between the structured learning of residency programs and continuing medical education in the "outside world," describe critical factors and limitations of clinical preparation in residency training, and describe three dimensions that are well-covered and three that are not.

SUMMARY:

Increasingly, APA and academic medical centers have been focusing on recognizing and addressing the needs of recent residency graduates or early career psychiatrists (ECPs). Sponsored APA-based fellowships have begun to bring together early career psychiatrists and offer continuing structured learning and individual mentoring experiences. This forum will focus on an interactive discussion between ECPs and senior psychiatrists in an exploration of how we have, and have not, met young professionals' needs in our current training paradigms.

Trainees in every program learn the basics of differential diagnosis, psycho- and pharmacotherapeutics, and other aspects of clinical psychiatry. Many programs, however, address only peripherally, or not at all, essential needs to translate this information into practice. Ranging from operational assistance in such essentials as joining provider panels, purchasing office equipment, or deciding on malpractice insurance, to discussions on how best to continue one's ongoing medical education after formal training is over, we often provide young professionals with inadequate tools to face the challenges ahead. Hopefully, drawing on the real world expertise of both junior and senior panel members, we will be able to help further the discussion of what is most needed and how best to meet these needs as we prepare ourselves, our field, and our trainees for the millennium ahead.

TARGET AUDIENCE:

Early career psychiatrists and residents

REFERENCES:

1. The American Psychiatric Association: Practice Management for Early Career Psychiatrists, Washington DC, 1999.
2. The Association for Women Surgeons: The Pocket Mentor: A Manual for Surgical Interns and Residents, Westmont IL, 1997.

Leadership and Career Development Seminar 2 **Friday, October 12 2:00 p.m.-5:00 p.m.**

STEPPING UP AND SPEAKING OUT: EARLY CAREER PSYCHIATRIST LEADERS IN PUBLIC PSYCHIATRY

Edward Simmer, M.D., *Psychiatrist, U.S. Navy*; Satyanarayana Chandragiri, M.D.; Jill Williams, M.D.; Yiu K. Ng, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to make informed choices regarding careers in public sector psychiatry based on experiences recounted by Janssen public policy fellows.

SUMMARY:

Each year a cadre of fellows is selected to participate in the APIRE/Janssen Public Policy Program at the IPS. These early career psychiatrists are dynamic, emerging leaders in the field of public sector psychiatry. In this interactive workshop; several current fellows will present information on the innovative programs they manage. They will also give advice and guidance from their own experience regarding transitions from residency and why they decided to go into public-sector psychiatry. Special interests of the presenters include public policy surrounding the delivery of mental health services, HIV/AIDS, chronic mental illness, and comorbid substance abuse.

Fellows in the APIRE/Janssen program are matched with senior psychiatrist mentors, and these mentors will be encouraged to participate in this session.

TARGET AUDIENCE:

Early career psychiatrists and residents

REFERENCES:

1. Pollack DA, Cutler DL: Psychiatry in community mental health centers: everyone can win. Community Ment Health J. 1992; 28: 259–67.
2. Brauzer B, Lefley HP, Steinbook R: A module for training residents in public mental health systems and community resources. Psychiatr Serv 1996; 47: 192–4.

Leadership and Career Development Seminar 3 **Saturday, October 13 8:30 a.m.-11:30 a.m.**

CAREER DEVELOPMENT FOR INTERNATIONAL MEDICAL GRADUATES

Renato D. Alarcón, M.D., M.P.H., *Professor and Vice Chair, Department of Psychiatry, Emory University School of Medicine, and Chief, Psychiatry Service, VA Medical Center, 1670 Clairmont Road, Decatur, GA 30033*; Nyapati R. Rao, M.D.; Norma C. Panahon, M.D.; Gabrielle F. Beaubrun, M.D.

EDUCATIONAL OBJECTIVES:

To identify unique needs of IMGs in setting up a practice, developing careers in public psychiatry, and treating ethnically diverse populations.

SUMMARY:

Statistics from the American Medical Association show that 42 percent of all general psychiatry residents are international medical graduates (IMGs). Research also shows that IMGs practice more frequently in the public sector, and as a result, serve more ethnically diverse populations. This workshop, geared toward resident and early career IMGs will serve to identify and discuss the special needs of IMGs, including challenges surrounding acculturation, cultural-competency training, overcoming barriers to setting up a practice, and issues and challenges in public-sector psychiatry.

TARGET AUDIENCE:

Early career psychiatrists and residents

REFERENCES:

1. Salsberg E, Nolan J: The posttraining plans of international medical graduates and US medical graduates in New York State. JAMA 2000; 183:1749–1750.
2. Fiscella K, Frankel R: Overcoming cultural barriers: international medical graduates in the United States. JAMA 2000; 183:1751.

Leadership and Career Development Seminar 4 **Saturday, October 13 2:00 p.m.-5:00 p.m.**

ADVOCACY 101: INFLUENCING MENTAL HEALTH POLICY

Jay B. Cutler, J.D., *APA Special Counsel, and Director, APA Division of Government Relations, 1400 K Street N.W., Washington, DC 20005*; Heather Whyte; Ronald A. Shellow, M.D.

EDUCATIONAL OBJECTIVES:

To recognize current state and federal legislative issues that affect patients and the practice of psychiatry and how to engage effectively in legislative advocacy.

SUMMARY:

If you are registered to vote, you possess the most important qualification needed to be a successful advocate on legislative issues affecting your patients and your profession.

Participants will learn about current state and federal legislative issues, the legislative process, and resources available to stay on top of the issues. Attendees will learn how to shape the future of psychiatric practice through relevant legislative advocacy and be briefed on current state and federal legislative issues that affect patients and the practice of psychiatry.

APA's Division of Government Relations offers many resources to encourage and assist APA members to become successful advocates. For example, APA's Web-based advocacy tool "Write to Congress" will be explained as well as other tools developed for APA members to enhance and increase the impact of their advocacy efforts. Psychiatric practitioners who have been successful lobbyists at both the state and federal levels will describe their experiences as advocates and explain why psychiatric practitioners' participation in the legislative process is crucial to the development of mental health public policy. Attendees will learn about legislative activity in the 107th Congress, pressing legislative issues in key states, and their influence as constituents in the development of mental health policy in the 21st century.

TARGET AUDIENCE:

Early career psychiatrist and residents

REFERENCES:

1. The Dance of Legislation. University of Washington Press, Volume 7, November 2000.
2. What have medical lobbyists done for you lately? organized medicine has clout, but practicing physicians are more effective at the influence game. Medical Economics, 2000; pp. 46–60.

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

TREATING PATIENTS WITH A BORDERLINE PERSONALITY DISORDER: STRUGGLES, TROUBLES, AND TRIUMPHS

Marcia Kraft Goin, M.D., Ph.D., *Vice President, APA Board of Trustees, and Clinical Professor of Psychiatry, University of Southern California Keck School of Medicine, 1127 Wilshire Boulevard, Suite 1115, Los Angeles, CA 90068*

EDUCATIONAL OBJECTIVES:

To acquire an organized, structured approach to the treatment of patients with borderline personality disorder that takes into account the complexities of evolving a therapeutic alliance, transference and countertransference phenomena, and psychological developmental issues; to provide practical tools in the management and therapeutic work needed to resolve clinical issues; to understand the developmental and neurochemical factors that contribute to the affective dysregulation in BPD.

SUMMARY:

Developing a therapeutic alliance, designing a framework for the treatment that acknowledges the patients' psychological deficits, and attending to boundaries, limit setting, and structure are some of the major struggles and troubles in our clinical work with patients suffering from borderline personality disorder (BPD). Creating approaches to these tasks must occur in the context of sensitivity to transference and countertransference. Successful management leads to attainment of treatment goals and a sense of professional achievement.

This lecture discusses BPD in the context of its biopsychosocial complexity. Strategies to structure treatment parameters and a therapeutic alliance will be described. Transference and countertransference issues will be addressed, including their utility in fulfilling treatment goals. The word "borderline" has garnered an unfortunate patina of stigma and an undeserved sense of therapeutic helplessness. Understanding the complex neurobiological and psychological deficits that dominate the psychic life of these patients allows for an organized, realistic, and compassionate approach to treatment.

REFERENCES:

Clarkin JF, Yeomans FE, Kernberg OF: Psychotherapy for Borderline Personality, New York, John Wiley & Sons, 1999.

Gunderson JG, Borderline Personality Disorder: A Clinical Guide, Washington, D.C., American Psychiatric Press, 2001.

Lecture 2 **Wednesday, October 10**
1:30 p.m.-3:00 p.m.

VISION AND PSYCHOSIS

George Tarjan Award

Busharat Ahmad, M.D., F.A.C.S., *Practice of Ophthalmology, Cornea, External Diseases, and Refractive Surgery, 26872 East River Road, Grosse Ile, MI 48138*

EDUCATIONAL OBJECTIVES:

To help in differential diagnosis of visual hallucinations in psychosis and brain and ophthalmic lesions.

SUMMARY:

Eye-tracking dysfunction is a putative trait, a marker for susceptibility to schizophrenia. Subjects with schizoaffective disorder have an early visual inflammation processing known as backward marking. Substantial evidence shows that schizophrenics have a defect in face processing. In dementia with lewy bodies, vision-related cognitive and behavioral symptoms are common, with involvement of occipital visual cortex. It has been demonstrated in functional neural imaging studies. A visual hallucination with white matter lesions and disease severity is evidenced in Parkinson's disease. Retinopathy in acute pancreatitis also commonly manifests as hallucinations. It also happens with Charles Bonnet syndrome, where propulsid was used as treatment. These hallucinations are also common after photocoagulation for choroidal neovascularisation, which is accompanied by photopsia, flashlights, and different colors. Charles Bonnet syndrome is also associated with estrogen intake.

Ocular motility in visual hallucinations is sometimes caused by the following: 1.) hysteria and malingering, 2.) combining medications like fluoxetine and dextromethorphan, 3.) after stroke especially in chronic schizophrenics, 4.) post-grief reaction, 5.) macular degeneration, 6.) after minor surgery especially with lidocaine anesthesia, 7.) during and after recovery from cortical blindness, 8.) after open-heart surgery.

REFERENCES:

1. Weller M, Wiedmann P: Visual hallucinations. Int. Ophthalmology 1989; 13:193–199.
2. Borrual FX: Visual hallucinations and illusions. Klin. Monatsbl. Augenhulka. 1999; 214:324–327.

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

WOMEN PATIENTS, PUBLIC SYSTEMS: WE CAN DO BETTER

Nada L. Stotland, M.D., M.P.H., *Speaker, APA Assembly, and Private Psychiatry Practice, 5511 South Kenwood Avenue, Chicago, IL 60637-1713*

EDUCATIONAL OBJECTIVES:

Mental health professionals who attend this lecture will learn to: identify the unique needs of women in public mental health systems, take appropriate reproductive histories from women patients, and address the custody and parenting issues of women patients.

SUMMARY:

The physiology and circumstances of women with psychiatric illnesses differ from those of men. Inpatient and outpatient care must include attention to the menstrual cycle, vulnerability to sexual and other abuse, contraception, pregnancy, abortion, and protection from sexually transmitted diseases. Psychiatric evaluations should address these issues. Many of our patients will not receive these services if their mental health care professionals do not arrange for or provide them. Women with severe and persistent mental illnesses, in this age of deinstitutionalization, have fertility rates approaching those of the age-matched general population. Custody and child-care issues are important to many women patients, impacting treatment attendance and adherence as well as treatment outcome. Attention to these specific needs of women patients must be integrated into all mental health care.

REFERENCES:

1. Jensvold MF, Halbreich U, Hamilton JA: Psychopharmacology and Women: Sex, Gender, and Hormones. Washington DC, American Psychiatric Press Inc. 1996.
2. Psychological Aspects of Women's Health Care: The Interface Between Psychiatry and Obstetrics and Gynecology, edited by Stotland NL, Stewart DE, Washington, D.C. American Psychiatric Press, Inc., 2001.

Lecture 4 **Wednesday, October 10**
1:30 p.m.-3:00 p.m.

HUMILITY IN PSYCHIATRIC LEADERSHIP: EXPLORING A PATH TO AUTHORITY

Clifton R. Tennison, Jr., M.D., *Chief Clinical Officer, Helen Ross McNabb Center at Knoxville, Clinical Assistant Professor of Medicine, University of Tennessee Graduate School, and Clinical Professor of Psychiatry, East Tennessee State University School of Medicine, 1520 Cherokee Trail, Knoxville, TN 37920*

EDUCATIONAL OBJECTIVES:

Attendees will be able to demonstrate an understanding of the importance of personal humility to the practice of professional ethics, including the establishment of ethical boundaries, confidentiality, informed consent, professional distance, ethical practice management, and interprofessional ethics.

Attendees will be able to demonstrate an understanding of the importance of ethical behavior, and therefore humility, to the establishment of psychiatric authority.

SUMMARY:

Professional authority depends on adherence to ethical principles. Ethical behavior requires humility. Healers and helpers in the fields of mental health, substance abuse, mental retardation, rehabilitation, and social service, and perhaps especially physicians, to whom leadership responsibility is given through tradition, law, and societal expectation, must model, practice, and teach professional ethics through personal humility in order to establish the authority required to do their jobs.

As we move from serendipitous discovery toward a more predictable psychopharmacology, and from behavioral observation and theoretical constructs toward the sifting through of billions of base pairs in the human genome, we must remain humble in our publications, training efforts, and relationships with patients and their families, lest we skew the interpretation of data.

Control wrested from others inevitably demeans the bully's position and interferes with therapy. Practicing with an actively humble approach, avoiding passivity, and utilizing kindness as a guiding principle enhance interprofessional collaboration, patient protection, and clinical outcomes.

REFERENCES:

1. HH Dalai Lama, Cutler HC: The Art of Happiness: A Handbook for Living. New York, Riverhead Books, 1998.
2. Moffic HS: The Ethical Way: Challenges and Solutions for Managed Behavioral Healthcare. San Fransisco, Jossey-Bass Publishers, 1997.

Lecture 5 **Wednesday, October 10**
3:30 p.m.-5:00 p.m.

ELECTRONIC COMMUNICATION AND CONFIDENTIALITY

Patient Advocacy Award

Latanya Sweeney, Ph.D. *Assistant Professor of Public Policy and Computer Science, Carnegie-Mellon University, 4800 Forbes Avenue, Pittsburgh, PA 15213*

EDUCATIONAL OBJECTIVES:

Educational objectives, a summary, and literature references were not provided for this lecture; therefore, participants who attetnd this lecture will receive category 2 CME credit.

Lecture 6 **Thursday, October 11**
8:00 a.m.-9:30 a.m.

THE CRITICAL TIME INTERVENTION FOR THE PREVENTION OF HOMELESSNESS: A REVIEW OF TEN YEARS OF CLINICAL AND RESEARCH FINDINGS

Alan D. Felix, M.D., *Director, Critical Time Intervention Mental Health Program, New York Presbyterian Hospital, 622 West 168th Street, New York, NY 10032*

EDUCATIONAL OBJECTIVES:

To understand the risk factors for recurrent homelessness and the challenges consumers face as they attempt to transition from institutional settings to community-based housing. To understand the principles underlying the Critical Time Intervention and the basic components of this model of care. To become familiar with current and past outcome studies of the Critical Time Intervention model.

SUMMARY:

The Critical Time Intervention (CTI) was developed with the aim of preventing recurrent homelessness in a group of men with severe and persistent mental illness living in a New York City shelter. Recognizing the typical discontinuity between the provision of services in the shelter and those in the community, along with an increased need for support during the transition, the authors of CTI devised a time-limited case management model to address these factors. CTI was studied in this population under an NIMH grant from 1990–1994. In a randomized case-control study, CTI demonstrated a significant reduction in recurrent homelessness. The CTI model is now being tested in different populations and settings. Current projects include CTI for men and women discharged from Rockland Psychiatric Center (a state facility); CTI for homeless families living in shelters in Westchester County, NY; and a 10-year follow-up of the original CTI subjects.

REFERENCES:

1. Caton CLM, Shrout PE, Eagle PF, et al: Risk factors for homelessness among schizophrenic men: a case-control study. Am J of Public Health, 1994; 84: 265–270.
2. Susser E, Valencia E, Conover S, et al: Prevention of homelessness among mentally ill men: a randomized clinical trial of a critical time intervention. Am J of Public Health, 1997; 87: 256–262.

Lecture 7 **Thursday, October 11**
10:00 a.m.-11:30 a.m.

CHANGING THE WORLD: DEVELOPING A COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEM OF CARE FOR INDIVIDUALS WITH CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS

Kenneth M. Minkoff, M.D., *Medical Director, Choate Health Management, and Consultant and Trainer, Integrated Treatment Systems and Interventions for Co-Occurring Disorders, 500 West Cummings Park, Suite 3900, Woburn, MA 01801*

EDUCATIONAL OBJECTIVES:

To identify seven principles of evidence-based treatment intervention upon which to base the design of a comprehensive, continuous, integrated system of care; to describe the components of a CCISC, using DDC and DDE terminology; to identify funding strategies to maximize resources for treatment of dual diagnosis; to delineate change strategies at the system, program, clinical practice, and clinician competency levels to implement a CCISC.

SUMMARY:

The lecture reviews research-based principles of successful treatment intervention for individuals with co-occurring disorders in the context of a parallel disease and recovery-integrated conceptual framework that uses a common language that makes sense from the perspective of both the addiction field and the mental health field. The lecture then illustrates the application of these principles to the design of a comprehensive, continuous, integrated system of care for psychiatric and substance disorders that maximizes use of all existing resources for initiating integrated treatment. The discussion then illustrates a systematic process for implementing this model, utilizing simultaneous interventions at the system, program, clinical practice, and clinician levels, and reports on progress of various system-changing initiatives using an assortment of strategies from different parts of the country.

REFERENCES:

1. Minkoff K: Individuals with Co-Occurring Disorders in Managed Care Systems; Standards of Care, Practice Guidelines, Workforce Competencies, and Training Curricula. SAMHSA, January, 1998.
2. Minkoff K: An integrated model for the management of co-occurring psychiatric and substance disorders in managed care systems. Disease Management and Health Outcomes 2000; 8:251–57.

Lecture 8 **Thursday, October 11**
1:30 p.m.-3:00 p.m.

SEX RECEPTORS: MECHANISMS OF DRUG ACTION VIA BIOCHEMICAL RECEPTORS ON SEXUAL RESPONSE

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

EDUCATIONAL OBJECTIVES:

To understand which biochemical substrates that affect libido, arousal, and orgasm; to apply the biochemical understanding in choosing antidepressant treatment and other medication that may affect sexual function.

SUMMARY:

Sexual concerns are of great importance to patients. Physicians, especially psychiatrists, should routinely take a sexual history of patients and understand psychological forces as well as biological forces that may impact on sexual function or dysfunction. Biologically, there are a number of substances that may increase or decrease sexual libido, arousal, and/or orgasm. Serotonin drugs, which increase prolactin release, can cause decrease in sexual desire and inhibited orgasm by 5HT2c and possibly 5HT1b stimulation. Dopamine reuptake inhibitors may enhance desire. Possibly 5HT3 blockers may also stimulate desire as may 5HT1a stimulation. Drugs, which enhance nitric oxide (like sildenafil or cialis), may potentiate arousal, while drugs that inhibit it (like paroxetine), decrease arousal. Not every person has exactly the same receptor sensitivity, so some effects may outweigh others. Still, by understanding the biochemical effects medications have on sexual function, a physician can more easily determine how to avoid or treat sexual dysfunction.

REFERENCES:

1. Saks BR: Sex receptors: mechanisms of drug action via biochemical receptors on sexual response of women. Journal of Sex Education and Therapy 2000; 25:33–35.
2. Saks BR: Identifying and discussing sexual dysfunction. Journal of Clinical Psychiatry Monographs 1999; 17:4–8.

Lecture 9 **Thursday, October 11**
1:30 p.m.-3:00 p.m.

TEACHING PSYCHOTHERAPY, DOING PSYCHOTHERAPY: THE STRUGGLE FOR COMPETENCE

Carol A. Bernstein, M.D., *Treasurer, APA Board of Trustees, Director of Residency Training in Psychiatry, and Associate Professor of Clinical Psychiatry, New York University School of Medicine, 550 First Avenue, NB 20-N-11, New York, NY 10016*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, participants should have an understanding of the process by which educational organizations concluded that competencies needed to be established for psychiatric training. Participants will also have an understanding of the current status of efforts within the field of psychiatry to identify competency requirements for residents in various types of psychotherapy.

SUMMARY:

At its meeting in February 1999, the ACGME endorsed general competencies for residents in the areas of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice. In addition, over the years both the LCME and the ABPN have become increasingly involved in efforts to identify competencies for medical students, residents, and practitioners.

Last year, APA joined in the process by establishing a Task Force on Core Competencies chaired by Sherwyn Woods, M.D., Ph.D. after the Psychiatry RRC went ahead and identified competence in a variety of psychotherapies as a requirement for residency training beginning in July 2001.

This talk will discuss the background for these developments in education and will review the current status of efforts made in the field to define core competencies in the various psychotherapies. Highlighted in this review will be results of an impressive effort undertaken by AADPRT under the stewardship of Drs. Lisa Mellman and Gene Beresin to identify specific skills that should be taught to residents to help them develop competence in performing psychodynamic psychotherapy, CBT, brief therapy, and psychotherapy with medication as treatment modalities.

REFERENCES:

1. ACGME Outcome Project: General Competencies, 2000.
2. ACGME: Program Requirements for Residency Training in Psychiatry, 2000.

Lecture 10 **Thursday, October 11**
3:30 p.m.-5:00 p.m.

THE PSYCHIATRIST AS A FOSTER PARENT: LESSONS LEARNED

Margery Sved, M.D. *Adjunct Associate Professor, Department of Psychiatry, University of North Carolina*

School of Medicine, P.O. Box 37247, Raleigh, NC 27627-7247

EDUCATIONAL OBJECTIVES:

To discuss the potential benefits and difficulties of a psychiatrist serving as a foster parent.

SUMMARY:

As many as 500,000 children are likely to be in foster care in the United States at any given time. Three-fourths of these children will return to live with biological family members. Many children who have experienced one or more foster placements receive mental health services at some time, and psychiatrists and mental health professionals should be aware of the issues faced by children in foster care and their families.

The presenter, a psychiatrist who is also a foster and adoptive parent, will discuss relevant experiences as a foster parent. This will include an overview of a typical foster care system and the advantages and difficulties of being a psychiatrist while fostering. In addition, interactions with numerous agencies and entitlement programs, and the role of poverty, will be discussed. Knowledge of abnormal development learned from parenting traumatized children will also be included.

TARGET AUDIENCE:

Child psychiatrists, anyone involved with children in foster care.

REFERENCES:

1. Cournos F: A psychiatrist recalls life as a foster child. Psych Services 1999; 50:479–80.
2. Rosenfeld AA, et al: Foster care: an update. J Am Acad Child Adol Psych 1997; 36:448–57.

Lecture 11 **Thursday, October 11**
3:30 p.m.-5:00 p.m.

OLD WINE IN A NEW BOTTLE: A KLEINMAN'S CULTURAL PARADIGM FOR UNDERSTANDING PSYCHOTHERAPY

Albert C. Gaw, M.D., *Speaker-Elect, APA Assembly; Medical Director, San Francisco Mental Health Rehabilitation Facility; and Medical Director for Long-Term Care, Community Mental Health Services, Department of Public Health, San Francisco, 887 Potrero Avenue, San Francisco, CA 94110*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be able to understand the cultural context of psychotherapy that transpired at the realm of meanings, and to understand Kleinman's paradigm on the structural organization of healing on the level of symbolic healings that unified all healing systems, including psychotherapy.

SUMMARY:

Jerome Frank defined psychotherapy as "a planned, emotionally charged, confiding interaction between a trained, socially sanctioned healer and a sufferer." Frank asserted that all psychotherapeutic endeavors transpire entirely in the realm of meanings, i.e., all psychotherapies depend on the fact that a human being's feeling and behavior are guided largely by the person's assumption about reality, that is, meanings that he or she attributes to events and experiences, rather than their objective properties. In this sense, psychotherapy resembles rhetoric and hermeneutics. But how do words and relationship actually heal? How do changes in the meanings of an individual's experience lead to microphysiological healing? In this presentation, I will summarize Kleinman's theoretical paradigm for the structural organization of healing on the level of symbolic meanings that unified all healing systems, including psychotherapy, and draw implications of such a paradigm for the teaching and research of psychotherapy.

REFERENCES:

1. Gaw A: Concise Guide to Cross-Cultural Psychotherapy. Washington, DC, The American Psychiatric Press, 2001.
2. Kleinman A: Rethinking Psychiatry. New York, Free Press, 1988.

Lecture 12 **Friday, October 12**
8:00 a.m.-9:30 a.m.

COMPETENCE TO RESIDE IN THE COMMUNITY

Howard Telson, M.D., *Associate Clinical Director, Community Mental Health Services, Visiting Nurse Service of New York, 1250 Broadway, New York, NY 10001*

EDUCATIONAL OBJECTIVES:

At this end of this lecture the audience will understand: variations in the meanings of competence and commitment in America; the utility of the concept of competence to reside in the community in the present mental health system.

SUMMARY:

American law presumes that adults are reasonable and competent to exercise their rights. Competence was traditionally a unitary concept, which required a threshold of mental functioning. When a court declared someone incompetent due to mental impairment, the individ-

ual lost all rights and required the appointment of a guardian.

The development of the hospital system caused mentally ill individuals to be evaluated less for competence than for civil commitment. This was based on the need for treatment or dangerousness due to disease. Whether by statute or informal practice, however, patients were considered incompetent once they underwent civil commitment.

After the World War II new theories about psychiatric treatment and civil rights led to deinstitutionalization and fundamental changes in mental health law. Competence became specific to individual rights, commitment required dangerousness, and the presumption of incompetence upon commitment was eliminated.

While intended to correct past injustices and improve treatment, the new principles added a layer of complexity to the mental health system that profoundly affected the delivery of care. The concept of competence to reside in the community may be useful in promoting a more integrated, clinical viewpoint in current thinking about individuals with severe mental illness.

REFERENCES:

1. Jones BN, Jayaram G, Samuels J, Robinson H: Relating competency status to functional status at discharge in patients with chronic mental illness. J Am Acad Psychiatry Law 1998; 26:149–55.
2. Allen M, Smith VF: Opening Pandora's box: the practical and legal dangers of involuntary outpatient commitment. Psych Services 2001; 52: 342–6.

Lecture 13 **Friday, October 12**
8:00 a.m.-9:30 a.m.

BARRIERS TO HELP-SEEKING AND TREATMENT FOR ADHD

Regina Bussing, M.D., *Associate Professor of Psychiatry, University of Florida, Box 100177, Gainesville, FL 32610-0234*

EDUCATIONAL OBJECTIVES:

The audience will be able to identify three sociodemographic risk factors for delayed help-seeking for ADHD and learn about parental explanations for not seeking care.

SUMMARY:

Effective treatments for attention deficit/hyperactivity disorder (ADHD) have been clearly established, yet a significant proportion of affected children do not receive appropriate interventions. This study examines barriers to help-seeking and treatment for ADHD, with a focus on the role of gender and ethnicity. A telephone survey of a stratified random sample of 1,615 parents of elementary school students assessed previous help-seeking steps for ADHD among youth above clinical cut-off on the Swanson-Nolan-and-Pelham IV. Those at increased risk for ADHD completed personal interviews, including the Diagnostic Interview Schedule for Children, version 4, and a barrier inquiry. Females and minority children had lower rates of detection, evaluation, professionally assigned ADHD diagnoses, and current treatment than boys and Caucasians, respectively. In multiple logistic regression, gender and parental ADHD knowledge, but not ethnicity, emerged as independent predictors of these help-seeking steps for ADHD.

REFERENCES:

1. Hoagwood K, Kelleher KJ, Feil M, Comer DM: Treatment services for children with ADHD: a national perspective. J Am Acad Child Adolesc Psychiatry 2000; 39:198–206.
2. Bussing R, Zima BT, Belin TR: Differential access to care for children with ADHD in special education programs. Psychiatric Services 1998; 49:1226–1229.

Lecture 14 **Friday, October 12**
10:00 a.m.-11:30 a.m.

ENHANCING MEDICAL STUDENT RECRUITMENT INTO PSYCHIATRIC CAREERS

Ana E. Campo, M.D., *Associate Professor of Clinical Psychiatry, and Director of Medical Student Education, University of Miami School of Medicine, 4330 Surrey Drive, Coconut Grove, FL 33133*

EDUCATIONAL OBJECTIVES:

The attendee will learn the factors that contribute to the shifts in trends in psychiatric recruitment in the U.S. residency programs, factors that influence medical student choices in selecting a specialty, including psychiatry, and ways in which medical school curriculum and extracurricular activities can help enhance recruitment into psychiatric residencies.

SUMMARY:

In order to produce the best psychiatrists, it is of utmost importance that we as a profession recruit the best medical students in significant numbers to fill our psychiatric residencies.

This lecture will present a comprehensive review of the literature dealing with medical student education, career choices, and trends in psychiatric careers.

In 1994, only 3.2% of U.S. medical school graduates chose psychiatry, the lowest proportion since 1929. (1) Authors studying the factors that contributed to this trend concluded that those departments with higher recruit-

ment rates are the ones giving considerable priority to and resources for medical student psychiatric education.

Other authors (2) surveying medical students in their freshman year, found that medical students had negative attitudes about psychiatry that are based on objectifiably false beliefs. These negative attitudes that are brought into medical school can be remediated within the medical school curriculum.

The lecture will present results from questionnaires given to second- and third-year medical students regarding attitudes towards psychiatric careers including reasons for career choices. It will also highlight medical student curriculum psychiatric and extracurricular psychiatric activities that have enhanced recruitment into psychiatric residencies.

REFERENCES:

1. Sierles FS, Taylor MA: Decline of U. S. medical student career choice of psychiatry and what to do about it. Am J Psychiatry 1996; 153:1372–1373.
2. Feifel D, Moutier CY, Swerlow NR: Attitudes toward psychiatry as a prospective career among students entering medical school. Am J Psychiatry 1999; 156:1397–402.

Lecture 15 **Friday, October 12**
1:30 p.m.-3:00 p.m.

CHILDHOOD VIOLENCE: CLINICAL ASPECTS

Harold I. Eist, M.D., *Past President, American Psychiatric Association, and Medical Director, Montgomery Child and Family Health Services, 10436 Snow Point Drive, Bethesda, MD 20814*

EDUCATIONAL OBJECTIVES:

To recognize and identify the enormous social problems of violence, discuss the impact of violence, the suffering inflicted on society, examine basic risk factors, and explain what violence reflects. Also, to identify critical psychodynamic issues, understand the critical reaching for the "inner world of being" of children, evaluate current interventions and biopsychosocial treatment strategies, and understand psychiatry's role in and contributions to modify violence.

SUMMARY:

Violence begins in our families and communities and produces enormous suffering for individuals and for all society. Violence suffered in childhood, whether psychological, physical, or sexual has long-term consequences. The mistreatment and neglect of children initiates a cycle of violence that rampages through generations. Domestic violence has increased, parenting styles have changed, and parents are often reluctant to identify the problems their children may have. Children both witness violence and are victims of violence. During turbulent adolescent development, girls (there has been a marked increase in violent crimes among female adolescents) and boys deal with high levels of distress, fears, anger, vulnerability, dependency, frustration, and frequent exposure to easily imitated, violent media. Even when they try to listen and make special efforts, parents and schools may not be hearing.

Violence is often predictable and preventable. Four basic risk categories of violence are defined. Case reports and current interventions are examined. In our society, there are problems differentiating between psychopathology and sociopathy. Reports of violence are demographic and not psychodynamic. Psychodynamic issues are critical to understanding violent children. It is critical to reach their inner world of being. Biopsychosocial, responsible, direct treatment strategies are discussed. Additionally, the public's perception that individuals with mental disorders are violent is an important aspect of stigma against the mentally ill. Stigma is condoned by our current laws, discrimination in health insurance, and the legal system. This is also a form of violence.

Psychiatry, the quintessential biopsychosocial medical specialty, is resolute in its opposition to violence, and we have the wide breadth essential to make major contributions to the understanding of and finding approaches to modify violence.

REFERENCES:

1. Lewis DO, Yeager CA: Juvenile violence. Child and Adolescent Psychiatric Clinics of North America, October 2000; 21: 32–36.
2. Cole TB, Flanagin A: What can we do about violence?. JAMA, August 4, 1999; 43: 482–486.

Lecture 16 **Friday, October 12**
3:30 p.m.-5:00 p.m.

GREEN EGGS AND HAM: DEVELOPING A PASSION FOR PUBLIC PSYCHIATRY

Jacqueline M. Feldman, M.D., *Patrick H. Linton Professor, Department of Psychiatry, University of Alabama, Birmingham, and President, American Association of Community Psychiatrists, 4-CCB, 908 20th Street, South, Birmingham, AL 35294*

EDUCATIONAL OBJECTIVES:

By the end of the presentation the audience will: understand training in community psychiatry, including innovative training programs, learn strategies to recruit into public psychiatry, and be reminded of the idiosyncratic "green eggs and ham" joy of public psychiatry.

SUMMARY:

"I do not like green eggs and ham, I do not like them, Sam-I-am." These lines might typify many psychiatrists' opinion of community/public psychiatry, reflecting a visceral rejection of a culinary delight. Like the energetic, persistent, and ever-hopeful Sam-I-Am, Dr. Feldman seeks to explore the resistance to tasting a somewhat idiosyncratic dish. She will review literature and research related to public psychiatry training and will offer strategies to entice her psychiatric colleagues to try a nibble, confident that one bite will convince the predisposed soul that a vocation of public psychiatry can offer a variety of astonishing rewards.

REFERENCES:

1. Geller JL: The last half-century of psychiatric services as reflected in Psychiatric Services. Psychiatric Services 2000; 51: 41–67.
2. Ranz J, Rosenheck S, Deakins S: Columbia University's fellowship in public psychiatry. Psychiatric Services 1996; 47: 512–516.

Lecture 17 **Friday, October 12**
3:30 p.m.-5:00 p.m.

MENTAL HEALTH CARE AND PUERTO RICO'S HEALTH CARE REFORM: WHERE HAS THE QUEST TO INCREASE ACCESS AND QUALITY THROUGH MARKET INCENTIVES LED US AND AT WHAT COST?

Sarah Huertas-Goldman, M.D., Ph.D., *Associate Professor and Acting Chair, Department of Psychiatry, University of Puerto Rico School of Medicine, 20 Calle Washington, Apt. 6-A, San Juan, PR 00907-1534*

EDUCATIONAL OBJECTIVES:

At the end of this session, participants will be able to: describe evidence of the impact of system reforms on the provision of mental health care in the U.S., consider the impact of reform on aspects of a mental health system other than direct provision of services, and discuss the potential relevance of the case of reform in Puerto Rico for the design of service delivery and financing models.

SUMMARY:

In 1994, Puerto Rico dramatically "re-formed" its public health care system. In contrast with the U.S. Puerto Rico had a regionalized system, which came about both from local tradition and from a process of systematic planning in the 1950's and 1960's. The majority of general public health care facilities were privatized and, in the case of mental health facilities, gradually closed. Contracts for provision of mental health services were established with insurance companies using a behavioral carve out managed care model. The organization and delivery of services for half the population were dramatically altered in a period of about six years. Service utilization and epidemiological data from ongoing studies allow for systematic assessment of some aspects of the impact of reform on mental health care. We review some relevant literature, discuss impact on psychiatric practice and training, and offer potential lessons for the implementation of mental health care systems, particularly for economically disadvantaged groups.

REFERENCES:

1. Alegria M, McGuire T, Vera M, et al: Changes in access to mental health care for the poor and non-poor with managed care: results from the health care reform in Puerto Rico. In press. Am J Public Health.
2. Ma C, McGuire T: Costs and incentives in a behavioral health carve out. Health Affairs. 1998; 17:53–69.
3. Gold M: Markets and public programs: insights from Oregon and Tennessee. J Health Politic Policy Law. 1997;22:633–666.

Lecture 18 **Saturday, October 13**
8:00 a.m.-9:30 a.m.

PSYCHOTHERAPIST AS HEALER

T. Byram Karasu, M.D., *Silverman Professor and University Chairman, Albert Einstein College of Medicine, 2 East 88th Street, New York, NY 10128-0555*

EDUCATIONAL OBJECTIVES:

At the end of the lecture, the participant will be able to define the nature of soul and spirituality in practical terms and differentiate being a technician of psychotherapy from a healer psychotherapist.

SUMMARY:

The therapist must anchor himself or herself in emotional intimacies and communal engagements and ground his or her being in the serenity of loving and believing. That means to live a soulful and spiritual existence. The way of soulfulness is love: love of others, love of work, and love of belonging. The way of spirituality is believing: believing in the sacred, believing in unity, and believing in transformation. These six complementary dimensions of soulfulness and spirituality are separately exalting, and each opens the door for the others. Together they make a divine union. Only through such transcendence may a therapist may find his or her own authentic healing self, as all healing techniques ultimately emanate from within the healer.

REFERENCES:

1. Karasu TB: Deconstruction of Psychotherapy. Northvale, NJ, Jason Aronson, 1996.
2. Karasu TB: The Therapist as Healer, Northvale, NJ, Jason Aronson (in press).

Lecture 19 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

HOW TO BECOME A BUSINESS EXPERT: RUNNING YOUR PRIVATE PSYCHIATRIC PRACTICE

George L. Warren, M.D., *Private Psychiatry Practice, 516 Lakeview Road, Villa 9, Clearwater, FL 33756*; Walter G. Griffith, Jr., M.D., *Private Psychiatry Practice, 2685 Ulmerton Road, Suite 105, Clearwater, FL 34622*

EDUCATIONAL OBJECTIVES:

To identify the major business obstacles in private practice that must be overcome to successfully build an efficient and profitable practice, to learn the means to build a support network of peers and mentors to master and overcome the business challenges of private practice, and to gain an conceptual framework of private practice business success.

SUMMARY:

This presentation will provide a methodology for psychiatrists—whether in solo or group practice—to gain mastery over the diverse business challenges of private practice. Establishing and maintaining a successful private practice requires tremendous breadth of business savvy and expertise, despite a lack of any formal business training from the many years of medical school and residency. Participating in a new format called NetworkMD, eight Clearwater, Fla., psychiatrists committed to attending monthly meetings to pool their efforts and business expertise to learn to practice psychiatry with a smarter business perspective and approach. Collectively focusing on a broad agenda of private practice business issues—personnel, management, liability, technology, investing, negotiating managed care contracts, Medicare compliance—the psychiatrists used a team-oriented, problem-solving approach to substantially reduce expenses and risk exposure, increase revenues, and improve the efficiency and quality in their individual practices.

Attendees will hear an introductory speaker followed by a panel composed of the Clearwater psychiatrists who participated in NetworkMD who will discuss their experience and new knowledge base. For practitioners desiring to partake in a network and support group of peers and mentors offering ongoing examination and discussion of the multitude of business issues that arise in private practice, this presentation will provide a way to fulfill this profound need.

REFERENCES:

1. Johnson BE: Many physician incomes decline, but psychiatrists' show increase. Psychiatric Practice & Managed Care 2000; Vol. 6, 386–392.
2. APA: Practice Management for Early Career Psychiatrists. Washington D.C., APA Office of Healthcare Systems and Financing, 1999.

Lecture 20 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

THE HAND THAT ROCKS THE CRADLE ROCKS THE BOAT

Alexandra Symonds Award

Ann Ruth Turkel, M.D., *Department of Psychiatry, St. Luke's-Roosevelt Hospital Center, 350 Central Park West, New York, NY 10025-6547*

EDUCATIONAL OBJECTIVES:

To examine the psychodynamic issues involved in the empowerment of women as well as those involved in the inhibition of their ambition.

SUMMARY:

Women are in a vastly different place from where they were 20 years ago and from where they will be 20 years from now. I am referring now not to the external obstacles in the professional and corporate worlds that restrict women's career advancement, but to the psychological glass ceiling, which is far more important than external restrictions.

The psychodynamic factors that enhance the empowerment of women will be examined, as well as the negative elements that inhibit ambition and success. The internal conflicts for women are mostly invisible: sex-role socialization, low self-esteem, coping with aggression and anger—both their own and that of others—fear of failure, fear of success, and fear of deviance. The dynamics of power relationships between men and women, role conflicts, and the particular difficulties women experience around issues of leadership, authority, and influence will be examined.

REFERENCES:

1. Jordan JV., Kaplan A, Miller JB., et al: Women's Growth in Connection: Writings from the Stone Center. New York, The Guilford Press, 1991.
2. The Psychodynamics of Leadership. edited by Klein EB., Gabelnick F, Herr P. Madison, Conn., International Universities Press, 1999.

Lecture 21 **Saturday, October 13**
1:30 p.m.-3:00 p.m.

FORGING COLLABORATIONS: OBSTACLES, OPPORTUNITIES, AND INNOVATIONS

Wesley E. Sowers, M.D., *Medical Director, Allegheny County Office of Behavioral Health, and Clinical Associate Professor, Department of Psychiatry, University of Pittsburgh School of Medicine, 400 45th Street, Pittsburgh, PA 15201*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture participants should be able to: discuss factors that have traditionally created barriers to the formation of collaborative endeavors in mental health systems, identify ways in which stakeholders can redefine themselves and their relationships to enhance cooperative ventures, and recognize innovations that have potential to move systems toward greater mutuality in the management of their community's mental health.

SUMMARY:

There is little doubt that the development of effective mental health service systems requires the orchestration of the various elements that make them up, yet there have traditionally been significant barriers to the realization of this goal. This lecture will consider various opportunities to enhance the degree of collaboration between stakeholders in these service systems: consumers, providers, and payers. An evolving concept of professionalism will be considered as the basis for entering into new types of partnerships and enhancing our ability to meet the emerging needs of the service-using population. In addition, participatory dialogues as one method to create alliances between professionals and service users, collaborative methods to guide service intensity decisions and reduce adversarial interactions and administrative waste, developing incentives that promote cooperative arrangements affecting transitions, and the integration of programs for clients with multiple needs will be discussed. Other types of creative collaborations will be solicited from participants.

REFERENCES:

1. Sowers W, George C, Thompson K: Level of care utilization system for psychiatric and addiction services (LOCUS): a preliminary assessment of reliability and validity. Community Mental Health Journal 1999; 35: 621–842.
2. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA): Participatory Dialogues—A Guide to Organizing Interactive Discussion on Mental Health Issues among Consumers, Providers, and Family Members. Consumer Information Series, Vol 3, Washington, D.C., 2000, SMA 00-3472.

Lecture 22 **Saturday, October 13**
3:30 p.m.-5:00 p.m.

FAMILY EDUCATION/ PSYCHOEDUCATION IN SCHIZOPHRENIA: WHAT ARE WE WAITING FOR?

Harriet P. Lefley, Ph.D., *Professor, Department of Psychiatry, University of Miami School of Medicine, D-29, P.O. Box 016960, Miami, FL 33101*

EDUCATIONAL OBJECTIVES:

Participants will know the research foundation for family psychoeducation as evidence-based practice in schizophrenia, understand barriers to implementing family psychoeducation in mental health systems, become familiar with a range of alternative models of therapeutic family education, and be able to formulate solutions for implementing family education/psychoeducation in service delivery.

SUMMARY:

Numerous research projects have established that family psychoeducation significantly reduces relapse in schizophrenic patients. Although recommended in consensus guidelines as evidence-based treatment for schizophrenia, family psychoeducation is rarely offered and has yet to become accepted as standard practice. To meet families' needs for information and support, a range of alternative models have been developed by mental health practitioners. Additionally, in numerous states the NAMI Family to Family program offers public courses in which professionally developed educational materials are administered by trained family members. The lecture will explore various types of family interventions, including the role of support groups in maintaining continuity of knowledge and support. Empirically based psychoeducational programs are contrasted with various models of family education in terms of duration, content, target groups, and desired outcome. Unresolved questions regarding cultural appropriateness, feasibility and staff resistance, as well as how to deal with disparate needs of patients and family members will be noted. Among patients without families, alternative models of psychoeducation of residential staff and others acting in caregiving roles may be needed. The discussion will focus on potential solutions for implementing family/caregiver education as standard practice and expected benefits to schizophrenic patients and their families.

REFERENCES:

1. Dixon L, Lyles A, Scott J, et al: Services to families of adults with schizophrenia: from treatment recommendations to dissemination. Psychiatric Services 1999, 50:233–238.
2. McFarlane WR, Lukens EP, Link B, et al: Multiple-family groups and psychoeducation in the treatment of schizophrenia. Arch Gen Psychiatry, 1995;52:679–687.
3. Lefley HP: Family Caregiving in Mental Illness. Thousand Oaks, CA, Sage, 1996.

Lecture 23 **Sunday, October 14**
8:00 a.m.-9:30 a.m.

SYSTEMS OF CARE FOR CHILDREN'S MENTAL HEALTH: FAILURES, AND OPPORTUNITIES

American Association of Community Psychiatrists

Andrés J. Pumariega, M.D., *Professor and Director, Child and Adolescent Psychiatry, James H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70567, Hillrise Hall, Johnson City, TN 37614-9567*

EDUCATIONAL OBJECTIVES:

At the end of this lecture, participants, will become familiar with the history and principles of the system of care movement in children's mental health; understand the current status of the implementation of system of care principles in children's public mental health programs in the United States; recognize the benefits and limitations of the system of care model, both from the research literature and conceptually; understand the importance of increased involvement by psychiatry and child/adolescent psychiatry in this movement and model in order to address its shortcomings as well as psychiatrists' isolation from this approach.

SUMMARY:

The United States has had a longstanding ambivalent relationship with its children and youth. Our culture idealizes them, but our nation frequently withholds the resources necessary for the development of its young citizens. This has been especially true in the area of mental health and social services, where inadequate planning, funding, and implementation have led to the rapid rise of related morbidities: suicide, homicide, institutionalization, school drop-out, teen pregnancy, and drug abuse to name a few. As a result, a major part of our mental health disparities for racial and ethnic minorities can be traced back to their relative youth and consequent lack of access to such services. In 1983, Jane Knitzer's seminal book, Unclaimed Children, documented this crisis and spurred the concepts and early models of community-based systems of care for children's mental health. In the 25 years since Stroul and Friedman proposed this model, we have witnessed many advances in access and effectiveness of these services, but also an intensification of this crisis. This lecture will review the background and history of this model, highlight its achievements and shortcomings, and discuss its implementation and evaluation. It will also present recommendations for future revisions of the systems of care model and agenda. The role of psychiatry as a discipline within this model will be discussed, in terms of both its past absence and the importance of its future involvement.

REFERENCES:

1. Pumariega AJ, Nace D, England MJ, et al: Community-based systems approach to children's managed mental health services. Journal of Child and Family Studies. 1997; 6:149–164.
2. Pumariega AJ, Glover S: New developments in service delivery research for children, adolescents, and their families. Advances in Clinical Child Psychology, edited by Ollendick T, Prinz R. Volume 20. New York, Plenum Publishing Co., 1998.

Lecture 24 **Sunday, October 14**
10:00 a.m.-11:30 a.m.

BOUNDARY ISSUES IN CLINICAL PRACTICE

Thomas G. Gutheil, M.D., *Professor of Psychiatry, Harvard Medical School, 6 Wellman Street, Brookline, MA 02446-2831*

EDUCATIONAL OBJECTIVES:

Participants will learn how to avoid both the appearance and reality of boundary violations, how to respond to boundary violations observed in practice, and how to understand legal and clinical aspects of sexual misconduct.

SUMMARY:

The presentation will review the concept of boundary crossings and their relationship to sexual misconduct in clinical practice. Risk-management principles and techniques for clinical approaches will be outlined.

REFERENCES:

1. Appelbaum PS, Gutheil TG: Clinical Handbook of Psychiatry and the Law. Baltimore, Williams & Wilkins, 1991.
2. Gutheil TG: Patient-therapist sexual relations. Harvard Med Schl Mental Health Ltr 1989; 6:4–6.

3. Jorgenson L, Randles R, Strasburger L: The furor over psychotherapist-patient sexual contact: new solutions to an old problem. Wm. & Mary Law Rev 1991; 32:645–732.

Medical Update 1 **Wednesday, October 10**
3:30 p.m.-5:00 p.m.

THE EVALUATION AND TREATMENT OF DIABETES IN THE COMMUNITY SETTING

Eric Moore, M.D., *Physician, Private Family Practice, 3468 Foxton Court, Oviedo, FL 32765*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) understand the definitions of type 1 and type 2 diabetes; 2) review symptomatology of diabetes; 3) review the latest treatment options; 4) manage diabetic emergencies; and 5) develop management skills through case studies.

SUMMARY:

Diabetes remains one of the major causes of mortality and morbidity in the United States. With over 55 million diabetics in the U.S., knowing basic management skills is essential for all practicing physicians. Analyzation of case studies will provide the physician with the necessary tools to diagnose, and manage the diabetic patient in a variety of settings.

REFERENCES:

1. Majgerhee S, Decina P, Boccola V, et al: Diabetes Mellitus in Schizophrenic Patients, Compr Psychiatry 1996; 37:68–73.
2. Wirshing DA, Spellberg BJ, Erhar SM, et al: Novel Antipsychotics and New-Onset Diabetes, Biol Psychiatry 1998; 44:118–783.

Medical Update 2 **Thursday, October 11**
8:00 a.m.-9:30 a.m.

ERECTILE DYSFUNCTION: WHAT DOES THE MENTAL HEALTH PRACTITIONER NEED TO KNOW?

Jeffrey Thill, M.D., *Urologist, Winter Park Urology Associates, 1812 North Mills Avenue, Orlando, FL 32803*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to define and diagnose erectile dysfunction, and understand current treatment options and research trends in erectile dysfunction.

SUMMARY:

Erectile Dysfunction (ED) affects millions of men of all age groups. Causes can be singular or multifactorial. The anatomy of erectile function will be reviewed, as well as the biochemical events that must occur for adequate function. Pharmacological strategies will be discussed, including drug interactions in the ED patient, which encompass iatrogenic causes.

Current treatment options and future developments will round out the discussion.

REFERENCES:

1. Campbell's Urology: Walsh, et. al., 7th Edition 1998.
2. Textbook of Erectile Dysfunction: Carson, et. al., 1999.

Medical Update 3 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

HEPATITIS AND NEW SCREENING GUIDELINES FOR COLO-RECTAL CANCER

Barry Katz, M.D., *Gastroenterologist, Digestive Disease Consultants, 661 East Altamonte Drive, Suite 325, Altamonte Springs, FL 32701*

Medical Update 4 **Saturday, October 13**
1:30 p.m.-3:00 p.m.

THE EVALUATION AND TREATMENT OF HEADACHES

Marc I. Sharfman, M.D., *Neurologist, Headache and Neurological Treatment Institute, 1936 Lee Road, Suite 137, Winter Park, FL 32789*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: understand the epidemiology, pathophysiology, nondrug treatment, symptomatic treatment, rescue treatment, and preventive treatment of headache.

SUMMARY:

The last decade has witnessed an unprecedented growth in the understanding of the pathophysiology of headache and treatment options. This session will review pathophysiology of headache, classification of headache, nondrug treatment, and symptomatic and preventive treatment of headache.

REFERENCES:

1. Sharfman M: Update on headache. Comp Therapy 1998; Vol 24.
2. The Headaches, Second Edition, Edited by Olesen J, 1999.

Multimedia Session 1 Wednesday, October 10 1:30 p.m.-3:00 p.m.

VIDEO WORKSHOP: THE DIALECTICAL APPROACH TO UNDERSTANDING BORDERLINE PERSONALITY DISORDER

B. Perry Ottenberg, M.D., *Clinical Professor of Psychiatry, University of Pennsylvania, 210 West Washington Square, Suite 501, Philadelphia, PA 19106*

EDUCATIONAL OBJECTIVES:

To review the clinically relevant features of borderline personality disorder based on DSM-IV criteria, and to describe the underlying causes of the disorder.

SUMMARY:

This video workshop addressed three essential questions: 1) What is borderline personality disorder?, 2) What causes it?, and 3) How can it be effectively treated? The video is a straightforward introduction for therapists; the program explains borderline personality disorder and provides a thorough overview of Marsha M. Linehan's uniquely effective treatment approach, called dialectical behavior therapy.

REFERENCES:

1. Gunderson JG: Borderline Personality Disorder: A Clinical Guide. Wash. DC, American Psychiatric Publishing Inc.
2. Linehan MM: Cognitive Behavioral Therapy of Borderline Personality Disorders. New York, Guilford, 1993.

Multimedia Session 2 Wednesday, October 10 1:30 p.m.-3:00 p.m.

VIDEO WORKSHOP: UNTANGLING THE MIND

Brenda Wilson, M.D., *Psychiatrist, Lakeside Alternative, 1337 Ballentyne Place, Apopka, FL 32703*

EDUCATIONAL OBJECTIVES:

To review Dr. Heinz Lehmann's role in the development of the psychopharmacological treatment of schizophrenia.

SUMMARY:

This riveting documentary shows the transformation that occurred in psychiatric care through the pioneering work of Dr. Heinz Lehmann. When Dr. Lehmann fled Nazi Germany to Montreal in 1937, he devoted the next 60 years to finding new and more humane treatments for the mentally ill. One of his dramatic achievements, captured on archival film, was a series of experiments involving intense human contact with his most regressed women patients. They had spent their days smearing feces on the wall, but by the end of the treatment were nicely dressed and participating in activities.

But Dr. Lehmann's greatest legacy came with a single pill—Largactil—the first antipsychotic drug used in North America. By successfully treating patients with this drug. Lehmann introduced the world to the idea that biology plays a role in mental illness.

While "Untangling the Mind" is a record of Lehmann's perseverance and humanity, it is also an important historical record. Extraordinary archival footage of doctors performing electric shock therapy and lobotomies demonstrates how far psychiatric medicine has come. This film takes us to the world's loading brain research center in Washington, D.C. where Lehmann's remarkable work is being taken to the next level. This film will be an indispensable resource for courses in the history of psychiatry.

REFERENCES:

1. Lehmann HE; Ban TA: The history of the psychopharmacology of schizophrenia. Can J Psychiatry 1997; 42:152–62.
2. Lehman HE: Before they called it psychopharmacology. Neurophyschopharmacology 1993; 8:291–303.

Multimedia Session 3 Wednesday, October 10 3:30 p.m.-5:00 p.m.

VIDEO WORKSHOP: THE DIALECTICAL APPROACH TO TREATING BORDERLINE PERSONALITY DISORDER

Louise I. Buhrmann, M.D., *Private Psychiatry Practice, Lakeview Office Park, 1485 South Semoran Boulevard, Winter Park, FL 32792-5508*

EDUCATIONAL OBJECTIVES:

To review the clinically relevant features of borderline personality disorder based on DSM-IV criteria, and to describe treatment approach options.

SUMMARY:

This video workshop addresses three essential questions: 1) What is borderline personality disorder?, 2) What causes it?, and 3) How can it be effectively treated? The video is a straightforward introduction for therapists; the program explains borderline personality disorder and provides a thorough overview of Marsha M. Linehan's uniquely effective treatment approach, called dialectical behavior therapy.

REFERENCES:

1. Gunderson, JG: Borderline Personality Disorder: A Clinical Guide. Wash. DC, American Psychiatric Publishing, Inc.
2. Linehan, MM: Cognitive Behavioral Therapy of Borderline Personality Disorders. New York, Guilford, 1993.

Multimedia Session 4 Wednesday, October 10 3:30 p.m.-5:00 p.m.

VIDEO WORKSHOP: THE PERSONALS

Ian E. Alger, M.D., *Multimedia Consultant, APA Institute Scientific Program Committee, and Clinical Professor of Psychiatry, New York Presbyterian Hospital-Cornell Medical Center, 500 East 77th Street, #132, New York, NY 10162-0025*

EDUCATIONAL OBJECTIVES:

To discuss how older people deal with issues of intimacy, love, and sexuality.

SUMMARY:

This video offers an extraordinary look at the emotional lives of elderly Americans. "The Personals" follows a group of senior citizens as they rehearse and present an original play at a community theater on Manhattan's Lower East Side. Drawn from the comedy and drama of their own lives, the play is structured around their quest for dates through the personal ads. On stage, the seniors perform their roles with energy and laughter. Off stage, their lives are often lonely and silent.

REFERENCES:

1. Blazer DG: Depression in the elderly. N Eng J Med 1989; 320:164–166.
2. Birren JE, Sloane RB, Cohen GD: Handbook of Mental Health and Aging. 2nd Edition. New York, Academic, 1992.

Multimedia Session 5 Thursday, October 11 8:30 a.m.-11:30 a.m.

VIDEO WORKSHOP: BOYS DON'T CRY: A TRANSSEXUAL PSYCHIATRIST'S PERSPECTIVE

Melanie E. Spritz, D.O., *Community Psychiatrist, 9102 Colonial Road, #4E, Brooklyn, NY 11209-6156*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participants will be able to understand the processes and pain that a transgendered individual feels as he or she undergo transition from one gender to another. They shall also learn methods to properly diagnose and treat transgendered individuals, as well as have an awareness of the sociopolitical context exemplified by the film.

SUMMARY:

This film captures the emotional turmoil that transgendered patients face as they undergo the transition from one gender to the other, as well as exemplifying their nightmares. This film will be placed into context from both psychodynamic perspectives, as well as from the practical experiences of someone who has undergone the processes. This film is specifically about a case that heightended the political awareness of the transgender community and helped to unite it with the lesbian and gay communities. It also paints a portrait of the sociological, political, and economic burdens that transgendered individuals face in their daily lives.

TARGET AUDIENCE(S):

Psychiatrists who are interested in treating this group, as well as anyone who saw this film and desires to know more about the clinical issues.

REFERENCES:

1. Moss D, Zeajin L. The Real Thing? A Review of Boys Don't Cry. Prepublication American Imago-Circled.
2. Clelaud C, The Psychoanalyst and the Transexual Patient. Int J. Psychoanalysis, 2000, 81:21–35.

Multimedia Session 6 Thursday, October 11 8:30 a.m.-11:30 a.m.

VIDEO WORKSHOP: AS GOOD AS IT GETS: PROGRESS IN THE UNEASY RELATIONSHIP BETWEEN PSYCHIATRY AND AMERICAN FILM

Steven E. Pflanz, M.D., *Chief, Mental Health Services, F.E. Warren Air Force Base, U.S. Air Force, 408 West First Avenue, Cheyenne, WY 82001*

EDUCATIONAL OBJECTIVES:

To critically examine contemporary American films with mental health content and understand how the images portrayed in these films influence the public perception of psychiatry and mental illness.

SUMMARY:

Released in 1997, "As Good As It Gets" was nominated for best picture and garnered Academy Awards for best actor (Jack Nicholson) and best actress (Helen Hunt). The critical and commercial success of "As Good As It Gets" gave its portrayal of mental illness and the

mentally ill a wide audience and a powerful opportunity to shape the American public's view of our profession. A generation earlier, Jack Nicholson won his first Academy Award in 1975 for his portrayal of another psychiatric patient in "One Flew Over The Cuckoo's Nest," a film that left an enduring mark on the American consciousness and colored heavily the public perception of psychiatry for years. Twenty-six years later, it remains critical to understand the powerful images that contemporary films put forward about our profession and our patients. In particular, films that achieve dual success at the box office and with the critics are essential to examine due to their far-reaching appeal with the public. "As Good As It Gets" portrays a man with a mental illness struggling with the issues of everyday life and provides us with a glimpse of what it might be like to cope with suffering from a mental illness. After viewing the film, the audience will discuss the film and the images of psychiatry and mental illness portrayed in the film.

TARGET AUDIENCE(S):

general Psychiatrists

REFERENCES:

1. Gabbard GO, Gabbard K: Psychiatry and the Cinema, 2nd Edition. Washington, D.C., American Psychiatric Press, Inc., 1999.
2. Hesley JW, Hesley JG: Rent Two Films and Let's Talk in the Morning: Using Popular Movies in Psychotherapy. New York, John Wiley & Sons, Inc., 1998.

Multimedia Session 7 Thursday, October 11 1:30 p.m.-3:00 p.m.

VIDEO WORKSHOP: 7-UP IN AMERICA

Walter J. Muller III, M.D., *Private Psychiatry Practice, 1215 Louisiana Avenue, Winter Park, FL 32789-2303*

EDUCATIONAL OBJECTIVES:

To explore the view of the world through the eyes of a group of 7-year-old American children who were filmed by Michael Apted for his "7 Up Around the World Project."

SUMMARY:

The "7 Up Around the World" project captures the universal promise and innocent wisdom possessed by children the world over. Responding with disarming eloquence to basic questions regarding their present lives and future aspirations, these 7-year-olds are a unique window on a changing world. With spontaneity and openness they offer insights adults tend to lose sight of as they grow older. This documentary captures the lives of 14 7-year-olds in America.

REFERENCES:

1. Schaefermeyer MJ: Film criticism, in Common Culture edited by Petracca & Sorapurem M. N.J., Prentice Hall, 1997.
2. Andrew D: The neglected tradition of phenomenology in film theory. Wide Angle 1978; 2:44–49.

Multimedia Session 8 Thursday, October 11 1:30 p.m.-3:00 p.m.

VIDEO WORKSHOP: THE BRISTOL-MYERS SQUIBB FELLOWSHIP: HISTORY AND RESULTS

Leah J. Dickstein, M.D., *Associate Dean and Chair of Academic Affairs, and Director, Division of Attitudinal and Behavioral Medicine, Department of Psychiatry and Behavioral Science, University of Louisville, 500 South Preston Street, #214, Louisville, KY 40292*; Sharon S. Levine, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

To understand the historic goals and specifics of the Bristol-Myers Squibb Fellowship as reported by Henry Work, M.D., as well as past fellows' reports of its benefits.

SUMMARY:

Established in 1980 by APA Deputy Medical Director Henry Work, M.D., and Bristol-Myers Squibb executives, the APA Bristol-Myers Squibb resident fellowship has enabled several hundred trainees to meet leaders in the field and learn more about the field. This presentation will open with a video interview of Henry Work, M.D., by Leah J. Dickstein, M.D., current APA-BMS fellowship chair. Dr. Work recounts his and APA's goals and visions for the fellowship.

Results of a recent survey of past fellows concerning their professional experiences and current work sites, together with assessment of the fellowship benefits, will be presented. The session will end with an "open mike" for past fellows to add further comments.

TARGET AUDIENCE(S):

Resident, student, and faculty attendees.

REFERENCES:

1. Goetz R, Cutler DL, Pollack D et al: A three-decade perspective on community and public psychiatry training in Oregon, Psychiatric Services 1998; 49:1208–11.
2. Ranz J, Rosenheck S, Deakins S: Columbia University's fellowship in public psychiatry, Psychiatric Services, 1996; 47:512–6.

Multimedia Session 9 Thursday, October 11 3:30 p.m.-5:00 p.m.

VIDEO WORKSHOP: 7-UP IN SOUTH AFRICA

Ian E. Alger, M.D., *Multimedia Consultant, APA Institute Scientific Program Committee, and Clinical Professor of Psychiatry, New York Presbyterian Hospital-Cornell Medical Center, 500 East 77th Street, #132, New York, NY 10162-0025*

EDUCATIONAL OBJECTIVES:

To explore the view of world through the eyes of a group of 7-year-old children from South Africa.

SUMMARY:

"Age Seven in South Africa" is part of the acclaimed "Age Seven" documentary series of children from many countries who are revisited every seven years to document their growth and development. The 7-year-olds there have now been filmed again at ages 14, 21, 28, and just recently at 35. The South African children in this film were visited in 1991 and will be documented again in seven years. Of all the "Age Seven" films this one is unique in that the compelling portraits of the bright and charming children are strikingly contrasted with the social turbulence that surrounds them. The innocence that defines the children is sadly compromised by the intolerance of their communities.

REFERENCES:

1. Schaefermeyer MJ: Film Criticism in Common Culture, edited by Petracca, Sorapurem U. N.J., Prentice Hall, 1997.
2. Dudley A: The neglected tradition of phenomenology in film theory. Wide Angle 1978; 2:44–49.

Multimedia Session 10 Thursday, October 11 3:30 p.m.-5:00 p.m.

VIDEO WORKSHOP: FIRST PERSON PLURAL

Hae Ahm Kim, M.D., *121-16 Ocean Promenade, #6E, Rockaway Park, NY 11694*

EDUCATIONAL OBJECTIVES:

To review issues of a young Korean woman who was adopted by an American family as she attempts to reconcile her two identities.

SUMMARY:

In 1966, Deann Borahay Liem was adopted by an American family and sent from Korea to her new home. Growing up in California, the memory of her birth family was nearly obliterated until recurring dreams led Borshay Liem to discover the truth: her Korean mother was very much alive. Bravely uniting her biological and adoptive families, filmmaker Borshay Liem's heartfelt journey makes "First Person Plural" a poignant essay on family, loss, and the reconciling of two identities.

REFERENCES:

1. McGoldrick M, Giordano J: Ethnicity and Family Therapy. Second Edition. New York, Guilford Press, 1996.
2. Kanter J: Community-based management of ethnic clients. Clinical Social Work Journal, 18:23–41.

Multimedia Session 11 Friday, October 12 8:00 a.m.-9:30 a.m.

COMPUTER WORKSHOP: COMPUTERS IN PSYCHIATRY: EVENTS IN 2000-2001

Zebulon C. Taintor, M.D., *19 East 93rd Street, New York, NY 10128-1928*

EDUCATIONAL OBJECTIVES:

This session will introduce new software and hardware, including handheld devices; privacy and confidentially issues will also be discussed.

SUMMARY:

This session will focus on new software and hardware, including handheld devices; privacy and confidentiality issues.

REFERENCES:

1. McCormack J: Wooing Physicians to adopt electronic records. Health Data 1999; 7:128–132.
2. Maverson D: Sharing access, protecting privacy. Imaging and Document 1999; 8:12.

Multimedia Session 12 Friday, October 12 8:30 a.m.-11:30 a.m.

VIDEO WORKSHOP: PSYCHOLOGICAL ENGAGEMENT OF THE MEDICALLY ILL PATIENT AND THE FAMILY

Psychiatric Services Video Award

Milton Viederman, M.D., *Professor of Clinical Psychiatry, Weill Medical College, Cornell University, and Training and Supervising Psychoanalyst, Columbia Psychoanalytic Center, 525 East 68th Street, New York, NY 10021-4873*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will be familiar with the basic psychodynamic principles and techniques utilized to engage patients psychologically in the process of consultation and in a brief dynamic psychotherapy, as illustrated on videotapes. An additional objective is the examination of the issue of normal grief and substantial change in the context of a life crisis.

SUMMARY:

The session will begin with a brief discussion of the author's conceptual approach to consultation. This will be followed by a videotape presentation of a three-session dynamic psychotherapy with an eight-month follow-up divided into segments. Each segment will be discussed from the point of view of what is observed, what the patient communicates, and how the therapist uses this understanding to intervene. The patient's normal grief response after loss will be discussed in the eight-month follow-up.

The second half of the session will illustrate the conceptual approach to consultation, using videotape interviews with different patients who have different concerns and personalities.

REFERENCES:

1. Viederman M: The psychodynamic life narrative: a psychotherapeutic intervention useful in crisis situations. Psychiatry 1983; 46:236–246.
2. Viederman M: Presence and enactment as a vehicle of psychotherapeutic change. J Psychotherapy Practice and Research 1999; 8:274–283.

Multimedia Session 13 **Friday, October 12**
10:00 a.m.-11:30 a.m.

COMPUTER WORKSHOP: TELEPSYCHIATRY FROM ALL OVER WITH ALL TYPES

Roxy Szeftel, M.D., *Director, Child Psychiatry, Cedars Sinai Medical Center, 740 26th Street, Santa Monica, CA 90402-3150*

EDUCATIONAL OBJECTIVES:

To acquaint participants with a variety of current applications of telepsychiatry in a variety of settings.

SUMMARY:

Presentations from California (developmentally disabled), Texas (school consultations), and New York (prisons, rural general practice).

REFERENCES:

1. Alessi NE: The global forum on telemedicine: a bridge to the 21st century. Telemed J 1999; 5:213–4.
2. Karlinsky H: Telepsychiatry: under-appreciated barriers to implementation. ITCH 2000; 9:1421–1428.

Multimedia Session 14 **Friday, October 12**
1:30 p.m.-3:00 p.m.

VIDEO WORKSHOP: DRINKING APART

Kenneth P. Rosenberg, M.D., *Department of Psychiatry and Public Health, Cornell Medical College, 110 East 71st Street, New York, NY 10021-5011*

EDUCATIONAL OBJECTIVES:

To increase awareness of the impact of addiction on the family and to provide a document on use of family therapy.

SUMMARY:

"Drinking Apart: Families Under The Influence" is an original HBO documentary about families as they attempt to reconcile their lives in the wake of alcohol and drug addictions. The film follows families from varying socioeconomic classes and ethnicities as they seek intervention and guidance from New York City's Ackerman Institute for the Family and follows the lives of these three families:

- Toinette and Sam: Just released from jail and drug charges, Toinette comes home to her husband and three children. Sober for the first time in their relationship, Toinette and Sam deal with the responsibilities of marriage and parenting, while confronting the Herculean task of remaining sober.
- Eric and Jillian: After falling in love in a bar and quickly moving in with each other, this young couple finds that they have little in common when they put down the bottle.
- Patria and Erica: Throughout most of Erica's life, her mother Patria was strung out on heroin. Today, after being clean for three years, Patria finds that her teenage daughter Erica is on a similar path of self-destruction and desperately seeks a way to prevent her child from following in her footsteps.

REFERENCES:

1. Steinglass P: The Alcoholic Family, New York, Basic Books.
2. Inskip HM, Marris EC, Barraclough B: Alcoholism destroys families. British Journal of Psychiatry 1998; 172:35–37.

Multimedia Session 15 **Friday, October 12**
2:00 p.m.-5:00 p.m.

VIDEO WORKSHOP: HOOP DREAMS

Joel S. Feiner, M.D., *Clinical and Training Director, Mental Health Connections, and Professor of Psychiatry, University of Texas Southwestern Medical Center, 5909 Harry Hines Boulevard, #9, Dallas, TX 75235-6209*

EDUCATIONAL OBJECTIVES:

To discuss how African-American culture in urban life impacts on the emotionally live cycle of adolescents and families.

SUMMARY:

They have nothing—except talent and a dream—and in this tough Chicago neighborhood, dreams are all they can count on, "Hoop Dreams" is the critically acclaimed true-life story of Arthur Agee and William Gates and the unforgettable five-year experience that turns them into men. You will come to know them and root for them as if they were your friends, your family, as against all odds, these boys prove that with faith, talent, and a little luck, anyone can achieve the American dream.

REFERENCES:

1. Blum D: Rumbles on the court. Chronicle of Higher Education 1994; A34–35.
2. Nelson G: Elevating the Game: Black Men and Basketball. New York, Harper-Collins, 1992.

Multimedia Session 16 **Friday, October 12**
3:30 p.m.-5:00 p.m.

VIDEO WORKSHOP: 7-UP IN THE SOVIET UNION

Jeffrey A. Danziger, M.D., *Private Psychiatry Practice, 7251 University Boulevard, # 200, Winter Park, FL 32792*

EDUCATIONAL OBJECTIVES:

To discuss the growth and development of 20 7-year-old children in the Soviet Union; to review how this documentary stimulates our thoughts about the structure of life in the 20th century.

SUMMARY:

"Age Seven In The Soviet Union" is one of the finest productions in the acclaimed "Age Seven" documentary series about children from many countries who are revisited every seven years to document their growth and development. The first such project was in England, and the 7-year-olds there have now been filmed again at ages 14, 21, 28, and just recently at 35. The Soviet children in this film were visited in 1990 and documented again in 1997. Of all the "Age Seven" films this one is perhaps the most compelling. It presents an intimate portrait of 20 totally captivating children who are wise beyond their years. Strong, often eloquent, yet delightfully frivolous as well. The pathos at times, however, is heartbreaking.

REFERENCES:

1. Schaefermeyer MJ: Film Criticism in Common Culture, edited by Petracca Sorapurem U, N.J., Prentice Hall, 1997.
2. Dudley A: The neglected tradition of phenomenology in film theory. Wide Angle 1978; 2:44–49.

Multimedia Session 17 **Saturday, October 13**
8:00 a.m.-9:30 a.m.

VIDEO WORKSHOP: 14-UP IN THE SOVIET UNION

B. Perry Ottenberg, M.D., *Clinical Professor of Psychiatry, University of Pennsylvania, 210 West Washington Square, Suite 501, Philadelphia, PA 19106*

EDUCATIONAL OBJECTIVES:

To discuss the growth and development of 20 14-year-old children in the Soviet Union; to review how this documentary stimulates our thoughts about the structure of life in the 20th century.

SUMMARY:

This film is part of the documentary study of development in various countries, filming children at seven year intervals. This documentary compares the changes in these Russian children from their first documentation seven years earlier (Multimedia Session 16); the children now are 14.

REFERENCES:

1. Schaefermeyer MJ: Film Criticism in Common Culture, edited by Petracca, Sorapurem U., N.J., Prentice Hall, 1997.
2. Dudley A: The neglected tradition of phenomenology in film theory. Wide Angle 1978; 2:44–49.

Multimedia Session 18 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

VIDEO WORKSHOP: AN EDUCATIONAL INTERVENTION TO ENHANCE COMPLIANCE IN SCHIZOPHRENIA

Gary J. Remington, M.D., Ph.D., *CAMH, 250 College St., Toronto, Ont., Canada.* April Collins

EDUCATIONAL OBJECTIVES:

To better understand the role of educational interventions in schizophrenia; to obtain knowledge and skills that can be utilized to improve treatment adherence.

SUMMARY:

Poor medication compliance, which is reported to occur in up to 80% of outpatients, is one of the major determinants of outcome in schizophrenia. Notably, Baumi et al (1993) found that patient compliance could be improved by 30%, and first-year readmission rates reduced by 20% after employing a series of eight educational sessions. Thus, there is reason to believe that compliance-improving strategies like psychoeducation have potential for reducing health care costs and the personal suffering that schizophrenia places on affected individuals, their families and the community at large.

This multimedia presentation will describe the development of an eight-week education program for patients with schizophrenia and their families, which is designed to improve awareness of illness and treatment adherence. DVD technology with voice over is used and provides didactic information, in combination with case material, to highlight key points. Additionally, a workbook has been produced that is used in conjunction with the DVD and includes exercises that attempt to personalize the information; that is, patients are asked about how the information applies to their specific circumstances. This education program is an important supplement to basic treatment, and its use in groups makes it economically viable and well accepted by patients.

REFERENCES:

1. Dixon L, Adams C, Luckstead A: Update on family psychoeducation for schizophrenia. Schizophrenia Bulletin 2000; 26:5–20.
2. Fenton WS, Blyler CR, Heinssen RK: Determinants of medication compliance in schizophrenia: empirical and clinical findings. Schizophrenia Bulletin 1997; 23:637–651.

TARGET AUDIENCE(S):

Psychiatrists, multidisciplinary allied health practitioners, families, clients

Multimedia Session 19 Saturday, October 13 1:30 p.m.-3:00 p.m.

VIDEO WORKSHOP: CLINICAL VIRTUAL REALITY

Ian E. Alger, M.D., *Multimedia Consultant, APA Institute Scientific Program Committee, and Clinical Professor of Psychiatry, New York Presbyterian Hospital-Cornell Medical Center, 500 East 77th Street, #132, New York, NY 10162-0025*; Larry F. Hodges, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand new advances in applications of virtual reality therapy in PTSD by virtual reality immersion.

SUMMARY:

Dr. Larry Hodges, a leading researcher in the field of virtual reality therapy, will show current advances in the application of this modality in PTSD with Vietnam War veterans now participating in VA-sponsored research. In addition, applications of virtual reality in the treatment of various phobias, especially fear of flying, will be demonstrated.

REFERENCES:

1. Rothman BO, Hodges LF, Kooper R, et al: Effectiveness of virtual reality graded exposure in treatment of acrophobia. American Journal of Psychiatry 1995; 152:626–628.
2. Medicine Meets Virtual Reality. Burke, Va, IOS Press, 1999.

Multimedia Session 20 Saturday, October 13 2:00 p.m.-5:00 p.m.

VIDEO WORKSHOP: ORDINARY PEOPLE: PSYCHOSOCIAL FORMULATION TRAINING USING COMMERCIAL FILMS

Donald A. Misch, M.D., *Associate Professor of Psychiatry, Medical College of Georgia, 1515 Pope Avenue, Augusta, GA 30912*

EDUCATIONAL OBJECTIVES:

To list the basic elements of and to construct a useful psychosocial case formulation.

SUMMARY:

The traditional methods of teaching psychosocial case formulation—written references, individual psychotherapy supervision, clinical case conferences—can be complemented and enhanced by the use of group formulation exercises using commercial films. This approach offers a number of benefits and opportunities. First, all participants begin with the same patient database. Everyone sees the same scenes, from the same perspectives, and is thus equally able to contribute to the discussion. Second, in movies, just as in the psychiatrist's daily work, aspects of an individual's life are presented in a series of snapshots or vignettes that are necessarily incomplete; and, in both, the material omitted may be just as impor-

tant as the material included. Third, both films and patients "distort" the data, emphasizing the importance of considering the perspective from which data are reported. A fourth advantage is that psychopathology as embodied in relatively sterile intellectual theory—cognitive distortions, defense mechanisms, impulsivity, narcissism, object relations, empathic failures—comes alive through the use of movies. Finally, the group approach promotes critical thinking and teamwork in a safe and enjoyable atmosphere.

This multimedia session will be used to demonstrate the use of commercial films in psychosocial formulation training. For the first half of the session, the movie "Ordinary People" will be shown in its entirety. Thereafter, participants will work as group, in conjunction with a facilitator, to construct a step-by-step psychosocial formulation of the principal characters. This highly interactive session is designed for psychiatry residents, medical students, and other mental health trainees with a basic knowledge of psychopathology and case formulation.

REFERENCES:

1. Misch DA: Psychosocial formulation training using commercial films. Acad Psych 2000; 24:99–104.
2. Perry R, Cooper AM, Michels R: The psychodynamic formulation: its purpose, structure, and clinical application. Am J Psychiatry 1987; 144:543–550.

Multimedia Session 21 Saturday, October 13
3:30 p.m.-5:00 p.m.

VIDEO WORKSHOP: VIRTUAL REALITY THERAPY DEMONSTRATION

Ian E. Alger, M.D., *Multimedia Consultant, APA Institute Scientific Program Committee, and Clinical Professor of Psychiatry, New York Presbyterian Hospital-Cornell Medical Center, 500 East 77th Street, #132, New York, NY 10162-0025*; Hunter Hoffman, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand new advances in applications of virtual reality therapy in phobias and for pain reduction in burn patients mitigated by virtual reality immersion.

SUMMARY:

The Human Interface Technology Laboratory (HIT Lab) in Seattle, Washington, produces a continuing stream of new ideas and applications in virtual reality. Hunter Hoffman, Ph.D., a research scientist from the HIT Lab, will demonstrate the use of immersive virtual reality to reduce burn pain during wound care and physical therapy.

REFERENCES:

1. Hoffman HG, Prothero J, Wells M, Groen J: Virtual chess: the role of meaning in the sensation of presence. International Journal of Human-Computer Interaction, in press.
2. Medicine Meets Virtual Reality. Burke, Va, IOS Press, 1999.

POSTER SESSION 1

Posters 1–34

Poster 1 **Thursday, October 11**
3:30 p.m.-5:00 p.m.

TOPIRAMATE USE FOR PEDIATRIC BIPOLAR DISORDER: A RETROSPECTIVE CHART REVIEW

Ortho-McNeil Parmaceuticals, Inc.

Melissa Delbello, M.D., *Assistant Professor of Psychiatry and Pediatrics, University of Cincinnati, 231 Bethesda Avenue, Cincinnati, OH 45267*; Robert A. Kowatch, M.D.; Juliet Warner, B.A.; Katherine B. Rappaport, M.D.; John P. Daniels, M.D.; Keith D. Foster, M.D.; Daniel P. Nelson, M.D.; Stephen M. Strakowski, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the efficacy and safety of topiramate use in the pediatric bipolar disorder population.

SUMMARY:

Introduction: Previous investigations have suggested that the antiepileptic agent topiramate, may be effective for the treatment of bipolar disorder (BPD) in adults. To our knowledge, there have been no studies evaluating the use of topiramate for the treatment of pediatric BPD. The aim of this study was to assess the safety, tolerability, and effectiveness of topiramate for the treatment of children and adolescents with BPD.

Methods: We reviewed the outpatient medical charts of youths (ages 5–21 years) with a DSM-IV diagnosis of bipolar I or II disorder who were treated with topiramate. Response was evaluated by two child and adolescent psychiatrists using the Clinical Global Impression (CGI) Scale and defined as a CGI improvement score of ≤2.

Results: Twenty-six children and adolescents with the diagnosis of bipolar I or II disorder who were treated with topiramate were identified. Treatment length ranged from one to 30 months. Dosages ranged from 50mg/day to 500mg/day. Most patients received concomitant psychotropic medications. No severe adverse events occurred during treatment. Only three (12%) patients discontinued therapy secondary to side effects.

Conclusions: Preliminary results indicate that topiramate is safe and well tolerated for the treatment of pediatric BPD. We will also present data on treatment effectiveness.

REFERENCES:

1. Calabrese JR, Keck PE, McElroy SL, et al: Topiramate as monotherapy: a pilot study in acute mania, (Scientific Poster). Presented at the American Psychiatric Association's 152nd Meeting, Washington, DC, May 15–20, 1999
2. Chengappa KN, Rathore D, Levine J, et al: Topiramate as add-on treatment for patients with bipolar mania. Bipolar Disord 1999;1:42–53

TARGET AUDIENCE:

Psychiatrists.

Poster 2 **Thursday, October 11**
3:30 p.m.-5:00 p.m.

QUETIAPINE AS ADJUNCTIVE TREATMENT FOR ADOLESCENT MANIA

AstraZeneca Pharmaceuticals

Melissa Delbello, M.D., *Assistant Professor of Psychiatry and Pediatrics, University of Cincinnati, 231 Bethesda Avenue, Cincinnati, OH 45267*; M. L. Schwiers, M.D.; H. L. Rosenberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that quetiapine is effective as well as safe and well tolerated for the treatment of manic, depressive and psychotic symptoms in bipolar adolescents.

SUMMARY:

Introduction: The objective of this study was to examine the use of quetiapine as an adjunct to divalproex for acute mania in adolescents with bipolar disorder.

Methods: Thirty manic or mixed bipolar I adolescents (12–18 years) received an initial divalproex dose of 20 mg/kg and were randomized to quetiapine (n=15) or placebo (n=15) for six weeks. Efficacy, safety, and tolerability were assessed weekly using the YMRS, CDRS, PANSS, CGI/CGI-C, SAS, Barnes Akathisia, AIMS, laboratory tests, and vital signs.

Results: Mean quetiapine dose was 432 mg/d. Mean VPA levels were 106 and 93 in the VPA + placebo and VPA + quetiapine groups, respectively. No significant group differences from baseline to endpoint in EPS ratings, QTc interval, thyroid functions, prolactin, HCT, or weight were noted. Repeated measures ANOVAs of completers (n=22) indicated overall better response for treating depressive, manic, and psychotic symptoms in the VPA + quetiapine group. There was a significantly greater response rate (YMRS reduction >50%) in the VPA + quetiapine group (87%) than VPA + placebo group (53%, Fisher's exact test, P=0.05).

Discussion: Quetiapine is effective, safe, and well tolerated for the treatment of manic, depressive, and psychotic symptoms in bipolar adolescents. Further investigations examining the efficacy of quetiapine in the treatment of bipolar disorder are warranted.

REFERENCES:

1. Dunayevich E, et al: Am J Psychiatry 2000;157:1341.
2. McConville BJ, et al: J Clin Psychiatry 2000;61:252–260.

TARGET AUDIENCE:

Psychiatrists

Poster 3 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

LONGER-TERM TREATMENT WITH TOPIRAMATE FOR BIPOLAR DISORDER

Ortho-McNeil Parmaceuticals, Inc.

David B. Marcotte, M.D., *Private Psychiatric Practice, 210 Fairway Drive, Fayetteville, NC 28305-5512*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify and manage common side effects of treatment for bipolar disorder.

SUMMARY:

The use of topiramate, an antiepileptic agent, has been investigated in a number of open-label studies as a mood stabilizer. While these have reported favorable treatment outcomes for patients with bipolar disorder, all of these studies have focused on use of this agent for six months or less and included only a small number of patients. This new research focuses on longer-term treatment with this agent in a large patient population.

Approximately 150 patients diagnosed with bipolar I and II were treated with topiramate. Exposure to this agent continued for six months to three years, with no severe adverse events reported, including absence of renal calculi. Of these patients, approximately 80% were female and 20% were male. The CGI scale was used to assess success. Patient assessment intervals varied from once every week to a maximum of once every three months. No patients discontinued due to serious adverse events, delirium, or exacerbation of psychiatric symptoms. The author will report on treatment compliance, dose-related side effects, and effect on weight. Our results will show that topiramate is an effective treatment in bipolar disorder, both as a stand-alone therapy and as additive therapy to other pharmacologic agents.

REFERENCES:

1. Marcotte DB: Use of topiramate, a new anti-epileptic as a mood stabilizer. J Aff Disord 1998;50:245–251
2. Chengappa R, et al: Topiramate as add-on treatment for patients with bipolar mania. Bipolar Disorders 1999;1:42–53

TARGET AUDIENCE:

Psychiatrists

Poster 4 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

EVALUATION AND INTERVENTION OF PRODROMAL SYMPTOMS OF BIPOLAR I DISORDER

Mohammad Z. Hussain, M.D., *Chief Psychiatrist, Mental Health Centre, Prince Albert Health District, 2727 2nd Avenue, West, Prince Albert, SK Canada S6V 5E5*; Zubaida A. Chaudhry, M.D., *Mental Health Centre, Prince Albert Health District, 2727 2nd Avenue, West, Prince Albert, SK Canada S6V 5E5*; Seema Hussain, M.D.

SUMMARY:

Bipolar mood disorder often emerges in childhood or adolescence, but the average interval between prodromal symptoms and diagnosis is ten or more years. To allow early intervention, we need to define symptoms and diagnose patients during the subthreshold period of the syndrome.

Forty-four children were diagnosed with bipolar I prodrome state. They had positive family history, episodic mood, and energy symptom fluctuation, with anger dyscontrol, irritability, defiance, demanding behavior, conduct problems, sleep disturbance, anxiety, tension, worrying, stubbornness, somatic complaints, and intrusive and excessive behaviors. A 25-item, four-point prodrome scale was created with items relevant to children from DSM-IV criteria for bipolar I mood disorder, Hamilton Depression and Young Mania scales. This scale reflects the atypical presentation of bipolar disorder in childhood; comorbidities were recognized, which add another dimension to evaluation. The group of 28 males and 16 females with a mean age of 11 years (range 7–16) all received mainstay treatment of topiramate in a dose range 25–200 mg qhs with some subjects requiring adjunct treatment. Eleyen discontinued treatment secondary to adverse effects and poor response. They were rated at base line, 1-, 2-, 3-, 6-, 9-, and 12-month intervals. Thirty-three subjects responded with 70% to 90% symptom reduction in consecutive assessments.

REFERENCES:

1. Marcotte D: Use of topiramate: a new anti-epileptic as a mood stabilizer. J Affect Dis 1998;50:245–251
2. Egeland JA, Hostetter AM, Pauls DL, Sussex JN: Prodromal symptoms before onset of manic-depressive disorder suggested by first hospital admission histories. J Am Acad Child Adolesc Psychiatry 2000;39(10):1245–1252

TARGET AUDIENCE:

psychiatrists

Poster 5 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

TOPIRAMATE IN THE TREATMENT OF REFRACTORY BIPOLAR DEPRESSION

Mohammad Z. Hussain, M.D., *Chief Psychiatrist, Mental Health Centre, Prince Albert Health District, 2727 2nd Avenue, West, Prince Albert, SK Canada S6V 5E5*; Zubaida A. Chaudhry, M.D., *Mental Health Centre, Prince Albert Health District, 2727 2nd Avenue, West, Prince Albert, SK Canada S6V 5E5*; Seema Hussain, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand the seriousness and management difficulties of bipolar mood disorder, effectiveness of topiramate as a mood stabilizer, and significance of weight loss in treatment compliance.

SUMMARY:

Bipolar disorder, a serious debilitating illness, affects over 2% of the population. Frequent treatment failure remains a major concern. The novel antiepileptic drugs lamotrigine, gabapentin, and topiramate have been successfully used as mood stabilizers. Most trials have been short term with limited follow-up. Long-term studies are essential to assess efficacy and patient acceptability because of the chronic, recurrent nature of this illness.

A total of 135 patients meeting DSM-IV criteria for bipolar I or II disorder, depressed phase, received open-label treatment with topiramate. There were 46 males and 89 females with a mean age of 34, mean age of onset 21, mean duration of current episode 11 weeks; bipolar I(62) and bipolar II(73). All were previously treated with mood stabilizers and antidepressants but failed to respond adequately. They were rated on Hamilton Depression Rating Scale, met criteria for major depression, and were subsequently rated at one-, two-, three-, six-, 12-, 18-, 24-, and 30-month intervals. Topiramate was given at a starting dose of 25 mg/hs, increasing every two days to 200 mg/hs and up to a maximum of 600 mg/day. All patients completing the 30-month trial were good responders (HDRS score 0–8). Clinically significant responses were seen within two to four weeks. A total of 47 patients discontinued medication. Results support evidence that topiramate is an effective mood stabilizer. Mean weight loss was 17.2 kg by completion of the study.

REFERENCES:

1. McElroy SL, Suppes T, Keck PE Jr, et al: Open-label adjunctive topiramate in the treatment of bipolar disorders. Biol Psychiatry 2000;47:1025–33
2. Marcotte D: Use of topiramate: a new antiepileptic as a mood stabilizer. J Affect Disord 1998;59:245–51

TARGET AUDIENCE:

psychiatrists

Poster 6 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

RIVASTIGMINE TARTRATE IN NEUROCOGNITIVE DEFICITS CLOZAPINE TREATED PERSONS WITH SCHIZOPHRENIA

Mohammad Z. Hussain, M.D., *Chief Psychiatrist, Mental Health Centre, Prince Albert Health District, 2727 2nd Avenue, West, Prince Albert, SK Canada S6V 5E5*; Zubaida A. Chaudhry, M.D., *Mental Health Centre, Prince Albert Health District, 2727 2nd Avenue, West, Prince Albert, SK Canada S6V 5E5*; Seema Hussain, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize neurocognitive deficits in schizophrenia and the effect of acetylcholinesterase activity of clozapine on cognition and its management with rivastigmine tartrate.

SUMMARY:

Many patients with schizophrenia have difficulty in the community functioning even when psychiatric symptoms are well controlled. Deficits in social functioning, vocational outcome, and independent living contribute to high levels of disability and are most often the result of neurocognitive deficits. The novel neuroleptics improve cognition profiles for many patients, but there still remain a considerable number of patients with neurocognitive deficits. Clozapine and other neuroleptics with anticholinergic activity lead to adverse effects in visual memory and other cognitive functions. The cholinergic hypothesis of Alzheimer's disease proposes that cognitive deterioration is related to deficits in central choliner-

gic function, and amelioration of the cholinergic deficit leads to improvement. Acetylcholinesterase inhibitors should produce similar improvement in schizophrenia by neutralizing the anticholinesterase-mediated effects of clozapine.

Eighteen patients suffering from schizophrenic illness receiving clozapine and exhibiting neurocognitive deficits were treated with rivastigmine tartrate 3–6 mg daily. Nine patients showed significant improvement in their cognitive functions measured on different neurocognitive tests and have shown improvement in attention, memory, and problem-solving, with improved social and vocational functioning. Five showed moderate improvement in motivation and alertness, and four discontinued due to ineffectiveness. Acetylcholinesterase inhibitors have beneficial effect on neurocognitive deficits related to clozapine.

REFERENCES:

1. Kane J: Clinical efficacy of clozapine in treatment of refractory schizophrenia: an overview. British Journal of Psychiatry 1992;18 (Suppl 17):41–54
2. M Rosler, R Anand, A Cicin, et al: Efficacy and safety of rivastigmine in patients with Alzheimer's disease: international randomized controlled trial. British Medical Journal 1999;318:633–638.

TARGET AUDIENCE:

Psychiatrists

Poster 7 **Thursday, October 11**
3:30 p.m.-5:00 p.m.

SWITCHING TO OLANZAPINE: EFFECT ON HOSPITAL SERVICES UTILIZATION

Eli Lilly and Company

Eduardo Dunayevich, M.D., *Assistant Professor of Clinical Psychiatry, and Director, Clinical Psychobiology Program, Department of Psychiatry, University of Cincinnati, 231 Bethesda Road, Cincinnati, OH 45267*; Claude M. Bridges, M.D.; Jeff A. Welge, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to examine the effects of the switch from conventional antipsychotics to olanzapine in ER and hospital utilization.

SUMMARY:

Summary: A retrospective database review of records of the University Hospital in Cincinnati, Oh identified 46 schizophrenic or schizoaffective patients with ages between 18 and 65, who had been hospitalized between 10/14/96 and 4/14/97 and switched to OLZ from conventional antipsychotic therapy. Demographic and clinical characteristics were gathered. ER visits, hospital admissions, and total number of days hospitalized were compared between a similar period of at least 26 weeks immediately before and after switch to OLZ.

Results: 72% (33) of patients were maintained on OLZ and did not receive other antipsychotic medication during the study period. In that group, the switch was associated with a reduction in ER visits equivalent to one visit per patient/year (p=0.038) and a reduction in hospital utilization equivalent to 0.9 hospitalizations/year (p=0.002) and 8.9 less days hospitalized/year (p=0.029). Sensitivity analyses for the entire sample (patients maintained on OLZ + those who received further antipsychotic therapy) suggested that reductions in utilization were strongest for hospitalizations and weakest for ER visits and days spent hospitalized.

Conclusion: OLZ therapy appears efficacious in general clinical populations as manifested by associations with decreased utilization of ER and hospital-based psychiatric services.

REFERENCES:

1. Conley RRT, Love RC, Kelly DL, Bartko JJ: Rehospitalization rates of patients recently discharged on a regimen of risperidone or clozapine. Am J Psychiatry 1999; 156:863–868
2. Rabinowitz J, Lichtenberg P. Kaplan Z, Mark M, Nahon D, Davidson M: Rehospitalization rates of chronically ill schizophrenic patients discharged on a regimen of risperidone, olanzapine, or conventional antipsychotics. Am J Psychiatry 2001;158:266–269

TARGET AUDIENCE:

Psychiatrist, nurses, social workers, physician assistants.

Poster 8 **Thursday, October 11**
3:30 p.m.-5:00 p.m.

USE OF COMBINED RISPERIDONE AND LITHIUM IN THE TREATMENT OF BIPOLAR DISORDER AND SCHIZOAFFECTIVE DISORDER

Janssen Pharmaceutica

Jerry A. Bennett, Pharm.D., *College of Pharmacy and Department of Psychiatry, University of Cincinnati, 3223 Eden Avenue, P.O. Box 670004, Cincinnati, OH 45267-0004*; M. Glick, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to review the results and findings of risperidone in the treatment of patients with acute exacer-

bations of bipolar or schizoaffective disorders in combination with lithium.

SUMMARY:

Objective: To examine the thymoleptic properties and safety of combined lithium and risperidone in acute exacerbations of bipolar and schizoaffective disorder.

Methods: A retrospective chart review identified 13 patients treated with a combination of lithium and risperidone who were experiencing either manic (n=3), mixed (n=4), or depressed (n=4) exacerbations of bipolar or schizoaffective disorder (n=2). CGI ratings were determined upon admission and discharge.

Results: Mean daily doses of risperidone and lithium were 3.15 mg and 1096 mg respectively, with a mean lithium level of 0.77 meq/L. Mean age was 35.8 years, mean length of stay 9 days, and mean medication trial length was 7.3 days. Mean CGI scores on admission were 5.1 (markedly ill), 3.3 (mildly ill) upon discharge, with mean CGI change of 1.9 (much improved). Three patients were considered very much improved, eight were much improved, two were minimally improved. A single patient experienced parkinsonism (resolved with dose reduction), and one experienced GI distress resolving with lithium dose reduction. No discontinuations were attributed to side effects or lack of response.

Conclusions: The combination of lithium and risperidone is well tolerated and may be efficacious in acute exacerbations of bipolar and schizoaffective disorders. No evidence of neurotoxicity or increased propensity to extrapyramidal side effects was noted.

REFERENCES:

1. Sachs G: Safety and efficacy of risperidone vs placebo vs haloperidol as add-on therapy to mood stabilizers in the treatment of manic phase of bipolar disorder. Presented at the meeting of the American College of Psychopharmacology, Acapulco, Dec. 14, 1999.
2. Freeman MP, Stoll AL: Mood stabilizer combinations: a review of safety and efficacy. Am J Psychiatry 1998;155(1):12–21.

Poster 9 **Thursday, October 11**
3:30 p.m.-5:00 p.m.

ZIPRASIDONE VERSUS OLANZAPINE IN SCHIZOPHRENIA: RESULTS OF A DOUBLE-BLIND TRIAL

Pfizer Inc.

George M. Simpson, M.D., *Interim Chairman, Department of Psychiatry, University of Southern California Medical Center, 2020 Zonal Avenue, IRDRM 204 POC, Los Angeles, CA 90033*; Robert L. Horne, M.D., *Physician, Lake Mead Hospital, 2915 West Charleston Boulevard, Suite 4, Las Vegas, NV 89102*; Peter J. Weiden, M.D.; Mohammed A. Bari, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate an understanding of the study data comparing the efficacy and tolerability of ziprasidone and olanzipine in patients with schizophrenia, which suggest comparable efficacy in improving psychopathology and global illness severity, but improved health parameters with ziprasidone.

SUMMARY:

Objective: To compare the efficacy, tolerability, and safety of ziprasidone and olanzapine in acute inpatients with schizophrenia or schizoaffective disorder.

Methods: In a six-week, double-blind, multicenter trial, 269 acute inpatients with schizophrenia or schizoaffective disorder were randomly assigned to ziprasidone (40–80 mg BID) or olanzapine (5–15 mg QD). Primary efficacy evaluations included BPRS and CGI-S. Secondary assessments included PANSS. Tolerability and safety measurements included weight, fasting laboratory tests (including fasting insulin, glucose, total cholesterol, low-density lipoprotein cholesterol [LDL-C], and triglycerides), an insulin resistance (IR) index (HOMA IR=[Ins × Glu]/22.5), and treatment-emergent adverse events.

Results: There were no statistically significant differences in BPRS total and core scores, PANSS total scores, or CGI-S (all patients, last observation carried forward) in ziprasidone- and olanzapine-treated patients. The two agents were well tolerated, with movement disorder ratings generally improving with both treatments. Patients receiving olanzapine had significantly greater mean weight gain ($P<0.0001$) and increases from baseline in fasting insulin ($P<0.0001$), HOMA IR (log) ($P<0.0001$), total cholesterol ($P<0.0001$), triglycerides ($P<0.0001$), and LDL-C ($P<0.0004$).

Conclusions: Ziprasidone and olanzapine yielded comparable improvement in psychopathology and global illness severity, but there were significant differences favoring ziprasidone in important health parameters.

REFERENCES:

1. Tandon RK, Harrigan E, Zorn SH: Ziprasidone: a novel antipsychotic with unique pharmacology and therapeutic potential. Serotonin Res 1997;4:159–77
2. Daniel DG, Zimbroff DL, Potkin SC, et al: Ziprasidone 80 mg/day and 160 mg/day in the acute exacerbation of schizophrenia and schizoaffective disorder: a 6-week, placebo-controlled trial. Neuropsychopharmacol 1999;20:491–505

TARGET AUDIENCE:

Psychiatrists and other health professionals who care for patients with schizophrenia

Poster 10 **Thursday, October 11**
3:30 p.m.-5:00 p.m.

SWITCHING PSYCHIATRIC PATIENTS FROM DIVALPROEX DELAYED RELEASE TO DIVALPROEX EXTENDED RELEASE

Abbott Laboratories

Robert L. Horne, M.D., *Physician, Lake Mead Hospital, 2915 West Charleston Boulevard, Suite 4, Las Vegas, NV 89102*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should know how to safely convert psychiatric patients from divalproate delayed release (twice a day) to divalproate extended release (once a day).

SUMMARY:

Successful medication treatment requires good patient compliance. Prior studies showed compliance increased from 60% to 80% with change from bid to qd dosing. The FDA recently approved Depakote ER for qd use to prevent migraines.

Method: Psychiatric patients (N=55) were on Depakote DR bid (x = 1827 mg, range 500–5000). Diagnoses were mood disorders =63%, schizophrenia =27%, other = 10%. Inpatients = 25%, outpatients = 75%. On Day 1 a baseline VPA level was drawn. Patients then received their usual morning dose of Depakote DR. At hs of Day 1 and qhs thereafter they received Depakote ER at a dose = total daily DR dose. Blood levels were drawn at 36, 84, and 132 hours post first dose. Efficacy was measured by the PANSS and side effects by the UKU scale at baseline and Day 7.

Results: VPA levels were: Baseline (Day 1)=81.5; Day 3=87.4; Day 5=88.7; and Day 7=88.5. Efficacy did improve in positive symptoms (PANSS 17.8 to 16.3, $p<.01$)), general symptoms (38.0 to 35.9, $p<.02$) and total score (71.6 to 67.3, $p<.02$). Side effects decreased both in number (7.7 to 6.2, $p<.0001$) and severity (12.5 to 9.7, $p<.0001$). Implications will be discussed. Research grant provided by Abbott.

REFERENCES:

1. Mulleners WM, Whitmarsh TE, Steiner TJ: Noncomplience may render migrane prophylaxis useless, but once-daily regimens are better. Cephalalgia (Norway), 1998; 18(1) p52–6.
2. Bowden CL, Brugger AM, Swann AC, et al: Efficacy of divalproex vs lithium and placebo in the treatment of mania. The Depakote Mania Study Group. JAMA 1994;271(12):918–924.

Poster 11 **Thursday, October 11**
3:30 p.m.-5:00 p.m.

ABNORMAL CORTICAL EXCITABILITY IN OBSESSIVE-COMPULSIVE DISORDER

Mark J. Smith, M.D., *Special Volunteer, National Institutes of Mental Health, 10 Center Drive, Building 10, Room 3-D41, Bethesda, MD 20892*; Jersino Jean-Mary, B.A., *Research Associate, National Institutes of Mental Health, 10 Center Drive, Building 10, Room 3-D41, Bethesda, MD 20892*; Dennis L. Murphy, M.D.; Eric M. Wassermann, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize responses to transcranial magnetic stimulation in OCD patients.

SUMMARY:

Background: We previously studied responses to transcranial magnetic stimulation (TMS) in OCD patients and extensively screened controls. Motor evoked potential (MEP) thresholds during rest and voluntary target muscle contraction, a measure of corticospinal neuron excitability, were reduced. Response to paired-pulse TMS, a measure of cortical GABA-glutamate balance, showed increased excitability in patients. We repeated this study in a larger sample of treated patients comparing them with general population controls.

Methods: We measured bilateral MEP thresholds and responses to paired TMS in 26 patients and 32 controls.

Results: Both resting ($p=.04$) and contracting ($p=.02$) MEP thresholds in the left cortex were significantly decreased in patients, as was the contracting ($p = .02$) threshold in the right cortex, which also showed a trend in resting threshold ($p=.07$), showing higher corticospinal neuron excitability in patients. No differences were found for paired-pulse excitability.

Discussion: The decreased MEP thresholds at rest and during muscle contraction in patients are likely related to abnormal potentiation of excitatory synapses on motor cortex pyramidal cells. The aberrant connectivity in the motor cortex revealed by the abnormal potentiation detected in this study could reflect an anomaly distributed throughout the cerebral cortex or a subcortical problem.

REFERENCES:

1. Ziemann U, Rothwell JC, Ridding MC: Interaction between intracortical inhibition and facilitation in human motor cortex. J Physiol (Lond) 1996;496:873–881.

2. Greenberg BD, Ziemann U, Harmon A, Murphy DL, Wassermann EM: Decreased neuronal inhibition in cerebral cortex in obsessive-compulsive disorder on transcranial magnetic stimulation. Lancet 1998;12:352(9131):881–2.

Poster 12 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

SIGNIFICANT MENSTRUAL CYCLE-RELATED CHANGES IN CORTICAL EXCITABILITY

Mark J. Smith, M.D., *Special Volunteer, National Institutes of Mental Health, 10 Center Drive, Building 10, Room 3-D41, Bethesda, MD 20892*; Jersino Jean-Mary, B.A., *Research Associate, National Institutes of Mental Health, 10 Center Drive, Building 10, Room 3-D41, Bethesda, MD 20892*; L. Adams; John C. Keel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should understand how cortical excitability differs between the mid-follicular and mid-luteal phases of the menstrual cycle.

SUMMARY:

Objective: In vitro cortical excitability increases with estradiol (E2) and decreases with progesterone (P4) metabolites, which may act through the GABA-A receptor. Human cortical excitability may be measured by paired-pulse transcranial magnetic stimulation (pTMS), which appears sensitive to changes in the cortical glutamate/GABA balance.

Method: pTMS measured the effect of a subthreshold conditioning pulse on the response to a second suprathreshold test pulse; results were expressed as the ratio of the amplitudes of the conditioned to the test pulses. Menstrual cycle variation in pTMS ratio means were studied in 14 normal women by ANOVA-R on measures done in the early follicular (days 2–5: low E2, low P4), late follicular (days 9–12: high E2, low P4), and luteal phases (6–12 days after the LH surge: high E2, high P4). E2 and P4 levels at each time point were consistent with ovulatory cycles.

Results: pTMS ratios showed a significant effect of phase ($F = 3.81$; $p = 0.035$), increasing from early follicular (mean = 0.871) to late follicular phase (mean = 1.001), then decreasing in the luteal phase (mean = 0.880). Post-hoc Bonferroni tests showed significant differences between early follicular and late follicular phases ($t = 2.5$, $p < 0.05$) and between late follicular and luteal phases ($t = 2.32$, $p < 0.05$).

Conclusions: These results suggest that the follicular rise in cortical excitability may be related to the rise in estradiol levels and that there may be P4-enhanced GABA activity related to the decrease in cortical excitability during the luteal phase.

REFERENCES:

1. Smith MJ, Keel JC, Greenberg BD, Adams LF, et al: Menstrual cycle effects on cortical excitability. Neurology 1999; 53(9):2069–72.
2. Ziemann U, Rothwell JC, Ridding MC: Interaction between intracortical inhibition and facilitation in human motor cortex. J Physiol (Lond) 1996;496:873–881.

Poster 13 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

ANTIDEPRESSANT-INDUCED CHRONIC IRRITABLE DYSPHORIA IN BIPOLAR PATIENTS

Anoop Karippot, M.D., *Resident, Department of Psychiatry, University of Louisville, 69 Highwood Place, Louisville, KY 40206*; Rifaat S. El-Mallakh, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to learn about the effects of antidepressants on bipolar patients.

SUMMARY:

Antidepressants administered to bipolar subjects may induce manias, mixed states, or rapid cycling. Usually, discontinuation of the offending agent results in rapid resolution. More recently we have noted that long-term use of antidepressants may induce a chronic dysphoric, irritable state.

Methods: A case series is presented in which six type-I bipolar subjects receiving antidepressants continuously for several years developed chronic dysphoria.

Results: A triad of dysphoric mood, irritability, and middle insomnia that is frequently associated with occupational dysfunction can occur in some bipolar patients receiving antidepressants for at least three years. Typically initial treatments with antidepressants for the index episode were effective. Over time, depressive symptoms returned and would transiently improve with dose increase or change of agents. Ultimately, the dysphoria and associated symptoms became chronic and resulted in dysfunction. Discontinuation of antidepressants was associated with a slow and gradual improvement in these symptoms over the ensuing year.

Concomitant mood stabilizer did not appear to alter this pattern.

Conclusion: Additional studies are required to investigate safety of long-term use of antidepressants in bipolar illness.

REFERENCES:

1. Wehr TA, Goodwin FK: Can antidepressants cause mania or worsen the course of affective illness? Am J Psychiatry 1987;144:1403–1411
2. Altshuler LL, Post RM: Antidepressant-associated mania and cycle acceleration: a controversy revisited. Am J Psychiatry 1995;152:11–113

TARGET AUDIENCE:

Psychiatrists and mental health professionals

Poster 14 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

ASSESSMENT OF HANDHELD COMPUTER USE AMONG PSYCHIATRY HOUSE STAFF AND FACULTY

Anoop Karippot, M.D., *Resident, Department of Psychiatry, University of Louisville, 69 Highwood Place, Louisville, KY 40206*; Kusum Sharma, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the use of hand-held computers in psychiatry.

SUMMARY:

Hand-held computers or personal digital assistants (PDA) have become increasingly popular in recent years. While there has been interest regarding the potential for hand-held computers in medical education, no studies have described HHC use among psychiatry house staff and faculty in an academic setting. We describe the prevalence and patterns of HHC/PDA use among psychiatry house staff and faculty in a university setting.

Methods: All psychiatry house staff and faculty in the department of psychiatry at the University of Louisville School of Medicine were surveyed. Basic demographic data, type of HHC, the operating system (OS) used, medical purposes for which the HHC was used, as well as the type of medical software installed on the HHC was obtained.

Results: 102 surveys were given, and there were 62 respondents (response rate 59.3%). Thirty-two of the population surveyed (31.4%) owned a HHC/PDA, and of these, psychiatric faculty contributed 37.5% of the HHC use. Epocrates was the most commonly used drug reference.

Conclusion: Most psychiatry house staff and faculty do not own a PDA. The potential is great for increasing the utility of PDAs among psychiatry house staff and faculty for medical education and clinical practice, particularly in the realms of medical knowledge and evidence-based medicine.

REFERENCES:

1. Malan TK, Haffner WH: Hand-held computer operating system Program for collection of resident. Obstetric Gynecology 2000; 96: 792–794.
2. Ebell M, Rovner D: Information in the palm of your hand. Journal of Fam Pract 2000; 49: 243–251.

TARGET AUDIENCE:

Psychiatry residents, psychiatry faculty, and all mental health professionals

Poster 15 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

VENLAFAXINE IN THE PREVENTIVE TREATMENT OF RECURRENT MAJOR DEPRESSIVE DISORDER

Wyeth-Ayerst Laboratories

Nadia R. Kunz, Pharm.D., *Director, Clinical Research and Development, Wyeth-Ayerst Laboratories, 145 King of Prussia Road, Radnor, PA 19087*; Richard Entsuah, Ph.D.; Dean Lei, Ph.D.; Richard L. Rudolph, M.D.; David Hackett, M.S., B.Sc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify venlafaxine as effective in the long-term prevention of recurrence in patients with major depressive disorder.

SUMMARY:

Objective: To evaluate the efficacy of venlafaxine as prophylactic treatment in outpatients with recurrent major depressive disorder (MDD).

Design: A multicenter, six-month, open-label treatment period followed by a one-year, double-blind, placebo-controlled, recurrence-prevention period.

Methods: Patients who responded to treatment with venlafaxine, 100 to 200 mg/d, and remained in remission during the six-month, open-label period were randomly assigned to continue venlafaxine treatment for up to 12 months or to receive placebo. The primary outcome measure was the number of patients with recurrence of depression (Clinical Global Impressions-Severity of Illness score ≥4). Time to recurrence was analyzed by a survival analysis procedure using the log-rank test.

Results: Of 286 patients who completed the six-month open-label period, 235 entered the recurrence-prevention phase, and 225 (109 venlafaxine and 116 placebo) pro-

vided data for the survival analysis. The cumulative recurrence rates after 12 months were 22% for the venlafaxine-treated patients and 55% for the placebo group. The chi-square statistic of the log-rank test was 17.6 with 1 degree of freedom ($P<0.001$). Notably, the dropour rate, due to lack of efficacy, was more than twice as high in the placebo group than in the venlafaxine group (48% vs 21%; $P\leq0.001$).

Conclusion: In patients who were treated successfully with venlafaxine for six months, maintenance treatment with venlafaxine for up to 12 months was significantly more effective than placebo in preventing a recurrence of MDD.

REFERENCES:

1. Andrews JM, Ninan PT, Nemeroff CB: Venlafaxine: a novel antidepressant that has a dual mechanism of action. Depression 1996; 4: 48–56.
2. Lecable P, Letzelter J-M, Lichtblau E, et al: An open-label study of the clinical acceptability of venlafaxine for depression. Primary Care Psychiatry 1995; 1: 119–125.

TARGET AUDIENCE:

Psychiatrists who treat major depressive disorder

Poster 16 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

VENLAFAXINE EXTENDED RELEASE IS SUPERIOR TO PLACEBO IN RELAPSE PREVENTION FOR PATIENTS WITH MAJOR DEPRESSIVE DISORDER

Wyeth-Ayerst Laboratories

Nadia R. Kunz, Pharm.D., *Director, Clinical Research and Development, Wyeth-Ayerst Laboratories, 145 King of Prussia Road, Radnor, PA 19087*; Richard Entsuah, Ph.D.; Dean Lei, Ph.D.; Richard L. Rudolph, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the efficacy of long-term venlafaxine XR treatment in preventing relapse in patients with major depressive disorder.

SUMMARY:

Objective: To evaluate the efficacy of venlafaxine XR, a serotonin-norepinephrine reuptake inhibitor, in the prevention of relapse in patients with major depressive disorder.

Design: The study consisted of eight-week, open-label venlafaxine XR treatment followed by a randomized, double-blind, placebo-controlled, six-month evaluation of venlafaxine XR.

Methods: Patients who responded to eight weeks open-label treatment with venlafaxine XR 75 to 225 mg/day were randomly assigned to either continue venlafaxine XR treatment for up to six months or be switched to placebo under double-blind conditions. The primary efficacy outcome was the number of patients who had a relapse of depression (Clinical Global Impressions-Severity score ≥4). Time to relapse was assessed by survival analysis procedure using the log-rank test. Of the 401 patients who completed the eight-week acute treatment phase, 328 entered the relapse prevention phase and 318 (161 venlafaxine XR and 157 placebo) provided data for the survival analysis.

Results: Cumulative relapse rates for venlafaxine XR-treated patients were 18.5% and 28.0% at three and six months, respectively, and 43.2% and 52.4% for placebo-treated patients. The chi-square statistic of the log-rank test was 19.3 with $P<0.001$. The positive survival analysis results are further supported by the finding that nearly twice as many patients in the placebo group (42%) as in the venlafaxine XR group (24%) discontinued because of lack of efficacy ($P<0.001$).

Conclusion: These data show that venlafaxine XR was significantly more effective than placebo in preventing relapse of depression during six months of continuation treatment in patients who had responded to open-label treatment with venlafaxine XR.

REFERENCES:

1. Thase ME, for the Venlafaxine XR 209 Study Group: Efficacy and tolerability of once-daily venlafaxine extended release (XR) in outpatients with major depression. J Clin Psychiatry 1997; 58: 393–398.
2. Entsuah AR, Rudolph RL, Hackett D, Miska S: Efficacy of venlafaxine and placebo during long-term treatment of depression: a pooled analysis of relapse rates. Int Clin Psychopharmacol 1996; 11: 137–145.

TARGET AUDIENCE:

Psychiatrists who treat major depressive disorder in a hospital or private practice setting

Poster 17 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

MEDICAL CLEARANCE IN THE EMERGENCY DEPARTMENT: WHO NEEDS IT?

Jeffrey J. Bazarian, M.D., *Assistant Professor, Department of Emergency Medicine, University of Rochester, 601 Elmwood Avenue, Box 655, Rochester, NY 14642*; Robert A. Stern, M.D., *General Psychiatrist, Unity Health System, 3 Kerry Hill, Fairport, NY 14450*; Paul Wax, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the characteristics among patients with behavioral complaints that place them at high risk for having a medical illness and, thus, needing medical clearance.

SUMMARY:

Introduction: Medical clearance of patients presenting to the emergency department (ED) with behavioral complaints is a time-consuming process complicated by a lack of information on variables that may identify patients particularly likely to have an acute medical illness.

Objective: To identify variables present at the point of ED triage that may predict those patients with a high probability of having a medical cause of their behavior.

Methods: Prospective, observational study of 514 patients presenting to the ED of the University of Rochester Medical Center with one of 14 predetermined behavioral complaints. The collection of variables present at the point of triage (history, vital signs, demographics) was standardized by use of a data collection instrument. These variables were correlated with the outcome, which was the final ED diagnosis listed in the chart by the emergency or psychiatric attending. Discharge diagnoses were classified as "medical" or "psychiatric" based on a categorization made before the study began.

Analysis: All variables were subject to univariate (chi-square, t-test) and multivariate (stepwise logistic regression) analysis.

Results: Mean patient age was 36.7; 53% were female, 71% were Caucasian. Medical illnesses were listed as the cause of the presenting behavior in 22.6%. Multivariate analysis revealed that "no past history of psychiatric illness" was associated with a medical cause of behavior (OR=5.21, 95% CI: 2.0, 13.5). Univariate analysis revealed several factors more prevalent among those with a medial illness: history of major medical problems (71% vs 49%, $p<0.001$), history of drug/alcohol abuse (59% v 43%, $p=0.004$), onset of behavior in last 24 hours (44% v 14%, $p<0.001$), symptoms of delirium (34% v 12%, $p<0.001$), and symptoms of dementia (23% v 8%, $p<0.001$).

Conclusions: Several variables available at the point of ED triage can predict which patients with a behavioral complaint might be at high risk for having a medical illness and thus most deserving of medical clearance efforts. Prospective validation is required.

REFERENCES:

1. Korn CS, Currier GW, Henderson SO: "Medical Clearance" of psychiatric patients without medical complaints in the ED. Journal of Emergency Medicine 2000;18(2):173–6.
2. Tintinall JE: Emergency medical evaluation of psychiatric patients. Ann Emerg Med 1994;23:854–62.

TARGET AUDIENCE:

Hospital and emergency psychiatrists, psychiatric nurses, nurse practitioners, and social workers.

Poster 18 **Thursday, October 11**
3:30 p.m.-5:00 p.m.

REMERON SOLTAB IN DEPRESSED PATIENTS WHO ARE AT LEAST 50 YEARS OLD

Organon Inc.

Steven P. Roose, M.D., *Professor of Clinical Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032-2603*; Peter J. Holland, M.D., *Director of Pediatric Studies, Summit Research, 7284 West Palmetto Park Road, Boca Raton, FL 33433*; Howard A. Hassman, M.D.; Murray H. Rosenthal, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should be able to (1) describe the design and methods of this clinical trial using mirtazapine in patients who are at least 50 years old, (2) describe the efficacy and safety of mirtazine orally disintegrating tablets in actual clinical practice.

SUMMARY:

Purpose: To assess the antidepressant effectiveness and safety of mirtazapine orally disintegrating tablets in an observational study of older adult patients that reflects treatment in actual psychiatric and primary care clinical practice settings. Mirtazapine has demonstrated antidepressant and anxiolytic effects that may benefit these depressed patients.

Methods: A total of 10,000 patients with physician-diagnosed depression requiring pharmacological treatment will be enrolled in this multicenter, open-label six-week trial. Subjects must be $\geq$ 50 years of age and diagnosed with depression requiring pharmacological treatment. Exclusion criteria include patients who have taken a monamine oxidase inhibitors (MAOI) within 14 days prior to the start of the study or are currently residing in a long-term care facility. Subjects will be given mirtazapine tablets at a starting dose of 30 mg/day, which can be titrated in 15 mg increments as clinically indicated up to a maximum of 45 mg/day. Medical history and severity of comorbid illness are being recorded using the CIRS-G for all subjects. The investigator will record the severity of the depressive illness using the Clinical Global Impression Scale (CGI)-Severity. Effectiveness will be assessed using the Investigator CGI-Improvement. Also, the Patient Clinical Global Impression Scale—Improvement (PGI-I) and the Patient HAMD-24 assessment will be recorded with a Tele-

phone Interactive Voice Response System (IVRS). Preliminary results will be available in the third quarter of 2001.

REFERENCES:

1. De Boer T: The pharmacologic profile of mirtazapine. J Clin Psychiatry 1996; 57 (Suppl 4): 19–25
2. Holm KJ, Markham A: Mirtazapine: a review of its use in major depression. Drugs 1999; 57 (4) 607–631

TARGET AUDIENCE:

Psychiatrists, mental health clinicians

Poster 19 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

A MULTIDISCIPLINARY COMPARISON OF INPATIENTS DIAGNOSED WITH BIPOLAR DISORDER: MANIC VERSUS MIXED

Nurun N. Shah, M.D., M.P.H., *Associate Professor, Department of Psychiatry, University of Texas at Houston, 2800 South MacGregor Way, #3-E-55, Houston, TX 77021-1032*; Patricia M. Averill, Ph.D., *Assistant Professor, Department of Psychiatry, University of Texas at Houston, 2800 South MacGregor Way, Houston, TX 77021*; Andrew V. Shack, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify useful diagnostic tools for multidisciplinary use; recognize differences in baseline between manics and mixed; recognize differences in symptoms at admission between manics and mixed; understand how to implement assessment tools in an inpatient acute care setting.

SUMMARY:

Rapid diagnostic accuracy has important treatment implications in acute inpatient settings. In comparing patients diagnosed with bipolar disorder, manic (manics) versus mixed (mixed), researchers have found that mixed are more likely to be female, have psychotic features, be suicidal, substance abusers, have increased agitation, a worsening course of illness, and increased inpatient LOS (eg., Suppes et al., 2000; Akiskal et al., 1998). The current study seeks to increase this knowledge by comparing mixed versus manic adult inpatients at admission and discharge. Fifty-five manics were compared with 27 mixed on demographic information, clinician-rated variables, conducted by a multidisciplinary team, and patient-completed self-report measures, at admission and discharge. Results revealed that mixed were more likely to be female, of Hispanic-American origin, and have less education, whereas manic were more likely to be involuntary. Among clinician-rated variables, manics had higher admission scores on the BPRS Negative Factor Scale, and higher total ADRS scores. At discharge, manics had higher GAF scores, while mixed were more irritable on the OAS. Among self-report measures, mixed had higher BDI scores at discharge. Repeated measures ANOVAs revealed greater improvement in GAF scores among manics. These findings support and augment previous studies. Treatment implications will be discussed.

REFERENCES:

1. Akiskal HS, et al: Gender, temperament, and the clinical picture in dysphoric mixed mania: findings from a French national study. Journal of Affective Disorders 1998; 50: 175–186.
2. Suppes T, et al: The longitudinal course of bipolar disorder. Journal of Clinical Psychiatry 2000; 61: 23–30

Poster 20 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

TREATMENT OF DEPRESSION IN HIV AND AIDS PATIENTS WITH CITALOPRAM

Forest Laboratories, Inc.

M. Beatriz Currier, M.D., *Director of Consultation Psychiatry Division, University of Miami, P.O. Box 016960, Miami, FL 33101*; Germán Molina, M.D., *Assistant Professor of Psychiatry, University of Miami, P.O. Box 016960, Miami, FL* 33101; Raúl Rodríguez, M.D.; Louviran Baptista, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the safety and efficacy of citalopram in the treatment of depression in HIV seropositive and AIDS patients and identify potential adverse effects associated with citalopram in this medical population.

SUMMARY:

Objectives: To date, there have been no prospective studies of citalopram among depressed HIV/AIDS patients. The purpose of this study is to evaluate the efficacy and safety of citalopram in the treatment of depression among 20 HIV seropositive adult outpatients. In addition, to determine if clinical variables such as HIV disease staging, chronicity of HIV illness, and chronicity of depression are significantly associated with depression treatment response.

Methods: Outpatients with HIV spectrum illness, ages 18–75 years, with baseline Beck Depression Inventory (BDI) scores >15, baseline Mini Mental State Exam (MMSE) scores >20, a SCID-confirmed DSM-IV diagnosed major depressive disorder, and no other Axis I active diagnoses were recruited into a six-week, prospective, open-label study of citalopram (flexible dose 20–40 mg/day as tolerated). Responders were defined by a Clinical Global Improvement (CGI) score of "much improved" or "very much improved" and a 50% reduction in baseline BDI scores and Hamilton Depression Rating Scale (HDRS-17) scores.

Results: To date, ten patients (7 males, 3 females; mean age 43.2 ± 8.1 years) have been recruited into the study. The HIV (1) sample includes three asymptomatic, one symptomatic, and five AIDS patients. The mean duration of HIV illness in this sample is 50 ± 48 months. The mean CD4 cell count in this sample is 287 cells. Viral loads are detectable in six patients with RNA copies ranging from 3946 to 300000. Six patients are on anti-retroviral medications. Seven patients reported a prior history of depression and six patients had received prior antidepressant pharmacotherapy. Baseline measures of this sample included a mean BDI score of 33 ± 10.94 and a mean HDRS score of 23.6 ± 3.57. Thus far, 50% of the completers have responded to citalopram at a mean dose of 30 mg daily. Clinical variables, such as CDC staging, CD4 cell counts, viral load, and chronicity of depression, which may serve as predictors of depression treatment response to citalopram, have not been analyzed due to the small number of completers at this point in the study. Two patients discontinued the study secondary to adverse events (rash, nausea). Fifty percent of the sample reported no adverse effects. Mild and transient adverse events included dry mouth, dizziness, and tremor.

Conclusions: Preliminary findings suggest that citalopram is effective for the treatment of depression in HIV/AIDS patients. Furthermore, it appears that citalopram is well tolerated among patients with AIDS-related medical conditions. Double blind, placebo-controlled trials are needed to confirm these findings.

REFERENCES:

1. Rabkin JG, Wagner GI, Rabkin R: Floxetine treatment of depression in patients with HIV and AIDS: a randomized, placebo controlled trial. Am J Psychiatry 1999;156: 101–107
2. Fernanco SJ, Goldman J, Charnes WE: Selective serotonin reuptake inhibitor treatment of depression in symptomatic HIV infection and AIDS. General Hospital Psychiatry 1997;19: 89–97

TARGET AUDIENCE:

Consultation/liaison psychiatrists, primary care physicians

Poster 21 **Thursday, October 11**
3:30 p.m.-5:00 p.m.

MOOD SENSITIVITY TO HIGH POLLEN COUNT PREDICTS SEASONALITY

Teodor T. Postolache, M.D., *Director of Psychopharmacology Division, Saint Elizabeth's Hospital, 2700 Martin L. King Jr. Avenue, S.E., Washington, DC 20032*; Vladimir Nikiforouk, M.D., *Physician, Saint Elizabeth's Hospital, 2700 Martin L. King Jr. Avenue, S.E., Washington, DC 20032*; Manjula Borge, M.D.; Alvaro Guzmán, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participants should be able to recognize the possibility that factors other than light may contribute to SAD.

SUMMARY:

Introduction: Seasonal changes in mood vary from none or mild to seasonal episodes of major depression (Rosenthal 1984). Beside light deprivation, other factors, such as pollen allergy, may contribute to SAD. We hypothesized that a high pollen count will predict seasonality.

Methods: We used the Seasonal Pattern Assessment Questionnaire (SPAQ) in college students living in the Washington, D.C. area, as approved by the IRB of the DC-CMHS. A global seasonality score (GSS) was calculated according to Kasper, et al 1989. *Seasonal* subjects were diagnosed by standard criteria for either SAD or subsyndromal SAD, and the rest were defined as *nonseasonal.* According to their seasonal pattern, *seasonals* were further divided into a *winter* and *non-winter* type. The negative effect of high pollen count and short days on mood were documented as binary variables. We used a three-way ANCOVA with post-hoc t tests to analyze *GSS* and a multiple logistic regression to analyze the *seasonal vs. nonseasonal* diagnosis as predicted by reported mood sensitivity to high pollen count, adjusted for age, gender, and mood sensitivity to short days.

Results: GSS was highly related to mood sensitivity to high pollen count (N: 521, F=15.540, $p < 0.001$). GSS was higher ($p < 0.001$) in subjects with mood sensitivity to high pollen count (9.13 ± 5.07) than in those without sensitivity to high pollen count (6.83 ± 4.98). Mood sensitivity to high pollen count predicted a diagnosis of seasonality with non-winter pattern (N= 481, –0.271, odds ratio 0.76,95%,CI 0.60–0.97, $p < 0.025$).

Conclusion: Mood sensitivity to high pollen count is a strong predictor of seasonality. Possible underlying mechanisms of these results will be discussed and deserve further study.

REFERENCES:

1. Kasper S, Wehr TA, Bartko JJ, Gaist PA, Rosenthal NE: Epidemiological findings of seasonal changes in mood and behavior. A telephone survey of Montgomery Country, Maryland. Arch Gen Psychiatry 1989; 46:823–833
2. Rosenthal NE, Sack DA, Gillin JC, Lewy AJ, Goodwin FK, et al: Seasonal affective disorder, a description of the syndrome and preliminary findings with light therapy. Arch Gen Psychiatry 1984; 41:72–80

TARGET AUDIENCE:

Biological psychiatrists, medical students

Poster 22 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

CROSS-SECTIONAL STUDY COMPARING WEIGHT GAIN AND ANDROGEN LEVELS IN WOMEN WITH EPILEPSY TAKING LAMOTRIGINE COMPARED TO VALPROATE MONOTHERAPY

GlaxoSmithKline

Gema M.A. Gomez, B.A., *Principal Clinical Research Scientist, GlaxoSmithKline, 5 Moore Drive, Research Triangle, NC 27709*; Fiona O'Neill, *Principal Clinical Research Scientist, GlaxoSmithKline, One Greenford Road, Greenford, England*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that lamotrigine would be a desirable option for women taking anti-epileptic drugs because it is not associated with weight gain, does not disrupt menstrual cycle length or variability, and has a favorable endocrine profile.

SUMMARY:

Women with epilepsy may develop hormonal and metabolic disorders associated with polycystic ovary syndrome (PCOS) when taking certain anti-epileptic drugs. There is now growing concern that the use of these drugs for psychiatric conditions may also lead to PCOS. This study compared the incidence of PCOS symptoms in women with epilepsy taking either lamotrigine (LTG) or valproate (VPA) monotherapy. In a cross-sectional observational study, women on LTG or VPA monotherapy for eight to 60 months completed a study visit on Day 1–3 of their menstrual cycle. During the follow-up phase, they completed menstrual diaries and urine ovulation tests. A total of 119 LTG and 103 VPA patients completed the study visit. Women in VPA group had significantly higher total serum testosterone (0.96nmol/L VPA, 0.72nmol/L LTG, p=0.001) and androstenedione (12.6nmol/L VPA, 10.1nmol/L LTG, p= 0.015) levels than LTG group. The mean weight in the VPA group increased between start of VPA treatment and study visit (63.0 kg, 67.7 kg), while that of the LTG group did not change (71.5 kg, 71.5 kg). Patients on VPA reported longer and more variable cycle lengths (29.5 days, SD=5.9) than LTG patients (28.3 days, SD= 3.0). Preliminary results suggest LTG monotherapy is a desirable option for women taking anti-epileptic drugs because it is not associated with weight gain, does not disrupt menstrual cycle length or variability, and has a favorable endocrine profile.

REFERENCES:

1. Herzog AG, Seibel MM, Schomer DL, et al: Reproductive endocrine disorders in women with partial seizures of temporal lobe origin. Arch Neurol 1986;43:341–346
2. Isojarvi, JIT, Rattya, J, et al: Valproate, lamotrigine, and insulin-mediated risks in women with epilepsy. Ann Neurol 1998;43:446–51

Poster 23 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

PRESENTATION OF DEPRESSION IN DIFFERENT CULTURES

Mushtaq Ahmed, M.D., *D-45 Darakshan Villas, DHA-6, Karachi, Pakistan (West)*; Maqsood Ahmed, M.D., *D-45 Darakshan Villas, DH A-6, Karachi, Pakistan (West)*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participants will be able to recognize the depression presentation in different ways in different cultures.

SUMMARY:

Objective: To assess depression and its presentation in our social and cultural set up and compare the results with published papers in developed countries.

Methods: In this study about 200 patients living in Keamari who visited neuropsychiatric clinic in Keamari and psychiatric unit of KPT were inducted. The depression was diagnosed according to DSM-IV Criteria. A psychosocial questionnaire was devised and completed.

Results: About 50% of the patients presented with the complaint of lethargy and weakness. When we asked them about somatoform symptoms about 73% of the patients had persistent headache, 80% of the patients had nonspecific cardiovascular symptoms, and about 73% had GIT disturbance. As regards the biological symptoms, 83% reported insomnia, 70% reported poor appetite, and 25% reported sexual dysfunction. On mental state examination, 83% had depressed mood, 24% had somatic delusions, 13% had hallucinations, 90%

had lack of attention and concentration, and 2% reported suicidal attempts.

Conclusion: From this study of a small number of depressed patients, we conclude that in our cultural set up the depression is represented differently than in developed countries. Here depressed patients present with somatic complaints rather than symptoms like pessimistic thoughts or feelings of guilt. Very few people showed suicidal tendencies.

REFERENCES:

1. Spitzer RL, Endicott J, Robins E, et al: Research and diagnostic criteria: rationale and reliability. Archives of General Psychiatry 1978; 35: 17–24
2. Sartorius, N: Depressive disorder in different cultures. Journal of Affective Disorders 1983; Supplement 2: 360–384

Poster 24 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

FACTORS INFLUENCING PSYCHIATRISTS' CHOICE OF ANTIDEPRESSANTS: A PROSPECTIVE STUDY

Mark Zimmerman, M.D., *Associate Professor, Department of Psychiatry, Brown University, 235 Plain Street, Suite 501, Providence, RI 02905*; Michael A. Posternak, M.D.; Naureen Attiulah, M.D.; Scott E. Baymiller, M.D.; Steven Singer, M.D.; Shahzad Rahman, M.D.; Kersten K. Uy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the most common factors influencing psychiatrists' choice of antidepressants for the treatment of depression.

SUMMARY:

Objective: Numerous studies have searched for predictors of preferential antidepressant treatment response with, at best, modest success. With a wide array of antidepressants to choose from, there is thus little empirical data guiding the clinician in choosing an antidepressant. The goal of the present study was to prospectively examine the factors considered by psychiatrists at the time an antidepressant is selected.

Methods: The Factors Associated with Antidepressant Choice Survey (FAACS) lists 43 items that might be considered when selecting an antidepressant. The list includes clinical factors (e.g., symptom profile/target symptoms, depression subtype, comorbid conditions), demographic variables, medication properties (e.g., side effects, half-life, dosing frequency), and insurance considerations (e.g., formulary, co-pay), and other miscellaneous items. The FAACS was completed by psychiatrists immediately after the patient encounter. To date, psychiatrists have completed the FAACS on 121 depressed outpatients presenting for treatment.

Results: The factors most frequently considered by psychiatrists when selecting an antidepressant were symptom profile (73.6%), the presence of a comorbid condition (64.5%), and side-effect profile (50.4%). Of the specific vegetative symptoms of depression, the presence of insomnia most frequently influenced antidepressant selection (36.4%). Generalized anxiety disorder and panic disorder were the comorbid disorders that most frequently influenced antidepressant choice (34.7% and 25.6%, respectively). The side effects that psychiatrists most frequently hoped to avoid were sexual dysfunction, weight gain, fatigue, and agitation.

Conclusions: Although antidepressants are generally considered equally effective, and there is little literature identifying patient characteristics associated with preferential response to one AD over another, psychiatrists routinely base their treatment selection on patients' clinical profile.

REFERENCES:

1. Janicak PG, Davis JM, Preskorn SH, Ayd FJ: Principles and Practice of Psychopharmacology. Baltimore, MD, Williams and Wilkins, 1997
2. American Psychiatric Association Practice Guideline for the Treatment of Patients with Major Depressive Disorder (Revision) American Journal of Psychiatry 2000; 157: supplement

Poster 25 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

CITALOPRAM TREATMENT OF DEPRESSION IN NURSING HOME PATIENTS

Forest Pharmaceuticals, Inc.

John M. de Figueiredo, M.D., *Department of Neuroscience, Center for Psychiatry, 1389 West Main Street, Room 106, Waterbury, CT 06708*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that citalopram was effective and well-tolerated in treating depressed geriatric patients.

SUMMARY:

Citalopram, the most selective of the SSRIs, has demonstrated efficacy in the treatment of depression. Citalopram is of particular interest in the treatment of geriatric

depression because of its low potential for drug interactions and incidence of side effects. This chart review determined if citalopram reduced depressive symptoms in geriatric patients. Residents of an academically affiliated nursing home who met the DSM-IV criteria for one of the depressive disorders were included. Citalopram was initiated at 10–20 mg/day. A rater independently reviewed each chart for change using the Clinical Global Impressions Scale (CGI). The mean age of the 24 patients was 75.8 years. All patients had concurrent nonpsychiatric comorbidities, and all were taking multiple nonpsychiatric medications. Fourteen patients had failed or not tolerated previous antidepressant treatment. After eight weeks, 83% of the patients were rated as "very much improved" or "much improved" on the CGI (responders). The response rate among patients who failed previous antidepressant treatment (86%) was similar to that in treatment naive patients (80%). Adverse events were mild and did not interfere with treatment.

This study suggests that citalopram is well tolerated and safe for the treatment of depression in geriatric nursing home patients with a wide range of nonpsychiatric diagnoses and receiving multiple nonpsychiatric medications.

REFERENCES:

1. Willetts J, Lippa A, Beer B: Clinical development of citalopram. J Clin Psychopharmacol 1999; 19: 36S–46S.
2. Mulchahey JJ, Malik MS, Sabai M, Kasckow JW: Serotonin-selective reuptake inhibitors in the treatment of geriatric depression and related disorders. Int J Neuropsychopharmcol 1999; 2:121–127.

TARGET AUDIENCE:

General psychiatrists, allied health professionals

Poster 26 **Thursday, October 11**
3:30 p.m.-5:00 p.m.

FULL-SUSTAINED REMISSION RATES AMONG CITALOPRAM-TREATED PATIENTS

Forest Pharmaceuticals, Inc.

Michael E. Thase, M.D., *Professor, Department of Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213*; David J. Kupfer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that citalopram-treated patients achieve DSM-IV defined remission.

SUMMARY:

Studies of acute phase antidepressant therapy usually define response as at least a 50% reduction in symptoms. However, several lines of evidence support use of the stricter goal of remission, defined as a virtual absence of residual symptoms, as the optimal therapeutic outcome. During continuation phase antidepressant therapy, the comparable goal is full-sustained remission, which is defined by DSM-IV as a period of at least two months in which there are no significant symptoms of depression. There is some evidence that antidepressants are not equally likely to produce remission and, in particular, it has been suggested that antidepressants with effects on multiple neurotransmitter systems may have advantages over SSRIs. To gauge the impact of longer-term antidepressant therapy with the SSRI citalopram, a retrospective analysis was conducted.

Data from four studies of at least 20 weeks in duration, evaluating more than 800 patients, were examined. Sustained remission rates ranged from 53% to 72% among patients entered in the long-term studies. These results indicate that the majority of citalopram-treated patients will achieve DSM-IV-defined sustained remission. Prospective studies using such rigorous criteria for sustained remission criterion are needed to assess relative remission rates among various antidepressant therapies.

REFERENCES:

1. Willetts J, Lippa A, Beer B: Clinical development of citalopram. J Clin Psychopharmacol 1999; 19:36S–46S.
2. Stahl SM: Placebo-controlled comparison of the selective serotonin reuptake inhibitors citalopram and sertraline. Biol Psychiatry 2000; 48:894–901.

TARGET AUDIENCE:

General psychiatrists and allied health professionals

Poster 27 **Thursday, October 11**
3:30 p.m.-5:00 p.m.

CITALOPRAM IN ADOLESCENTS WITH MOOD, ANXIETY, AND COMORBID DISORDERS

Forest Pharmaceuticals, Inc.

Jeff Q. Bostic, M.D., *15 Parkman Street, WAC 725, Boston, MA 02114*; Jefferson B. Prince, M.D., *15 Parkman Street, WAC 725, Boston, MA 02114*; Michael Monuteaux; Kenneth M. Brown, M.D.; Suzanne Place, M.S.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that citalopram may be

effective and well-tolerated in treating adolescent mood and anxiety disorders, even when comorbidities are present.

SUMMARY:

This chart review assessed the effectiveness and tolerability of citalopram in adolescents with primary mood and anxiety disorders as well as comorbid disorders. Medical charts from 28 adolescents prescribed citalopram at a community mental health center between 1998–1999 were retrospectively reviewed by an independent child psychiatrist. Primary outcome measures were the Clinical Global Impressions (CGI). Severity and Improvement scales for both depression and anxiety. Seventy-six percent of the adolescents with mood disorders demonstrated significant improvement on the CGI. Of the adolescents with anxiety, 82% had a significant clinical response. Eight of 10 patients with comorbid anxiety and depression experienced significant improvement in both anxiety and depression. Citalopram markedly improved mood symptoms in six of seven patients with comorbid depression and attention deficit hyperactivity disorder (ADHD) and improved anxiety symptoms in five of six patients with comorbid anxiety and ADHD. Gender, age, prior SSRI exposure, and presence of side effects did not predict response to citalopram. Of 14 patients with inadequate responses to previous SSRI trials, 10 responded to citalopram. This chart review suggests that citalopram may be effective and well tolerated in the treatment of adolescent mood and anxiety disorders, including patients with comorbid ADHD.

This study was supported by a grant from Forest Laboratories.

REFERENCES:

1. Willetts J, Lippa A, Beer B: Clinical development of citalopram. J Clin Psychopharmacol 1999; 19:36S–46S.
2. Thomsen PH: Child and adolescent obsessive-compulsive disorder treated with citalopram: findings from an open trial of 23 cases. J Child Adolesc Psychopharmacol 1997; 7:157–66.

TARGET AUDIENCE:

Adolescent psychiatrists, allied health professionals

Poster 28 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

ESCITALOPRAM RAPIDLY IMPROVES ANXIETY SYMPTOMS IN DEPRESSED PATIENTS

Forest Pharmaceuticals, Inc.

R. Bruce Lydiard, M.D., Ph.D., *One Poston Road, Suite 150, Charleston, SC 29407*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that escitalopram is efficacious in the treatment of anxiety symptoms in depression.

SUMMARY:

Anxiety, a common symptom in depressed patients, is associated with poor outcome and increased severity of the disorder. An optimal antidepressant drug should therefore also rapidly alleviate anxiety symptoms. Escitalopram is the single isomer responsible for the SSRI activity of the racemic antidepressant citalopram. Recently, three randomized (one fixed and two flexible dose), double-blind, eight-week, placebo-controlled, multicenter studies of escitalopram (10–20 mg/day) and citalopram (20–40 mg/day) were conducted in patients with major depressive disorder (DSM-IV). All the studies had a common design and patient entry criteria. Depression symptoms were measured by the Montgomery Asberg Depression Rating Scale (MADRS), and anxiety symptoms by the MADRS inner-tension item. The pooled data from these studies show that both escitalopram and citalopram significantly improved both anxiety and depressive symptoms compared with placebo. By-visit analysis of the MADRS inner-tension item showed that escitalopram significantly improved anxiety symptoms within one week of treatment. Escitalopram also significantly improved MADRS scores in the most anxious patients within one week. These data clearly demonstrate that escitalopram is efficacious in the treatment of anxiety symptoms in depression.

REFERENCES:

1. Hyttel J, Bogeso KP, Perregaard J, Sanchez C: The pharmacological effect of citalopram residues in the (S)-(+)-enantiomer. J Neural Transm Gen Sect 1992;88:157–60.
2. Lepola UM, Wade AG, Leinonen EV, et al: A controlled, prospective, 1-year trial of citalopram in the treatment of panic disorder. J Clin Psychiatry 1998;59:528–34.

Poster 29 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

A PILOT STUDY OF THE EFFECTIVENESS OF CITALOPRAM IN PMS PATIENTS WITH PRIOR SSRI TREATMENT FAILURE

Forest Pharmaceuticals, Inc.

Ellen W. Freeman, Ph.D., *Research Professor, Departments of Obstetrics and Gynecology and Psychiatry, University of Pennsylvania Medical Center, 3400 Spruce*

Street, Philadelphia, PA 19104; S. Jabara, M.D.; R. Auletto, M.S.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that citalopram effectively reduced the symptoms of PMS.

SUMMARY:

Premenstrual syndrome (PMS) is a chronic mood disorder afflicting reproductive-aged women. Data suggest that the SSRIs effectively reduce PMS symptoms. In a placebo-controlled study, intermittent dosing (luteal phase) of citalopram, the most selective SSRI, significantly improved PMS symptoms. This open-label trial examined whether intermittent dosing of citalopram reduced PMS symptoms in women who did not respond to previous SSRI treatment. Women (18–45 years old) with no improvement in symptoms after two menstrual cycles on an SSRI were eligible. The 17-item daily symptom report (DSR) and each of five symptom clusters measured response to citalopram. Intermittent and daily dosing scores were compared. Seventeen women (11 intermittent dosing, six daily dosing) were administered citalopram (20–40 mg/day) for three months. Baseline DSR scores significantly improved (P = 0.02) in both groups, with no difference between the intermittent and daily dosing groups. Clinical improvement (>50% decrease in baseline DSR) was reported by 80% and 66% of the intermittent and daily dosing groups, respectively. Symptoms were reduced to postmenstrual levels in 60% of the intermittent group. Mood and appetite improved significantly; function and pain also improved. Patients who did not respond to previous treatment with another SSRI also improved significantly. These results suggest that intermittent citalopram dosing is effective for treating PMS.

REFERENCES:

1. Freeman EW, Halbreich U: Premenstrual syndromes. Psychopharmacol Bull 1998;34:291–5.
2. Wikander I, Sundblad C, Andersch B, et al: Citalopramin premenstrual dysphoria: is intermittent treatment during luteal phases more effective than continuous medication throughout the menstrual cycle? J Clin Psychopharmacol 1998;18:390–8.

TARGET AUDIENCE:

Clinical psychiatrists and allied health professionals

Poster 30 **Thursday, October 11**
3:30 p.m.-5:00 p.m.

DEPRESSION BREAKTHROUGH SERIES: SUSTAINABLE QUALITY IMPROVEMENT

Robert Wood Johnson Foundation

David J. Katzelnick, M.D., *Distinguished Scientist, Madison Institute of Medicine, 7617 Mineral Point Road, Suite 300, Madison, WI 53717*; Michael Von Korff, M.D., *Associate Director of Research, Group Health Cooperative, 1730 Minor Avenue, Suite 1600, Seattle, WA 98101*; Henry Chung, M.D.; Lloyd P. Provost

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that sustainable improvement in depression care is possible in diverse medical settings using Breakthrough Series initiatives; describe the key depression change concepts used in the BTS; list the six components of the chronic illness care model.

SUMMARY:

Background: Two previous Institute for Healthcare Improvement (IHI) Breakthrough Series (BTS) initiatives (sponsored by the Robert Wood Johnson Foundation National Program on Improving Chronic Illness Care) have successfully reorganized care for diabetes and congestive heart failure producing sustainable change. The goal of this BTS is to discover if the same changes can be achieved for depression care in diverse health care systems.

Methods: Twenty-three ethnically and geographically diverse health care organizations agreed to participate in the Depression BTS. Many were community health centers funded by the Bureau of Primary Care. Each team attended three learning sessions that emphasized the chronic illness care model, key depression change concepts, and how to initiate Plan-Do-Study-Act (PDSA) cycles. An e-mail list-serve, monthly reporting of data and progress, and teleconferences were used to facilitate collaboration between learning sessions. Most sites used the PRIME-MD Patient Health Questionnaire-9 (PHQ-9) for structured depression diagnosis and severity and the MacArthur Foundation Depression Tool-kit.

Results: Seventeen of the 20 plans completing the BTS achieved significant improvement as measured by a faculty assessment of at least a 4 out of 5. More than 2,000 patients initiated depression treatment and were registered in the plan's depression registries. Data will be presented on percent of patients receiving a structured depression assessment, six months of antidepressant medication, and achieving at least a 50% decrease in depression severity. The Bureau of Primary Care and many of the plans are now spreading the initiative.

Conclusion: The IHI Breakthrough Series is a viable method of disseminating evidence-based depression care in diverse medical settings.

REFERENCES:

1. Wagner EH, Glasgow RE, Davis C, et al: Quality improvement in chronic illness care: a collaborative approach. Jt Comm J Qual Improv 2001;27:63–80.
2. Spitzer RL, Kroenke K, Williams JB: Validation and utility of a self-report version of PRIME-MD; the PHQ primary care study. Primary Care Evaluation of Mental Disorders. Patient Health Questionnaire. JAMA 1999;282:1737–1744.

TARGET AUDIENCE:

Psychiatrists, other mental health specialists, and primary care clinicians interested in depression quality improvement.

Poster 31 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

LIMITATIONS OF CURRENT ANTIDEPRESSANTS IN OLDER PATIENTS WITH DEPRESSION

Pharmacia Corporation

William S. Edell, Ph.D., *Senior Vice President of Development, Mental Health Outcomes, 1500 Waters Ridge Drive, Lewisville, TX 75057*; Kevin Mayo, Ph.D., *Health Economic Scientist, Pharmacia Corporation, 100 Route 206, North, Peapack, NJ 07977*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe some of the common areas of deficit in the behaviors, cognition, and instrumental functioning among older patients with depression that are often not remedied with the use of current agents.

SUMMARY:

While current antidepressants are reasonably effective in ameliorating depressive symptomatology, less is known about their impact on common areas of deficit, including cognition, maladaptive behaviors, and instrumental activities of daily living (IADL's).

Objective: To examine changes in cognition, maladaptive behaviors, and IADLs of geropsychiatric patients with major depression (ICD-9-CM codes 296.20–296.36) treated with fluoxetine, mirtazapine, sertraline, or venlaxafine.

Method: Data were obtained from the CQI+^{sm} Outcomes Measurement System, an ORYX/JCAHO accepted performance improvement system, which tracked patients admitted to geropsychiatric inpatient programs in 111 general hospitals across 33 states from 1997–1999. The instruments used to measure cognition, maladaptive behaviors, and IADL's were the Mini-Mental State Examination (MMSE), Psychogeriatric Dependency Rating Scale (PGDRS), and Duke Multidimensional Functional Assessment of Older Adults, respectively. One-way analyses of variance and, if significant, Tukey's pairwise comparisons, compared medication groups on changes across admission, discharge, and three-month follow-up.

Results: At admission, patients exhibited moderate to severe impairment in all three dimensions measured. Measured groups were indistinguishable on change scores with only modest improvement observed, if any.

Conclusions: Antidepressants in this analysis were associated with modest improvement, suggesting the need for new treatment modalities that enhance cognition, behaviors, and functioning along with depressive symptomatology. Further controlled studies are needed.

REFERENCES:

1. Mueller TI, Leon CC: Recovery, chronicity, and levels of psychopathology in major depression. Psychiatric Clinics of North America 1996; 19:85–102
2. Wells KG, Stewart A, Hayes RD, et al: The functioning and well-being of depressed patients: Results from the medical outcomes study. Journal of the American Medical Association 1989; 262:914

TARGET AUDIENCE:

Psychiatrists, other physicians, mental health professional

Poster 32 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

RAPID-LOADING OF EXTENDED RELEASE DIVALPROEX SODIUM

Abbott Laboratories

Brian P. Miller, M.D., *Department of Psychiatry, University of California at San Diego, 200 West Arbor Drive, San Diego, CA 92103*; William Perry, Ph.D.; David Feifel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should become familiar with preliminary data for an aggressive treatment strategy to stabilize acutely manic inpatients using extended-release divalproex sodium in a rapid-loading dosage regimen.

SUMMARY:

Divalproex sodium has been well accepted as effective treatment for bipolar disorder. Rapid-loading strategies

for divalproex sodium have been shown to be safe and effective in treating acutely manic patients. An extended-release formulation of divalproex sodium has recently been approved for once-a-day dosing in the treatment of migraine headaches. We present data from 11 patients with a diagnosis of either bipolar disorder or schizoaffective disorder, bipolar type, who were currently manic and treated openly with extended-release divalproex sodium in the inpatient setting. Patients were started on a single dose of 30mg/kg given once a day. Serial blood levels of valproic acid were obtained. A retrospective chart review was performed to evaluate side effects and to rate patients' improvement. There were no serious adverse events, and only 1/11 patients had to stop treatment due to side effects. These very preliminary results show that extended-release divalproex sodium is well tolerated and effective when given as a once-a-day dose of 30mg/kg in the inpatient setting to stabilize acutely manic patients.

REFERENCES:

1. Keck PE Jr, McElroy SL, Tugrui KC, et al: Valproate oral loading in the treatment of acute mania. J Clin Psychiatry 1993;54:305–308.
2. Hirschfeld RMA, Allen MH, McEvoy JP, et al: Safety and tolerability of oral loading divalproex sodium in acutely manic bipolar patients. J Clin Psychiatry 1999;60:815–818.

TARGET AUDIENCE:

Psychiatrists, residents, medical students

Poster 33 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

RISK FACTORS FOR SUICIDAL BEHAVIOR IN THE CANADIAN ARCTIC

University of Western Ontario, Baffin Regional Health Board

John M. Haggerty, M.D., *Department of Psychiatry, Lakehead Psychiatric Hospital, University of Western Ontario, 580 North Algoma Street, Thunder Bay, ON Canada P7B 5G4*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will gain an understanding of the the high prevalence of suicidal behavior in the Arctic region and the association of psychiatric disorders and age to its occurrence.

SUMMARY:

Introduction and method: Rates of completed suicide in the circumpolar region rank as some of the highest in the world. We undertook a random household survey in a Canadian Arctic Inuit community (N = 111) using a four-item self-report questionnaire (in English or in Inuktitut) dealing with thoughts of killing oneself in the past week, suicide attempts, plans to kill oneself, and wish to die within the last six months. The respondents were also administered the Hospital Anxiety and Depression Scale (HAD).

Results: Thirty percent of those responding attempted suicide within the last six months, 52.9% reported a wish to die in the past six months, 30.3% reported having a plan to die in the last six months, and 43.6% have thought of committing suicide in the past week. Our present analysis combined data from these four items in composite measure to identify respondents who fell in the top quartile (high suicide ideation). We used a multivariate logistic regression model to determine the independent contribution of age, gender, language, anxiety, and depression to increased suicidal behavior. Age less than 35 (OR = 6.12, 95% CI = 1.30, 28.77) and high anxiety (OR = 3.68, 95% CI = 1.04, 10.07) were strongly associated with high suicidal ideation and behavior. Gender, language and depression were not.

Conclusion: Suicidal behavior in the Arctic is a frequent event and the relationship between high anxiety in young Inuit and suicide behavior must be examined further to ascertain causality.

Funding sources: University of Western Ontario, Baffin Regional Health Board.

REFERENCES:

1. Kettle PA, Bixler EO: Suicide in Alaska Natives, 1979–1984. Psychiatry 1991; 54, 55–63.
2. Haggarty J, Cernovsky ZZ, Kermeen P, Merskey H: Psychiatric disorders in an Arctic community. 2000;45:357–362.

TARGET AUDIENCE:

Psychiatrists with a special interest in cross-cultural work, suicidology, and the epidemiology of mental disorders.

Poster 34 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

TREATMENT INITIATION PROGRAM: A PILOT INTERVENTION TO IMPROVE ADHERENCE

National Alliance for Research on Schizophrenia and Depression

Jo Anne Sirey, Ph.D., *Associate Professor of Psychology, Weill Cornell Medical College, 21 Bloomingdale Road, White Plains, NY 10605*; Martha L. Bruce, Ph.D., *Department of Psychology, Weill Cornell Medical College, 21 Bloomingdale Road, White Plains, NY 10605*;

George S. Alexopoulos, M.D.; Barnett S. Meyers, M.D.; Kim Morrison, B.A.; Christina Butler, M.A.; Dimitris Kiosses, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be more aware of the psychological barriers (e.g. perceived stigma and misconceptions) to depression treatment experienced by older adults and learn about a new early intervention to try to address these barriers and improve knowledge and adherence to antidepressant therapy.

SUMMARY:

In spite of effective treatments for major depression, many elderly are undertreated. Psychological barriers such as misattribution of symptoms and perceived stigma can lead to treatment discontinuation. We report on a early intervention to "initiate" older adults into treatment.

New depressed outpatients who had been recommended pharmacotherapy were randomized to antidepressant therapy with the intervention (TIP) or pharmacotherapy alone. TIP consisted of three visits with a clinician who provided individualized psychoeducation and reviewed perceived stigma, attribution of symptoms, and the treatment plan. Assessments for depression (HDRS), anxiety (CAS), and perceptions of depression and treatment were administered at admission and six-week follow-up.

There were no age, education, or depression severity differences. Preliminary data on 21 subjects (11 control and 10 TIP) found that the TIP intervention patients had better understanding of their treatment plan (p=.01) and less fear of medication (p=.08). All of TIP patients, as compared with 66% of the controls, were still on antidepressants and reported greater reduction of depressive (p=.08) and anxiety symptoms (p=.006).

These data are consistent with the hypothesis that increasing knowledge and addressing perceived stigma increases treatment adherence resulting in improved patient outcomes. Future work needs to validate these findings with a larger sample.

REFERENCES:

1. Sirey J, Bruce ML, Alexopoulos GS, et al.: Perceived stigma as a predictor of treatment discontinuation in young and older outpatients with depression. Am J Psychiatry 2001; 158:479–481.
2. Bruce ML, Pearson JL: Designing an intervention to prevent suicide: PROSPECT (Prevention of suicide in primary care elderly: Collaborative trial). Dialogues in Clinical Neuroscience 1999; 1:100–112.

TARGET AUDIENCE:

Clinicians who treat older adults with depression

POSTER SESSION 2

Posters 35–67

Poster 35 **Friday, October 12**
10:00 a.m.-11:30 a.m.

CLINICAL EXPERIENCE WITH SWITCHING PATIENTS TO ZIPRASIDONE OR OLANZAPINE

Eli Lilly and Company

Gabriel Cizinsky, M.D., *Psykiatriska Klinken, Centrallasarettet, Västeras, Sweden 72189;* Rolf Adolfsson, M.D., *Psykiatriska Klinken, Norralnds Universitetssjukus, Umea, Sweden 90185;* Borje Ekeroth, M.D.; Michael Klingert, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be aware of the clinical experiences observed in Sweden with switching patients to ziprasidone or olanzapine.

SUMMARY:

Purpose: To report 19 cases of patients switched to ziprasidone or olanzapine.

Methods: Patients (9 men, 10 women, 31–59 years) were diagnosed with schizophrenia, schizoaffective, or bipolar disorder. Reasons for switching, scores for Clinical Global Impression-S and C, Global Assessment of Functioning, Quality of Life, and Satisfaction with Medication; EPS, and weights were recorded. Physicians rated switch as negative, positive, or neutral.

Results: Fourteen patients switched to ziprasidone and five to olanzapine. CGI-S and CGI-C scores improved in switches from typicals to ziprasidone (TZ) and worsened on GAF and SWM; QOL was unchanged. Switches from typicals to olanzapine (TO) improved on all scales; from olanzapine to ziprasidone (OZ) worsened on all scales; from risperidone to ziprasidone (RZ) showed improved CGI-S and SWM scores and worsening on CGI-C. QOL and GAF were unaffected. Some patients showed stabilization or weight loss after switching to ziprasidone. One patient gained weight in each of TZ, RZ, and TO. In TZ, physicians rated three switches positive and two negative. In OZ or RZ, one was rated positive, six negative, and two neutral. Of the five switches to olanzapine, four were positive and one neutral.

Conclusion: Although ziprasidone therapy led to some weight stabilization or loss, efficacy was compromised, especially when switched from olanzapine.

REFERENCES:

1. Tandon R, et al: Ziprasidone: a novel antipsychotic with unique pharmacology and therapeutic potential. J Serotonin Res 1997; 4:159–177
2. Tollefson GD, et al: Olanzapine versus haloperidol in the treatment of schizophrenia and schizoaffective and schizophreniform disorders: results of an international collaborative trial. Am J Psychiatry 1997; 154:457–465

Poster 36 **Friday, October 12**
10:00 a.m.-11:30 a.m.

CARDIAC CONDUCTION DISTURBANCES IN TWO PATIENTS RECEIVING ZIPRASIDONE MONOTHERAPY

Eli Lilly and Company

Rolf Adolfsson, M.D., *Psykiatriska Klinken, Norralnds Universitetssjukus, Umea, Sweden 90185;* Yvonne Lindblom, M.D., *Psykiatriska Klinken, Norralnds Universitetssjukus, Umea, Sweden 90185*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to attend this session, one will have a better understanding of the relationship between the antipsychotic ziprasidone and cardiac conduction abnormalities.

SUMMARY:

Purpose: To report two cases of cardiac conduction disturbances during ziprasidone monotherapy.

Background: Certain antipsychotics produce myocardial conduction disturbances that can lead to potentially lethal ventricular arrhythmia and sudden death.

Method: Psychiatrists documented patient histories, clinical course, and outcome.

Results: A 34-year-old female with borderline personality disorder, anxiety syndrome, and mental retardation was switched to ziprasidone. At 160 mg/day, the patient's cognitive functions were clinically improved; however, she developed a 110 ms increase in QTc interval. At 80 mg/day, minimal clinical improvement was observed and the patient was hospitalized due to suicidal thoughts. A 53-year old male with paranoid schizophrenia was medication free for seven months and had a normal ECG. After psychotic relapse and seven weeks of ziprasidone therapy at 160 mg/day, patient developed type I AV-block. There were no baseline values for psychotic symptoms, but symptom improvement was observed.

Conclusions: At a clinically effective dose, ziprasidone therapy was temporally associated with myocardial conduction disturbances in two patients. The potential benefits of ziprasidone treatment must be weighed against the potential risk of serious and unpredictable cardiac dysfunction. These patients developed complications without concomitant medications. Many psychiatric patients receive multiple medications that may interact with ziprasidone to produce serious cardiac conduction disturbances.

REFERENCES:

1. Welch R, Chue P: Antipsychotic agents and QT changes. J Psychiatry Neurosci 2000; 25(2):154–160
2. Reilly JG, Ayis SA, Ferrier IN, Jones SJ, Thomas SHL. QTc-interval abnormalities and psychotropic drug therapy in psychiatric patients. Lancet 2000; 355:1048–1052

Poster 37 **Friday, October 12**
10:00 a.m.-11:30 a.m.

OLANZAPINE IMPROVES TARDIVE DYSKINESIA IN PATIENTS WITH SCHIZOPHRENIA

Eli Lilly and Company

Bruce J. Kinon, M.D., *Senior Clinical Research Physician, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285;* Virginia L. Stauffer, Pharm.D., *Pharmacist, Eli Lilly and Company, Lilly Corporate Center, DC 4133, Indianapolis, IN 46285;* Lynn Wang, Ph.D.; Khanh T. Thi, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to present this poster, the attendee will better understand the effect of olanzapine on treating the symptoms of tardive dyskinesia.

SUMMARY:

Introduction: Tardive dyskinesia (TD), a persistent abnormal involuntary movement disorder usually considered neuroleptic induced, currently has no specific treatment. We report preliminary findings of the effects of olanzapine (OLZ) treatment upon TD.

Methods: Eligible schizophrenic subjects met restricted Research Diagnosis Tardive Dyskinesia criteria (restricted RD-TD) that specified for abnormal involuntary movements to be of at least moderate severity. Subjects received OLZ, 5–20 mg/day for eight months within a double-blind design that included up to two medication reduction (75%) periods of two weeks dura-

tion. TD was assessed with the Abnormal Involuntary Movement Scale (AIMS) and psychopathology with the Positive and Negative Syndrome Scale (PANSS).

Results: A significant reduction in mean AIMS total score was demonstrated (N = 95; BL = 11.9; EP = 7.5; $p < .001$; LOCF). Nearly 70% of subjects no longer met the restricted RD-TD criteria after up to eight months of treatment, with greater than 50% improving as early as eight weeks. No statistically significant rebound worsening of TD was found during the blinded drug reduction periods. A significant improvement in the PANSS occurred (BL = 68.2; EP = 59.7; $p < .001$, LOCF).

REFERENCES:

1. Agarwal V, Kumar P: Olanzapine in the treatment of tardive dyskinesia: A report of 2 cases. J Clin Psych 2001; 62:298–299
2. Raja M, Antonella A, Maisto D: Three cases of improvement of tardive dyskinesia following olanzapine treatment. International Journal of Neuropsychopharmacology 1999; 2:333–334

Poster 38 **Friday, October 12**
10:00 a.m.-11:30 a.m.

PREVALENCE OF HYPERPROLACTINEMIA IN A LARGE COHORT OF SCHIZOPHRENIA PATIENTS TREATED WITH CONVENTIONAL ANTIPSYCHOTIC DRUGS OR RISPERIDONE

Eli Lilly and Company

Bruce J. Kinon, M.D., *Senior Clinical Research Physician, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285;* Julie A. Gilmore, Ph.D., *Medical Writer Associate, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285;* Hong Liu, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the prevalence of hyperprolactinemia across gender and race in patients receiving conventional antipsychotics or risperidone.

SUMMARY:

Objective: This open-label study was designed to determine the prevalence of hyperprolactinemia in a routine clinical setting.

Methods: A total of 402 adult patients with a diagnosis of schizophrenia, schizophreniform disorder, or schizoaffective were analyzed from a one-day, point prevalence trial. Patients were treated with a conventional antipsychotic drug or risperidone for a minimum of three months prior to study entry. Patients whose prolactin levels were above the upper limit of normal (>18.77 ng/ml for males, and >24.20 ng/ml for females) were considered to have hyperprolactinemia.

Results: Serum prolactin was obtained from 147 females (age range: 21–69 years; mean age = 44.51 years) and 255 males (age range: 18–66 years; mean age = 40.76 years). The prevalence of hyperprolactinemia across all pre-, peri- and post-menopausal females was 65.6% (mean serum prolactin = 49.9 ng/ml), 100% (mean serum prolactin = 88.6 ng/ml), and 45.1% (mean serum prolactin = 30.0 ng/ml), respectively. The prevalence of hyperprolactinemia across all males was 42.4% (mean serum prolactin = 20.2 ng/ml). Further prevalence analyses across race and menopausal status and the relationship between dose and prolactin concentration will be provided in the poster.

Conclusions: This study reports the widespread prevalence of hyperprolactinemia across gender, race, and antipsychotic treatment.

REFERENCES:

1. Dickson RA, Glazer WM: Neuroleptic-induced hyperprolactinemia. Schizophrenia Research 1999; 35:75–86
2. Petty G: Prolactin and antipsychotic medications: mechanism of action. Schizophrenia Research 1999; 35:67–73

Poster 39 **Friday, October 12**
10:00 a.m.-11:30 a.m.

POTENTIAL CLINICAL CONSEQUENCES OF HYPERPROLACTINEMIA ON REPRODUCTIVE HORMONES AND MENSTRUAL FUNCTION IN PREMENOPAUSAL FEMALE PATIENTS WITH SCHIZOPHRENIA

Eli Lilly and Company

Bruce J. Kinon, M.D., *Senior Clinical Research Physician, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285;* Julie A. Gilmore, Ph.D., *Medical Writer Associate, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285;* Hong Liu, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the potential clinical consequences of hyperprolactinemia on reproductive hormones and its ability to ultimately compromise menstrual activity.

SUMMARY:

Objective: This study investigates the potential clinical consequences of hyperprolactinemia on reproductive hormones and menstrual function in a routine clinical setting.

Methods: A total of 402 adult patients with schizophrenia, schizophreniform disorder, or schizoaffective were analyzed from a one-day, point prevalence trial. Patients were required to have been treated with a conventional antipsychotic drug or risperidone for a minimum of three months prior to study entry. Rigorous assessments of serum prolactin, reproductive hormones, and menstrual status were performed.

Results: Serum prolactin was obtained from 90 premenopausal females (mean age = 37.8 years). The prevalence of hyperprolactinemia among females taking risperidone was 96%, with 48% of those females experiencing abnormal periods. Of all females with hyperprolactinemia, 31.6% experienced estradiol levels ≤19.8 pg/ml, which was significantly lower than patients with normal prolactin levels ($p < .05$). Additionally, there was a significant correlation ($p = .027$) between prolactin concentration and menstrual abnormality. Further analyses of reproductive hormones and menstrual irregularity will be presented in the poster.

Conclusions: This study suggests the relationship between hyperprolactinemia and hypogonadism in a cohort of pre-menopausal females taking antipsychotic drugs that may produce marked prolactin elevations. These data describe the potential clinical consequences of hyperprolactinemia on reproductive hormones and its ability to ultimately compromise menstrual activity.

REFERENCES:

1. Dickson RA, Glazer WM: Neuroleptic-induced hyperprolactinemia. Schizophrenia Research 1999; 35:75–86
2. Petty G: Prolactin and antipsychotic medications: mechanism of action. Schizophrenia Research 1999; 35:67–73

Poster 40 **Friday, October 12**
10:00 a.m.-11:30 a.m.

THE EFFICACY OF OLANZAPINE PLUS ADJUNCTIVE LORAZEPAM TO CONTROL ACUTE AGITATION IN PERSONS WITH SCHIZOPHRENIA

Eli Lilly and Company

Julie A. Gilmore, Ph.D., *Medical Writer Associate, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285;* Bruce J. Kinon, M.D., *Senior Clinical Research Physician, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285;* Matthew D. Rotelli, Ph.D.; Lynn Wang, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to suggests that olanzapine, in combination with lorazepam, may provide rapid and safe control of acutely agitated patients with schizophrenia.

SUMMARY:

Objective: To determine the efficacy of olanzapine, alone or in combination with lorazepam as needed, in the treatment of acute behavioral agitation in schizophrenia.

Methods: One hundred inpatients with a diagnosis of schizophrenia or related disorder and acute behavioral agitation were randomized either to double-blind olanzapine (10–20 mg/day p.o.) or haloperidol (10–20 mg/day p.o.), plus adjunctive lorazepam (up to 12 mg/day p.o. or I.M. on an as needed basis). Efficacy was measured by change from baseline in the Positive and Negative Syndrome Scale (PANSS) Agitation Subscale over three weeks. Multiple safety parameters were reported.

Results: Significant improvement was demonstrated in PANSS Agitation Subscale score from baseline to endpoint for both olanzapine ($p < .001$) and haloperidol ($p < .001$) treatment groups, and this improvement was seen as early as one hour after randomization. Olanzapine-treated patients trended toward a response sooner than haloperidol-treated patients ($p = .088$). More extrapyramidal symptoms were found in the haloperidol group.

Conclusions: The results of this study suggest the rapid control of acutely agitated schizophrenia inpatients with olanzapine in combination with lorazepam, as needed, may provide clinicians with an alternative to the wide-spread practice of utilizing haloperidol and adjunctive lorazepam in the acute care setting.

REFERENCES:

1. Beasley CM, Tollefson G, Tran P, et al: Olanzapine versus placebo and haloperidol: acute phase results of the North-American double-blind olanzapine trial. Neuropsychopharmacology 1996; 14:111–123
2. Tollefson GD, Beasley CM, Tran PV, et al: Olanzapine versus haloperidol in the treatment of schizophrenia and schizophreniform disorders: results of an international collaborative trial. Am J Psychiatry 1997; 154:457–465

Poster 41 **Friday, October 12**
10:00 a.m.-11:30 a.m.

IMPROVEMENT IN QUALITY OF LIFE AND DEPRESSIVE SYMPTOMS IN PATIENTS WITH SCHIZOPHRENIA IS ASSOCIATED WITH ROBUST ACUTE TREATMENT RESPONSE OF OLANZAPINE VERSUS HALOPERIDOL

Eli Lilly and Company

Bruce J. Kinon, M.D., *Senior Clinical Research Physician, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285;* Zhongyun Zhao, Ph.D., *Researcher, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285;* Beth L. Barber, Ph.D.; Julie A. Gilmore, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the association of improvement in QoL and depressive symptoms with robust acute treatment response of olanzapine (OLZ) versus haloperidol (HAL).

SUMMARY:

Background: To explore the association in QoL and depressive symptoms improvement with robust acute treatment response of olanzapine (OLZ) versus haloperidol (HAL).

Methods: Data were analyzed post-hoc from a randomized (OLZ versus HAL), double-blind trial of 1,996 patients with schizophrenia or related disorder. Treatment response was classified into four groups at six weeks: <20%, 20–40%, 40–65% and >65% Brief Psychiatric Rating Scale (BPRS) total scores improvement. Mean percent changes of Quality of Life Scale (QLS) scores and Montgomery-Asberg Depression Rating Scale (MADRS) scores were determined.

Results: There was a significant association between the more robust level of response and improvements in depressive symptoms and QLS across treatment groups. Patients treated with OLZ accessed moderate improvement (>10% improvement) in QLS once they attained a ≥20% improvement in BPRS, while only those HAL-treated patients who had a 65% or greater response in BPRS could exceed moderate QLS improvement. Similar observations were demonstrated in improvement on the MADRS.

Conclusion: A more robust acute treatment response resulted in greater improvement in QoL and depressive symptoms. Additionally, even for patients attaining the same level of treatment response, there may be significantly greater improvements in QoL and depressive symptoms for OLZ- versus HAL-treated patients.

REFERENCES:

1. Tollefson GD, Beasley Jr CM, Tran PV, et al: Olanzapine versus haloperidol in the treatment of schizophrenia and schizoaffective and schizophreniform disorders: results of an international collaborative trial. Am J Psychiatry 1997; 154:457–65.
2. Beasley Jr CM, Tollefson G, Tran P: Olanzapine versus placebo and haloperidol: acute phase results of the North American double-blind olanzapine trial. Neuropsychopharmacology 1996; 14:111–23.

Poster 42 **Friday, October 12**
10:00 a.m.-11:30 a.m.

RIGOROUS CRITERIA FOR TREATMENT RESPONSE DIFFERENTIATED EFFICACY OF OLANZAPINE VERSUS HALOPERIDOL IN PATIENTS WITH SCHIZOPHRENIA

Eli Lilly and Company

Bruce J. Kinon, M.D., *Senior Clinical Research Physician, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285;* Zhongyun Zhao, Ph.D., *Researcher, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285;* Beth L. Barber, Ph.D.; Julie A. Gilmore, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to determine whether progressive raising of the threshold for definition of treatment response elucidates the greater likelihood of patients with schizophrenia responding to the novel antipsychotic olanzapine (OLZ) as compared with haloperidol (HAL).

SUMMARY:

Objective: To demonstrate that the definition of treatment response elucidates the greater likelihood of patients with schizophrenia responding to olanzapine (OLZ) compared with haloperidol (HAL).

Methods: Data were analyzed post-hoc from a double-blind, randomized (OLZ versus HAL; mean modal dose = 13.2 versus 11.8 mg/day, respectively) trial of patients with schizophrenia or related disorder, or schizoaffective disorder. The cumulative proportion of patients achieving *a priori* defined response criteria at each of three thresholds (≥20%, ≥40%, and ≥65% in endpoint to baseline Brief Psychiatric Rating Scale [BPRS] Total scores) was determined.

Results: As the threshold for a responder increased, the relative divergence between drug-response curves increased with the OLZ-treated patients consistently attaining higher proportions of responders versus HAL-treated patients. At a minimal threshold for response (≥20%), 77% of OLZ vs 70% of HAL patients responded

by week 6 (p = .002). At a high bar threshold for response (≥65%), 25.9% of OLZ vs. 15.6% of HAL patients responded by week 6 (p < .001).

Conclusion: Rigorous as compared with minimal defined thresholds for response clearly differentiate the greater likelihood of patients attaining superior improvement on the novel antipsychotic. OLZ as compared with HAL.

REFERENCES:

1. Tollefson GD, Beasley Jr CM, Tran PV, et al: Olanzapine versus haloperidol in the treatment of schizophrenia and schizoaffective and schizophreniform disorders: results of an international collaborative trial. Am J Psychiatry 1997; 154:457–65.
2. Beasley Jr CM, Tollefson G, Tran P: Olanzapine versus placebo and haloperidol: acute phase results of the North American double-blind olanzapine trial. Neuropsychopharmacology 1996; 14:111–23

Poster 43 **Friday, October 12 10:00 a.m.-11:30 a.m.**

USE OF NOVEL ANITPSYCHOTIC MEDICATIONS IN DIABETES: A RETROSPECTIVE REVIEW

Benjamin P. Yu, M.D., *Resident Physician, Department of Psychiatry, University of California Medical Center, 101 City Drive, Route 88, Building 3, Orange, CA 92868;* Gerald A. Maguire, M.D., *Assistant Clinical Professor of Psychiatry, University of California at Irvine, 101 City Drive, Route 88, Building 3, Orange, CA 92868;* Yun S. Chong, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the program, participants shall be able to understand the trends of glucose regulation in individuals with diabetes mellitus treated with novel antipsychotic medications and develop a rational treatment plan for treating diabetic individuals with psychosis.

SUMMARY:

Novel antipsychotic medications have been reported through isolated case reports to lead to glucose intolerance and possible induction of diabetes mellitus. However, new research has revealed that no one antipsychotic medication has an increased risk over any other. Also, little is known of the effects of these medications on individuals with known diabetes mellitus. Twenty-one subjects (aged 23 to 86, 14 female, seven male) with diabetes mellitus and comorbid psychotic disorders were reviewed in regard to the effects on fasting glucose levels associated with treatment with novel antipsychotic medications. In this retrospective analysis, patient charts were reviewed for fasting glucose levels and time course of antipsychotic medication. Ten subjects received olanzapine (doses from 2.5mg to 30mg), nine subjects received risperidone (doses from .25mg to 8mg), and two subjects received quetiapine (doses from 25mg to 800mg) with a mean duration of therapy of 24.6 days. Analysis revealed no worsening of fasting blood glucose associated with any one agent. Of note, olanzapine was associated with a reduction of fasting blood glucose and favorable modification of diabetes medication treatment in four of the 10 cases analyzed.

REFERENCES:

1. Cavazzoni et al: Annualized Incidence of Diabetes Mellitus in Specific Antipsychotic Treatment Cohorts, presented at MCDEU, May 2001.
2. Wirshing DA, Spellberg BJ, Erhart SM, et al: Novel antipsychotics and new onset diabetes. Biological Psychiatry 1998; 44:778–83.

TARGET AUDIENCE(S):

Psychiatrists and other mental health clinicians

Poster 44 **Friday, October 12 10:00 a.m.-11:30 a.m.**

MODAFINIL AS A TREATMENT FOR NEGATIVE SYMPTOMS OF SCHIZOPHRENIA

Benjamin P. Yu, M.D., *Resident Physician, Department of Psychiatry, University of California Medical Center, 101 City Drive, Route 88, Building 3, Orange, CA 92868;* Gerald A. Maguire, M.D., *Assistant Clinical Professor of Psychiatry, University of California at Irvine, 101 City Drive, Route 88, Building 3, Orange, CA 92868*

EDUCATIONAL OBJECTIVES:

At the conclusion of the session, participants should be able to understand the rationale for using modafinil to improve negative symptoms of schizophrenia, develop a patient profile of when to utilize such therapy, and understand a possible pharmacologic means of reducing novel antipsychotic associated weight gain.

SUMMARY:

The newer generation of antipsychotic agents are associated with greater efficacy and fewer motor side effects, yet a greater weight-gain potential-than the conventional agents. The negative symptoms of schizophrenia are often difficult to treat, even with the advancements of our newer agents. We present cases of two patients with schizophrenia that suggest that modafinil may be a potential pharmacologic agent for the treatment of

negative symptoms of schizophrenia, with the possible added benefit of the reduction of antipsychotic-associated weight gain.

REFERENCES:

1. Beaslen CM Jr, Sanger T, Satterlee W, et al: Olanzapine versus placebo: results of a double-blind, fixed-dose olanzapine trial. Psychopharmacology 1996; 124:159–67.
2. Marder SR: Management of treatment-resistant patients with schizophrenia. Journal of Clinical Psychiatry 1996; 57 Suppl 11:26–30.

TARGET AUDIENCE:

Psychiatrists and other mental health clinicians

Poster 45 **Friday, October 12**
10:00 a.m.-11:30 a.m.

ZIPRASIDONE VERSUS HALOPERIDOL IN SEQUENTIAL IM/ORAL TREATMENT OF SCHIZOPHRENIA

Pfizer Inc.

Shlomo Brook, M.D., *Physician, Research Unit, Sterkfontain Hospital, Private Bag x2010 1740, Krugersdorp, South Africa 1740;* Jorge Walden, M.D., *University of Freiburg, Heidelberg, Germany;* Isma Benattia, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to fully explore data from this study comparing ziprasidone and haloperidol in patients with schizophrenia, which suggest that efficacy is comparable but improvement in some symptoms is faster with ziprasidone and movement disorders are less common with this agent.

SUMMARY:

Objective: To compare efficacy and tolerability of sequential IM/oral ziprasidone and haloperidol in acute schizophrenia or schizoaffective disorder.

Methods: Patients were randomized to six weeks of ziprasidone (≤40 mg/d IM, then 40–80 mg BID oral; n = 417) or haloperidol (≤10 mg/d IM, then 5–20 mg/d oral; n = 133). Primary efficacy measures included BPRS and CGI-S/CGI-I scales. The Extrapyramidal Symptom Rating Scale (ESRS), and the Barnes Akathisia Scale (BAS) were used to assess movement disorders.

Results: Change in BPRS total score was greater with ziprasidone at visit 1 (Day 1) (P = 0.0035) and comparable at last visit. No significant differences between groups occurred in CGI-S/CGI-I scores by visit. More ziprasidone completers improved by visit 1 (P = 0.03) and visit 2 (Day 2) (P = 0.006) than haloperidol completers. Changes in BPRS anxiety scores were comparable throughout. Haloperidol users had greater mean change in BAS and ESRS scores at all visits (P < 0.0001). Common adverse events included anxiety, insomnia, and somnolence with ziprasidone; akathisia, dystonia, extrapyramidal syndrome (EPS), hypertonia, tremor, and insomnia with haloperidol.

Conclusions: IM/oral ziprasidone was as effective as IM/oral haloperidol, with some symptoms responding faster to IM ziprasidone and no loss of efficacy during oral therapy. Ziprasidone was well tolerated, with a significantly lower EPS rate.

REFERENCES:

1. Brook S, Lucey JV, Gunn KP: Intramuscular ziprasidone compared with intramuscular haloperidol in the treatment of acute psychosis. Ziprasidone I.M. Study group. J Clin Psychiatry 2000; 61:933–941
2. Lesem MD, Zajecka JM, Swift RH, Reeves KR, Harrigan EP: Intramuscular ziprasidone, 2 mg versus 10 mg, in the short-term management of agitated psychotic patients. J Clin Psychiatry 2001; 62:12–18

TARGET AUDIENCE:

Psychiatrists and other health professionals who care for patients with schizophrenia

Poster 46 **Friday, October 12**
10:00 a.m.-11:30 a.m.

EXPERIENCE WITH SWITCHING PATIENTS TO ZIPRASIDONE FROM OTHER ANTIPSYCHOTICS

Dee Ann Estes, Pharm.D., *Department of Psychiatric Pharmacy, Arizona State Hospital, 2500 East Van Buren, Phoenix, AZ 85008;* Jerry L. Dennis, M.D., *Chief Medical Officer, Department of Pharmacy, Arizona State Hospital, 2500 East Van Buren, Phoenix, AZ 85008*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate the ability to switch patients with schizophrenia spectrum diagnoses from a previous antipsychotic to ziprasidone and better understand the safety of ziprasidone related in serum glucose levels, serum lipids and weight management.

SUMMARY:

Introduction/Objectives: To obtain a clearer understanding of how to switch treatment-resistant patients with schizophrenic spectrum diagnoses from one antipsychotic agent to the new atypical antipsychotic ziprasidone, and to further assess efficacy and safety.

Methods: Patients were switched based upon the discretion of their treating psychiatrist from either conventional or atypical antipsychotics to ziprasidone. A cross taper from their previous antipsychotic and upward titration of ziprasidone was employed over a 30-day period. Fasting serum glucose, serum lipids, and weights were obtained. Baseline BPRS, GAF, and AIMS scores were assessed. The above data will be obtained on a monthly basis for three months and then quarterly for an additional nine months.

Initial results: To date 28 patients have been started on ziprasidone. Seven of these patients have been discontinued due to lack of effectiveness and/or intolerance. Six patients are maintained on ziprasidone as their sole antipsychotic at doses of 40mg–160mg per day. Thirteen of the patients are still on two antipsychotics. Nine patients have been titrated up to a daily dose of 160mg of ziprasidone.

Conclusion: Additional efficacy and safety data will be provided to guide clinicians using ziprasidone in a difficult to treat population.

REFERENCES:

1. Keck P, Buffenstein A, Ferguson J, et al: Ziprasidone 40 mg/day and 120 mg/day in the acute exacerbation of schizophrenia and schizoaffective disorder: a 4-week placebo-controlled trial. Psychopharmacology 1998; 140:173–184
2. Daniel DG, Zimbroff DL, Potkin SG, et al: Ziprasidone 80 mg/day and 160 mg/day in the acute exacerbation of schizophrenia and schizopaffective disorder: a 6-week placebo-controlled trial. Neuropsychopharmacology 1999; 20:491–505

Poster 47 **Friday, October 12**
10:00 a.m.-11:30 a.m.

COSTS OF SCHIZOPHRENIA CARE ASSOCIATED WITH OLANZAPINE, RISPERIDONE, OR HALOPERIDOL IN A PUBLIC MENTAL HEALTH SYSTEM

Eli Lilly and Company

P. Joseph Gibson, Ph.D., *Senior Research Scientist, Health Outcomes Department, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285;* Janet L. Ramsey, M.S., *Senior Research Associate, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285;* Robert Damler; F. Anne Jackson; Theresa Wilder; Eric Edgell, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate how baseline adjustments affect cost estimates, group comparisons, and interpretation of results.

SUMMARY:

Objective: To assess the impact of medication choice on Medicaid costs for persons with schizophrenia.

Methods: Michigan Medicaid claims from 1/1996 to 9/1997 were analyzed for persons with schizophrenia diagnoses initiating treatment with olanzapine (n = 458), risperidone (n = 481), or haloperidol (n = 252). Changes in total adjusted Medicaid costs were compared between the treatment groups one year before and after treatment initiation. Separate analyses were performed for dually Medicare and Medicaid enrolled patients (olanzapine n = 801, risperidone n = 606, haloperidol n = 288).

Results: Significant baseline differences existed between the groups. The olanzapine groups had more prior clozapine use, antipsychotic medications, and assertive community treatment than the risperidone and haloperidol groups, and fewer recent hospitalizations.

For Medicaid non-dual enrollees, the average prior year costs were $13,120 per patient. After baseline adjustment, there were no significant differences in mean total cost change (olanzapine +$1,112, risperidone +$1,819, haloperidol +$1,012). Excluding index medication costs, the olanzapine group's cost change (–$1,106) was significantly lower than risperidone (+$529, $p < 0.0001$) or haloperidol (+$717, $p < 0.0001$). The cost change results were similar for dual enrollees.

Conclusion: Relative decreases in service costs may indicate lower service use and greater patient benefit associated with use of olanzapine, with no significant impact on total cost.

REFERENCES:

1. Edgell E, et al: Olanzapine versus risperidone: a prospective comparison of clinical and economic outcomes in schizophrenia. Pharmacoeconomics 2000; 18(6):567–79
2. Jerrell JM: A comparison of the effectiveness and costs of atypical and conventional antipsychotic medications in South Carolina. Report released by the University of South Carolina School of Medicine, November 1999

TARGET AUDIENCE:

Psychiatrists and mental health outcome researchers

Poster 48 **Friday, October 12**
10:00 a.m.-11:30 a.m.

ARIPIPRAZOLE AND RISPERIDONE VERSUS PLACEBO IN SCHIZOPHRENIA AND SCHIZOAFFECTIVE DISORDER

William H. Carson, Jr., M.D., *Department of Neurosciences, 5 Research Parkway, Wallingford, CT 06492;*

Mary J. Kujawa, M.D., *Medical Director, Bristol-Myers Squibb Company, 777 Scudders Mill Road, Princeton, NJ 08545*

EDUCATIONAL OBJECTIVES:

Demonstrate the effectiveness of once-daily treatment with aripiprazole relative to placebo, in patients with acute exacerbation of schizophrenia or schizoaffective disorder and compare to that of risperidone administered twice daily.

Appreciate that aripiprazole may have tolerability advantages over other atypical antipsychotics.

SUMMARY:

Objectives: To evaluate the efficacy and safety of aripiprazole in patients hospitalized due to an acute relapse of schizophrenia or schizoaffective disorder.

Methods: This multicenter, double-blind, placebo-controlled study involved 404 inpatients with acute exacerbation of schizophrenia or schizoaffective disorder (DSM-IV). All patients had a history of response to antipsychotic therapy. Following a three- to five-day washout period, patients were randomized to receive: placebo (n = 103), aripiprazole 20 mg qd (n = 101), aripiprazole 30 mg qd (n = 101), or risperidone 3 mg bid (n = 99) for four weeks. Baseline PANSS scores ranged from 92 to 95 in the four treatment arms.

Results: Positive and negative symptoms were significantly reduced in all active treatment groups compared with placebo ($p < 0.02$); earlier improvement in negative symptoms was seen with aripiprazole (week 1). Aripiprazole and risperidone were also well tolerated. Neither drug produced significant extrapyramidal symptoms. Mean plasma prolactin levels showed no change with aripiprazole but increased five-fold over placebo in the risperidone group. The incidence of QTc prolongation (>10% over baseline) was similar to placebo in the aripiprazole group, and approximately two-fold greater than placebo in the risperidone group.

Conclusions: Aripiprazole provides effective treatment for acute relapse of schizophrenia and may have tolerability advantages over available antipsychotics.

REFERENCES:

1. Leucht S, Pitschel-Walz G, Abraham D, Kissling W: Efficacy and extrapyramidal side effects of the new antipsychotics olanzapine, quetiapine, risperidone and sertindole compared to conventional antipsychotics and placebo. A meta-analysis of randomized controlled trials. Schizophrenia Res 1999; 35:51–68
2. Kikuchi T, et al: 7-{4-[(2,3-Dichlorophenyl)-1-piperazinyl]butyloxy}-3,4-dihydro-2 (1*H*)-quinolinone (OPC-14597), a new putative antipsychotic drug with both presynaptic and postsynaptic D-2 receptor antagonist activity. J Pharmacol Exp Ther 1995; 274:329–336

TARGET AUDIENCE:

Psychiatrists

Poster 49 **Friday, October 12**
10:00 a.m.-11:30 a.m.

CONCOMITANT USE OF QTC PROLONGATING DRUGS IN PERSONS WITH SCHIZOPHRENIA

Eli Lilly and Company

Haya Ascher-Svanum, Ph.D., *Research Scientist, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285;* John S. Kennedy, M.D.; David Lee, Ph.D.; Merle Haberman, Ph.D.; Shonda Foster

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the utilization pattern, prevalence, and cardiac safety issues associated with concomitant use of medical QTc prolongating drugs in the treatment of individuals with schizophrenia.

SUMMARY:

Some drugs that prolong cardiac repolarization and the QT interval of the ECG (QTc prolongators) have been linked to ventricular arrhythmia and sudden, unpredictable death. Use of QTc prolongators by individuals with schizophrenia, may further increase their pre-existing high risk for cardiovascular morbidity and mortality. This study retrospectively examined one-year concomitant use of QTc prolongators for medical purposes in 1,938 patients with schizophrenia.

Method: Prevalence and utilization pattern of concomitant QTc prolongators were retrieved from integrated medical and pharmacy claims of a large, geographically diverse, commercially insured population.

Results: Overall, 34% of the patients were prescribed at least one QTc prolongator, for an average days supplied of 62 days/year. Utilization rates varied across age groups, gender, and antipsychotic treatment regimen.

Conclusions: A third (34%) of the individuals with schizophrenia were prescribed QTc prolongators for medical purposes. Clinicians, patients, and their family members need to be aware of the clinical significance of QTc lengthening medication(s), alone or in combination. Polypharmacy with QTc prolongators, which may additively increase the length of the QTc, is a broad concern. In particular this may increase the potential for compounding an already magnified risk of cardiac mortality during treatment of schizophrenia.

REFERENCES:

1. Welch R, Chue P: Antipsychotic agents and QT changes. Journal of Psychiatry and Neuroscience 2000; 25:154–160

2. Reilly JG, Ferrier IN, Jones SJ, et al: QTc-interval abnormalities and psychotropic drug therapy in psychiatric patients. The Lancet 2000; 355:1048–1052

TARGET AUDIENCE(S):

Psychiatrists, prescribing clinicians, consumers, family members

Poster 50 **Friday, October 12**
10:00 a.m.-11:30 a.m.

DIABETIC KETOACIDOSIS IN PATIENTS WITH SCHIZOPHRENIC DISORDERS

Enrico Cagliero, M.D., *Assistant Professor of Medicine, Harvard Medical School, 50 Staniford Street, Boston, MA 02114;* David C. Henderson, M.D.; David M. Nathan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the elevated incidence of severe abnormalities of glucose metabolism in schizophrenic patients treated with atypical antipsychotic agents.

SUMMARY:

Use of atypical antipsychotic agents has been linked to increase incidence of diabetes mellitus in patients with schizophrenia, and cases of diabetic ketoacidosis (DKA) have been described in such patients. We identified patients with a diagnosis of schizophrenic disorders, diabetes, and DKA attending a large urban teaching hospital between 1/95 and 1/01. The prevalence of diabetes in 3,753 schizophrenic patients was 11.2%, compared with 4.5% in the general hospital population (n = 642,823), confirming the high frequency of diabetes in these patients. Fifteen patients with schizophrenic disorders had DKA, and chart review showed that six developed DKA without a prior diagnosis of diabetes. The incidence of DKA in the schizophrenic patients without a prior diagnosis of diabetes, all of whom were on atypical antipsychotic agents (four on olanzepine, one on clozapine, and one on clozapine and risperidone) was 10.6/10,000 patient year, nearly ten-fold higher than that reported in a non-diabetic population (1.4/10,000). Their age was 37 ± 8 years (mean ± SD), body mass index (BMI) was 30.2 ± 5.4, four were males, four were Caucasian, one African American, and one Hispanic. At the time of presentation with DKA, mean glucose was 812 ± 350 mg/dl, pH 7.23 ± 0.24, bicarbonate 14.5 ± 5.96 mmol/L, and hemoglobin Alc (HbAlc) 12.25 ± 1.29%. After 2.2 ± 1.5 years of follow-up, only one patient required long-term insulin therapy, excluding the diagnosis of type 1 diabetes for most, and HbAlc decreased to 7.72 ± 1.84. In conclusion, patients with schizophrenic disorders have a very high incidence of DKA. The cases were observed only in patients treated with atypical antipsychotic agents, supporting a link between the use of these drugs and severe abnormalities of glucose metabolism.

REFERENCES:

1. Henderson DC, Cagliero E, et al: Clozapine, diabetes mellitus, weight gain, and lipid abnormalities: a five-year naturalistic study. Am J Psychiatry 2000; 57:975–981
2. Goldstein LE, Sporn J, et al: New-onset diabetes mellitus and diabetic ketoacidosis associated with olanzepine treatment. Psychosomatics 1999; 40:438–443

Poster 51 **Friday, October 12**
10:00 a.m.-11:30 a.m.

QUETIAPINE AUGMENTATION FOR INADEQUATE RESPONSE TO COMBINATION ATYPICAL ANTIPSYCHOTICS

AstraZeneca Pharmaceuticals

Guy Chouinard, M.D., M.Sc., *Professor of Psychiatry, McGill University and the University of Montreal, 1025 Pine Avenue West, Montreal, PQ Canada H3A 1A1;* Howard C. Margolese, M.D.; T.T. Kolivakis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to realize that quetiapine augmentation for inadequate responses to combination atypical antipsychotic medication is effective for treatment-resistant schizophrenia and schizoaffective disorder.

SUMMARY:

Objective: To demonstrate that quetiapine is an excellent augmentation strategy in atypical antipsychotic treatment-resistant schizophrenia and schizoaffective disorder.

Methods: Six patients with treatment-resistant schizophrenia (n = 4) or schizoaffective disorder (n = 2) were selected (mean duration of illness = 27.67 ± 10.40 years; current mean length of hospitalization = 17.0 ± 13.19 years). Patients had an inadequate response to combinations of risperidone (n = 6) and olanzapine (n = 6), with four also receiving clozapine. Other medications to augment response included valproic acid (n = 4), lamotrigine (n = 5), and gabapentin (n = 3). Quetiapine was added to augment treatment response. Olanzapine was added after quetiapine in one patient not receiving it previously.

Results: All six patients showed improvement on quetiapine. Mean daily quetiapine dose was 187.50 ± 185.57 mg. Improvement was measured by CGI-Global Improvement. One patient was "very much" improved, two "much" improved, and three "minimally" improved. No patient worsened. Nurses noted that patients had a decrease in aggressivity and required less time in the seclusion room. Patients remained ill with a mean CGI-Severity of Illness score of 5.17 ± 0.82, corresponding to a marked mean level of illness. However, even a mild improvement in these patients is considered clinically relevant.

Conclusions: Quetiapine augmentation for inadequate responses to combination atypical antipsychotic medication is effective for atypical antipsychotic treatment-resistant schizophrenia and schizoaffective disorder.

REFERENCES:

1. Morera AL, et al: Acta Psychiatr Scand 1999; 99:305–07.
2. Raskin S, et al: Acta Psychiatr Scand 2000; 101:334–36.

TARGET AUDIENCE:

Psychiatrists

Poster 52 **Friday, October 12**
10:00 a.m.-11:30 a.m.

NOVEL ANTIPSYCHOTIC TREATMENT OUTCOMES IN COMMUNITY MENTAL HEALTH CENTERS

Eli Lilly and Company

David M. Ziegler, M.A., *President, Southeastern Consulting, Incorporated, 120 Boyton Plank Drive, Stephens City, VA 22655*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that several consumer and mental health system outcomes can be positively impacted when novel antipsychotics are available to severely mentally ill consumers in community mental health center settings.

SUMMARY:

Objective: This study compared clinical and economic outcomes pre- and post-initiation on novel antipsychotics for adults in a publicly funded community mental health care system.

Methods: Retrospective chart reviews were conducted on a random sample of 58 seriously mentally ill (SMI) adult consumers from three community mental health centers (CMHC). Patient inclusion criteria were (a) major psychotic disorder diagnosis; (b) minimum 24-month treatment on any novel antipsychotic(s); (c) active CMHC treatment for a 36-month period from 1994 through 2000. For each consumer, a 12-month pre-novel period was compared with a 24-month post-novel period. Descriptive statistics compared employment, hospitalization/crisis stabilization utilization, costs and Global Assessment of Functioning (GAF) scores.

Results: When the 12-month pre-novel period was compared with the 24-month post-novel period, employment improved 15.5%, average inpatient length of stay decreased 18.5 days the first year and 29.2 days the second year. Average system costs (inpatient plus medication) were reduced $4,625 the first year and $6,106 the second year post-novel initiation. Average GAF scores increased 3.5 points during the second year of novel treatment.

Conclusion: These findings suggest that economic and clinical outcomes may improve for SMI adult CMHC consumers when novel antipsychotics are initiated and treatment is maintained for an extended period of time.

REFERENCES:

1. Galvin PM, et al: The clinical and economic impact of newer versus older antipsychotic medications in a community mental health center. Clinical Therapeutics 1999; 21:1105–1116.
2. Rupp A, Keith SJ: The costs of schizophrenia: assessing the burden. Psychiatric Clinics of North America 1993; 16:413–423.

TARGET AUDIENCE(S):

Community mental health center providers and administrators

Poster 53 **Friday, October 12**
10:00 a.m.-11:30 a.m.

EVALUATING THE WINDFALL: OREGON'S ATYPICAL ANTIPSYCHOTIC MEDICATION PROGRAM

State of Oregon, Contract Number 89260

William H. Wilson, M.D., *Associate Professor of Psychiatry, Oregon Health Sciences University, 3181 S.W. Sam Jackson Park Road, UNH-79, Portland, OR 97201;* Douglas A. Bigelow, Ph.D., *Associate Professor of Psychiatry, Oregon Health Sciences University, 3181 S.W. Sam Jackson Park Road, GH-153, Portland, OR 97201;* Bentson H. McFarland, M.D.; Jay Smith, M.A.

EDUCATIONAL OBJECTIVES:

To list five dimensions of response to atypical antipsychotic medications among underserved populations; list

four elements for effective naturalistic evaluation of medication distribution programs; and compare medication distribution to underserved Americans to food distribution to refugees by international relief agencies.

SUMMARY:

In May 2000, the Oregon legislature appropriated $1.9 million to provide atypical antipsychotic medications to Oregonians who needed the medications but could not otherwise afford them. The state mental health division was instructed to begin immediate distribution of medication, complete the project in one year, and spend 70% of the budget on purchase of medications. Based on previously published studies of atypical medication response, the legislature anticipated (1) cost savings from reduced hospitalization rates, (2) improved mental and social functioning of the individual and their family, (3) decreased contact with law enforcement and the criminal justice system, and (4) increased employment. Our group is conducting an evaluation of the program using a "one group, pre-post and time-series design" as well as operations research methodology. A midpoint analysis of the first 135 clients reveals achievement of some clinical outcome expectations, but significant issues in "distribution" and program implementation techniques. Clinical outcomes will be reported. Methods and results will be compared with the international relief techniques of quickly providing needed food and medication to refugee populations.

REFERENCES:

1. Oregon Health Resources Commission: Medical Technology Assessment and Health Resources Plans with Recommended Clinical Practice Guidelines for Antipsychotic Drugs. March, 1999, Salem, OR.
2. Jaspers S: Solidarity and Soup Kitchens: A Review of Principles and Practice for Food Distribution in Conflict. Humanitarian Policy Group Report *#7*, Overseas Development Institute, London, 2000.

TARGET AUDIENCE:

Mental health policy makers, community mental health program designers, services researchers

Poster 54 **Friday, October 12**
10:00 a.m.-11:30 a.m.

INSIGHT AND PSYCHOPATHOLOGY IN SCHIZOPHRENIA

Laurie J. Polubinsky, M.D., *Associate Physician, Department of Psychiatry, Medical Associates, 1000 Langworthy, Dubuque, IA 52002;* Serge M. Sevy, M.D.; Kay Nathanson, M.P.H.; Xavier Amador, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to understand the various aspects of insight in schizophrenia and the relationship between insight and psychopathology.

SUMMARY:

Objective: To examine the relationship between insight and the positive, negative, excited, depressed, and cognitive dimensions of symptoms in patients with a diagnosis of schizophrenia.

Methods: 98 patients with a diagnosis of schizophrenia were assessed with PANSS and SUMD-revised version. PANSS data were analyzed based on a five-factor model defined by Kay and Sevy (1990).

Results: Percentage of patients having a moderate or severe lack of awareness was 32.7% for illness, 58.2% for symptoms, 18.4% for treatment response, and 41.8% for social consequences. Lack of awareness of symptoms was significantly correlated with all five-symptom factors. Lack of awareness for the illness and unawareness of treatment response were only correlated with the positive dimension, while unawareness of social consequences was correlated with both positive and excited dimensions.

Conclusion: Poor insight is a common feature of schizophrenia and has a complex relationship to other symptoms of the illness. Our results suggest some aspects of insight to be more closely tied to positive symptoms than other aspects. Treatment studies that measure insight could answer the question of whether these deficits in awareness improve along with positive symptoms.

REFERENCES:

1. Amador XF, Strauss DH, Yale SA, et al: Assessment of insight in psychosis. Am J Psychiatry 1993; 150:873–879.
2. Kay SR, Sevy S: Pyramidical model of schizophrenia. Schizophrenia Bull 1990; 537–545

Poster 55 **Friday, October 12**
10:00 a.m.-11:30 a.m.

ANOREXOGENIC EFFECTS OF TOPIRAMATE IN SCHIZOPHRENIA

Psychopharmacology and Pharmacopsychiatry Fund, Minnesota Medical Foundation

Faruk S. Abuzzahab, Sr., M.D., *Clinical Professor, Department of Psychiatry, University of Minnesota, 2450 Riverside Avenue, F-282/2-AW, Minneapolis, MN 55454-1495;* Victoria L. Brown, *Pre-Medical Student, University of Minnesota, 2450 Riverside Avenue, F-282/2-AW, Minneapolis, MN 55454-1495*

EDUCATIONAL OBJECTIVES:

To understand that topiramate, a novel anticonvulsant with a unique fructopyranose structure, has produced weight loss in bipolar disorder. This report addresses topiramate use in schizophrenia with comorbid obesity.

SUMMARY:

Method: Twenty outpatients, 14 females and six males, with an average age of 42.45 +/– 8.07 years, who met the DSM-IV criteria for schizophrenia received topiramate for at least three months concomitantly with their neuroleptic medications. Patients were started on the lowest dose of 12.5 mg and gradually increased as tolerated.

Results: At three months the average topiramate dose was 421.5 mg +/– 302.42 mg. The average weight of the 20 patients at pretreatment was 95.13 kg +/– 16.22 kg. After three months of treatment with topiramate the average weight dropped to 91.31 kg +/– 15.8 kg. Using a t-test it was found that with a 95% confidence level the mean weight loss was between 0.89 kg and 6.74 kg after three months, between .05 kg and 10.31 kg for the 13 patients taking topiramate after six months, and between 0 kg and 14.69 kg for the nine patients after nine months.

Conclusion: Although the exact mechanism of topiramate's action is unknown, its unique anorexogenic property, which was observed in convulsive disorder, bipolar disorder, and unipolar depression, is extended through this report to schizophrenia.

REFERENCES:

1. Perucca E: A pharmacological and clinical review on topiramate, a new antiepileptic drug. Pharmacological Research 1997; 35:242–243.
2. Marcotte D: Use of topiramate, a new antiepileptic as a mood stabilizer. J Affective Disorders 1998; 50:245–251.

Poster 56 **Friday, October 12**
10:00 a.m.-11:30 a.m.

RISPERIDONE ON REDUCING TARDIVE DYSKINESIA: A DOUBLE-BLIND PLACEBO-CONTROLLED STUDY

Janssen Pharmaceutica

Pai-Ya Mei, M.D., *Attending Physician, Yu-Li Veterans Hospital, 91 Shin-Shin, Yu-Li, Hua-Lian, Taiwan;* Chao-Cheng Lin, M.D.; Shun-Chieh Yu, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that changing to risperidone can decrease tardive dyskinesia more significantly than neuroleptic withdrawal for chronic schizophrenia patients with severe TD study.

SUMMARY:

Objective: Tardive dyskinesia (TD) is a severe side effect of classical antipsychotics. We designed the double-blind, placebo-controlled study to evaluate the effect of risperidone on reducing the severity of TD.

Method: Fifty cases of schizophrenia, with severe TD were included. Their original antipsychotic dosage was less than cholpromazine 200mg/day equivalent. All the antipsychotics were withdrawal for four weeks, then the patients were randomly assigned to the risperidone or placebo group. Risperiodne 6mg/day and an identical-looking placebo were prescribed to each group for 12 weeks. The TD condition was evaluated blindly by a psychiatrist with the Abnormal Involuntary Movement Scale (AIMS) every two weeks.

Result: Eight patients dropped out due to unstable psychiatric or medical conditions. The final sample consisted of 22 cases in the risperidone group, and 20 cases in the control group. The baseline AIMS score of all patients was 16.4 ± 4.1. Sixteen cases (72.7%) in the risperidone group, and five cases (20%) in the control group had significant improvement on TD (Fisher's Exact p = 0.005). The final average AIMS score was 9.9 ± 4.3 for the risperidone group, and 15.3 ± 5.7 for the control group (t = 3.517, df = 40, p = 0.001).

Conclusion: For patients with severe TD, changing to risperidone can decrease TD more significantly than neuroleptic withdrawal.

REFERENCES:

1. Chouinard G: Effects of risperidone in tardive dyskinesia: an analysis of the Canadian Multicenter Risperidone Study. J Clin Psychopharmacology 1995: 15 (suppl 1):36–44
2. Kopala LC, Honer WG: Schizophrenia and severe tardive dyskinesia responsive to risperidone. J Clin Psychopharmacol 1984: 14: 430–431

Poster 57 **Friday, October 12**
10:00 a.m.-11:30 a.m.

A COMPARISON OF EXPENDITURES BY INDIGENT PATIENTS CONTINUOUSLY TREATED WITH ANTIPSYCHOTIC AGENTS WITHIN A BEHAVIORAL HEALTH ORGANIZATION IN TEXAS

Janssen Pharmaceutica

Michael Johnsrud, M.D., *Department of Psychiatry, University of Texas at Austin, 2409 University Avenue, Austin, TX 78712;* M. Lynn Crismon, Pharm.D.; Ann Thompson, M.B.A.; Amy Grogg, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to assess the benefits of risperidone in treating children with conduct and other disruptive behavior disorders.

SUMMARY:

Background: On July 1, 1999, Texas began enrolling one region of indigent (non-Medicaid) mental health patients into a managed mental health pilot program, with the goal of providing greater access to and more continuity of mental health services.

Objectives: This study compares prescription and mental health services expenditures for indigent schizophrenia patients treated with one of two atypical antipsychotic agents.

Methods: Prescription and mental health service records were extracted from the administrative database of a regional behavioral health organization for the period of July 1, 1999, through June 30, 2000. Schizophrenia related expenditures were collected for patients continuously prescribed either risperidone or olanzapine.

Results: No significant differences between risperidone (n = 57) and olanzapine (n = 84) were shown in mean age (43.4 vs. 43.8, p = 0.813), percent female (36.8% vs. 40.5%, p = 0.664), or ethnicity, non-white (43.9% vs. 42.9%, p = 0.280). Mean total prescription costs were significantly lower for risperidone patients ($2,347 vs. $3,502, p < 0.001). Risperidone patients also had significantly lower schizophrenia related inpatient and outpatient medical costs ($715 vs. $1,445, p = 0.020) and total overall schizophrenia-related expenditures ($3,062 vs. $4,947, p < 0.001).

Conclusion: Indigent schizophrenia patients within a Texas behavioral health organization continuously treated with risperidone, as compared with olanzapine, had significantly lower annual schizophrenia-related prescription and medical expenditures.

REFERENCES:

1. Hanson MA: Pharmacoeconomics of schizophrenia in the 21st century. J Clin Psychiatry 1999; 60 (suppl 1):26–30.
2. Revicki DA. Pharmacoeconomic studies of atypical antipsychotic drugs for the treatment of schizophrenia. Schizophr Res 1999; 35 (suppl):S101–S109.

Poster 58 **Friday, October 12**
10:00 a.m.-11:30 a.m.

OPTIMAL DOSE OF RISPERIDONE: REANALYSIS OF PIVOTAL TRIALS

Janssen Pharmaceutica

Stephen R. Marder, M.D., *Professor and Vice Chairman, Department of Psychiatry, UCLA School of Medicine, 11301 Wilshire Boulevard, Los Angeles, CA 90073*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to determine the optimal doses of risperidone in the treatment of chronic schizophrenia.

SUMMARY:

Background: Since antipsychotic agents were introduced, determining the optimal dose has remained a challenge for clinicians. The risperidone pivotal studies suggested an effective dose range higher than that reported in post-marketing surveys of clinical practice.

Objective: To determine the optimal dose of risperidone by a reanalysis of pivotal studies.

Methods: This post-hoc analysis combined data from two pivotal eight-week trials (North American, n = 523; European, n = 1632). Therapeutic response was compared for patients receiving risperidone (1, 2, 4, 6, 8, and 10 mg/day), placebo, and haloperidol (10 and 20 mg/day).

Results: Risperidone at 4 mg/day was as effective as higher doses. Risperidone at 4, 6, and 8 mg/day was significantly more effective than 1 and 2 mg/day, which were more effective than placebo.

Conclusion: Results suggest that 4 mg/day of risperidone is an effective and well tolerated dose for these patients with chronic schizophrenia, consistent with post marketing surveys of current clinical practice.

REFERENCES:

1. Marder SR, Meibach RC: Risperidone in the treatment of schizophrenia. Am J Psychiatry 1994; 151:825–835.
2. Kasper S. Risperidone and olanzapine: optimal dosing for efficacy and tolerability in patients with schizophrenia Int Clin Psychopharmacol 1998; 13:253–262.

Poster 59 **Friday, October 12**
10:00 a.m.-11:30 a.m.

EFFICACY OF RISPERIDONE ADD-ON TO MOOD STABILIZERS IN ACUTE AND CONTINUATION TREATMENT OF MANIA

Janssen-Ortho, Inc., Canada

Lakshimi Yatham, *Director, Mood Disorders Clinical Research Unit, University of British Columbia, 2255 Westbrook Mall, Vancouver, BC Canada V6T 2A1;* Carin Binder, B.S.C.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to review the efficacy of risperidone in conjunction with mood stabilizers in patients with bipolar disorders.

SUMMARY:

Objective: To determine efficacy and safety of addition of risperidone to mood stabilizers in treatment of the manic phase of bipolar disorder over 12 weeks.

Method: Patients with manic episodes (n = 106) who gave written informed consent were recruited. All subjects were on one to two mood stabilizers at the time of initiation of risperidone (range 0.5–4 mg). No other antipsychotic or ongoing benzodiazepine therapy was allowed.

Results: There was a significant decrease in YMRS scores from baseline (27.1 ± 7.5) to week 1 (−10.2, $p < 0.0001$); week 3 (17.3, $p < 0.0001$) and to week 12 (−22.1, $p < 0.0001$). When response was defined as 50% reduction in YMRS scores from baseline, 30%, 66%, and 88% of patients met criteria at weeks 1, 3, and 12, respectively. Significant decreases in HAM-D 21 scores from baseline (12.3) to week 3 (5.7, $p < 0.0001$) and week 12 (−5.7, $p < 0.0001$) were also observed. No changes in extrapyramidal symptoms were noted between baseline and endpoint. The mean daily dose of risperidone was 2 mg with a median of 18 mg and a range of 4mg to 4.2 mg.

Conclusion: These results suggest the addition of risperidone to mood stabilizers is safe and effective treatment for acute and continuation treatment of mania.

REFERENCES:

1. Ghaemi SN, Sachs GS. Long-term risperidone treatment in bipolar disorder: 6-month follow-up. Int Clin Psychopharmacol 1997; 12:333–339.
2. Vieta E, Gasto C, Colom E, et al: Treatment of refractory rapid cycling bipolar disorder with risperidone. J Clin Psychopharmacology 1998; 18:172–174.

Poster 60 **Friday, October 12**
10:00 a.m.-11:30 a.m.

THE ASSOCIATION OF ANTIPSYCHOTIC MEDICATION USE WITH PRODUCTIVITY

Janssen Pharmaceutica

Amy Grogg, Pharm.D., *Director, Outcomes Research, Janssen Pharmaceutica, 1125 Trenton-Harbourton Road, Titusville, NJ 08560;* Susan C. Bolge; Ramy Mahmoud, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to conclude that risperidone treatment is associated with better productive activity than conventional antipsychotics.

SUMMARY:

Objective: To evaluate the association of antipsychotic medication with the productivity of people with schizophrenia.

Methods: Schizophrenia patients (N = 390) identified through the National Alliance for the Mentally Ill (NAMI) and community mental health centers completed self-administered questionnaires in June 2000. Those reporting any paid employment, volunteer work, or school attendance were considered productive. To determine the association of antipsychotic medications with productive activity, a logistic regression was used, controlling for disease severity, demographics, and other prescription medications. The Psychological General Well-Being Scale (PGWB) was used as a surrogate measure for disease severity.

Results: An average of 53% of respondents participated in at least one productive activity a week. Thirty-three percent engaged in paid employment, 26% engaged in volunteer work; and 9% were in school. Respondents with less severe disease were more likely to be productive ($P = 0.001$). Although risperidone users had more severe disease than did patients receiving conventional antipsychotics (PGWB scores 60.7 vs. 66.4), this did not negatively affect productivity. Fifty-eight percent of risperidone users were productive compared with 49% of patients receiving conventional antipsychotics. Logistic regression found that risperidone was the only antipsychotic in either group (conventional or atypical) that was significantly associated with productive activities (OR = 1.85, $P = 0.047$).

Conclusion: Risperidone use had a positive impact on the productivity of community patients with schizophrenia.

REFERENCES:

1. Bell MD, Lysaker PH, Milstein RM: Clinical benefits of paid work activity in schizophrenia. Schizophr Bull 1996; 22(1):51–67.
2. Priebe D, Warner R. Hubschmid T, Eckle I: Employment, attitudes toward work, and quality of life among people with schizophrenia in three countries. Schizophr Bull 1998; 24(3):469–77.

Poster 61 **Friday, October 12**
10:00 a.m.-11:30 a.m.

COMPARISON OF RISPERIDONE AND OLANZAPINE IN BIPOLAR DISORDER AND SCHIZOAFFECTIVE DISORDER

Janssen Pharmaceutica

Subhdeep Virk, M.D., *Resident, State University of New York Upstate Medical University at Syracuse, 731 Harrison Street, PBS, 3rd Floor, Syracuse, NY 13210;* Pra-

kash S. Masand, M.D.; Sanjay Gupta, M.D.; Xiaohong Wang, M.D.; Thomas L. Schwartz, M.D.; M. Ahmad Hameed, M.D.; Michael Wade

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to assess that risperidone and olanzapine are equally effective in the treatment of bipolar or schizoaffective disorders, and that olanzapine is associated with a higher acquisition cost than risperidone in this population.

SUMMARY:

Background: While conventional neuroleptics have long been the drugs of choice in patients with bipolar or schizoaffective disorder requiring antipsychotic treatment, atypical antipsychotics offer several advantages, including superior efficacy for negative and mood symptoms and a lower risk of extrapyramidal symptoms (EPS) and tardive dyskinesia (TD). There are, however, few studies of atypical antipsychotics in bipolar or schizoaffective patients.

Methods: We conducted a retrospective chart review of 35 patients with bipolar or schizoaffective disorder seen in three settings. Risperidone and olanzapine were compared for efficacy, tolerability, need for concomitant mood stabilizers, and cost of treatment.

Results and Conclusion: The mean doses were 3.7 ± 3.5 mg/d of risperidone and 12.0 ± 5.4 mg/d of olanzapine. Between-drug differences in patient demographics, psychiatric history, Clinical Global impressions ratings, or treatment duration were not significant. Side effects, including EPS, akathisia, TD, and precipitation of mania by the respective drug, also showed no significant differences between drugs. Patients in the olanzapine group received a higher dose of concomitant lithium than those in the risperidone group (mean doses, 863 ± 256 mg/d and 1,210 ± 186 mg/d, respectively; P = 0.03). The total acquisition cost for olanzapine was $11.84/d versus $5.81/d for risperidone.

REFERENCES:

1. Ghaemi SN, Goodwin FK: Use of atypical antipsychotic agents in bipolar and schizoaffective disorder: review of the empirical literature. J Clin Psychopharmacol 1999; 19:354–361.
2. Guille C, Sachs GS, Ghaemi SN: A naturalistic comparison of clozapine, risperidone, and olanzapine in the treatment of bipolar disorder. J Clin Psychiatry 2000; 61:638–642.

Poster 62 **Friday, October 12**
10:00 a.m.-11:30 a.m.

RISPERIDONE AND OLANZAPINE IN ELDERLY PATIENTS WITH SCHIZOPHRENIA AND SCHIZOAFFECTIVE DISORDER

Janssen Pharmaceutica

Dilip V. Jeste, M.D., *Professor of Psychiatry and Neurosciences, and Chief, Division of Geriatric Psychiatry, University of California at San Diego, VA San Diego Healthcare System, 3350 La Jolla Drive, San Diego, CA 92161-0001;* Subramoniam Madhusoodanan, M.D.; Yoram Barak, M.D.; Rick A. Martínez, M.D.; Paul Kershaw, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to review the efficacy of risperidone or olanzapine treatment of schizophrenia or schizoaffective disorders in elderly patients.

SUMMARY:

Background and Method: In an international, double-blind, eight-week study, 176 patients aged >60 years and with DSM-IV schizophrenia or schizoaffective disorder were randomly assigned to receive flexible doses of risperidone (1–3 mg/day) or olanzapine (5–20 mg/day).

Results: At median doses of 2 mg/day of risperidone and 10 mg/day of olanzapine, PANSS total score (primary endpoint) decreased significantly in both groups at endpoint ($p < 0.001$). Between-group differences at endpoint were not significant. Baseline and endpoint scores on Clinical Global Impressions scale were similar in the two groups. Two-thirds of all patients had minimal or greater improvement on CGI. Extrapyramidal Symptom Rating Scale (ESRS) scores were equivalent at baseline and improved significantly in risperidone-treated patients at every assessment, but showed significant improvement only at week 8 in the olanzapine group. Total EPS-related adverse events were reported in 9% of the risperidone patients and 14% of the olanzapine patients. Risperidone and olanzapine groups did not differ in incidence of common adverse events.

Conclusions: At doses appropriate in elderly patients with schizophrenia, reductions in psychopathology were seen in both treatment groups with a greater numeric improvement in the risperidone group at every timepoint. Overall side-effect profiles were similar, with significant reductions in total ESRS scores in risperidone patients but not olanzapine patients at most timepoints.

REFERENCES:

1. Guille C. Sachs GS, Ghaeirni SN: A naturalistic comparison of clozapine, risperidone, and olanzapine in

the treatment of bipolar disorder. J Clin Psychiatry 2000; 61(9):638–42.
2. Nemerott CB: An ever-increasing pharmacopoeia for the management of patients with bipolar disorder. J Clin Psychiatry 2000; 61 Supp 13:19–25. Review

Poster 63 **Friday, October 12 10:00 a.m.-11:30 a.m.**

PSYCHIATRIC SYMPTOMS AND SELF-REPORTED ADVERSE EVENTS FOR PERSONS WITH SCHIZOPHRENIA

Eli Lilly and Company

Hea-Won Kim, Ph.D., *Research Associate, Department of Psychology, Indiana University, 402 North Blackford Street, LD-124, Indianapolis, IN 46202;* Sandra L. Tunis, Ph.D.; Gary R. Bond, Ph.D.; Kriscinda Marks, M.S.; Piper Meyer, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize differences in psychiatric symptoms and perceived distress from adverse events commonly reported during antipsychotic treatment among clients with schizophrenia.

SUMMARY:

Objective: This analysis assessed psychiatric symptoms and adverse events commonly reported during antipsychotic treatment, including weight gain, among clients with schizophrenia attending psychiatric rehabilitation programs.

Method: Clients being treated with olanzapine (n = 29), risperidone (n = 23) or traditional antipsychotics (n = 23) were interviewed. Median duration on antipsychotic medication across all groups was 14.6 months. Symptoms were measured using five subscales of the Positive and Negative Syndrome Scale (PANSS). Adverse events were reported by clients with an adaptation of the 12-item Subjective Side Effect Rating Scale.

Results: Psychiatric symptoms did not significantly differ by antipsychotic treatment. For seven of 12 adverse events (akinesia, rigidity, tremor, change in appearance, stigma from medications, anticholinergic effects, and sexual dysfunction), a significantly smaller proportion of olanzapine-treated clients reported moderate or serious distress compared with those treated with risperidone or traditional agents. There were no significant differences between medication treatment groups for the remaining adverse events.

Conclusions: In this small community sample of individuals with schizophrenia participating in psychiatric rehabilitation programs, clients on olanzapine reported less distress from adverse events than did clients on other antipsychotics.

REFERENCES:

1. Kay SR, Fiszbein A, Opler LA: The positive and negative syndrome scale (PANSS) for schizophrenia. Schizophrenia Bulletin 1987; 13(2), 261–276.
2. Weiden P: Clinical Report Form: Effectiveness of Olanzapine in Psychiatric Rehabilitation Settings (Grant F1D-MC-HGEC). Indianapolis, Eli Lilly, 1996.

TARGET AUDIENCES:

Psychiatrists and other mental health professionals involved in care of persons with schizophrenia

Poster 64 **Friday, October 12 10:00 a.m.-11:30 a.m.**

REHOSPITALIZATION RATES OF PATIENTS ON NOVEL OR TYPICAL ANTIPSYCHOTICS

Zakaria Siddiqui, M.D., *Resident, Department of Psychiatry, Creighton University, 7319 Wirt Circle, #21, Omaha, NE 68134;* Subhash C. Bhatia, M.D.; Alina Y. Faramazyan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand that atypicals require fewer hospitalizations compared with typical antipsychotics.

SUMMARY:

Introduction: Atypical antipsychotics with fewer adverse effects are frequently prescribed compared with conventional antipsychotics. Upfront medication costs are cited as a reason for their limited use without factoring in the rehospitalization rates. The purpose of this study was to compare the rehospitalization rates of patients while being treated with atypical or conventional antipsychotics.

Methods: Patient records with a DSM-IV diagnosis of schizophrenia hospitalized between 1/98 to 3/01 (N = 377) were reviewed retrospectively and rehospitalization data were collected. Patients with a comorbid diagnosis of substance use disorders and those lost to followup were excluded. Total of 161 patient records qualified.

Results: Patients on atypicals were (N = 122/75%), and on typicals were (N = 39/25%). Rehospitalization rates among patients on atypicals were 28.1%, haloperidol 50%, and other typicals 19%. Patients not hospitalized during this period while on atypicals were 22%, and while on typicals 6%.

Conclusion: This study demonstrates that the rehospitalization rates for patients on atypicals were lower when compared with typicals. A reason for higher rehospitalization rates among patients on typicals might be noncompliance due to side effect intolerance. Further studies are needed to ascertain these differences.

REFERENCES:

1. Conley RR, Love RC, Kelly DL, Bartko JJ. Rehospitalization rates of patients recently discharged on a regimen of risperidone or elozapine: Am J Psychiatry 1999; 156(6):863–8.
2. Rabinowitz J, Lichtenberg P, Kaplan Z, Mark M, Nahon D, Davidson M: Rehospitalization rates of chronically ill schizophrenic patients discharged on a regimen of risperidone, olanzapine, or conventional antipsychotics: Am J Psychiatry 2001; 158(2):266–9.

TARGET AUDIENCE:

Psychiatrists, nurse practitioners

Poster 65 **Friday, October 12 10:00 a.m.-11:30 a.m.**

CURRENT TRENDS IN THE MANAGEMENT OF ANTIPSYCHOTICS IN A LONG-TERM CARE DEMENTIA POPULATION: FOCUS ON ADVERSE EVENTS

Janssen Pharmaceutica

Harlan Martin, R.Ph., *President, Pharma-Care Incorporated, 136 Central Avenue, Clark, NJ 07066;* Michael P. Slyk, Pharm.D.; Sheila Deymann

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to evaluate the use of atypical antipsychotics in elderly patients with dementia.

SUMMARY:

Purpose: To assess the adverse events associated with the routine use of risperidone and olanzapine in long-term care patients with dementia and behavioral disturbances.

Methods: An observational analysis was conducted at five consulting pharmacist sites across the U.S. Patients' average age was 82 years and Alzheimer's dementia was the primary diagnosis in 47%. Target behaviors for antipsychotic use included verbally and physically aggressive behaviors. The effects of risperidone and olanzapine were determined after 91 days of patient use.

Results: At risperidone and olanzapine doses of 2 mg/d and 10 mg/d, respectively; the incidence of anxiety in both groups was lower than that reported in the product literature. Anxiolytic use tended to decrease in the risperidone group and did not change in the olanzapine group. The incidence of the anticholinergic event constipation (as measured by frequency of laxative use) was higher in the olanzapine than the risperidone group (19% versus 4%; $p < 0.01$). Falls were recorded in 10% of olanzapine patients versus 4% of risperidone patients ($p < 0.01$).

Conclusions: The lower incidence of adverse events (anxiety, anticholinergic effects and falls) with risperidone suggests that low doses of this agent may be a favored antipsychotic for use in the long-term care setting.

REFERENCES:

1. Tariot PN, Podgorski CA, Blazina L: Mental disorders in the nursing home: another perspective. Am J Psychiatry 1993; 150:1063–1069.
2. Jeste DV, Rockwell E, Harris MJ, et al: Conventional vs. newer antipsychotics in elderly patients. Am J Geriatr Psychiatry 1999; 7:70–76.

Poster 66 **Friday, October 12 10:00 a.m.-11:30 a.m.**

RISPERIDONE MICROSPHERES INJECTABLE FORMULATION FOR TREATMENT OF PATIENTS WITH SCHIZOPHRENIA

Janssen Pharmaceutica

John M. Kane, M.D., *Department of Psychiatry, Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004-1150;* Samuel J. Keith, M.D. *Professor and Chair of Medicine, Department of Psychiatry, University of New Mexico, 2400 Tucker Avenue, N.E., Suite 404, Albuquerque, NM 87131;* Marielle Eerdekens, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this presentation, participants will be able to evaluate the efficacy and tolerability of a long-acting intramuscular atypical antipsychotic.

SUMMARY:

Background: Risperidone microspheres (RIS MS) injectable formulation, the first long-acting atypical antipsychotic, was investigated in patients with schizophrenia in a double-blind trial.

Methods: After a seven-day down-titration from previous antipsychotics and a subsequent seven-day oral risperidone run-in up to 4 mg/day, patients were randomized to receive IM injections every two weeks with placebo or risperidone at 25, 50, or 75 mg for 12 weeks. During the first three weeks patients received risperidone to ensure adequate plasma levels of risperidone until release from the initial RIS MS injection or placebo.

Primary efficacy at endpoint was determined by change vs. baseline on total PANSS score. Three hundred seventy patients were included in the intent-to-treat analysis (minimum one injection and one post baseline assessment).

Results: Compared with placebo, significantly greater reductions in total PANSS scores were seen in all RIS MS groups ($P = 0.002$: 25 mg; $P < 0.001$: 50 and 75 mg). The incidence of extrapyramidal symptoms was similar in the placebo and 25-mg RIS MS groups; there was an increased incidence with higher doses. No unexpected adverse events were seen during the treatment with RIS MS. Local injection site reactions were minimal.

Conclusion: Long-acting IM risperidone appears to be efficacious and well tolerated.

REFERENCES:

1. Peuskens J, Risperidone Study Group: Risperidone in the treatment of patients with chronic schizophrenia: a multi-center, double-blind, parallel-group study versus haloperidol. Br J Psychiatry 1995; 166:712–726.
2. Marder SR, Davis JM, Choumard G: The effects of risperidone on the five dimensions of schizophrenia derived by factor analysis combined results of the North American trial. J Clin Psychiatry 1997; 58:538–546.

Poster 67 **Friday, October 12**
10:00 a.m.-11:30 a.m.

DIVALPROEX SODIUM ENHANCES ANTIPSYCHOTIC-INDUCED IMPROVEMENT IN SCHIZOPHRENIA

Abbot Laboratories

David G. Daniel, M.D., *Clinical Professor of Psychiatry, George Washington University, 1071 Cedrus Lane, McLean, VA 22102;* Tram Tran-Johnson, Pharm.D.; Murray H. Rosenthal, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant will become familiar with the clinical beliefs, safety, and tolerability of divalproex sodium in combination with an atypical antipsychotic (risperidone or olanzapine in the treatment of patients hospitalized for an exacerbation of schizophrenia.

SUMMARY:

Objective: Examine the safety and efficacy of divalproex sodium in combination with risperidone or olanzapine versus risperidone or olanzapine monotherapy in the treatment of schizophrenia.

Design/Method: In a randomized, double-blind, four-week trial, hospitalized patients with schizophrenia and a minimum-PANSS total score of 60 were assigned to one of four groups. Antipsychotic medication was titrated during the first six days to fixed daily doses of 6mg risperidone or 15mg olanzapine. Divalproex, initiated at 15mg/kg, was titrated to effect over the first 14 days. The PANSS was administered on Days 3, 5, 7, 10, 14, 21, and 28 with the primary measurement on Day 28. Additional efficacy and safety assessments were obtained.

Results: 249 patients were randomized with baseline PANSS total scores of 100 (monotherapy) and 103 (combination therapy). 38% of the monotherapy group versus 28% of the combination therapy group prematurely discontinued the study. The PANSS total score was significantly ($p \leq 0.05$) improved in the combination group compared to the monotherapy group at all time points except Day 28. Safety was similar between the groups.

Conclusions: Divalproex when added to olanzapine or risperidone significantly improves psychosis, as early as Day 3, compared with antipsychotic monotherapy.

REFERENCES:

1. Citrome L, et al: Changes in use of valproate and other mood stabilizers for patients with schizophrenia from 1994 to 1998. Psychiatric Services 2000; 51:634–8.
2. Wassef AA, et al: Divalproex sodium augmentation of haloperidol in hospitalized patients with schizophrenia: Clinical and economic implications. J of Clinical Psychopharm 2001; 21:21–6.

TARGET AUDIENCE:

Psychiatrists, pharmacists, psychiatric nurses, mental health and health care professionals

POSTER SESSION 3

Posters 68–101

Poster 68 **Friday, October 12**
3:30 p.m.-5:00 p.m.

MANIC-LIKE SYMPTOMS IN PATIENTS WITH SCHIZOPHRENIA TREATED WITH OLANZAPINE, HALOPERIDOL, AND PLACEBO

Eli Lilly and Company

Robert W. Baker, M.D., *Clinical Research Physician, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285;* Beth E. Juliar, M.S., *Researcher, Eli Lilly and Company, One Lilly Corporate*

Center, Indianapolis, IN 46285; Virginia L. Stauffer, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the completion of this presentation, the audience will have a better understanding of the effect of olanzapine and haloperidol on treating manic-like symptoms in schizophrenia.

SUMMARY:

Background: Published case reports describe induction of manic-like symptoms during treatment of schizophrenia with olanzapine. We explored the relationship of olanzapine to manic-like symptoms within the olanzapine schizophrenia clinical trial database.

Methods: Three double-blind, randomized trials investigating the efficacy of olanzapine versus haloperidol and/or placebo over six weeks were included in these analyses. "Mania cluster" was extracted from the BPRS and its correlation to the YMRS was explored within olanzapine's mania registration database.

Results: The BPRS mania cluster was highly correlated with the YMRS (R=0.8, p<.001) in pooled mania trials. In the schizophrenia trials, in no instance was mean change on any dose of olanzapine statistically inferior to placebo or haloperidol. Olanzapine was superior in these comparisons: Study 1, 10 mg vs. placebo (p=.009) and 15 mg vs. placebo (p=.002); Study 3 vs. haloperidol (p=.018).

Conclusion: This retrospective analysis disputes the suggestion of anecdotal reports that olanzapine provokes symptoms of mania in schizophrenia.

REFERENCES:

1. Tollefson GD, Beasley CM, Tran PV, et al: Olanzapine versus haloperidol in the treatment of schizophrenia and schizoaffective and schizophreniform disorders: Results of an International collaborative trial. Amer J Psychiatry 1997; 154: 457–465
2. Beasley, CM, Tollefson GD, Tran PV, et al: Olanzapine versus placebo and haloperidol. Acute phase results of the North American double-blind olanzapine trial. Neuropsychopharmacology 1996; 14: 111–123

Poster 69 **Friday, October 12**
3:30 p.m.-5:00 p.m.

OLANZAPINE VERSUS DIVALPROEX SODIUM FOR THE TREATMENT OF ACUTE MANIA AND MAINTENANCE OF REMISSION: A 47-WEEK STUDY

Eli Lilly and Company

Robert W. Baker, M.D., *Clinical Research Physician, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285;* Julie A. Gilmore, Ph.D., *Medical Writer Associate, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285;* Michael F. Luther, M.S.; Richard C. Risser, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to compare the longer-term efficacy and safety of the mood stabilizers olanzapine versus divalproex for the treatment of mania.

SUMMARY:

Objectives: We report a 47-week comparative trial of olanzapine vs. divalproex for treatment of mania.

Methods: This 47-week, randomized, double-blind study compared olanzapine (5–20 mg/day) with divalproex (500–2500 mg/day) for the treatment of manic or mixed episodes of bipolar disorder (N=251). The primary efficacy instrument was the Young-Mania Rating Scale (Y-MRS). Several safety measures and secondary efficacy ratings were employed.

Results: Over the 47-week trial, mean YMRS improvement was significantly greater by 1.98 for the olanzapine treatment group (p<.001). Among acute phase remitters, rates of relapse into mania were higher but not statistically significant for divalproex during the 44-week, double blind continuation: olanzapine (24/59, 40.7%), divalproex (21/42, 50%) (p=0.418). The median time to mania relapse was 270 days for olanzapine patients compared with 74 days for divalproex patients (p=0.392). Treatment-emergent adverse events and/or laboratory abnormalities occurring more frequently during treatment with olanzapine (p<.05) were somnolence, dry mouth, increased appetite, weight gain, akathisia, and liver function test (ALT increase), and for divalproex (p<.05) were nausea, nervousness, manic reaction, rectal disorder, and decreased platelets.

Conclusions: Olanzapine-treated patients had significantly greater mania improvement than divalproex-treated patients over a period of 47 weeks. Rates of relapse were higher and time to relapse shorter for divalproex, but these differences were not statistically significant.

REFERENCES:

1. Tohen M, Sanger TM, McElroy SL, Tollefson GD, et al: Olanzapine versus placebo in the treatment of acute mania. American Journal of Psychiatry, 1999; 156(5):702–9
2. Tohen M, Jacobs TG, Grundy SL, Banov MC, et al: Efficacy of olanzapine in acute bipolar mania: a double-blind, placebo-controlled study. Arch Gen Psych 2000; 57(9):841–849

Poster 70 **Friday, October 12 3:30 p.m.-5:00 p.m.**

PSYCHOSIS OF ALZHEIMER'S DISEASE: VALIDITY AND RESPONSE TO RISPERIDONE

Janssen Pharmaceutica

Lon S. Schneider, M.D.; *Associate Professor of Psychiatry, University of Southern California;* Ira R. Katz, M.D.; Sohee Park, M.S.; Stanley Azen, M.D.; Rick A. Martinez, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to evaluate the concept of psychosis of Alzheimer's disease as a homogeneous syndrome.

SUMMARY:

Purpose: The concept of "behavioral and psychological symptoms in dementia" has been criticized as a heterogeneous grouping of poorly defined symptoms of unclear severity, clinical significance, and natural history. The concept of psychosis of AD (Jeste and Finkel, 2000) has been advanced as a homogeneous syndrome with potentially specific diagnostic criteria and a potential target for a therapeutic drug claim (FDA, March 9, 2000). We sought evidence for its validity by examining a database of AD patients enrolled in a randomized trial of risperidone (Katz et al 1999).

Method and Results: Of 625 patients enrolled, 463 were identified as probably fulfilling criteria for psychosis of AD. Compared with the 162 other patients with (n=69) and without (n=93) psychotic symptoms during the screening period patients with psychosis of AD were significantly more likely to be women and to have higher MMSE scores and better ambulatory ability. Two thirds of patients (treated with placebo) maintained psychosis criteria over the 12-week period. There was a clear and robust response in risperidone, 1 or 2 mg/d especially with respect to aggressiveness.

Conclusion: These analyses provide evidence of the validity of psychosis of AD, its course, and the response of patients with psychosis of AD to antipsychotic treatment.

REFERENCES:

1. Jeste DV, Finkel SI: Psychosis of Alzheimer's disease and related dementias: diagnostic criteria for a distinct syndrome. Am J Geriatr Psychiatry 2000;8:29–34.
2. Katz IR, Jeste DV, Mintzer JE, et al: Comparison of risperidone and placebo for psychosis and behavioral disturbances associated with dementia: a randomized, double-blind trial. J Clin Psychiatry 1999;60:107–115.

Poster 71 **Friday, October 12 3:30 p.m.-5:00 p.m.**

PSYCHOSIS OF ALZHEIMER'S DISEASE: EVIDENCE FROM COMMUNITY DWELLING AND NURSING HOME PATIENTS

Janssen Pharmaceutica

Georges Gharabawi, M.D., *Senior Director, Department of Medical Affairs, Janssen Pharmaceutica, 1125 Trenton-Harbourton Road, Titusville, NJ 08560;* Rick A. Martinez, M.D.; Judy Napolitano, R.N.; Paul Kershaw, M.D.; Akiko Okamoto, Sc.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to assess whether the concept of a psychosis of dementia is a definable entry.

SUMMARY:

Purpose: Determine whether there is a definable psychotic syndrome in elderly patients with Alzheimer's disease (AD) and other dementias.

Methods: Data were derived from a five-month study of community-dwelling patients with mild to moderate dementia (study 1) and a three-month study of nursing-home residents with severe dementia (study 2). Psychosis was defined according to scores on the Neuropsychiatric Inventory or the Behavioral Pathology in Alzheimer's Rating Scale.

Results: Of the 285 placebo patients in study I, all had AD, and of the 162 placebo patients in study 2. 84% had AD and 16% other dementia. In study 1.12% of patients showed psychosis before the baseline assessment and 64% had a persistent psychosis for at least one month, 12% of patients without psychosis at baseline developed psythosis. In study 2.63% of patients had psychosis at baseline, which persisted for at least two weeks in 75%. 17% in patients without psychosis at baseline developed psychosis. Persistent or continuous psychosis was present in 29% of the patients for 12 weeks.

Conclusion: The data support the concept that psychosis of dementia is a clinically definable entity across the spectrum of AD from mild to severely impaired patients.

REFERENCES:

1. Leste DV, Finkel SI. Psychosis of Alzheimer's disease and related dementia. Diagnostic criteria for a distinct syndrome. Am J Geriatr Psychiatry 2000;8:29–34.
2. Rovner BW. Kafonck S. Filipp L. et al. Prevalence of mental illness in a community nursing home. Am J Psychiatry 1986;143:1446–1449.

Poster 72 **Friday, October 12 3:30 p.m.-5:00 p.m.**

ATYPICAL ANTIPSYCHOTICS AND DRUG TREATMENT PATTERNS IN A NATURALISTIC SETTING

Eli Lilly and Company

Zhongyun Zhao, Ph.D., *Researcher, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285;* Maureen J. Lage, Ph.D., *Research Scientist, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand the impact of initiating atypical antipsychotics (OLZ vs RISP) on treatment patterns in clinical practice.

SUMMARY:

Objective: Compare drug treatment patterns for patients who initiated on olanzapine (OLZ) versus risperidone (RIS).

Methods: Retrospective analysis of a large, geographically diverse claims database of insured individuals identified 670 enrollees who (1) were diagnosed with schizophrenia, (2) initiated on OLZ (n=423) or RIS (n=247) monotherapy, and (3) had no use of OLZ or RIS in one-year prior initiation. Multivariate analyses were used to compare the OLZ and RIS cohorts with respect to treatment duration during the one year post-initiation, likelihood of switching between study drugs, likelihood of being at least 80% compliant, and likelihood of receiving concomitant treatment for adverse events. Regressions controlled for demographics, comorbidities, and previous medication use patterns.

Results: Compared with RIS (mean dose = 3.32 mg/day), patients treated with OLZ (mean dose = 10.45 mg/day) experienced a 29.4% increase in treatment duration (162 days vs. 213 days; $p<0.0001$), a decrease in the probability of using concomitant treatment for adverse events (Odds Ratio = 0.639; $p=0.0284$), and a higher probability of being at least 80% compliant (Odds Ratio = 2.057, $p=0.0002$). Patients who initiate on OLZ were significantly less likely to switch to RIS than vice versa (Odds Ratio = 0.275; $p<0.0001$).

Conclusion: Compared with RIS, patients treated with OLZ experienced a longer duration of therapy, an increased likelihood of being compliant with medication, a decreased likelihood of using adverse event medications, and a lower probability of switching among treatment drugs.

REFERENCES:

1. McCombs JS, Nichol MB, Stimmel GL, Shi J, Smith RR: Use patterns for antipsychotic medications in Medicaid patients with schizophrenia. Journal of Clinical Psychiatry 1999;154:452–459
2. Tran PV, et al: Double-blind comparison of olanzapine versus risperidone in the treatment of schizophrenia and other psychotic disorders. Journal of Clinical Psychopharmacology 1997;106:262–265.

TARGET AUDIENCE:

Psychiatrists, mental health service researchers

Poster 73 **Friday, October 12 3:30 p.m.-5:00 p.m.**

OLANZAPINE COMPARED TO DIVALPROEX FOR ACUTE MANIA: LONG-TERM OUTCOMES

Eli Lilly and Company

Baojin Zhu, M.S., *Statistical Analyst, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285;* Maureen J. Lage, Ph.D., *Research Scientist, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285;* Mauricio Tohen, M.D., Ph.D.; Lizheng Shi, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand the long-term difference in resource utilization and quality of life associated with olanzapine versus divalproex.

SUMMARY:

Objective: Compare long-term quality of life and economic outcomes associated with the use of olanzapine versus divalproex for treatment of mania.

Methods: Data were collected from a randomized, double-blind, clinical trial, with a three-week acute phase and a nine-month maintenance phase, comparing olanzapine 5-20 mg/day to divalproex 500-2500 mg/day. Change in quality of life for each of the eight dimensions of the SF-36 was measured from baseline to endpoint for olanzapine- and divalproex-treated patients using last observation carried forward. Differences in means for total costs and component costs were compared for olanzapine- or divalproex-treated patients.

Results: For patients who entered the maintenance phase, olanzapine was associated with significantly greater long-term improvement in quality of life. Specifically, olanzapine-treated patients (N=69) showed significantly greater improvement on general health ($p = .007$), mental health ($p=.021$), physical functioning ($p=.011$), role-emotional ($p=.031$), and social functioning ($p=.048$) components of the SF-36 compared with divalproex patients (N=63). Treatment with olanzapine (N=77) versus

divalproex (N=69) resulted in no significant difference in total medical costs ($18,933 versus $19,918; p=.843).

Conclusion: The use of olanzapine over an extended period resulted in a significantly greater improvement in health-related quality of life than did treatment with divalproex, while not resulting in any significant difference in total costs.

REFERENCES:

1. Tohen M Sanger JM, McElroy JL, et al: Olanzapine versus placebo in the treatment of acute mania. Olanzapine HGEH Study Group
2. Ware JE, Snow KK, Kosinski M, et al: SF-36 health survey: manual and Interpretation Guide, The Health Institute, New England Medical Center, 1993

TARGET AUDIENCE:

Psychiatrists and mental health outcomes researchers

Poster 74 **Friday, October 12 3:30 p.m.-5:00 p.m.**

USE OF ATYPICAL ANTIPSYCHOTICS AND THE INCIDENCE OF DIABETES

Eli Lilly and Company

Maureen J. Lage, Ph.D., *Research Scientist, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285;* Jason Kemner, M.P.H., *Research Associate, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand the relative impact of the use of typicals versus atypical antipsychotics, olanzapine or risperidone versus typical antipsychotics, and olanzapine versus risperidone on the incidence of diabetes.

SUMMARY:

Objective: Compare the incidence of diabetes between patients initiating treatment with typical or atypical antipsychotics.

Methods: Retrospective analysis of the IMS Lifelink™ claims database identified 6,758 enrollees with the following characteristics: (1) age 18–65; (2) initiated on typical (n = 3,381), or atypical (n = 3,377) between October 1996 and December 1998; (3) no use of antipsychotics for six months prior-initiation; (4) not classified as diabetic (i.e., no diagnosis of diabetes or receipt of any diabetic medication for one year prior to initiation).

Logistic regressions were used to estimate odds ratios (OR) of a diagnosis of diabetes or use of any diabetic medication in the one year post-initiation, controlling for age, gender, and regional differences.

Results: Higher probability of becoming diabetic was not evident following initiation on atypicals (mean duration of therapy = 135 days) compared with typicals (mean duration of therapy = 84 days) (OR = 1.032; p= 0.825) or initiation on olanzapine (OLZ) or risperidone (RIS) compared with typicals (OR=0.977, 1.170; p= 0.899, 0.35, respectively. The probability of developing diabetes was less in patients treated with OLZ (mean dose 9.01 mg/day) than in patients treated with RIS (mean dose 2.37 mg/day) (OR=0.834; p=0.277), although the difference was not statistically significant.

Conclusion: The probability of developing diabetes was no more likely following treatment with atypicals than typicals. Within atypical use, the probability of developing diabetes was less during treatment with OLZ than with RIS, although the difference was not statistically significant.

REFERENCES:

1. Henderson DC, Cagliero E, Gray, et al: Clozapine, diabetes mellilus, weight gain, and lipid abnormalities: a five year naturalistic study. Am J Psychiatry 2000;157:975–981
2. Sixon L, Weiden P, Delahanly J, et al: Prevalence and correlates of diabetes in national schizophrenia samples. Schizophrenia Bulletin 2000;26(4):903–12

TARGET AUDIENCE:

Psychiatrists, mental health outcomes researchers

Poster 75 **Friday, October 12 3:30 p.m.-5:00 p.m.**

FLEXIBLE DOSE STUDY OF OLANZAPINE IN THE TREATMENT OF TRICHOTILLOMANIA

Eli Lilly and Company

Rege S. Stewart, M.D., *Associate Professor, University of Texas Southwestern Medical School, 5959 Harry Hines Boulevard, P.O. Box I, #600, Dallas, TX 75390-9101;* Vicki A. Nejtek, Ph.D.; Joseph Gilbert, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize current pharmacotherapy options in the treatment of TTM and the efficacy of olanzapine; understand possible relationship between trichotillomania depression, and anxiety.

SUMMARY:

Twenty-one patients were screened for a 12-week, open-label study of olanzapine for TTM. Patients with comorbid psychiatric disorders were excluded. With the exception of one patient, none of them were on any

psychoactive medication. Sixteen patients were treated with olanzapine, which was titrated from the initial dose of 2.5 mg. to 10 mg. by eight weeks of the study.

Patients were assessed at baseline, week 1, 2, 4, 6, 8, and 12, using the Hamilton Depression Scale (HamD) and Hamilton Anxiety Scale (HamA), the Simpson Angus Scale (SAS), the Clinician rated Global Improvement Scale (CGI-S) and the Massachusetts General Hospital Hair Pulling Scale (MGH-HPS). Patients were also required to keep daily hair pulling diary.

Data analysis of the 16 patients indicates significant decrease in MGH-HPS and CGI-S $p < 0.001$ using Wilcoxon signed rank test. MGH-HPS dropped from initial mean score of 17.2 at baseline to 5.76 at completion of the study. CGI-S initial mean was 4.4 at baseline and 2.2 at completion. HamA improvement was significant to $p < 0.05$. Change in HamD was not significant. Two patients developed major depressive disorder at the end of the study even though their TTM was in complete remission. Of the 16 patients entered, eight completely recovered from TTM.

REFERENCES:

1. Keuthen NJ, O'Sullivan RL, Spick-Buckminster S: Trichotillomania: current issues in conceptualization and treatment. Psychother Psychosom 1998;67:202–213
2. Jaspers JPC: The diagnosis and psychopharmacologic treatment of trichotillomania: a review. Pharmacopsychiat 1996;29:115–120

TARGET AUDIENCE:

Psychiatrists and psychopharmacologists

Poster 76 **Friday, October 12**
3:30 p.m.-5:00 p.m.

WEIGHT GAIN IN ADOLESCENT MALES ON ATYPICAL ANTIPSYCHOTICS

Lee S. Cohen, M.D., *Assistant Clinical Professor, Department of Psychiatry, Columbia University, 623 Warburton Avenue, Hastings, NY 10706;* David E. Cohen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand additional uses for atypical antipsychotics in children and adolescent. The participant will also be able to recognize weight gain issues in children/adolescents on atypical antipsychotics.

SUMMARY:

There is currently significant use of atypical antipsychotic compounds in child and adolescent psychiatric populations. This use is not limited to the treatment of psychotic illnesses and controlled data regarding these medications in youth are sparse. In addition these are minimal published data on the adverse reaction profiles of these compounds to guide clinicals when they are prescribing these medications for children and adolescents. Studies in the adult literature indicate that weight gain is a significant side effect when using atypical compound and this has concomitantly been associated with the development of diabetes and other condition associated with the development of obesity.

This study examines the naturalistic use of both risperidone (N=5) and quetiapine (N=5) longitudinally in a group of 10 children who are residential students and monitors their weight gain over time with exposure to these two compounds. Comparative data are presented.

Methods: All children in our residential setting (N= 15) that were on an atypical compound had their weights monitored from the point of admission (when placed on compound) and monitored on a monthly basis until the end of the study. (Avg. time on risperidon N = 5 months, Avg. time on Quetiapine = 10.8 months). Ten total patients were analyzed as those who were switched from one neuroleptic to another were excluded, as it would be unclear when compound contributed to the weight change. Doses of medication were monitored and patients were left on adjunctive compounds, as we believed that these data would be most relevant to clinicians. Patients had a mean age of 13.8 (Range 11–14), all male, and carried the following diagnose. ADHD, 2 Bipolar Disorder NOS, 2 Adjustment Disorder with mixed disturbance of conduct and emotions, 1 intermittent explosive disorder, 1 ODD, 1 MDE with psychotic features.

Patients in the risperidone group (avg 1.25mg/day range .25–2mg/day) had an avg start weight of 62.3 kg and avg end weight of 71.8kg in 5 months (9.5kg = 1.9kg/month). 1 patient was on sertraline 100mg/day.

Patients in the quetiapine group (avg 400mg/day range 200–800mg/day) had an avg start weight of 64.5 kg and avg end weight of 72.3 kg in 10.8 months (7.8kg = 7kg/month). 3 patients were on 750–1000mg/day of divalproex sodium (1 with 1200mg/day LiCO3), 1 on amphetamines (adderall) 30mg/day and 1 on paroxetine 20 mg/day.

This pilot study reveals a trend of weight differences between the two study groups at a 92.6% confidence interval utilizing the t test. The small sample size, however, was unable to detect statistical significance at the 95% confidence interval. Further studies should be performed to delineate this potential adverse event in child and adolescent populations.

REFERENCES:

1. Alison DB, Mentare JL, Heo M, Chandler LP, et al: Antipsychotic-induced weight gain: A comprehensive research synthesis. Am J Psychiatry 1999;156(11):1686–1696

2. Conley RR: Risperidone side effects. J Clin Psychiatry 2000;61:20–25
3. Martin A, Kocnig K, Scohill L, Bregman J: Open-label quetiapine in the treatment of children and adolescents with autistic disorder, J Child Adolesc Psychopharmacol 1999;9(2):99–107

TARGET AUDIENCE:

Psychiatrists treating children and adolescents

Poster 77 **Friday, October 12 3:30 p.m.-5:00 p.m.**

CONVERTING PATIENTS FROM BRAND NAME CLOZAPINE TO GENERIC CLOZAPINE

IVAX Pharmaceuticals, Inc.

Terrie A. Sajbel, Pharm. D., *Department of Pharmacy, Colorado Mental Health Institute, 1600 West 24th Street, Pueblo, CO 81003;* Gary W. Carter, R.Ph.; Roy B. Wiley, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) recognize the similarities of brand versus generic clozapine, (2) list the safety concerns and monitoring necessary to compare products, (3) understand the interchangeability of these products, and (4) appreciate the financial benefit of utilizing the generic product over the brand name product

SUMMARY:

Objective: Evaluation of the safety and dosage requirements when converting from brand to generic clozapine.

Methods: November 1999, patients on brand-name product, at Colorado Mental Health Institute at Pueblo (CMHIP) were changed to generic clozapine. Seventeen patients on brand-name clozapine for three years were included in the study. Dosage, white blood cell (WBC) values, and adverse drug reaction reports were compared. Brand-name patient data were evaluated retrospectively for the months of November, December, January, and February during 1996/97, 1997/98, and 1998/99. The same patients were evaluated on generic clozapine for the same months in 1999/2000. Also a one-year comparison of brand 1998/99 to generic 1999/2000 was performed. Statistical analysis included a standard test comparing WBC values and a Brown-Forsythe test for comparing dosages.

Results: There were no differences between the brand and the generic products. WBC values for the three-year data resulted in a p-value = 0.9992, one-year data p-value = 0.9991. Dosage comparison at three years and one year, p-value = 0.9999 and p-value = 0.9993, respectively.

Conclusions: No differences were found between the brand and the generic groups with regard to WBC, dosage, and adverse events. The conversion to generic is projected to save the pharmacy $90,000 annually.

REFERENCES:

1. Zenith Goldline Pharmaceuticals. Abbreviated New Drug Application 74–949. Data on file
2. Bellnier TJ, Singh RP, Karki S, Sundberg J: Evaluation of the interchangeability of generic clozapine with brand name Clozaril $_R$. Abstract presented at the 11th Annual New York State Mental Health Research Conference, 1999

TARGET AUDIENCE:

Practicing psychiatrists formulary or Medicaid committee members

Poster 78 **Friday, October 12 3:30 p.m.-5:00 p.m.**

NOVEL ANTIPSYCHOTICS: HYPERGLYCEMIA, HYPERLIPIDEMIA, AND EKG CHANGES IN THE "REAL WORLD"

Sanjay Gupta, M.D., *Chair, Department of Psychiatry, Olean General Hospital, 515 Main Street, Olean, NY 14760-1921;* Bradford L. Frank, M.D., M.P.H., *President, Psychiatric Network, P.C., 2200 Foote Avenue, Extension #4, Jamestown, NY 14701;* Charles Steinmeyer, M.D.; Kari Lockwood, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should recognize the current controversies with the novel antipsychotics and utilize the information in practice.

SUMMARY:

Objective: To study the differences between groups of patients treated with conventional antipsychotics and various atypical agents with regard to hyperglycemia, hyperlipidemia, and EKG abnormalities.

Methods: The sample (n=162) was divided into groups of patients on conventional agents (n=41), risperidone (n=35), olanzapine (n=73), quetiapine (n=13). The patients had a variety of diagnoses, including schizophrenia, schizeaffective disorder, bipolar disorder, major depression with psychosis, and psychotic disorder not otherwise specified. The majority of the patients (71%) were in the schizophrenia spectrum. The sample included inpatients, those from a continuing day treatment program, hospital outpatient clinic, as well as office

practice. Fasting blood glucose and fasting lipidprofile values were obtained from the chart. The EKGs were reviewed for rhythm abnormalities as well as the duration of the QT/QTc interval.

Results: A one-way analysis of variance revealed no significance between group differences with regard to hyperglycemia, lipid abnormalities, EKG changes.

Conclusion: There is a need for a prospective study to assess the potential concerns of hyperglycemia, hyperlipidemia, and EKG changes with the atypical agents.

REFERENCES:

1. Masand PS, Guptas: Long-term adverse effects of novel antipsychotics. Journal of Psychiatric Practice 2000;6:299–301
2. Mukerjee S, Decina P, Bocola V: Diabetes Mellitus in schizophrenic patients. Comprehensive Psychiatry 1996;37:68–73

TARGET AUDIENCE:

Psychiatrists and mental health professionals

Poster 79 **Friday, October 12 3:30 p.m.-5:00 p.m.**

CARDIAC ARREST APPEARS TO VARY LITTLE BY CHOICE OF ANTIPSYCHOTIC DRUG

Pfizer Inc.

Sean Hennessy, Pharm.D., *Center for Epidemiology, University of Pennsylvania School of Medicine, 803 Blockley Hall, 423 Guardian Drive, Philadelphia, PA 19104;* Warren B. Bilker, *University of Pennsylvania School of Medicine, 803 Blockley Hall, 423 Guardian Drive, Philadelphia, PA 19104;* David J. Margolis; Stephen E. Kimmel

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should be able to demonstrate an understanding of the study data suggesting that the effects of antipsychotic drugs on electrocardiographic QT interval prolongation do not necessarily increase risk of cardiac arrest or ventricular arrhythmia among schizophrenic patients.

SUMMARY:

Objective: To compare the risk of cardiac arrest and ventricular arrhythmia among patients with schizophrenia taking clozapine, risperidone, thioridazine, or haloperidol.

Methods: We used records from three U.S. Medicaid programs to perform a cohort study, drawing data over the period 1993–1996. Primary outcome was a diagnosis of ventricular arrhythmia or cardiac arrest. We used Cox regression models to estimate rate ratios and 95% confidence intervals (CIs) adjusted for sex, age, and state of residence, and to evaluate potential confounding by diagnoses and concomitant medications.

Results: A total of 95,472 individuals experienced 91 events during 78,077 person-years of follow-up, for an event rate of 1.2 per 1000 person-years. The adjusted rate ratios, using haloperidol as the reference drug, were: thioridazine, 1.0 (CI 0.6–1.7); risperidone, 1.1 (CI 0.6–2.1); and clozapine, 0.9 (CI 0.4–1.9).

Conclusions: There were no discernible differences in the risk of cardiac arrest and ventricular arrhythmia among the four examined medications. This suggests that a neuroleptic's ability to prolong the electrocardiographic QT interval may not necessarily connote a marked increase, on average, in the risk of cardiac arrest or ventricular arrhythmia.

REFERENCES:

1. Buckley NA, Sanders P: Cardiovascular effects of antipsychotic drugs. Drug Safety 2000;23:215–228
2. Reilly JG, Ayis SA, Jones SJ, Thomas SHL: QTc-interval abnormalities and psychotropic drug therapy in psychiatric patients. Lancet 2000;355:1048–1052

TARGET AUDIENCE:

Psychiatrists and other health professionals who care for patients with schizophrenia

Poster 80 **Friday, October 12 3:30 p.m.-5:00 p.m.**

PATIENT ATTITUDE AFTER SWITCHING TO ZIPRASIDONE FROM OTHER ANTIPSYCHOTICS

Pfizer Inc.

George A. Awad, M.D., *Professor, Department of Psychiatry, University of Toronto Institute of Medical Science, One Kings College, Medical Science Building 1, Toronto, ON Canada M5S 1A1;* Lakshmi N.P. Vourganti, M.D., *Department of Psychiatry, University of Toronto Institute of Medical Science, One Kings College, Medical Science Building 1, Toronto, ON Canada M5S 1A1;* Ashish Dugar, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate an understanding of the study data, which indicate that schizophrenic patients switched from other antipsychotics to ziprasidone report improved attitudes about their medication.

SUMMARY:

Objective: To determine changes in medication attitude in patients switched from other antipsychotics to ziprasidone.

Methods: Three six-week, multicenter, open-label, parallel-group trials were undertaken in outpatients with stable schizophrenia who switched from conventional antipsychotics (n=108), olanzapine (n=104), or risperidone (n=58) because of insufficient efficacy or poor tolerability. Patients were randomized to one of three switch strategies—"slow" taper, "rapid" taper, or "abrupt discontinuation" before starting ziprasidone. A 10-question Drug Attitude Inventory (DAI) was administered at baseline and week 6, with data combined from all switch subsets. A categorical linear model was used to analyze marginal probabilities of favorable responses over the total, attitudinal, and subjective question sets.

Results: DAI scores improved significantly for patients switched from conventional agents (P=0.003) or risperidone (P=0.008). Categorical analysis showed improvement in patients switched from conventional agents (P=0.05 all items, P=0.02 subjective) and a trend toward improvement in those switched from olanzapine (P=0.06 for both). DAI improvement was driven by changes in subjective feelings after initiation of ziprasidone.

Conclusions: Outpatients switched to ziprasidone from other antipsychotics reported feeling better about medication use, especially if switched from conventional agents or risperidone. These findings suggest improved compliance with ziprasidone.

REFERENCES:

1. Awad AG, Hogan TP, Voruganti LN, Heslegrave RJ: Patients' subjective experiences on antipsychotic medications: implications for outcome and quality of life. Int Clin Psychopharmacol 1995;10(suppl 3):123–132
2. Daniel DG, Weiden PJ, O'Sullivan RL: Improvement in indices of health status following a switch to ziprasidone from conventional and novel antipsychotics. Presented at APA 2000 Annual Meeting, May 13–18, 2000, Chicago, Ill

TARGET AUDIENCE:

Psychiatrists and other health professionals who care for patients with schizophrenia

Poster 81 **Friday, October 12 3:30 p.m.-5:00 p.m.**

COST OUTCOMES OF RISPERIDONE VERSUS OLANZAPINE: A COMPUTER DATABASE AND CHART REVIEW COMPARISON AT FIVE VETERANS ADMINISTRATION SITES

Janssen Pharmaceutica

Matthew J. Byerly, M.D., *Clinical Assistant Professor, Department of Psychiatry, University of Texas Southwestern Medical School, 5959 Harry Hines Boulevard, P.O. Box 1, Suite 600, Dallas, TX 75390;* Ann Thompson, M.B.A., B.S.N.; Michael Kashner, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize factors relevant to the cost outcomes of antipsychotic treatments, and recognize the relative cost outcomes specific to risperidone and olanzapine treatment among persons with schizophrenia or schizoaffective disorder.

SUMMARY:

The study evaluated costs of care among risperidone- and olanzapine-treated patients with schizophrenia and schizoaffective disorder.

Data at five geographically diverse Veterans Administration centers was evaluated in the nine months before and after patients began at least nine months of continuous risperidone (N=201) or olanzapine (N=322) therapy. Inclusion dates were 9/1997–11/2000. Analyses included hierarchical linear models for continuous (antipsychotic and psychiatric outpatient costs) and binary (psychiatric hospital utilization) outcomes. Demographic covariates were controlled.

Mean age was similar (risperidone=49.2, olanzapine=48.2; p=.24). Olanzapine patients were more likely to be male (95% vs. 91%; p=.0001). Mean risperidone and olanzapine doses equaled 4.6±2.5 and 14.2±6.5 mg/d.

Increases in antipsychotic costs were statistically significantly higher in the olanzapine-treated group (p<.0001). Risperidone (p<.0001) and olanzapine (p<.0001) were associated with statistically significant within-group (pre- vs. post-treatment) decreases in psychiatric hospital utilization. However, between-group differences in psychiatric hospital utilization (p=.81) and psychiatric outpatient costs (p=.07) lacked significance. Mean monthly pre- vs. post-treatment changes were as follows (risperidone/olanzapine): antipsychotic costs = +$102.05/+$172.82; psychiatric outpatient costs = +$1.46/–$5.48, and psychiatric hospital utilization = –0.35days/–0.95days.

Risperidone and olanzapine had similar effects on psychiatric inpatient utilization and psychiatric outpatient care costs. However, antipsychotic cost increases were 41% lower in the risperidone group.

REFERENCES:

1. Voris JC, Glazer WM: Use of risperidone and olanzapine in outpatient clinics at six Veterans Affairs hospitals. Psychiatric Services 1999; 50:163–4
2. Procyshyn RM, Zerjav S: Drug utilization patterns and outcomes associated with in-hospital treatment with risperidone or olanzapine. Clinical Therapeutics 1998; 20(6):1203–17

TARGET AUDIENCE:

Prescribers of antipsychotic medications

Poster 82 **Friday, October 12 3:30 p.m.-5:00 p.m.**

SYMPTOM SPECIFIC GROUP THERAPY FOR MEDICATED INPATIENTS WITH SCHIZOPHRENIA

Joseph Battaglia, M.D., *Clinical Director, Bronx Psychiatric Center, and Assistant Clinical Professor of Psychiatry, Albert Einstein College of Medicine, 1500 Waters Place, Bronx, NY 10461;* Anne-Marie Shelley, Ph.D., *Clinical Director, Bronx Psychiatric Center, and Assistant Clinical Professor of Psychiatry, Albert Einstein College of Medicine, 1500 Waters Place, Bronx, NY 10461;* Albert Ellis, Ph.D.; Lewis A. Opler, M.D.; Jeffery Lucey, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that for inpatients with schizophrenia, pharmacotherapy can improve up to a point, after which improvement plateaus. However, addition of symptom-specific groups using cognitive, behavioral and psychoeducational methods leads to further significant gains. This illustrates how treatment can be optimized using a combination of 'mind-brain' techniques.

SUMMARY:

Objective: To examine whether medicated chronic-schizophrenic inpatients show improvements when a cognitive-behavioral symptom-specific group therapy (SSGT) program is added to standard pharmacotherapy and routine clinical care.

Methods: A total of 25 patients were assessed on the Positive and Negative Syndrome Scale (PANSS). Problem symptoms were matched to appropriate treatment groups including: positive symptoms, attention, and affect regulation. Patients received three to five sessions of group per week (total of 50–100 sessions), re-assessed on the PANSS, and compared with a control group of 23 inpatients receiving pharmacotherapy and routine clinical care only.

Results: Patients receiving SSGT showed a 22% decrease in total symptom severity on the PANSS. The improvement occurred on the positive, negative, and general symptom scales, and on four of the five PANSS factors: negative symptoms, dysphoric mood, activation, and autistic preoccupation. Controls did not show a change from baseline.

Conclusions: Both the study and control groups were receiving medication plus routine care, and had symptoms in the mild to moderate range. The results suggest that improvement in symptoms with pharmacotherapy plateaus. The addition of symptom-specific groups using cognitive-behavioral and psychoeducational methods leads to further significant improvements. The treatment groups of our program have been manualized, and we are planning a double-blind, random-allocation study.

REFERENCES:

1. Shelley AM, Battaglia J, Lucey J, Ellis A, Opler LA: Symptom-specific group therapy for inpatients with schizophrenia. Einstein Quarterly, in press
2. Opler LA, Ramirez PM: Use of the Positive and Negative Syndrome Scale (PANSS) in clinical practice. Journal of Practical Psychiatry and Behavioral Health 1998; 4:157–162

TARGET AUDIENCE:

Clinicians and researchers working with patients with psychotic symptoms.

Poster 83 **Friday, October 12 3:30 p.m.-5:00 p.m.**

TWO QTC PROLONGATION WITH ZIPRASIDONE IN THE ELDERLY

John D. Justice, M.D., *Medical Director, West Virginia Forensic Institute, 4825 MacCorkle Avenue, S.W., Suite C, South Charleston, WV 25309;* Daniel B. Thistlethwaite, M.D., *Chief of Psychiatry, Thomas Memorial Hospital, 4825 MacCorkle Avenue S.W., Suite C, South Charleston, WV 25309-1331;* Russell I. Voltin, M.D.; Timothy L. Thistlethwaite, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to have a better understanding of the risk of QTc prolongation with the atypical antipsychotic ziprasidone in the elderly and how to recognize patients at potential risk.

SUMMARY:

Background: Ziprasidone was recently approved by the FDA for the treatment of schizophrenia. It is important to be aware that ziprasidone does have the potential to prolong the QT interval more so than currently available atypical antipsychotics. We report two cases of QTc prolongation in the elderly.

Results: Case 1, an 86-year-old female was hospitalized due to agitation. Medical history: bipolar disorder, dementia, coronary artery disease, hyperthyroidism, hypertension, glaucoma, and Parkinson's disease. ECG performed two days prior to the start of ziprasidone revealed a QTc interval of 439 msec. Within two weeks of starting ziprasidone, the QTc interval was 559 msec.

Ziprasidone was discontinued and three days later the QTc decreased to 478 msec.

Case 2, a 71-year-old male admitted to the psychiatric unit with increased aggressive behavior due to Alzheimer's disease. Ziprasidone 20 mg twice daily was initiated. Pretreatment ECG was 408 msec. A week after initiation of treatment, RB displayed an increase in agitation. ECG at this time showed a QTc of 486 msec. Ziprasidone was discontinued and olanzapine 10 mg was initiated. Three days following this change, his QTc decreased to 424 msec.

Conclusion: Data are limited regarding the effect of ziprasidone on the QT interval in the elderly and in the meantime we recommend that ziprasidone be used with caution in the elderly.

REFERENCES:

1. De Brynue MC, Hoes AW, Kors JA, Hofman A, van Bemmel JH, Grobbe DE: QTc dispersion predicts cardiac mortality in the elderly: The Rotterdam Study. Circulation 1998;97:467–472.
2. Welch R, Chue P: Antipsychotic agents and QT changes. J Psychiatry and Neurosci 2000;25(2):154–60.

Poster 84 **Friday, October 12 3:30 p.m.-5:00 p.m.**

THE EFFECT OF OLANZAPINE ON DYSKINETIC MOVEMENTS IN PSYCHOTIC PATIENTS

Eli Lilly and Company

Jaspreet S. Brar, M.D., *Senior Program Coordinator, Western Psychiatric Institute and Clinic, 3501 Forbes Avenue, Room 412, Pittsburgh, PA 15213;* K.N. Roy Chengappa, M.D.; Ranjit Chalasani, M.D.; Haranath Parepally, M.D.

EDUCATIONAL OBJECTIVES:

This study compares the prevalence and severity of dyskinetic movements in patients treated with olanzapine or conventional antipsychotic medications, and underscores the importance olanzapine as a useful alternative antipsychotic medication for patients with tardive dyskinesia.

SUMMARY:

We evaluated the effect of treatment with olanzapine on the prevalence and severity of dyskinetic movements in patients with schizophrenia and other psychotic disorders. The sample was comprised of 69 newly admitted patients who were treated either with olanzapine (n=35) or with conventional antipsychotic agents (n=34). The prevalence of tardive dyskinesia as defined by Schooler-Kane criteria, and the severity as defined by the AIMS total score (items 1–7) was examined at baseline, at eight weeks and at six months in the two groups. There were no significant differences in the numbers of patients who met the TD criteria at baseline in the two groups. While there were trends suggesting a decreased prevalence of TD in the olanzapine group as compared with the group treated with conventional agents at eight weeks (X^2=3.35, p=0.067), these differences reached statistical significance at six months (X^2=8.99, p=0.003). Intragroup comparisons revealed a significant reduction in the prevalence of TD from baseline to eight weeks in the olanzapine group (p=0.039) but not in the group treated with conventional agents. Similar differences were observed in the severity of dyskinetic symptoms in the two study groups. Olanzapine may be a useful alternative antipsychotic medication for patients with tardive dyskinesia. The implications of these findings will be discussed.

REFERENCES:

1. Schooler NR, Kane JM: Research diagnosis for tardive dyskinesia. Archives of General Psychiatry 1982; 39(4): 486–7.
2. Beasley CM, Dellva MA, Tamura RN, Morgenstern H, et al: Randomised double-blind comparison of the incidence of tardive dyskinesia in patients with schizophrenia during long-term treatment of olanzapine or haloperidol. British Journal of Psychiatry 1999; 174(1): 23–30.

TARGET AUDIENCE:

Psychiatrists, social workers, and clinicians who treat patients with psychotic disorders

Poster 85 **Friday, October 12 3:30 p.m.-5:00 p.m.**

USE OF QUETIAPINE FOR THE TREATMENT OF ANTISOCIAL PERSONALITY DISORDER IN A MAXIMUM SECURITY INPATIENT FORENSIC PSYCHIATRIC FACILITY

AstraZeneca Pharmaceuticals

Candace L. Walker, M.D., *Staff Psychiatrist, Kentucky Correctional Facility, 1612 Dawkins Road, La Grange, KY 40031-9716;* Janice M. Thomas, M.D.; Timothy S. Allen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to realize there have been few effective treatments of antisocial personality disorder; quetiapine has demonstrated efficacy in aggression, impulsivity,

and irritability; quetiapine has a favorable adverse-event profile, and patients are willing to comply with it.

SUMMARY:

Objective: There have been few effective treatments of antisocial personality disorder. Preliminary work suggests that quetiapine can be valuable in decreasing irritability, impulsivity, and aggressiveness.

Methods: We collected data from four patients with antisocial personality disorder who were referred to a maximum-security inpatient forensic psychiatric facility for pretrial evaluation. The patients were treated with the atypical antipsychotic quetiapine for relief of symptoms associated with antisocial personality disorder.

Results: Quetiapine was effective in three of the four patients with severe antisocial personality disorder. Efficacy was indicated as a decrease in symptoms such as impulsivity, hostility, aggressiveness, irritability, and rage reactions. Typical dosage was 600 to 800 mg/d. Patients attribute their willingness to comply with quetiapine treatment to both the effectiveness of the drug and its favorable adverse-event profile. Quetiapine was successfully combined with mood stabilizers, particularly gabapentin, in patients in whom affective instability was prominent.

Conclusions: Quetiapine has demonstrated efficacy in aggression, impulsivity, and irritability and has proved to be an effective medication in patients with antisocial personality disorder. In addition, its favorable adverse-event profile makes patients willing to comply with it.

REFERENCES:

1. Dinwiddie SH: Psychiatric genetics and forensic psychiatry: a review. Bull Am Acad Psychiatry Law 1994;22:327–41.
2. Woody GE, Mclellan AT, Loborsky L, O'Brien CP: Sociopathy and psychotherapy outcome. Arch Gen Psych 42:1081–6.

TARGET AUDIENCE:

Psychiatrists

Poster 86 **Friday, October 12 3:30 p.m.-5:00 p.m.**

QUETIAPINE TREATMENT OF RAPID CYCLING BIPOLAR DISORDER: AN OPEN PROSPECTIVE STUDY

AstraZeneca Pharmaceuticals

James Ko, *Research Coordinator, Department of Psychiatry, Cambridge Hospital, 1493 Cambridge Street, Macht 111, Cambridge, MA 02139;* Nassir Ghaemi, M.D.; J. M. Goldberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that quetiapine improves rapid-cycling symptoms in bipolar disorder.

SUMMARY:

Objective: To study the effectiveness of quetiapine in patients with rapid-cycling bipolar disorder.

Method: This study is designed to recruit 40 bipolar I rapid-cycling subjects with up to one year of open, prospective follow-up of quetiapine treatment, with or without a concomitant mood stabilizer. We have recruited 16 subjects who have received regular HDRS and YMRS assessments, along with CGI for Bipolar Disorder (CGI-BP) and daily mood chart ratings. Patients enter the study with any mood symptomatology severe enough to require added medication intervention. Eight subjects received concomitant lithium and/or divalproex or concomitant lamotrigine. One patient was taking an antidepressant (fluoxetine).

Results: Mean dosage of quetiapine was 159.4±161.5 mg/d. There was improvement in HDRS and YMRS ratings. At week 8, depressive symptom improvement trended towards statistical significance, but not at week 12. Manic symptom improvement was statistically significant at weeks 4 and 12. CGI-BP ratings indicated improvement in both manic and depressive symptoms for week 2 onwards, with statistical significance for manic symptoms at week 4, and overall bipolar illness at weeks 4 and 8.

Conclusions: In this preliminary analysis of a partially recruited data set, early indications at three-month follow-up are that quetiapine improves rapid-cycling symptoms in bipolar disorder.

REFERENCES:

1. Post RM, et al: Bipolar Disord 2000;2:305–15.
2. Ghaemi SN: J Clin Psychiatry 2000;61:33–42.

TARGET AUDIENCE:

Psychiatrists

Poster 87 **Friday, October 12 3:30 p.m.-5:00 p.m.**

QUETIAPINE EFFECTIVELY TREATS BIPOLAR DISORDER AND ADHD IN ADOLESCENT PATIENTS

AstraZeneca Pharmaceuticals

J. Philip Reimherr, M.D., *Psychiatric Group, 30 Boston Street, Lynn, MA 01904*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that quetiapine is effective in treating symptoms of bipolar disorder and attention-deficit hyperactivity disorder (ADHD) in adolescent patients.

SUMMARY:

Introduction: Patients with bipolar disorder experience mood swings characterized by hyperactivity, irritability, and exaggerated self-confidence, alternating with depressive episodes characterized by sadness and hopelessness. Children with attention deficit/hyperactivity disorder (ADHD) display symptoms of inappropriate overactivity, inattention, academic underachievement, and impulsive behavior. Although conventional medications often produce limited efficacy, quetiapine can successfully alleviate and stabilize these symptoms.

Methods: Twelve adolescent patients diagnosed with bipolar disorder and ADHD displayed symptoms that included major depression, auditory hallucinations, disorganized thinking, irritability, hyperactivity, and episodes of rage. These patients had previously been treated with standard medications, all of which produced limited efficacy.

Results: When given quetiapine in doses of 75 to 600 mg/d, these 12 patients experienced substantial relief of their psychotic symptoms, hallucinations and delusions disappeared, mood disorders stabilized, and aggressive behavior improved markedly. Quetiapine was well tolerated and produced no EPS side effects.

Conclusions: Quetiapine produces marked cognitive and behavioral improvement in adolescent patients with bipolar disorder and ADHD, without adverse cholinergic or EPS side effects. Quetiapine is effective in treating symptoms of bipolar disorder and ADHD in adolescent patients.

REFERENCES:

1. Gottschalk A, et al: Arch Gen Psychiatry 1995;52:947–59.
2. Himmelhock JM, et al: Arch Gen Psychiatry 1976;33:1062–66.

TARGET AUDIENCE:

Psychiatrists

Poster 88 **Friday, October 12 3:30 p.m.-5:00 p.m.**

AN OPEN TRIAL OF QUETIAPINE IN ADOLESCENTS WITH A DIAGNOSIS OF A PSYCHOTIC DISORDER

AstraZeneca Pharmaceuticals

Jon A. Shaw, M.D., *Professor and Director, Division of Child Psychiatry, University of Miami School of Medicine, 1695 N.W. 9th Avenue, Room 1404-A, Miami, FL 33136;* Shlomo Pascal, M.D.; R. Sharma, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize the efficacy and tolerability of treatment with quetiapine in adolescents with psychosis, and realize that quetiapine is an effective treatment for psychotic disorders.

SUMMARY:

Objective: To study the effectiveness, safety, and tolerability of quetiapine in psychotic adolescents.

Methods: This eight-week, open trial studied effectiveness, safety, and tolerability using quetiapine with 15 adolescents (aged 13–17 years; mean age 15 years), with a diagnosis of a psychotic disorder (11 had diagnoses of schizophrenia or schizoaffective disorder). Primary measures included the BPRS, CGI, SANS, SAPS, and the Barnes Akathisia Scale. Secondary measures included adverse events, clinical laboratory tests, vital signs, electrocardiograms, and ophthalmologic examinations.

Results: Quetiapine significantly reduced psychotic symptoms and psychological dysfunction as measured by the BPRS, PANSS, YMRS, and CGI-Severity of Illness scores. The average weight gain was 4.1 kg. There was a slight increase in cholesterol and TSH, and a reduction in T_4. Common adverse effects were somnolence, agitation, drowsiness, and headache. No significant findings were noted on repeat electrocardiograms, EPS measures, prolactin levels, or ophthalmic examinations. The final average treatment dose was 467 mg/d.

Conclusion: Quetiapine is proved to be effective in psychotic adolescents and to have a favorable side-effect profile.

REFERENCES:

1. McConville B, et al: J Clin Psychiatry 2000;61:252–60.
2. Goldstein JM: Drugs Today 1999;35:192–210.

TARGET AUDIENCE:

Psychiatrists

Poster 89 **Friday, October 12 3:30 p.m.-5:00 p.m.**

EFFECTIVENESS OF QUETIAPINE IN PATIENTS WITH DUAL DIAGNOSIS

AstraZeneca Pharmaceuticals

Herbert A. Cruz, M.D., *Associate Clinical Instructor, Fresno County Health, 441 East Kings Canyon Road, Fresno, CA 93702*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to Understand that alleviating the symptoms of schizophrenia in a patient with dual diagnosis may reduce the patient's need to abuse chemicals to cope and that atypical agents may be better suited than typical agents to relieve the symptoms of schizophrenia.

SUMMARY:

Objective: To assess the effectiveness of quetiapine in treating delusions and hallucinations associated with schizophrenia in a patient with dual diagnosis.

Methods: We chronicled the case history of a 38-year-old man who was institutionalized for psychotic symptoms, suicidal ideation, and alcoholism. He was treated and then released to an outpatient dual-diagnosis program. His symptoms worsened during therapy with several typical antipsychotics, and side effects emerged. He developed dystonia, necessitating diphenhydramine. The diphenhydramine improved the dystonia but caused insatiable thirst. Due to his history of adverse reactions to typical antipsychotics, his good premorbid level of functioning, and the strong affective component of his illness, it was decided to change to quetiapine.

Results: After two weeks of quetiapine monotherapy, the patient demonstrated marked improvement, and his affect and hygiene had improved dramatically. His urge to ingest drugs and alcohol had ceased. After 18 months, the patient is living independently and resolving his personal problems.

Conclusions: Quetiapine is successful in treating the symptoms of schizophrenia in those patients also abusing alcohol or drugs. Alleviating the symptoms of schizophrenia may reduce the patient's need to abuse chemicals. The long-term utility of quetiapine in substance-induced or complicated psychotic disorder management warrants further investigation.

REFERENCES:

1. Duncan JC, Rogers R: Medications compliance in patients with chronic schizophrenia: implications for the community management of mentally disordered offenders. Journal of Forensic Sciences 1998;43:1133–1137.
2. Wiederanders MR, Choate PA: Beyond recidivism: measuring community adjustments of conditionally released insanity acquittees. Psychiatry Assessment 1994;19:61–66.

TARGET AUDIENCE:

Psychiatrists

Poster 90 **Friday, October 12**
3:30 p.m.-5:00 p.m.

QUETIAPINE FOR PSYCHOSIS IN PATIENTS WITH PARKINSON'S DISEASE

AstraZeneca Pharmaceuticals

Vicki J. Roberts, Ph.D., *Director of Neuropsychology, Neuropsychology Clinic, 1244 Clairmont Road, N.E., Atlanta, GA 30030;* Jorge L. Juncos, M.D.; C. D. Wood, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should realize that quetiapine is a safe and effective agent in the treatment of psychotic symptoms in patients with Parkinson's disease.

SUMMARY:

Purpose: To examine the effects of quetiapine on psychosis and cognition in 29 patients with Parkinson's disease who received up to 400 mg/d quetiapine, dosed according to clinical response and tolerability.

Methods: This was a 24-week, single-center, open-label study, during which we assessed psychiatric, motor, and cognitive functions at baseline and at periodic intervals. Assessments included the Brief Psychiatric Rating Scale (BPRS), Neuropsychiatric Inventory (NPI), Unified Parkinson's Disease Rating Scale (UPDRS), and tests of overall cognition, attention, and memory. Statistical analyses were used to assess change from baseline in psychiatric, motor, and cognitive measures. Additionally, we compared cognitive changes across time between our treatment group and a control group of 12 nonpsychotic patients with Parkinson's disease.

Results: Compared with baseline, our treatment group exhibited significant improvements in the 24-week BPRS total and NPI psychosis subscale scores and no decline in UPDRS total or motor subscale scores. On cognitive measures, significant treatment versus control group differences emerged only for sustained attention and delayed recall. Specifically, the control group exhibited no change in recall and significant decline in sustained attention, whereas the quetiapine group exhibited significant improvement in recall and nominal improvement in sustained attention.

Conclusions: Quetiapine is effective in improving both cognitive function and psychotic symptoms in patients with Parkinson's disease.

REFERENCES:

1. Friedman JH, Factor SA: Atypical antipsychotics in the treatment of drug-induced psychosis in Parkinson's disease. Movement Disorders 2000;15:201–211.

2. Yeung PP, Tairot PN, Schneider LS, et al: Quetiapine for elderly patients with psychotic disorders. Psychiatric Annals 2000;30:197–201.

TARGET AUDIENCE:

Psychiatrists

Poster 91 **Friday, October 12**
3:30 p.m.-5:00 p.m.

PSYCHIATRIC SERVICES FOR PATIENTS WITH MENTAL RETARDATION IN A COMMUNITY PSYCHIATRY CLINIC

Gerard Gallucci, M.D., J.D., *Director of Community Psychiatry, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, Baltimore, MD 21224;* Marie Cournoyer, R.N., *Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, Baltimore, MD 21224;* Florence Hackerman, L.C.P.; Donald Dyson, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the organization of psychiatric services for patients with mental retardation/developmental disabilities in a community psychiatry clinic. In addition, participants will understand the impact of these services on a variety of critical outcomes.

SUMMARY:

The special needs clinic is a component of the Community Psychiatry Program at the Johns Hopkins Bayview Medical Center and was developed to provide comprehensive mental health services for adults with psychiatric illness and mental retardation or developmental disabilities. This is a largely underserved population with unique and complex mental health needs. A multidisciplinary team staffs the program. Referrals have been accepted from other mental health providers, medical providers, DDA service coordinators, and from family members or other care providers. Services include evaluation and consultation, individual and family therapy, psychopharmacological management, and coordination of care with other health professionals. The program also provides case management services designed to assist clients in obtaining eligibility for Developmental Disabilities Administration services such as housing, respite, in-home support, and day programming.

Performance indicators will measure the effectiveness of the special needs clinic in a variety of areas including client/family satisfaction, improved functioning of the client, housing stability, reduction of crises and emergency room utilization, reduction in hospital days, linkage with somatic providers, and vocational placement. A description of the psychiatric diagnoses, treatment modalities and demographic characteristics of patients seen in the special needs clinic will be provided.

REFERENCES:

1. Sovner R, Hurley AD: Ten diagnostic principles for recognizing psychiatric disorders in mentally retarded persons. Psychiatric Aspects of Mental Retardation Reviews 1989;8:9–14.
2. Eaton LF, Menolascino FJ: Psychiatric disorders in the mentally retarded: types, problems, and challenges. Am J Psychiatry 1982;139:1297–1303.

TARGET AUDIENCE:

Physicians, nurses, social workers, mental health therapists

Poster 92 **Friday, October 12**
3:30 p.m.-5:00 p.m.

PSYCHOTROPIC PRESCRIBING GUIDELINES: PSYCHIATRISTS' PERSPECTIVES

Karen K. Milner, M.D., *Assistant Clinical Professor of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0020;* Mona Goldman, Ph.D.; Timothy D. Florence, M.D.; Rebecca F. Shriberg, M.S.W.; Frederic Blow, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss physician factors related to guideline acceptance and implementation.

SUMMARY:

As part of a larger project to evaluate the feasibility of using treatment guidelines for prescribing psychotropic medication in a CMHC, we developed a survey to look at use of, familiarity with, and attitudes toward guidelines generally and the Texas Medication Algorithm Project (TMAP) specifically. The 22-page survey was distributed to 24 psychiatrists working in four CMHCs in a regional consortium; 13 completed the survey. Ninety percent of the psychiatrists agreed that guidelines should be general and flexible, as opposed to specific and prescriptive. The majority agreed that guidelines should define how to measure response to a specific agent; fewer agreed that guidelines should specify dosage, side-effect management, or augmentation strategies. Psychiatrists were generally familiar with the TMAP algorithms, but none referred to it in their practice. Overall, variability in the level of agreement with the use of specific psychotropic agents at certain algorithmic stages was demonstrated. Perhaps more interestingly, disagreement

as to which factors (i.e., effectiveness, cost, patient preference, etc.) should be weighed most heavily in making prescribing decisions was noted. Disagreement with guidelines may result in lack of acceptance. The need for consensus building and local tailoring prior to guideline dissemination is demonstrated.

REFERENCES:

1. Miller AL, Chiles JA, Chiles JK, et al: The Texas Medication Algorithm Project (TMAP) schizophrenia algorithms. Journal of Clinical Psychiatry 1999;60:649–657
2. Cabana MD, Rand CS, Powe NR, et al: Why don't physicians follow clinical practice guidelines?: a framework for improvement. Journal of the American Medical Association 1999;282:1458–1465

TARGET AUDIENCE:

Psychiatrists; administrators

Poster 93 **Friday, October 12 3:30 p.m.-5:00 p.m.**

RISPERIDONE IN CHILDREN WITH VARIOUS DISRUPTIVE BEHAVIOR DISORDERS

Janssen Pharmaceutica

Atilla Turgay, M.D., *Chief of Psychiatry, The Scarborough Hospital, 3040 Lawerence Avenue, East, Scarborough, ON Canada M1P 2V5;* Michael G. Aman, M.D.; Carin Binder, B.S.C.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to assess the benefits of risperidone in rearing children with conduct and other disruptive behavior disorders.

SUMMARY:

Objective: Test the hypothesis that risperidone is effective in treating symptoms of ADHD in children with a concomitant diagnosis of ADHD associated with subaverage IQ and conduct and disorder, oppositional defiant disorder, or disruptive behavior disorder NOS.

Method: 218 children, 5–12 years, IQ 36–84 with various disruptive behavior disorders were randomized in a six-week, double-blind trial to risperidone or placebo. Comorbid ADHD existed in 155/218 children treated with/without psychostimulants. Psychostimulants were initiated prior to trial entry and maintained at stable doses throughout the trial.

Results: Mean dose of risperidone was 1.11 mg/kg/day (mean daily dose was 0.98mg). The Hyperactivity subscale of the Nisonger Child Behavior Rating Form (NCBRF) and Hyperactivity/Noncompliance subscale of the Aberrant Behavior Checklist both showed a significant decrease in children treated with risperidone. The effect was detected in the risperidone with/without psychostimulant groups when compared with placebo with/without psychostimulants indicating that the efficacy of risperidone is independent from concomitant use of psychostimulants. No unexpected adverse events or laboratory findings were noted in either group.

Conclusions: Risperidone is effective and safe in reducing symptoms of comorbid ADHD in children with sub average IQ and various disruptive behavior disorders.

REFERENCES:

1. Findling RL, McNamara NK, Branicky LA, et al: A double-blind pilot study of risperidone in the treatment of conduct disorder. J Am Acad Child Adolesc Psychiatry 2000;39:509–516
2. Vanden Borre R, Vermoic R, Burnens M. et al: Risperidone as add-on therapy in behavioural disturbances in mental retardation: a double-blind placebo-controlled cross-over study. Acta Psychiatr Scand 1993;87:167–171.

Poster 94 **WITHDRAWN**

Poster 95 **Friday, October 12 3:30 p.m.-5:00 p.m.**

RELATIONSHIP OF LENGTH OF STAY TO ATYPICAL ANTIPSYCHOTIC USE AMONG GEROPSYCHIATRIC INPATIENTS WITH DEMENTIA OF THE ALZHEIMER'S TYPE

Janssen Pharmaceutica

Marcia Rupnow, Ph.D., *Manager, CNS Outcomes Research, Janssen Pharmaceutica, 1125 Trenton-Harbourton Road, Titusville, NJ 08560;* George Papadopoulous, B.S.C.; William S. Edell, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to compare the costs of inpatient length of stay between atypical antipsychotics.

SUMMARY:

Objective: To examine the inpatient length of stay (LOS) associated with antipsychotics (olanzapine, quetiapine, and risperidone) in patients with dementia of the Alzheimer's Type (DAT).

Method: Data were obtained from the CQI+^{SM} Outcomes Measurement System, which tracked patients ad-

mitted to inpatient programs in 111 general hospitals across 33 states between 1997–1999. A Medication Usage Questionnaire was used to track prescribed medications. LOS was captured from the medical record. We only included patients who were taking one antipsychotic agent.

Results: Group sizes at discharge were olanzapine (n=66), quetiapine (n=41), and risperidone (n=147). Groups did not differ at admission in age, education, marital status, level of depression, and overall physical and mental health status. Patients taking risperidone (12.3 days) at discharge had a *shorter* LOS than those taking quetiapine (16.4 days) ($p<.02$) or olanzapine (14.9 days) ($p<.08$), with little evidence for different clinical outcomes.

Conclusions: Patients taking risperidone were hospitalized, on average, four fewer days than patients taking quetiapine, and about two and a half fewer days than those taking olanzapine. Using a conservative estimate of $492.00 for cost per day in the hospital, these findings suggest that savings per patient for those prescribed risperidone was $1,279.20 to $2,017.20 as compared with olanzapine or quetiapine, respectively.

REFERENCES:

1. Jeste DV, Finkel SI: Psychosis of Alzheimer's disease and related dementias: diagnostic criteria for a distinct syndrome. Am J Geriatr Psychiatry 2000; 8:29–34.
2. Inouye SK, Bogardus ST, Charpentier PA, et al: A multicomponent intervention to prevent delirium in hospitalized older patients. N Engl J Med 1999; 340(9):669–676.

Poster 96 **Friday, October 12**
3:30 p.m.-5:00 p.m.

RISPERIDONE IN BORDERLINE PERSONALITY DISORDER

Janssen Pharmaceutica

Alan H. Lai, M.D., *Assistant Clinical Professor of Psychiatry, and Director, Partial Hospitalization Program, University of California at San Diego, 401 Parnassus Avenue, Box F-0984, San Francisco, CA 94143*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to review the efficacy of risperidone in the treatment of patients with borderline personality disorder.

SUMMARY:

Background: Four case reports are presented of marked improvement in patients with borderline personality disorder and depression treated with risperidone in conjunction with an antidepressant.

Methods and Results: Case 1 has a long history of identity disturbance, impulsivity, self-mutilating behavior and was hospitalized after a suicide attempt. After the addition of 2 mg/day of risperidone to nefazodone, the patient was relaxed and self-assured and had decreased anxiety, and suicidal ideations. *Case 2* has a long history of depression and sustained childhood sexual trauma and was hospitalized because of increasing suicidal ideation. After the addition of risperidone (1.5 mg) to an SSRI, the patient had decreased dissociative episodes and reported fewer suicidal impulses. *Case 3* has a history of cutting behavior, dissociative episodes, and affective instability and was hospitalized for increasing depressive symptoms and suicidal ideations. Adjunct risperidone (1.5 mg) with sertraline resulted in control of suicidal impulses with fewer flashbacks of childhood trauma. *Case 4* has a history of sustained childhood physical abuse, recurrent suicidal ideation, and affective instability. Adjunct risperidone (1.5 mg) with nefazodone resulted in increased ability to tolerate rage and to take care of her children.

Conclusions: Risperidone appeared to be an effective adjunctive medication for patients with borderline personality disorder with an improved ability to tolerate overwhelming emotions with no side effects.

REFERENCES:

1. Montgomery SA, Montgomery D: Pharmacologic prevention of suicidal behavior. J Affect Disorders 1982;4:291–298.
2. Cornelius JR, Soloff PH, Perel JM, et al: Continuation pharmacotherapy of borderline personality disorder with haloperidol and phenelzine. Am J Psychiatry 1993;150:1843–1848.

Poster 97 **Friday, October 12**
3:30 p.m.-5:00 p.m.

THE USE OF RISPERIDONE IN ADULTS WITH MENTAL RETARDATION AND AUTISM

Janssen Pharmaceutica

Patricia Brierly-Bowers, Ed.D., *200 Rosewood Lane, Owen Mills, MD 21117;* Judy Curtis, Pharm.D.; Syeda Nasreen R. Hafiz, M.D.; Lisa S. Hovermale, M.D.; Stanley R. Platman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to assess the benefits of risperidone in treating adults with autism and mental retardation.

SUMMARY:

Background: Previously, behavior disorders of mental retardation and autism were only treated with neuroleptics and/or benzodiazepines without much improvement, or perhaps worsening of symptomology. Atypical antipsychotics, particularly risperidone, have become a first-choice medicine in the treatment of aggression, self-injury stereotypes of autism, and in the treatment of behavior disorders of mental retardation.

Methods: Thirty adults with mental retardation and autistic traits residing at a state residential facility were given open label trials of risperidone. Ten of these patients had previously failed trials of selective serotonin reuptake inhibitors. For each patient, baseline data were taken on specific behaviors related to their autistic traits. These behaviors include but are not limited to social withdrawal, ritualistic behaviors, and restricted interests.

Results: Risperidone was started at 0.5 mg daily and nirrated upwards until maximum clinical benefit occurred. Risperidone (1–3 mg daily) in these patients was associated with significant reduction of aggression, rituals, self-injury, and agitation. Eighty percent of this sample demonstrated a significant improvement in the target symptoms. Individual case reports will be presented.

Conclusions: Risperidone in low doses appears to significantly alter symptoms of autism in individuals with mental retardation.

REFERENCES:

1. Baker RW, Bermanzohn PC, Wirshing DA, Chengappa KN: Obsessions, compulsions, clozapine and risperidone. CNS Spectrums 1999;2:26–71.
2. Borre V, Vermote R, Burriens R, et al: Risperidone as add-on therapy in behavioral disturbances in mental retardation: a double-blind placebo-controlled crossover study. Acta Psychiatr Scand 1993;87:167–171.

Poster 98 **Friday, October 12 3:30 p.m.-5:00 p.m.**

PHARMACOLOGIC MANAGEMENT OF ACUTE DELIRIUM: A NATURALISTIC PROSPECTIVE

Janssen Pharmaceutica

Larry E. Tune, M.D., *265 Ledgemont Court, Atlanta, GA 30342;* D. Jewert, Ph.D.; S. Egeli, M.D.; Y. Green, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to compare the effects of atypical and conventional antipsychotics in the treatment of delirium in the elderly.

SUMMARY:

Purpose: In an ongoing prospective investigation of elderly demented patients, the efficacy and safety of atypical antipsychotics and haloperidol for the management of delirium were evaluated.

Methods: All patients satisfied DSM IV criteria for delirium. Patients were evaluated with the Confusion Assessment Method, the MMSE, the Cognitive Test for Delirium, the Simpson Scale for EPS, and the Pittsburgh Agitation Scale.

Results: Among the 52 patients studied to date, 15 received monotherapy with risperidone, five with olanzapine, and seven with quetiapine, nine received standing doses of haloperidol, seven pm haloperidol, and nine a combination of typical and atypical antipsychotics. Average length of stay (ALOS) was 13.8 days for patients receiving all atypicals, 13.4 days for standing doses of haloperidol, 29.4 days for pm haloperidol, and 22.3 days for the combination group EPS ratings improved overall in patients receiving atypicals, while those receiving combination antipsychotics or haloperidol alone showed significant deterioration in EPS.

Conclusions: These preliminary data show the superiority of atypical antipsychotics to standard therapy with haloperidol and especially to combination therapy with typical and atypical antipsychotics, for the management of acute delirium in elderly patients with dementia.

REFERENCES:

1. Mintzer JE, Madhusoodanan S, Brenner R: Risperidone in dementia. Psychiatr Ann 2000;30:181–187.
2. Jeste DV, Rockwell E, Harris MJ, et al: Conventional vs newer antipsychotics in elderly patients. Am J Geriatr Psychiatry 1999;7:70–76.

Poster 99 **Friday, October 12 3:30 p.m.-5:00 p.m.**

PROBENCID EFFECTS ON THE DISPOSITION OF OLANZAPINE AND RISPERIDONE

Janssen Pharmaceutica

John Markowitz, M.D., *Department of Behavioral Sciences, Medical University of South Carolina, 395 Col Vanderhorst Circle, Mt. Pleasant, SC 29466;* C. Lindsay DeVane, Pharm.D.; David Boulton, Ph.D.; Heidi Liston, Pharm.D.; S. Craig Risch, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the role of conjugative processes in the metabolism of two atypical antipsychotics.

SUMMARY:

Introduction: We compared the effect of probenecid (PB), a known inhibitor of UDP-glucuronosyltransferases (UDPGT) on the disposition of risperidone and olanzapine. It was hypothesized that the disposition of olanzapine, which undergoes extensive glucuronidation would be altered in the presence of probenecid, while risperidone disposition would be relatively unaffected.

Methods: In a single-dose, randomized, four-period, double-blind, crossover study, 12 healthy volunteers, aged 22–42 years, received a single dose of 5 mg of olanzapine or 1 mg of risperidone with and without PB 500 mg (eight doses over four days). Multiple blood samples were analyzed to assess the 48-hour time course of risperidone and olanzapine. Urine was assayed for free and glucuronidated drugs.

Results: Significant differences were observed between plasma pharmacokinetic parameters (C_{max} [$p<0.05$], $AUC_{0.24}$ [$p<0.01$]; T_{max} [<0.001]) when olanzapine was administered with PB. Clearance and τ 1/2 β were not significantly different between the treatment phases. Risperidone pharmacokinetics were not significantly different.

Conclusion: Inhibition of UDPGT appeared to influence the disposition of olanzapine but not risperidone. Phase II metabolism may significantly influence the disposition of antipsychotic drugs and may be an important aspect in the variability in metabolism, participation in drug-drug interactions, and clinical response to these agents.

REFERENCES:

1. Kassahun K, Mamuz E, Nyhart E, et al: Disposition and biotransformation of the antipsychotic agent olanzapine in humans. Drug Metab Dispos 1997;25:81–93.
2. Liston H, Markowitz JS, DeVane CL Glucuronidation: Implications in psychopharmacology. J Clin Psychopharmacol, (in press, 2001).

Poster 100 **Friday, October 12 3:30 p.m.-5:00 p.m.**

RISPERIDONE IN CHILDREN AND ADOLESCENTS WITH SEVERE DISRUPTIVE BEHAVIOR DISORDERS

Janssen Pharmaceutica

Robert L. Findling, M.D., *Professor of Pediatrics and Adolescent Health, and Director, Division of Child and Adolescent Psychiatry, University of Cleveland Medical Center, 11100 Euclid Avenue, Cleveland, OH 44106-5080;* Joerg M. Fegert, M.D.; Goedele DeSmedt, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be able to evaluate the use of an atypical antipsychotic in children and adolescents with severe disruptive behaviors.

SUMMARY:

Objective: To evaluate the long-term safety and efficacy of oral risperidone in children with severe disruptive behavior disorders and subaverage intelligence quotient (IQ):

Method: One-year open-label, multicenter study of children, 5–12 years old, with severe disruptive behaviors (including conduct disorder, oppositional defiant disorder, and disruptive behavior disorder not otherwise specified) and IQ between 35 and 84, inclusive.

Results: Interior analysis of 266 boys and 53 girls shows a mean age of 9.6 years and mean IQ of 63.4. Mean mode daily dose of risperidone is 0.02 ± 0.001 mg/kg/day. At endpoint, mean improvement on the Conduct Problem subscale of the Nisonger Child Behavior Rating Form (N-CBRF) is 15.6 from a baseline of 32.7. ($P<0.001$). There are also statistically significant improvements on all subscales of the N-CBRF, on the Aberrant Behavior Checklist and on the Visual Analogue Scale of the most troublesome symptom. In 65.6% of subjects the Clinical Global Impression indicates no symptoms or very mild or mild symptoms at endpoint. The most common adverse event is somnolence (28.2%). Extrapyranudal Symptom Rating Scale scores are very low (0.7) and mean increase in body weight is 6.3 kg., at endpoint. Mean prolactin levels increase through week 4 and decrease thereafter.

Conclusion: Risperidone is affective and well tolerated in the population studied.

REFERENCES:

1. Van Bellinghen M, De Troch C: Risperidone in the treatment of behavioral disturbances in children and adolescents with borderline intellectual functioning: a double-blind, placebo controlled pilot trial. J Child Adolesc Psychopharmacol 2001;11:5–13.
2. Vanden Borre R, Vermote R, et al: Risperidone as add on therapy in behavioural disturbances in mental retardation: a double-blind placebo-controlled cross-over study. Acta Psychiatr Scand 1993;87:167–171.

Poster 101 **Friday, October 12 3:30 p.m.-5:00 p.m.**

THE USE OF RISPERIDONE IN TEN ADULTS WITH MENTAL RETARDATION AND UNDIFFERENTIATED DIAGNOSES

Janssen Pharmaceutica

Judy Curtis, Pharm.D., *Residency Program Coordinator, University of Maryland, 100 Penn Street, Room*

240-D, Baltimore, MD 21201; Patricia Brierly-Bowers, Ed.D.; Stanley R. Platman, M.D.; Lisa S. Hovermale, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to assess the benefits of risperidone in treating adults with mental retardation.

SUMMARY:

Purpose: To investigate the efficacy of risperidone alone or combined with valproic acid to control targeted symptoms in subjects with mild to moderate mental retardation.

Method: Subjects were 10 adult residents of a state residential facility with mild to moderate mental retardation and psychiatric symptoms from undifferentiated diagnoses. Previous medication trials with convention antipsychotics, mood stabilizers, and antidepressants had failed. Eight were treated with risperidone alone and two with risperidone plus valproic acid. Target symptoms included explosive aggression, sleep disturbance, bizarre verbalizations, disrobing, enuresis, and anhodonia.

Results and Conclusion: Doses were 1–5 mg/day of risperidone and 75–125 mcg/ml of valproic acid. All subjects demonstrated significant reduction in target symptoms with risperidone or risperidone plus valproic acid. There were no treatment emergent side effects except for weight gain.

REFERENCES:

1. Williams H, Clarke R, Bouras N, Martin J, Holt G: Use of the atypical antipsychotics Olanzapine and Risperidone in adults with Intellectual disability. J Intellect Disabil Res. 2000;44(Pt 2):164–9.
2. Cohen SA, Ihrig K, Lott RS, Kerick JM: Risperidone for aggression and self-injurious behavior in adults with mental retardation. J Autism Dev Disord 1998;28(3):229–33.

POSTER SESSION 4

Posters 102–137

Poster 102 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

THE SOCIAL COST OF GAMBLING DISORDERS IN LOUISIANA FOR 1998

James R. Westphal, M.D., *Professor, Department of Psychiatry, Louisiana State University Health Science Center, 1501 Kings Highway, Shreveport, LA 71130;* Lee Stevens, M.D., *Department of Psychiatry, Louisiana State University Health Science Center, 1501 Kings Highway, Room 3-412, Shreveport, LA 71130-3932;* Joyce Johnson, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) recognize the social impact of gambling disorders, and (2) understand the public health approach to gambling disorders.

SUMMARY:

Objectives: Estimate the social cost of adult gambling disorders in Louisiana in 1998.

Methods: A detailed social cost inventory (including gambling-related missing and impaired work days, welfare, unemployment, theft, bad debts, divorce, treatment, and arrests) was completed by all willing Gamblers' Anonymous and state-supported gambling treatment participants (n=77). The total annual social cost was estimated at $10,958 per year for each treated gambler and split into annual and lifetime components. A statewide gambling disorder prevalence study determined the current prevalence of problem (2.3%) and pathological gamblers (1.6%). The study estimated the social cost of the community sample by attributing both lifetime and annual social costs to community gamblers by the proportion of their gambling disorder symptoms as found by the South Oaks Gambling Screen (SOGS) to the median SOGS score of the treated gamblers. The community sample's social costs were extrapolated to the state's adult population.

Results: A cost of $486 million dollars of gambling disorders for 1998 in Louisiana.

Conclusion: Annual costs per treated gambler were in the range of previous studies using similar methodology. Although gambling disorders affect a small minority of the adult population, the resulting social costs are substantial.

REFERENCES:

1. Walker DM: The social cost of gambling: an economic perspective. Journal of Gambling Studies 1999; 15(3):181–212
2. Korn DA, Shaffer HJ: Gambling and the health of the public: adopting a public health perspective. Journal of Gambling Studies 1999; 15(4):289–365

TARGET AUDIENCE:

General psychiatrists and other mental health practitioners

Poster 103 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

DEPRESSIVE DISORDERS IN WOMEN WITH DISABILITY

Daniel P. Chapman, Ph.D., *Psychiatric Epidemiologist, Department of Health Care, Centers for Disease Control*

and Prevention, 4770 Buford Highway, N.E., MS K-45, Atlanta, GA 30341; Vincent Campbell, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the relationships between depression and both disability and health status among women with disabilities.

SUMMARY:

Prior assessments of the relationship between disability and depression among women have not examined the potentially mediating role of health status to the increased prevalence of depressive disorders in this population. In this investigation, data were analyzed from the National Health Interview Survey on Disability, Phase I, a probability sample household survey of health status in the U.S. civilian noninstitutionalized population (n= 41,012 women). Respondents were categorized as either unable to perform the major activity for their age group (i.e., attend school, work, keep house), limited in their major activity, limited in other activities (i.e., recreation, visiting friends, attending worship services), or as having no limitation. Respondents were asked if they frequently felt depressed or anxious; those who reported they had experienced depressed mood and loss of interest in almost all activities for at least two weeks in the preceding year were categorized as having experienced major depression. Respondents whose reported activity limitations were caused by a mental disorder were removed from the analysis. A significant positive association was observed between degree of disability and major depression. When health status variables were entered into the model, the relationship between disability and major depression was reduced, but remained statistically significant. These findings suggest that as depression cannot solely be attributed to health status among disabled women, the presence and severity of activity limitation remains a potentially important indicator of depressive disorders in women.

REFERENCES:

1. Koenig HG, George LK: Depression and physical disability outcomes in depressed medically ill hospitalized older adults. Am J Geriatr Psychiatry 1998;6:230–247.
2. Callahan CM, Wolinsky FD, Stump TE, Nienaber NA, et al: Mortality, symptoms, and functional impairment in late-life depression. J Gen Intern Med 1998;13:746–752.

TARGET AUDIENCE:

Psychiatrists, nonpsychiatric physicians, nurses, psychologists

Poster 104 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

DEPRESSED AFFECT IN SEXUALY ASSAULTED WOMEN: THE ROLE OF ADVERSE CHILDHOOD EXPERIENCES

Daniel P. Chapman, Ph.D., *Psychiatric Epidemiologist, Department of Health Care, Centers for Disease Control and Prevention, 4770 Buford Highway, N.E., MS K-45, Atlanta, GA 30341;* Robert F. Anda, M.D., *Epidemiologist, Centers for Disease Control, 4770 Buford Highway, N.E., MS K-47, Atlanta, GA 30341;* Shanta Dube, M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the role of adverse childhood experiences to the prevalence of sexual assault among women and to the presence of depressed affect among women who have been sexually assaulted.

SUMMARY:

While depression is a common sequelae of sexual assault in women, the influence of factors potentially mediating this relationship has not been widely examined. In this investigation, we assessed the associations of adverse childhood experiences (ACEs) with both the risk of sexual assault during adulthood and the likelihood of depressed affect among sexually assaulted women. We analyzed data from 5,060 women who received standardized medical evaluations at Kaiser-Permanente Health Appraisal Clinic in San Diego. Participants provided information about their history of sexual assault during adulthood and depressed affect and their exposure to each of nine ACEs, including various types of abuse and household dysfunction. A strong dose-response relationship emerged between the number of ACEs reported and the risk of adulthood sexual assault ($p < .0001$). Women reporting sexual assault during adulthood ($n = 548$) were over twice as likely as those who had not been sexually assaulted to manifest current depressed affect [OR = 2.3 (CI: 1.9–2.7)]. However, when ACE score was adjusted for, the odds of depressed affect decreased significantly [OR = 1.7 (CI: 1.4–2.1)] representing a population attributable risk reduction of 46%, ($p < .0001$). These findings suggest ACEs are important predictors of the risk of both adulthood sexual assault and the presence of depressed affect among women who have been sexually assaulted.

REFERENCES:

1. Anda RF, Felitti VJ, Chapman DP, et al: Abused boys, battered mothers, and male involvement in teen pregnancy. Pediatrics 2001; 107 (2), e19.
2. Felitti VJ, Anda RF, Nordenberg D, et al: Relationship of childhood abuse and household dysfunction

to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) Study. Am J Prev Med 1998; 14:245–258.

TARGET AUDIENCE:

Psychiatrists, nonpsychiatric physicians, psychologists

Poster 105 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

STABILITY OF DIAGNOSIS IN LONG-TERM PSYCHIATRIC HOSPITALIZATION

Michelle Troche-Panetto, M.D., *Psychiatry Resident, Albany Medical College, 75 New Scotland Avenue, Albany, NY 12208;* Panakkal David, M.D., *Staff Psychiatrist, Saratoga County Mental Health Center, 211 Church Street, Saratoga Springs, NY 12866;* Suzanne Boram, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the need for reevaluation of patients hospitalized long-term in State Psychiatric hospital, with the need for revising diagnosis and treatments.

SUMMARY:

There have been no published reports of stability of psychiatric diagnosis during long-term psychiatric hospitalization. A study of acutely hospitalized patients reported that the diagnosis changed 66% at the time of discharge. Studies have reported that diagnosis-related groups (DRGs) predict less than 10% of the variation in hospital length of stay. Our study consisted of independently re-evaluating patients hospitalized more than two years at a state hospital. We also looked at the change of primary diagnosis in the record since admission. The preliminary findings indicate that the diagnosis only changed 33% over time. Re-evaluation showed the need for revision of patient's primary diagnosis 83.4% of the time. The diagnostic change for one patient hospitalized for over 20 years, resulted in a change of pharmacological treatment. This patient's Global Assessment of Functioning (GAF) improved from 25 to 45. This study reinforces the need for re-evaluation of chronically hospitalized psychiatric patients by an independent team. The frequency of this would depend on available resources. This has probable implications for utilization of resources and length of stay in state psychiatric hospitals.

REFERENCES:

1. Hollister LE: Stability of psychiatric diagnosis among acutely ill patients. Clin Neuropharmacology 1998; 21(4):254–250.
2. McCrone P: Diagnosis and length of psychiatric inpatient stay. Hosp Community Psychiatry 1994; 45(10):1021–1025.

TARGET AUDIENCE:

Psychiatrists, state hospital administrators.

Poster 106 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

REDUCTION OF HOSPITAL DAYS IN CLOZAPINE-TREATED NONSCHIZOPHRENIC PATIENTS

Panakkal David, M.D., *Staff Psychiatrist, Saratoga County Mental Health Center, 211 Church Street, Saratoga Springs, NY 12866;* Dianne Waters, R.N., *Nurse, Community Mental Health Department, Saratoga County Mental Health Center, 211 Church Street, Saratoga Springs, NY 12866;* Manuel Astruck, M.D.; Ivan J. Engel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that clozapine has the potential to reduce the number of hospital days in patients without schizophrenia treated in a community mental health center

SUMMARY:

A previously published study reports that clozapine significantly reduced days in the hospital in a group of treatment-resistent patients with schizophrenia. Another study examined the hospital utilization in patients with schizophrenia treated with clozapine in a state mental health care system, showing that clozapine-treated patients required little or no hospitalization in the 1.5 years following initiation of clozapine.

There have been no published reports of reduction in hospital days for patients without schizophrenia treated with clozapine. We did a focused retrospective study of all the patients treated with clozapine at a community mental health clinic. All patients without any form of schizophrenia were selected and their total number of hospital days were calculated for one year before and two years after starting clozapine. Only one out of the seven patients had been rehospitalized in two years. The total number of hospital days decreased from 308 days to four days for the seven patients. The level of functioning also improved dramatically. Our study illustrates that there is potential for substantial cost savings and improved functioning in patients treated with clozapine, even in the absence of schizophrenia.

REFERENCES:

1. Dickson RA: Hospital days in clozapine-treated patients. Psychol Med 1977; 4:961–966.
2. Reid WH: Psychiatric hospital utilization in patients treated with clozapine for up to 4.5 years in a state mental health care system. J Ment Health Adm 1995 Winter; 22(1):58–67.

TARGET AUDIENCE:

Psychiatrists, community mental health nurses.

Poster 107 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

USE OF HOME MENTAL HEALTH NURSES TO REDUCE REHOSPITALIZATION IN ELDERLY DEPRESSED FEMALE PATIENTS

John F. Delaney, M.D., Dr. P.H., *Associate Professor, Department of Psychiatry, Temple University School of Medicine, 4815 Liberty Avenue, Suite 123, Pittsburgh, PA 15224*

EDUCATIONAL OBJECTIVES:

At the end of this presentation the participant should be able to recognize the value of home health psychiatric nurses in the care of the elderly depressed female.

SUMMARY:

Objective: The purpose of this study was to test the hypothesis that home health care by psychiatric nurses is effective in reducing the hospital readmission rate of elderly female patients with the diagnosis of late-life depression. Elderly is defined for this study as being 65 years of age or greater and less than 90 years of age.

Method: A retrospective chart review of 661 patient with the diagnosis of major depression admitted to the Western Pennsylvania Hospital, Pittsburgh, Pa., between 1997–1999 was conducted. This study was approved by the Institutional Review Boards of the University of Pittsburgh and the Western Pennsylvania Hospital. All male patient charts and all female patients who did not fall within the age parameters were eliminated from the study. Other exclusion criteria were: (1) prior electroconvulsive therapy (ECT), (2) transferred off the psychiatric unit for medical conditions during the initial stay for depression, (3) late-life depression with psychotic features, (4) stroke, (5) terminal carcinoma, (6) renal failure, (7) central nervous system degenerative diseases, (8) patients who had ever lived in skilled nursing facilities, incomplete medical records, and (9) charts of patients with missing data.

Results: The results demonstrated that 59 of the 67 patients (88.1%) who received home health care by a psychiatric nurse were not readmitted during the three years reviewed. Eight of the 67 patients (11.9%) who received home care were readmitted only one time.

Conclusion: These findings show that home health intervention by a psychiatric nurse was likely to have reduced hospital readmission in this sample.

REFERENCES:

1. Flaherty JH, McBride M, Marzouk S, Miller DK, et al: Decreasing hospitalization rates for older home care patients with symptoms of depression. Journal of the American Geriatric Society 1998; 46: 31–38
2. Reynolds CF, Schneider LS, Lebowitz BD: Diagnosis and Treatment of Depression in Late Life. Washington, D.C., American Psychiatric Press, 1994.

Poster 108 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

USE OF DIVALPROEX SODIUM EXTENDED-RELEASE TABLETS IN BIPOLAR AFFECTIVE DISORDER

John F. Delaney, M.D., Dr. P.H., *Associate Professor, Department of Psychiatry, Temple University School of Medicine, 4815 Liberty Avenue, Suite 123, Pittsburgh, PA 15224;* Rose M. Hammond, Dr. P.H., *Research Associate, Department of Psychiatry, West Pennsylvania Hospital, P.O. Box 7, Beaver Falls, PA 15010*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to recognize that the use of the extended release form of divalproex sodium has demonstrated good clinical efficacy and represents a significant improvement over multiple daily doses.

SUMMARY:

Objective: To evaluate the extended release form of divalproex sodium in bipolar affective disorder.

Method: Ten patients with the diagnosis of bipolar affective disorder who had been stabilized by the use of divalproex sodium in the past were chosen to determine if the extended release form of the drug would provide adequate blood levels with once-a-day dosing. These patients ranged from 18–55 years of age and had the diagnosis made at least three years prior to the start of the study. All patients were stabilized on divalproex sodium of at least 1000mgs in divided doses. The study was designed so that patients would have a baseline valproic acid level and then be switched to the extended release form of divalproex sodium. After two weeks a clinical interview was conducted and another blood level was drawn. Symptoms of mood instability including hypomania and depression were evaluated. After one

month patients were again seen for a brief clinical visit and blood levels were drawn again.

Results: All patients in this study showed no real difference in terms of their symptoms. All patients had a slight decrease, in valproic acid levels with the extended release product but only one had to have an adjustment by increasing the dose.

Conclusion: The use of the extended release form of divalproex sodium has demonstrated good clinical efficacy and represents a significant improvement over multiple daily doses.

REFERENCES:

1. Manning JS, Connor PD, Sahai A: The bipolar spectrum: A review of current concepts and implications for the management of depression in primary care. Archives of Family Medicine 1998; 7(1):63–71.
2. McElroy SL, Keck PE, Pope HG, et al: Valproate in psychiatric disorders: Literature review and clinical guidelines. Journal of Clinical Psychiatry 1989; 50(3Supple):23–29.

Poster 109 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

FACTORS THAT INFLUENCE HEALTH-RELATED BEHAVIORS/CHOICES MADE BY LOW INCOME ELDERLY IN AN URBAN SENIOR CENTER

Rose M. Hammond, Dr. P.H., *Research Associate, Department of Psychiatry, West Pennsylvania Hospital, P.O. Box 7, Beaver Falls, PA 15010*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that health-related behaviors are not made solely on the need for health care, but are complex decisions based on many socio-economic factors in addition to the need for health care.

SUMMARY:

Objective: To examine the relationship between multiple socioeconomic factors, including out-of-pocket costs, as well as personal attitudes and beliefs, on the health-related behaviors/choices made by the elderly in an urban senior center.

Method: A framework combining the Theory of Reasoned Action and the Theory of Consumer Choice was developed and used as the theoretical model for this study. A telephone survey was conducted using a questionnaire designed by this researcher and limited to the membership list of a senior center in Pittsburgh, Pa.

Results: Examination of frequencies of the behavior variables revealed little variability among respondents with respect to these health-related behaviors. However, significant relationships were found between living alone and income, living alone and difficulty paying medical bills, income and not being able to meet basic needs, income and perception of general health, group membership and perception of general health, group membership and participation in exercise or some form of physical activity, and perception of general health and participation in exercise. Additionally, a series of stopwise logistic regressions was performed to investigate the extent to which selected explanatory factors could predict selected health-related outcomes.

Conclusions: From these analyses, income, health status, and supplemental insurance were predictors that may influence health care decisions. Income was a predictor for having difficulty paying medical bills, and age was a predictor for having difficulty maintaining health.

REFERENCES:

1. Ajzen I, Fishbein M: Understanding Attitudes and Predicting Social Behavior. Englewood Cliffs, New Jersey, Prentice-Hall, 1980.
2. Browning EK, Browing JM: Microeconomic Theory and Applications-4th ed. New York, New York, HarperCollins Publishers, Inc, 1992.

Poster 110 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

BODY WEIGHT AND QUALITY OF LIFE IN OUTPATIENTS WHO HAVE SCHIZOPHRENIA

Martin Strassnig, M.D., *Research Fellow, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213;* Rohan Ganguli, M.D., *Vice Chairman and Chief of Clinical Services, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213-2593;* Jaspreet S. Brar, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the associations of body weight and quality of life in schizophrenia.

SUMMARY:

Objective: To examine the associations between sociodemographic variables, body weight, and quality of life in schizophrenic outpatients.

Methods: Assessments included an interview to obtain sociodemographic data, administration of a quality of life questionnaire (the MOS SF-36), and measurement of height and weight. Body mass index was calculated (kg/m^2). SF-36 subscores were examined for statistical

differences based on BMI categories; healthy weight (BMI 24.9), overweight (BMI 25–29.9), and obese (BMI 30). Correlations with sociodemographic variables were also examined.

Results: Body weight was inversely correlated (level p 0.005) to the SF-36 items Physical Functioning (–.452), Role Limitations due to Physical Functioning (–.279), Role Limitations due to Emotional Functioning (–.256), Vitality (–.200), General Health (–.367), and Physical Component score (–.400). Mental Component Score was not significantly correlated to body weight. When comparing quality of life across BMI categories, obese subjects had worse Physical Functioning (p 0.0005) and General Health (p 0.005), reported more Role Limitations due to Emotional Functioning (p 0.05) and a lower Physical Component Score (p 0.005). Mental Component Score was not significantly influenced by BMI.

Conclusions: Quality of life in schizophrenic patients is related to body weight. The burden of obesity is primarily experienced as a physical problem.

REFERENCES:

1. Ware JE Jr, Snow KK, Kosinski M, Gandek B: SF-36 Health survey, manual, and interpretation guide. Boston, MA: The Health Institute New England Medical Center, 1994.
2. Han TS, Tijhus, MAR, Lean MEJ, Seidell JC. Quality of life in relation to overweight and body fat distribution. Am J Public Health 1998;88(12):1814–1820.

TARGET AUDIENCE:

Psychiatrists, primary care physicians

Poster 111 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

A SURVEY OF EATING HABITS IN PATIENTS WITH SCHIZOPHRENIA

Martin Strassnig, M.D., *Research Fellow, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213;* Rohan Ganguli, M.D., *Vice Chairman and Chief of Clinical Services, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213-2593;* Jaspreet S. Brar, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize dietary patterns in schizophrenic patients.

SUMMARY:

We studied eating habits of community-dwelling patients with schizophrenia and examined associations with BMI, type of antipsychotic medication, as well as their attitudes toward their body weight and desire for weight loss.

Method: An interview containing a 24-hour diet recall and questions on weight perception and history of dieting was performed with outpatients receiving care at our schizophrenia treatment center. Height and weight were obtained. Antipsychotic treatment was determined by patient chart review.

Results: For 146 patients interviewed, mean BMI was 32.66 (± 7.87) indicating that most patients are categorically obese. Compared with norms for the U.S. population, patients consumed more calories. We found correlations between BMI and patients' perception of being overweight as well as desire for weight loss and history of weight loss attempts. No statistically significant correlation between specific antipsychotics and BMI was found.

Conclusions: Obesity is a major health problem for schizophrenic patients. Data indicate high fat intake, which could be of etiologic importance. Patients seem to be aware of their obesity and motivated to lose weight. It would be important to develop professional weight loss programs for these patients.

REFERENCES:

1. Brown S, Birthwistle J, Roe L. Thompson C: The unhealthy lifestyle of people with schizophrenia. Psychol Med 1999; 29(3):697–701.
2. Gopalaswamy AK, Morgan R: Too many chronic mentally disabled patients are too fat. Acta Psychiatr Scand 1985; 72(3):254–258.

TARGET AUDIENCE:

Psychiatrists, primary care physicians

Poster 112 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

BEHAVIORAL TREATMENT FOR WEIGHT LOSS IN PATIENTS WITH SCHIZOPHRENIA

Rohan Ganguli, M.D., *Vice Chairman and Chief of Clinical Services, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213-2593;* Jaspreet S. Brar, M.D., *Senior Program Coordinator, Western Psychiatric Institute and Clinic, 3501 Forbes Avenue, Room 412, Pittsburgh, PA 15213;* Blair Mullen, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to compare the effectiveness of behavioral treatment with routine clinical care for weight loss in patients with schizophrenia. At the end of this session

participants will be able to consider behavioral treatment as an alternative method for weight management for their patients.

SUMMARY:

We are evaluating the effectiveness of a behavioral technique for weight loss in patients with schizophrenia. Patients who met an a priori criteria for bodyweight (BMI > 26) were recruited for this 14-week study (n = 8). Following recruitment, patients were randomly assigned to receive either behavioral treatment (BT, n = 4) or routine clinical care (RCC, control group, n = 4). Patients assigned to BT attend biweekly and then weekly sessions during which they are taught various techniques designed primarily to reduce their caloric intake. Patients in the RCC group are not given any special advice for weight management. The study is ongoing and patients in both groups have completed four weeks thus far. Of the three remaining patients in the BT group, a mean weight loss of 4.17 pounds is observed, while the group assigned to routine clinical care was essentially unchanged. These differences do not reach statistical significance perhaps due to the small sample and effect size. However it is expected that statistical significance will be obtained if this trend for weight loss continues over the duration of the study. If behavioral treatment results in significant weight loss, it would provide a useful alternative to clinicians and patients alike for managing weight gain.

REFERENCES:

1. Ackerman S, Nolan LJ: Bodyweight gain induced by psychotropic drugs: incidence, mechanisms and management. CNS Drugs 1998; 9:131–51.
2. Rotatori AF, Fox R, Wicks A: Weight loss with psychiatric residents in a behavioral self control program. Psychological Reports 1980; 46:483–486.

TARGET AUDIENCE:

Psychiatrists, social workers, and clinicians who treat patients with psychotic disorders

Poster 113 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

A COMMUNITY-BASED SOCIAL SKILLS PROGRAM FOR PEOPLE WITH MENTAL ILLNESS

Ethel and James Flinn Family Foundation

Mona Goldman, Ph.D., *Research Investigator, Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Box 0120, Ann Arbor, MI 48109;* Nancy Mann, R.N., *Clinical Nurse, Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109;* Rebecca F. Shriberg, M.S.W.; Rajiv Tandon, M.D.; Patrick Kraft, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand how to implement an effective social skills program and understand the design of the Life Skills Program—an efficient, versatile, community-based program.

SUMMARY:

Although social skills training programs have shown promise in improving the social and vocational skills of people with schizophrenia and other chronic mental illnesses, they have proven difficult to implement in community-based settings. Such settings require comprehensive, efficient, and flexible programs that meet the needs of clients with a broad range of functional deficits. Life Skills is a 20-session, social skills training program designed to embody these characteristics. Its procedures are clearly delineated in a teacher's manual and student workbooks. A variety of learning paradigms are used including didactics, role play, discussion, homework, and in-vivo practice. Lessons include practical skills such as problem solving, money management, communication, employment, and disease management. The program has been effectively implemented in a mental health clubhouse, client-run drop-in center, outpatient clinic, privately funded community agency, and a residential treatment facility. To date, more than 150 clients have participated, over 75% report satisfaction with the program, and the majority of clients report experiencing less difficulty implementing skills. An evaluation of sense of belonging, social adjustment, and generalization of skills is under way. The adaptability and utility of the program for a broad client base has been instrumental to its success.

REFERENCES:

1. Liberman RP, Wallace CJ, et al: Innovations in skills training for the seriously mentally ill: the UCLA social and independent living skills modules. Innovations & Research 1993; 2:43–60.
2. Bustillo JR, Lauriello J, et al: The psychosocial treatment of schizophrenia: an update. Am J of Psychiatry 2001; 158:163–175.

TARGET AUDIENCE:

Community-based treatment providers

Poster 114 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

GLUCOSE METABOLISM AND THE TREATMENT OF SCHIZOPHRENIA: A COMPLEX RELATIONSHIP

Michigan Diabetes Research and Training Center

Mona Goldman, Ph.D., *Research Investigator, Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Box 0120, Ann Arbor, MI 48109;* Karen K. Milner, M.D., *Assistant Clinical Professor of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0020;* Rebecca F. Shriberg, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to better understand the complex relationship among schizophrenia, atypical antipsychotics, glucose regulation, and obesity.

SUMMARY:

A complex relationship is emerging among atypical antipsychotics, abnormalities in glucose regulation, and obesity in schizophrenia. We investigated these relationships in a cross-sectional study of 96 patients with schizophrenia or schizoaffective disorder at a community mental health center (mean age = 45.3 years; 39% female; 72% Caucasian; 22% African American). Sixteen patients were diagnosed with DM. Fasting plasma glucose (FPG), fasting plasma insulin (FPI), and cortisol levels were assessed in the remaining 80 subjects. FPG (ADA criteria, 1999) identified an additional case of DM (total DM = 17.9% versus about 7.8% in the general adult population) and nine cases of impaired fasting glucose (IFG; 9.5%). Forty-six percent of the sample met criteria for obesity (body mass index greater than or equal to 30) versus about 32% of the general population. In a multiple regression analysis to assess the effect of age, body mass index (BMI), duration on medication, and type of medication (atypical versus typical) on fasting plasma glucose, BMI was the strongest correlate of elevated FPG (beta = .43; p = .01). After controlling for the other factors, there was little evidence for a differential effect of atypical compared with conventional agents on FPG (beta = .15; p = .46). These data confirm an increase in the prevalence of DM in persons with schizophrenia and suggest that obesity may be the primary mechanism underlying the increase in impaired glucose regulation in schizophrenia.

REFERENCES:

1. Henderson DC, Cagliero E, Gray C, et al: Clozapine, diabetes mellitus, weight gain and lipid abnormalities: a five-year naturalistic study. Am J of Psychiatry 2000;157:975–981.
2. Harris MI, Flegal KM, Cowie CC, et al: Prevalence of diabetes, impaired fasting glucose and impaired glucose tolerance in US adults: the Third National Health and Examination Survey, 1988–1994. Diabetes Care 1998;21:518–524.

TARGET AUDIENCE:

Psychiatrists who treat patients with schizophrenia

Poster 115 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

SERVING THE HOMELESS MENTALLY ILL: EVALUATION OF PROJECT OUTREACH

Ethel and James Flinn Family Foundation

Timothy D. Florence, M.D., *Clinical Instructor of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Box 0116, Ann Arbor, MI 48109;* Mona Goldman, Ph.D., *Research Investigator, Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Box 0116, Ann Arbor, MI 48109;* Mark C. Holter, Ph.D.; Lisa M. Becks, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this poster presentation, the participant should be able to describe effective engagement and treatment strategies for homeless persons with severe mental illness and understand the design, implementation, and evaluation of Project Outreach.

SUMMARY:

In many locales, the needs of homeless persons with severe mental illness have been inadequately addressed. The purpose of this study is to evaluate the effectiveness of a pilot program called the Project OutReach Team (PORT). PORT is a multidisciplinary team in a small urban area designed to (1) engage untreated homeless mentally ill persons, (2) provide treatment based on the PACT model, and (3) transition clients after psychiatric stabilization into the public mental health system. Program objectives are to improve access to care, improve clinical and functional outcomes, and shift the provision of services from acute-care settings to community-based sites. Validated research instruments are used at enrollment and every three months over on 18-month period to assess clinical status (BPRS, SANS, CGI, GAF), functional and quality-of-life outcomes (SCAP-HQ modified), and client satisfaction (CSQ). Housing status and service utilization are tracked monthly. Twenty subjects with primary psychotic or major mood disorders are thus far enrolled, with a refusal rate of 33%. Baseline

rating scale measures suggest serious functional impairment, and 65% have co-occuring substance use disorders. Longitudinal evaluation is underway. We hypothesize that PORT will be a clinically effective, cost-effective service delivery model adaptable to other communities.

REFERENCES:

1. Lehman AF, Dixon LB, et al: A randomized trial of assertive community treatment of homeless persons with severe mental illness. Arch Gen Psychiatry 1997; 54:1038–1043.
2. Susser E, et al: Preventing recurrent homelessness among mentally ill men: A ''critical time'' intervention after discharge from a shelter. Am J Public Health 1997; 87:256–262.

TARGET AUDIENCE:

Community mental health clinicians, homeless advocates

Poster 116 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

PATIENT AND CLINICIAN ATTITUDES TOWARD MULTIDISCIPLINARY TREATMENT

Parinda Parikh, M.D., *Resident, Department of Psychiatry, Brookdale Hospital, 155-07 Horace Harding Expressway, Flushing, NY 11367;* Saurabh Kaushik, M.D., *Resident, Department of Psychiatry, Brookdale Hospital, 7 Hegeman Avenue, #9-H, Brooklyn, NY 11212;* Vasundhara Kalasapudi, M.D.; El-Awady Mohammed, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to recognize the impact of split treatment on the therapist, psychiatrist, and the patient, and identify areas of concern and work effectively to address this concerns.

SUMMARY:

Patients receiving psychiatric treatment within a hospital setting are often exposed to services from a variety of clinicians representing numerous disciplines. This interaction of disciplines can be confusing if there is not a clear differentiation of roles for each clinician.

The present study was designed to assess patient and clinician attitudes toward their experience with such multidisciplinary treatment. Patients and staff on several hospital units (inpatient, outpatient, day treatment, emergency services) were asked to complete a brief, 15-item questionnaire assessing their feelings regarding the multidisciplinary care they were receiving or administering. All members of the psychiatry department at a large inner-city/teaching hospital were asked to participate. Professionals included nurses, social workers, psychiatrists, psychologists, occupational, and recreational therapists. All patients seen in the various units and clinics over a two-month period were also asked to complete a questionnaire. Participation for both staff and patients was voluntary.

Survey questions attempted to assess such areas as whether clinician roles were clear, whether communication between disciplines was adequate, as well as overall satisfaction for this type of service. While results have not yet been analyzed, the results will be compared by units and by discipline.

The goal of this study is to obtain information about the impact of multidisciplinary treatments on patients and clinicians and to begin to identify areas of concern. This information can then be used as a way of educating staff and thereby improving the quality of care delivery.

REFERENCES:

1. Imhof JE, Altman R, Katz JL: The relationship between psychotherapist and prescribing psychiatrist. Am J Psychotherapy 1998; 52:(3).
2. Schindler FE, Hannah MT, Beigel A: How the public perceives psychiatrists, psychologists, nonpsychiatric physicians, and members of the clergy. Professional Psychology: Research and Practice 18, 371–376.
3. Goldberg RS, Riba M, Tasman A: Psychiatrists' attitudes toward prescribing medication for patients treated by nonmedical psychotherapists. Hospital and Community Psychiatry 1991; 42:(3).

Poster 117 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

NONCOMPLIANCE WITH TREATMENT: IS IT ADAPTIVE OR MALADAPTIVE?

Parinda Parikh, M.D., *Resident, Department of Psychiatry, Brookdale Hospital, 155-07 Horace Harding Expressway, Flushing, NY 11367;* Saurabh Kaushik, M.D., *Resident, Department of Psychiatry, Brookdale Hospital, 7 Hegeman Avenue, #9-H, Brooklyn, NY 11212;* Safier Stanley, M.D.; El-Awady Mohammed, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to manage noncompliant patients and break the cycle of frequent hospitalizations.

SUMMARY:

In today's environment of brief hospital stays one often tends to focus on somatic parameters and ignore psychosocial issues. However, the key to managing hopelessly noncompliant patients lies in understanding

problems with primary support group; problems related to social, educational, occupational, and economic issues; and difficulties with access to health care. The following case report illustrates the above dilemma.

Ms F. is a 21-year-old, single, black, female who has been repeatedly hospitalized with life threatening symptoms of ketoacidosis or hyperglycemia secondary to noncompliance with insulin. During the hospitalization patient gains weight, eats better, shows significant clinical improvement, and wants to be discharged only to return in a few days or weeks for rehospitalization. The high frequency of her hospitalization secondary to her noncompliance precipitated a psychiatry consult. Initial psychiatric evaluation was focused on understanding the role of various family members in her psychopathology. After a period of evaluation, it was evident that the patient depended entirely on her family members for the treatment of her diabetes, which included twice daily administration of insulin.

The patient had no physical limitations and could very well administer insulin herself. This pattern of relying on others for her care was pervasive. In the absence of any prominent Axis I symptoms, our formulation was of a dependant personality disorder. Patient's mother, a single parent, is the primary caretaker for the patient, her five other siblings, and several nephews, nieces, and grandchildren. We hypothesized that the patient is maintaining her "noncompliant behavior" as a way of holding her mother's continued attention, which is very sparse. This led us to believe that the patient might have a variant of Munchausen's Syndrome. However, both these formulations of dependant personality disorder and of Munchausen's Syndrome did not help us in making any effective intervention.

These repeated hospitalizations were not distressing to the patient or her mother but to the hospital staff. This led us to move away from the diagnostic labels and look at the behavior as highly adaptive for the patient and her mother. For the mother the patient staying sick assures the patient's presence and prevents her child from getting lost in the crowd.

We are currently engaged in formulating an alternative reward system, which will help this patient break the cycle of frequent hospitalizations.

REFERENCES:

1. Trigwell P, Grant PJ, House A: Motivation and glycemic control in diabetes mellitus. Journal of Psychosomatic Research 1997; 43(3):307–15.
2. Sanders K, Mills J, Martin FI, Del Horne DJ: Emotional attitudes in adult insulin-dependent diabetics. Journal of Psychosomatic Research 1975; 19(4):241–6.

Poster 118 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

USING THE BRIEF PSYCHIATRIC RATING SCALE SUBSCALE TO MONITOR PROGRESS IN CHRONIC MENTALLY ILL PATIENTS

Daniele A. Longo, Ph.D., *Supervisor, Department of Psychology, Eastern State Hospital, P.O. Box 8791, 4601 Ironbound Road, B-26, Williamsburg, VA 23187;* Joselito B. Morales, M.D., *Staff Psychiatrist, Eastern State Hospital, 4601 Ironbound Road, Williamsburg, VA 23187*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand the utility of the BRRS subscale scores in monitoring progress in the treatment of chronic mentally ill patients.

SUMMARY:

Objective: To examine the relationship between the Brief Psychiatric Rating Scale (BPRS) total score and subscale score to specific diagnosis and explore their respective utility in charting clinical response to treatment.

Method: BPRS was completed on all patients admitted to the to the Psychosocial Rehabilitation Program, then monthly at a public psychiatric hospital in Williamsburg, Virginia. Data (demographic, diagnosis, BPRS total and subscale scores) were collected over a month period on all discharged patients. A retrospective data analysis was conducted utilizing mean change scores and correlation procedures.

Results: BPRS subscale scores show a good fit with their respective diagnosis, ie., withdrawal for depression, agitation for bipolar disorder, psychotic distortion for schizoaffective disorder, cognitive dysfunction, and withdrawal for schizophrenia. The calculated mean score change showed that regardless of the diagnosis the majority of patients responded to the treatment over time.

Conclusion: The overall findings support the utility of using the BPRS subscale in monitoring specific psychiatric symptoms and patients' response to treatment.

REFERENCES:

1. Varner RV, Chen YR, Swann AC, Moeller FG: The Brief Psychiatric Rating Scale as an acute inpatient outcome measurement tool: a pilot study. Journal of Clinical Psychiatry 2000; 61:418–421.
2. Thompson PA, Buckley PF, Meltzer, HY: The Brief Psychiatric Rating Scale; effect of scaling system on clinical response assessment. Journal of Clinical Psychopharmacology 1994; 14:344–346.

TARGET AUDIENCE:

Psychiatrists, psychologists

Poster 119 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

INPATIENT PSYCHOSOCIAL REHABILITATION PROGRAM AND ITS EFFECT ON PATIENT ELOPEMENT

Joselito B. Morales, M.D., *Staff Psychiatrist, Eastern State Hospital, 4601 Ironbound Road, Williamsburg, VA 23187;* Karen M. Marsh-Williams, OTR/L, *Rehabilitation Director, Eastern State Hospital, 107 Wilderness Lane, Williamsburg, VA 23188*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that an active and open inpatient psychosocial rehabilitation program can lower the elopement rate.

SUMMARY:

Objective: To determine the effect of an active inpatient psychosocial rehabilitation program on the elopment rate.

Method: An inpatient psychosocial rehabilitation program was established in 1997 at the nation's first state psychiatric hospital's long-term unit. All the patients were involved in various programs located in two activity buildings away from their "home" buildings daily. A level system was maintained, which dictated the type of program patients could participate in. The Average Annual Elopement Rates were tracked from 1993 to 2000, indicating patients with and without ground privileges.

Results: The average rate for 1993 was 27.9% (7.3 without privileges-20.6 with privileges); 12.5 for 1994 (7.4-5.1); 4.5 for 1995 (3.2-1.3); 3.1 for 1996 (2.5-0.6); 7.8 for 1997 (6.6-1.2); 7.6 for 1998 (4.7-2.9); and 5.4 in 2000 (93.8-1.6). The unusually low rates in 1995 and 1996 were the result of a statewide restriction following the elopement of a forensic patient from another facility.

Conclusions: The average annual elopement rate continues to drop since the establishment of an active and open inpatient psychosocial rehabilitation program. We have to pay particular attention to patients without ground privileges as they represented the majority of patients who eloped.

REFERENCES:

1. Smith RC: Implementing psychosocial rehabilitation with long term patients in a public psychiatric hospital. Psychiatric Services 1998; 49:593–595.
2. Conroy T, Jorqensen J: Decreasing elopement through interdisciplinary teamwork. Nursing Quality Connection 1995; 5(3):30.

TARGET AUDIENCE:

Psychiatrists, nurses, psychologists, social workers, activity therapists

Poster 120 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

EARLY-ONSET FEMALES WITH SCHIZOPHRENIA

Eli Lilly and Company

Patricia A. Russo, Ph.D., *Director of Outcomes, Research, and Econometrics, The Medstat Group, Incorporated, 4301 Connecticut Avenue, N.W., Suite 330, Washington, DC 20008;* Courtenay M. Harding, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to identify and apply the key findings and the methodology used in this age-of-onset study to their practice or research settings.

SUMMARY:

Objective: To test the hypothesis that persons with disease onset <25 will reflect a similar profile and that they will differ from their later onset (25–45) counterparts.

Methods: Baseline data from the Schizophrenia Care and Assessment Project (n=1717) were used. Dependent variables were PANSS: (PS), (NS), (GP); MADRS, QLS, GAF, marital status, and education. Contrast coding was used to test the relationship ($\mu_1 = \mu_2 < \mu_3 = \mu_4$) between the groups: (onset <25) early females (μ_1; n=424) and expected males (μ_2; n=843; (onset 25–45) expected females (μ_3; n=211) and delayed males (μ_4; n=239). OLS and logistic regression were applied.

Results: Directionally was supported for NS, OLS, GAF, marital status, and education, i.e., persons with onset <25 had lower scores and were less likely to be married or to have completed high school. Evidence supporting the equality ($\mu_1 = \mu_2$) was observed for GP and education, only. The equality $\mu_3 = \mu_4$, was partially supported (with the exception of GAF, marital status, and OLS), suggesting that those groups reflected a similar profile.

Conclusions: These analyses reveal that the relationship between age of onset, given gender, is more complex than previously thought. The findings suggest that persons with onset at younger age present a more severe profile than their counterparts, with regard of hallucinations/delusions.

REFERENCES:

1. Hafner H, an der Heiden W: Epidemiology of schizophrenia. Canadian Journal of Psychiatry 1997; 42:139–151.
2. Schultz S, Miller D, Oliver S, Arndt S, et al: The life course of schizophrenia: age and symptom dimensions. Schizophrenia Research 1997; 23:15–23.

TARGET AUDIENCE

Researchers, practitioners, and policy makers.

Poster 121 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

CLINICAL ASSESSMENT OF QUALITY OF LIFE AMONG SCHIZOPHRENIA PATIENTS WITH DEFICIT SYNDROME

Eli Lilly and Company

Patricia A. Russo, Ph.D., *Director of Outcomes, Research, and Econometrics, The Medstat Group, Incorporated, 4301 Connecticut Avenue, N.W., Suite 330, Washington, DC 20008;* Brian Kirkpatrick, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to identify and apply key findings of this study to their practice or research setting.

SUMMARY:

Objective: To determine whether persons with deficit syndrome exhibit a lower clinically assessed quality of life than do their non-deficit counterparts, controlling for clinical status and demographic factors.

Methods: Baseline data (QLS scale; mean=56) from participants in the SCAP study (n=781) were modeled as a linear function of covariates, including demographic, clinical, medication adherence, and site variables. Presence of deficit syndrome was assigned based on proxy methods (Kirkpatrick B., et al., 1989).

Results: Modeling revealed that deficit syndrome has a negative impact of 4.7 points ($p<.001$) on quality of life score 9 range (0–120), suggesting that persons with deficit syndrome may experience a significantly lower quality of life that their non-deficit counterparts, all else being equal. Those having higher hallucinations/delusions score ($p<.001$) exhibited lower QLS scores and those with higher functioning scores (GAF; $p<.001$) exhibited higher QLS scores.

Conclusions: The hypothesis that persons with deficit syndrome will experience lower quality of life that their non-deficit counterparts was upheld in these analyses. Our results suggest that persons with deficit functional scores are significant: the impact of deficit syndrome is six times greater than that of disorganization and three times greater than that of hallucinations/delusions.

REFERENCES:

1. Kirkpatrick B, Buchanan RW, McKenney PD, et al: The Schedule for the Deficit Syndrome: an instrument for research in schizophrenia. Psychiatry Research 1989; 30:119–123.
2. Kirkpatrick B, Buchanan RW, Carpenter WT Jr: Depressive symptoms and the deficit syndrome in schizophrenia. The Journal of Nervous and Mental Disease 1994; 182(8):452–455.

TARGET AUDIENCE:

Researchers, practitioners, and policy makers.

Poster 122 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

ASSESSING THE ABILITY OF PATIENTS WITH PSYCHOTIC DISORDERS TO CONSENT FOR CLINICAL TRIALS

Robert E. Litman, M.D., *Medical Director, Centers for Behavioral Health, 14915 Broschart Road, Suite 250, Rockville, MD 20850;* Pamela J. Woodard, M.S.S., L.C.S.W., *Social Worker/Research Coordinator, Centers for Behavioral Health, 14915 Broschart Road, Suite 250, Rockville, MD 20850*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation participants will be able to identify the issues and concerns related to informed consent with psychotic patients, use the MacCAT-CR to assess competence, understand the relationship between clinical variables and capacity to consent.

SUMMARY:

Background: Impaired capacity of schizophrenia patients to provide informed consent for clinical trials of experimental agents has been a cause for concern among clinical investigators, pharmaceutical manufacturers, and mental health consumers alike. Available studies suggest that these impairments are correlated to poor cognitive performance, not symptoms, and are mitigated when patients receive education about studies in a "real-study" setting.

Objectives: To further explore these issues, we assessed the capacity to provide informed consent for a hypothetical double-blind, placebo-controlled trial of experimental antipsychotic medication, as well as symptoms, cognitive performance, and illness awareness, in a community-based sample of schizophrenia patients

who have and have not previously participated in clinical trials.

Methods: The MacArthur Competence Assessment Tool for Clinical Research (MacCAT-CR) was administered to 22 (15M) patients with schizophrenia or schizoaffective disorder (11 of whom had participated previously in clinical trials, and 11 who were clinical trial-naïve), and to 11 (4M) normal volunteers. Symptoms, cognitive function, and illness awareness were assessed using the Positive and Negative Syndrome Scale (PANSS), the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS), and Wisconsin Card Sorting Test (WCST), and the Scale to Assess Unawareness of Mental Disorder (SUMD), respectively.

Results: MacCAT-CR total scores were significantly worse in clinical trial-naïve patients compared with normal volunteers (mean (SD)) MacCAT-CR total scores for normals: 36.7 (5.8); for trial-naïve patients: 26.7 (10.6); F=4.8, p=.02, *df*=2.30; post-hoc p<.05); MacCAT-CR total scores of patients with prior trial experience (32.9 (5.6)) were intermediate between, and not significantly different from, normal volunteers and clinical-trial naïve patients. A similar pattern of results was seen for MacCAT-CR subscales of Appreciation, Understanding, and Reasoning. Intact capacity to consent as measured by the MacCAT-CR Understanding sub-score was correlated with cognitive performance as measured by the RBANS total score (r=0.41, p<.06, 1-tailed) and the categories achieved on the WCST (r=0.59, p<.04, 1-tailed).

Conclusion: These data are consistent with the hypothesis that prior knowledge and/or experience regarding clinical trials may be related to improved capacity to give informed consent in schizophrenia patients. Moreover, capacity to give informed consent is correlated with cognitive ability, particularly prefrontal cortical function, as measured by neuropsychological testing.

Significance: These data argue for further education and exposure to research for clinical-trial naïve patients even when decisional capacity is questionable.

REFERENCES:

1. Carpenter WT, Gold JM, Lahti AC, Queern CA, et al: Decisional capacity for informed consent in schizophrenia research. Archives of General Psychiatry 2000; 57:533–538.
2. Applebaum PS, Grisso T: The Macarthur Competence Assessment Study I, II, III. Law and Human Behavior 1995; 19(2) 105–174.

TARGET AUDIENCE:

Clinicians, consumers, families, ethics committees

Poster 123 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

PRELIMINARY PROFILE OF SCHOOL VIOLENCE

Sadiq H. Al-Samarrai, M.D., *Department of Psychiatry, Cooper Hospital, 401 Haddon Avenue, E&R Building 356, Camden, NJ 08103;* Jeffrey B. Dunn, M.D.; Thomas S. Newmark, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will be able to recognize the preliminary profile of violence and some of the predictive factors and ways of intervention.

SUMMARY:

The aim of this study is to assess factors that may contribute to violent behaviors at schools and to identify any risk factors that may help to provide appropriate interventions very early, as well as to search for preventive strategies that may be applicable.

Violence affects children and adolescents widely. Aggressive habits seem to be learned early in life, and once established, are resistant to change. They can be predictive of serious adult antisocial behavior. Children may be exposed to violence within their family and/or peer group, as well as observing it in their neighborhoods and in the community at large. These behaviors are reinforced by what children and adolescents see on TV and in movies. Children's exposure to mass media may promote the learning of aggressive habits, a finding confirmed in numerous studies. Other important factors may contribute to violence, including substance abuse by parents, family psychiatric illness, parental violence, lack of parental monitoring, and parental separations. Other potentially important factors include provoking actions at school, psychiatric problems, and school performance deterioration. These factors are explored in depth and appear to contribute to potential violence. Ten charts were reviewed, belonging to students who were referred to our outpatient psychiatric service because of fighting at school and violent interactions with others. The poster shows the variables from which we may draw a preliminary profile of school violence represented numerically and graphically. A discussion of possible preventive measures is included.

The intended audience includes psychiatrists, physicians from other disciplines, residents, medical students, nurses, therapists, and social workers.

REFERENCES:

1. Schwartz DF: Violence. Pediatrics in Review 1996; 17:6.

2. Singer MI, et al: Contributors to violent behavior among elementary and middle school children. Pediatrics 1999; 104:4.

Poster 124 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

PATIENT- VERSUS STAFF-RATED OUTCOME: SIX-MONTH POST HOSPITAL DISCHARGE

Catherine A. Leslie, M.D., *Assistant Professor of Psychiatry, Western State Hospital, 1301 Richmond Road, Staunton, VA 24402;* Michael S. Shutty, Ph.D., *Psychologist, Western State Hospital, 1301 Richmond Road, Staunton, VA 24402;* Ludmila A. Kryzhanovskaya, Ph.D.; Jack W. Barber, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to provide knowledge about the validity of self-report BASIS-32, PANSS, and BPRS as treatment outcome instruments.

SUMMARY:

Objective: The aim of this study was to evaluate the predictive validity of patient self-reported symptom ratings using the BASIS-32 as an outcome measure in state hospital patients six months post-discharge.

Method: Patient self-ratings of functioning on the BASIS-32 and treatment satisfaction versus clinician ratings of symptom severity on the PANSS and BPRS at time of discharge and at six months post discharge were compared.

Results: Eighteen patients (83% males) with an average age of 37 (SD=9.4), whose mean length of hospitalization was 1,267 days (SD=1609.9), were studied. Comparisons across the six months revealed an overall, but nonsignificant, increase in total Basis-32 scores from 14.7 (SD=12.8) at discharge to 17.7 (SD=18.5) at six-months: eight subjects reported increased problems, whereas eight reported no change or improvements. In contrast, PANSS total scores evidenced an average decrease from 61.8 (SD=15.9) to 57.1 (SD=15.4) across the six-month period, as only three patients were rated as worse. BPRS total scores also evidenced an average decrease from 35.0 (SD=12.2) to 31.9 (SD=9.3) across the six-month period with only two patients rated as worse. No significant relationship was found between the BASIS-32 scores and the clinician ratings on the PANSS or BPRS. Treatment satisfaction scores at six months averaged 78.9%, (SD=4.8) evidencing a moderate, but nonsignificant, association with PANSS and BPRS scores, but no relationship to the BASIS-32 scales.

Conclusions: These findings raise concerns relative to the descriptive and predictive validity of using patient self-reported problems in the BASIS-32 as an outcome measure as it appears to be unrelated to clinician ratings of symptom severity and patient's own ratings of treatment satisfaction.

REFERENCES:

1. Varner RV, Chen YR, Swann AC, Moeller FG: The Brief Psychiatric Rating Scale as an acute inpatient outcome measurement tool: a pilot study. Journal of Clinical Psychiatry 2000; 61(6):418–421
2. Klinkenberg WD, Cho DW, Vieweg B: Reliability and validity of the interview and self-report versions of the BASIS-32. Psychiatric Services 1998; 49(9):1229–1231

TARGET AUDIENCE:

Psychiatry and psychology clinicians and researchers

Poster 125 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

RECENT WEIGHT GAIN AND ACUTE SERVICE USE AMONG PATIENTS WITH SCHIZOPHRENIA

Pfizer Inc.

Peter J. Weiden, M.D., *Professor of Psychiatry, State University of New York Health Sciences Center at Brooklyn, 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203;* Joan A. Mackell, Ph.D., *235 East 42nd Street, New York, NY 10017;* Diana D. McDonnell

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate an understanding of the study data on the apparent association between significant recent weight gain and use of acute services in patients with schizophrenia.

SUMMARY:

Objective: This study considers the possible association between recent weight gain and acute service use in patients with schizophrenia.

Methods: Questionnaires on treatment and health issues were mailed to people with schizophrenia identified through NAMI and NMHA (n=390). Data came from 251 respondents who reported, within the last six months, no weight change (n=106, 42%), some weight gain (between 1-14lb; n=70, 27.9%), or significant weight gain (≥15 lb; n=75, 29.9%). Acute service use was defined as an emergency room (ER) visit or hospitalization within six months.

Results: The group reporting significant weight gain was twice as likely to receive acute services as the other two groups ($p<0.001$ for hospitalization and $p<0.005$ for ER visit). The association remained significant when controlling for age, gender, ethnicity, and overall distress.

Conclusion: This study suggests that a recent history of significant weight gain is associated with greater use of acute services. If confirmed, there are several plausible explanations. First, physicians might change medications for patients who are doing poorly (eg, start a new medication after an acute psychiatric episode occurs). Alternately, acute medical services may be more likely to be needed after an episode of rapid weight gain.

REFERENCES:

1. Allison DB, Mentore JL, Heo M, Chandler LP, et al: Antipsychotic-induced weight gain: a comprehensive research synthesis. Am J Psychiatry 1999;156:1686–1696.
2. Allison DB, Fontaine KR, Heo M, Mentore JL, et al: The distribution of body mass index among individuals with and without schizophrenia. J Clin Psychiatry 1999;60:215–220.

TARGET AUDIENCE:

Psychiatrists and other health professionals who care for patients with schizophrenia

Poster 126 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

A QUALITY IMPROVEMENT INTERVENTION FOR LATE-LIFE DEPRESSION

Stuart H. Levine, M.D., *Chief Executive Officer, Topaz Health, and Former APA/Bristol-Myers Squibb Fellow, 540 South Helberta Avenue, Redondo Beach, CA 90277-4353;* Marc Hoffing, M.D.; Thomas Goodro, C.R.C.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the significance of a new model of care for the identification and treatment of late-life depression in the primary care setting.

SUMMARY:

Background: Project IMPACT is a multi-center initiative sponsored by the John A. Hartford Foundation and the California HealthCare Foundation. The four-year study is designed to evaluate the effectiveness of a quality improvement intervention for late-life depression in primary care settings. The project will determine if a primary care-based collaborative disease management program will improve patient outcomes such as depressive symptoms, health-related quality of life, quality of care for depression, and satisfaction with depression care when compared with care as usual.

Desert Medical Group (DMG) is one of seven sites in the United States selected to participate in Project IMPACT.

The study is ongoing, and outcomes are not available until Fall 2001. We will present the stepped collaborative care intervention model.

REFERENCES:

1. Callahan CM, Hendrie HC, Dittus RS, Brater DC, et al: Improving treatment of late life depression in primary care. J Am Geriatric Soc 1994;42:839–46.
2. Unutzer J, Katon W, Russo J, Walter EK, et al: Patterns of care for depressed older adults in a large staff model hMO. American J Geriatr Psychiatry 1999;7(3):235–243.

TARGET AUDIENCE:

Mental health clinicians

Poster 127 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

LACK OF MEDICAID ELIGIBILITY: FORMER SUPPLEMENTAL SECURITY INCOME RECIPIENTS WITH DRUG ABUSE AND ALCOHOLISM DISABILITY

Robert Wood Johnson Foundation

Daniel J. Luchins, M.D., *Associate Professor of Psychiatry, University of Chicago, 5841 Maryland Avenue, MC-3077, Chicago, IL 60637;* Patricia Hanrahan, Ph.D., *Associate Professor of Psychiatry, University of Chicago, 5841 Maryland Avenue, MC-3077, Chicago, IL 60637;* Lea Cloninger, Ph.D.; James Swartz, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to recognize the high level of psychiatric comorbidity among former SSI recipients who were disabled due to drug abuse and alcoholism. Additionally, the participant should also recognize the importance of reviewing these individuals' need for Medicaid and SSI entitlements on the basis of psychiatric impairments.

SUMMARY:

As of 1/1/97, Supplemental Security Income (SSI) recipients who were disabled due to drug abuse or alcoholism (DA&A) were no longer eligible for SSI and began to be eliminated from receiving this benefit. This endangered related benefits, notably Medicaid. The study purpose was (1) to determine baseline hospital

use as an indicator of medical need among those affected by the policy change, and (2) to examine the relationship of baseline medical need to their subsequent eligibility for Medicaid due to psychiatric and medical disability.

Design: Longitudinal cohort study of 11,740 Chicago residents who were eligible for SSI and Medicaid due to DA&A disability from 1995 to 1996.

Measures: Medicaid and state records for hospital use in 1995 and Medicaid eligibility files (1997–1998).

Results: 26% were hospitalized in 1995 (N = 3,098), including 535 for psychiatric problems, primarily psychotic disorders, 72% (N = 384). A year after the policy change (12/31/97) 42% had lost Medicaid eligibility as well as SSI (N = 4,911). Psychiatric hospitalization was minimally related to receiving Medicaid one year after the policy change (12/97). Further, 38% of those previously hospitalized with psychotic disorders were no longer eligible for Medicaid (N = 144), including 27% of schizophrenics.

Discussion: This policy change threatened access to Medicaid in a highly vulnerable population. Baseline hospital use suggested very high levels of medical need among SSI recipients whose disability status, DA&A, no longer qualified them for Medicaid after 1/97. Over one-fourth were hospitalized in 1995, which is about three times the rate in the general population of adults under age 65. Subsequently, substantial proportions of persons with serious psychiatric disorders lost their Medicaid benefit.

REFERENCES:

1. Mckay JR, et al: Characteristics of recipients of Supplemental Security Income (SSI) benefits for drug addicts and alcoholics. J Nerv Ment Dis 1998; 186 (5):290–8.
2. Swartz JA, Lurigio AJ, Goldstein P: Severe mental illness and substance use disorders among former Supplemental Security Income beneficiaries for drug addiction and alcoholism. Arch Gen Psychiatry 2000; 57(7):701–7.

TARGET AUDIENCE:

Administrators and clinicians

Poster 128 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

SEEKING APPROPRIATE FAMILY ENVIRONMENTS: THE CHICAGO SAFE PROJECT

Substance Abuse and Mental Health Services Administration

Thomas A. Simpatico, M.D., *Chief, Burrough of Chicago Network Manager, Chicago Read Mental Health Center, 4200 North Oak Park Avenue, Building K, Chicago, IL 60634;* Jerry Dincin, Ph.D., *Executive Director, Thresholds, 4101 North Ravenswood Road, Chicago, IL 60613;* Marion McCoy, Ph.D.; Mary Ann Zeitz, M.Ed.; Patricia Hanrahan, Ph.D.; Daniel J. Luchins, M.D.; Gail L. Patrick, M.P.P.; Lea Cloninger, Ph.D.; Theresa Greyhair

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that a substantial portion of the homeless are families headed by mentally ill mothers, and demonstrate an understanding a unique treatment approach to meet the special needs of this population.

SUMMARY:

In Chicago there are about 2,000 homeless families/ year, with many headed by mentally ill mothers. Yet there are few programs for mentally ill, homeless mothers with children. This study aims to describe an existing program, the Thresholds' Mothers Project, which serves a high proportion of homeless mothers.

Methods: Descriptive follow-up study of a cohort of mothers (N = 66) with children who have participated in the Mother's Project during fiscal year 1999.

Setting: Thresholds is a not-for-profit psychiatric rehabilitation agency.

Intervention: Case management, assistance in finding and keeping housing, a specialized therapeutic nursery and after-school program. A range of other individualized services.

Measures: MIS records, chart reviews and focus groups.

Subjects: African American: 74%, European American: 12%, Latin/Hispanic: 8%; Native American: 1%; Asian: 1%; other: 3% Mothers' mean age: 26. They averaged 11 years of education. About a fifth of the mothers had major depressive disorders (23%), or dysthymia (21%). Many had bipolar disorder (15%), adjustment disorders (15%), psychotic disorders (12%), and PTSD or other anxiety disorders (9%).

Results: Community tenure: The mothers remained in the community for a mean of 363 days. Very few were hospitalized (8%). Although many mothers viewed caring for their children as their primary work, 15% were employed outside the home. Basic preventive health care was provided with most mothers being screened for TB (91%), and all children having complete immunizations.

Quality of Life: The mothers scored 2.99 (Range: 1, low, to 4, high).

Discussion: Preliminary findings suggest that the Mother's Project is effective in meeting the needs of a highly vulnerable population, mentally ill mothers and their children. Given that there is very little study of interventions for homeless mothers with mental illness, there is a great need for further program evaluation.

REFERENCES:

1. Zeitz MA: The Mothers' Project: A clinical case management system. Psychiatric Rehabilitation Journal 1995; 19(1).
2. Zima B, Wells KB, Benjamin B, Duan N: Mental health problems among homelessmothers. Archives of General Psychiatry 1996; 53:332–338.

TARGET AUDIENCE:

Administrators, clinicians

Poster 129 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

HEALTH CARE UTILIZATION IN PATIENTS WITH TREATMENT-RESISTANT DEPRESSION

Cyberonics, Inc.

William H. Crown, Ph.D., *Vice President of Outcome Research, The Medstat Group, 125 Cambridge Park Drive, Cambridge, MA 02140;* Davina C. Ling, Ph.D.; Stanley N. Finkelstein, M.D.; Ernst R. Berndt, Ph.D.; Amy S. White, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate an understanding of the patterns of health care utilization as well as the importance of early identification and effective treatment for patients with treatment-resistant depression.

SUMMARY:

Purpose: Recent studies indicate that approximately 20% of depressed patients are resistant to traditional antidepressant treatments and approximately one-half of depressed patients have recurrent episodes. This study utilizes the 1995–1998 MarketScan® Claims Databases to profile the characteristics and health care utilization of patients with treatment-resistant depression.

Methods: Depression-diagnosed patients with adequate antidepressant dosing and treatment duration are selected. Patients are considered treatment resistant if they have switched/augmented initial medication with other antidepressants twice, or if they have switched/augmented initial medication and have depression-related hospitalizations or suicide attempts. Depression-diagnosed patients meeting selection criteria but not treatment resistant are used as comparisons.

Results: Treatment-resistant patients are at least twice as likely to have bipolar disorder, at least 1.5 times as likely to have anxiety disorders, and at least twice as likely to have substance-related disorders than the comparison group (p-values<0.01). Treatment-resistant patients are at least twice as likely to be hospitalized (depression and non-depression related), have 45% more outpatient visits than the comparison group, and use two to three times more psychotropic medications than the comparison group (p-values<0.01).

Conclusions: Treatment-resistant patients are high utilizers of depression-related and general medical services. Therefore, early identification and effective treatment of treatment-resistant patients is imperative to prevent future episodes.

REFERENCES:

1. Kocsis J: New strategies for treating chronic depression. J Clin Psychiatry 2000; 61(suppl 11):42–45.
2. Nelson JC: Treatment of antidepressant nonresponders: augmentation or switch? J Clin Psychiatry 1998; 59(suppl 15): 35–41.

TARGET AUDIENCE:

Clinicians, managed care organizations, and researchers

Poster 130 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

EFFECT OF AN INTEGRATED MEDICINE/PSYCHIATRY CLINIC ON DISEASE SCREENING/HEALTH PROMOTION

Narayana A. Reddy, M.D., *Medical Director, Human Service Center, 228 Jefferson Street, Peoria, IL 61654;* M. Boyle; James Gilligan, M.D.; M. Aiyer; S. Rusch, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to assess the effectiveness of integrated primary and psychiatric care in (1) providing early disease detection, appropriate cancer screening (2) increasing satisfaction of care, (3) altering frequency of emergency department (ED) visits in serious mentally ill population.

SUMMARY:

Background: The inability and unwillingness of the serious mentally ill to access traditional sources of medical care often leads to both fragmentation and poor quality of care. An Integrated Medical Psychiatric Clinic (IMPC) was established on-site of a community mental health center to provide high-quality health care to the serious mentally ill.

Methods: Following the pilot implementation phase, IMPC, the ED, and outpatient physician records were analyzed on 25 IMPC patients and 52 patients who received traditional care from (1996–1998). Data were

gathered on measurement of blood sugars, lipids and blood pressure, cancer screening, ED visits, and patient/mental health provider (MHP) satisfaction. SPSS 8.0 was used for comparative analysis.

Results: Compared with controls, IMPC patients had better screening for diabetes (48% vs. 10%) hypertension (84% vs. 19%), and hyperlipidemia (68% vs. 3.8%). There were 21 ED visits/patients in IMPC group vs. 81 ED visits/patients in control. Both MHP and IMPC patients reported increased satisfaction with care provided at IMPC.

REFERENCES:

1. Jeste DV, Gladsjo JA, Lindamer LA, Lacro JP. Medical Comorbidity in schizophrenia. Schizophrenia Bull 1996; 22:413–430.
2. Druss BJ, Rosenheck RA, Mental disorders and Access to Medical Care in the United States. Am J Psychiatry 1998 155:12; 1775–1777.

Poster 131 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

TREATMENT OF PEOPLE WITH SCHIZOPHRENIA IN THE ABSENCE OF MEDICATION

Ann L. Hackman, M.D., *Department of Psychiatry, University of Maryland School of Medicine, 630 West Fayette Street, Baltimore, MD 21201*

EDUCATIONAL OBJECTIVES:

At the conclusion of the session, the participant should understand that there are currently people with schizophrenia who are unable or unwilling to take medications and that these individuals can be successfully engaged and receive treatment.

SUMMARY:

Objective: Since the advent of antipsychotic medication, there is scant literature on unmedicated patients with schizophrenia. However, individuals who do not take medications continue to be seen in clinical settings. This study assessed patients enrolled in the University of Maryland's (UMD) Program of Assertive Community Treatment (PACT) who were unmedicated for at least one year.

Methods: The study was a retrospective chart review. Charts of all persons (N = 367) treated at PACT since 1991 were screened; 11 patients (3%) were identified who had schizophrenia spectrum diagnoses, active psychotic symptoms, and were unmedicated for 12 months or more. These were reviewed to assess patient characteristics, treatment approaches, and outcomes.

Results: Demographics were as follows: 4 female (36%), 7 male (64%); 4 Caucasian (36%), 7 African American (64%); age range 31 to 72. Time without medication ranged from 13 months to seven years 11 months. One person (9%) had a co-occurring substance use diagnosis; ten people (91%) had histories of homelessness. Reasons for not taking medications included pregnancy (9%), side effects (36%), and delusional reasons or denial of psychotic symptoms (55%). Treatment approaches included individual therapy, supportive treatment, behavioral plans, and case management. Four patients (36%) required hospitalizations. Four patients (36%) eventually agreed to antipsychotic medications and all of those were able to transition to less intensive services; the other seven remain in treatment with PACT and are maintained in the community.

Conclusions: People with schizophrenia who are unmedicated can be engaged, provided with services, and may maintain fair stability. Such individuals may eventually decide to take medications.

REFERENCES:

1. Green CA, Fenn DS, Moussaoui D, Kadri, Hoffman WF: Quality of life in never-treated schizophrenic patients. Acta Psychiatr Scand 2001; 103(4): 131–42.
2. Von Korff M, Nestadt G, Romanoski A, et al. Prevalence of treated and untreated DSM-III schizophrenia. Results of a two-stage community survey. J Nerv Ment Dis 1985; 173(10):577–81.

TARGET AUDIENCE:

Community treatment providers working with patients with severe mental illness

Poster 132 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

DIRECT AND INDIRECT COSTS OF ALZHEIMER'S DISEASE: A LONGITUDINAL STUDY

Novartis Pharmaceuticals Corporation

Micheline Dugue, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, One Gustave Levy Place, New York, NY 10029;* Deborah B. Marin, M.D.; James Schmeidler, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize how illness severity is significantly correlated with paid and unpaid caregiving.

SUMMARY:

Introduction: This study investigated the longitudinal course of direct and indirect costs in a sample of community dwelling Alzheimer's patients.

Methods: A total of 44 patients who resided with caregivers were evaluated over a one and a half-year period. The direct costs that were assessed include physician visits, medication use, hospitalizations, institutionalization, and paid home care. Indirect costs were assessed with the Caregiver Activity Survey, a five-item instrument that measures the amount of time a caregiver spends in daily tasks with the patient. Cognition and function were measured with the Mini Mental State Exam (MMSE) and Physical Self Maintenance Scale (PSMS).

Results: The average monthly direct and indirect costs totaled $638 and $3,065, respectively. Paid home care and indirect costs were significantly correlated with MMSE and PSMS scores at baseline and subsequent study visits. In contrast, hospitalizations, physician visits, medication use, and institutionalization were not correlated with cognition or function at most study visits. These cross-sectional relationships between costs and illness severity were maintained in longitudinal analyses.

Conclusion: For outpatients with Alzheimer's disease, unpaid caregiving accounts for the majority of costs associated with the illness. Both unpaid and paid caregiving costs are significantly correlated with cognitive and functional impairment. Overall, paid home care is the only direct cost that accounts for a substantial percentage of costs and correlates with illness severity.

Supported in part by National Institute of Aging grant #AG-02219, and a grant from Novartis.

REFERENCES:

1. Clipp E C, Moore M J: Caregiver time use: an outcome measure in clinical trial research on Alzheimer's disease. Clin Pharm Ther 1995; 58:228–236.
2. Davis K L, Marin D B, Kane R, et al. The caregiver activity survey (CAS): Development and validation of a new measure for caregivers of persons with Alzheimer's disease. Int J Geriatr Psychiat 1997; 12: 978–988.

TARGET AUDIENCE:

Physicians, nurses, social workers

Poster 133 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

HEALTH CARE UTILIZATION FOR MENTAL DISORDERS AMONG U.S. MILITARY PERSONNEL

Charles W. Hoge, M.D., *Chief, Department of Psychiatry and Behavioral Science, Walter Reed Army Medical Center, 503 Robert Grant Avenue, Silver Spring, MD 20910;* Charles C. Engel, M.D., *Chief, Deployment Health Clinical Center, 6900 Georgia Avenue, Room 3-G-04, Building 2, Washington, DC 20307;* Sandra E. Lesikar, Ph.D.; David T. Orman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to learn about the impact of mental disorders on a large healthy young adult population in terms of health care utilization and occupational functioning (measured by attrition from military service), 1990–1999.

SUMMARY:

Background: There have been limited studies of health care utilization and occupational impact of mental disorders in large working populations, such as the U.S. military.

Methods: Population-based analysis was conducted of hospitalizations among all active duty military personnel (16.4 million person-years) from 1990–1999 using the Defense Medical Surveillance System. Rates of hospitalization, ambulatory visits, and attrition from military service were compared for persons diagnosed with mental disorders and those diagnosed with the 15 other ICD-9 illness categories.

Results: Mental disorders emerged as the leading category of discharge diagnoses among men and the second leading category among women after 1996; 13% of all hospitalizations and 23% of all inpatient bed days were attributed to mental disorders. Six percent of the military population received ambulatory services for mental disorders per year in 1998 and 1999. Forty-seven percent of persons hospitalized for a mental disorder left military service within six months of their first hospitalization. This compared with an attrition rate of only 12% (range 11–18%) following hospitalization for any of the 15 other diagnostic categories (RR 4.04; 95% CI 3.91–4.17).

Conclusion: Mental disorders appear to represent the most important source of medical and occupational morbidity among active duty U.S. military personnel.

REFERENCES:

1. Murray CJL, Lopez AD (Eds.): The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries, and Risk Factors in 1990 and Projected to 2020. World Health Organization, Harvard University Press 1996.
2. Dlugosz LJ, Hocter JW, Kaiser KS, et al: Risk factors for mental disorder hospitalization after the Persian gulf war: U.S. Armed Forces, June 1, 1991-September 30, 1993. J Clin Epidemiol 1999; 52:1267–78.

TARGET AUDIENCE:

Health services researchers, psychiatric epidemiologists, clinicians

Poster 134 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

A ROLE FOR THE ADVANCED PHARMACIST PRACTITIONER IN ASSERTIVE COMMUNITY TREATMENT

Valerie U. Nwangwu, Pharm.D., *Director, Drug Information and Outcomes Center, 9888 Bissonnet, Suite 580, Houston, TX 77036;* Denise A. Ingham, M.D.; M. Lynn Crismon, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) recognize the potential usefulness of multidisciplinary roles in optimizing pharmacotherapy (2) design a cost-effective model for expanding patient access to medication management services.

SUMMARY:

Pharmacist involvement was piloted and evaluated in an assertive community treatment (ACT) program, a multidisciplinary, community-based psychiatric intensive care service. An advanced pharmacist practitioner (APP) could potentially provide a valuable role in promoting improved medication use outcomes. The study had two parallel arms, with and without pharmacist intervention. Each arm had mirror image design, incorporating a six-month retrospective and prospective medical record analaysis. Key areas of pharmacist involvement include collaborative drug therapy monitoring, management and consultation, case management and rehabilitative services, patient education and compliance skill training, pharmacokinetics, pharmacoeconomics, and the resolution of potential and actual medication-related problems (MRPs). Specific direct care costs are compared pre and post pharmacist intervention and in the parallel control group. APP involvement yielded a maintenance or improvement in Brief Psychiatric Rating Scale (BPRS), Global Assessment of Functioning (GAF), Multinomah Compliance and Abnormal Involuntary Movement Scale (AIMS) rating assessments, as well as patient and staff satisfaction. Expanding multidisciplinary roles in ACT will prove useful in enhancing patient access to and outcome of existing pharmacotherapeutic services.

REFERENCES:

1. Coleman J, Evans RI, Rosenbluth S: Expanded clinical roles for the pharmacist in psychiatric care. Am J Psych 1973; 30:1143–1146.
2. Loebeck F: The cost-effectiveness of a clinical pharmacy service in an outpatient mental health clinic. Hosp Comm Psychiatry 1989; 40:643–646.

TARGET AUDIENCE:

Health care administrators, physicians

Poster 135 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

STATE PSYCHIATRIC HOSPITAL ADMISSION SERVICES: DEVELOPING A CONCEPTUAL MODEL

John T. Hopkins, M.D., *Lead Physician, Department of Admissions, Georgia Regional Hospital, 3073 Panthersville Road, Decatur, GA 30034*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize similarities between general hospital emergency services and admission services of a state psychiatric hospital; better understand how the above intake services affect patient care.

SUMMARY:

The intake/admissions process of patients referred to a metropolitan area state psychiatric hospital has evolved to become more consistent with the intake process of a general hospital's emergency department. The reorganization of mental health, substance abuse, and mental retardation services (state of Georgia) has provided for an increased number and a diversity of referral sources, most of which are from hospital emergency services. An intake process model of hospital emergency services is used and compared with one intake process model currently used by a state hospital. Areas of similarity and differences are noted. The comparative assessment delineates areas where improved patient processing could be defined. The results are intended to be used in forming a conceptual model for use by state psychiatric hospitals generally.

REFERENCES:

1. Lynn SG, Hockberger RS, Kellermann A, et al: A report from the American College of Emergency Physicians Task Force on Hospital Overcrowding and Emergency Department Overload, Dallas, 1989, ACEP.
2. Reilly K, Salluzzo RF, Mulholland D et al: Factors affecting patients throughout time in an academic emergency department. Acad Emerg Med 1995; 2 (5):400.

TARGET AUDIENCE:

Health care managers, physicians, mental health professionals, consumers of services, general public.

Poster 136 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

FAMILIES IN TACT (FIT): AN INNOVATIVE FAMILY APPROACH TO ADDICTION TREATMENT

Cynthia Estelle, M.A., *Psychiatric Social Worker, University of Illinois at Chicago, 912 South Wood Street, 7th Floor, MC-913, Chicago, IL 60612;* Sylvia J. Dennison, M.D., *Chief, Addiction Section, Department of Psychiatry, University of Illinois, 912 South Wood Street, NPI #521, MC-913, Chicago, IL 60612;* Thomas Wilda, L.C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) recognize the benefits of enhancing traditional approaches to addiction treatment with a family-based component (2) understand the benefits of colloboration between treatment providers and the criminal justice system, a (3) demonstrate awareness of the benefits of providing the full spectrum of treatment services at one location.

SUMMARY:

The content of the poster will include the following: (1) A description of the Families. In Tact program, specifically, information pertaining to program components funding sources, cost effectiveness, and proposed staffing levels (clinician training, child care, and transportation providers, etc.) will be discussed. (2) A review of the first 18 months of participation. Total number of families serviced and demographic information will be provided. Data related to program outcome will also be presented. These data will explore the effect of the program on increasing treatment retention rates decreasing frequency of substance-exposed births (as compared with reported prevalency rates), and, over time, decreasing substance use. Number of program participants who subsequently loss custody of their children while enrolled in the program will also be discussed. (3) A comparative discussion of traditional vs. family-based approaches to substance abuse treatment will be presented. In particular, the effectiveness of using a family-based, holistic approach to chemical dependency will be proposed Costs and benefits associated with using a family-based approach will be presented. (4) Future directions for the Families-In-Tact (FIT) program and suggestions for others wishing to establish a similar program will be provided.

REFERENCES:

1. Nelson-Zlupko L: Women in recovery: their perceptions of treatment effectiveness. Journal of Substance Abuse Treatment 1996; 13: 51–59.
2. Kumper K: Effectiveness of a culturally tailored family-focused substance abuse program. Invited paper at the National Conference on Drug Abuse Prevention Research: Presentations, papers, and recommendations, Washington, DC, September 1996.

TARGET AUDIENCE:

Treatment providers, social service workers, judiciary members

Poster 137 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

THE SURVEY OF A VIRTUAL PSYCHIATRIC CLINIC

Chao-Cheng Lin, M.D., *Attending Psychiatrist, Yu-Li Veterans Hospital, 91 Hsing-Hsing Street, Hualien County, Yu-Li, Taiwan 981;* Jen-Yeu Chen, M.D., *Attending Psychiatrist, Yu-Li Veterans Hospital, 91 Hsing-Hsing Street, Hualien County, Yu-Li, Taiwan 9 81;* Ya-Mei Bai, M.D.; Chen-Jee Hong, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to learn the psychiatric services provided via Internet and understand who are the major clients of this service.

SUMMARY:

*Objective:*This is a cross-sectional survey of subjects asking questions about mental problems in a virtual psychiatric clinic via World Wide Web.

Method: Subjects were recruited and filled in the study form anonymously from the study website (http://www.psychpark.net/clinic). The mental health professionals answered the subjects' questions and returned them and to the subjects by e-mail. We analyzed the data of subjects who complete the study between Sep-9-1998 and Jul-8-1999.

Result: There were 186 subjects. Most were female (69.9%,n=130), single (77.3%, n=143), with stable job (41.4%, n=77), highly educated (mean education year: 15.0± 1.9), and young (mean age: 26.1± 5.8). Fifty-one percent of subjects (n=95) never had a psychiatric visit. Of those ever having a psychiatric visit (n=90), 42% (n=38) had no psychiatric diagnosis, 13.3%(n=112) didn't know their exact diagnosis, 15.6%(n=14) had anxiety disorder, and 11.1%(n=10) had depressive disorder. The majority of reasons using virtual psychiatric service is convenience (49.5%, n=92). Seventy-three percent of subjects (n=136) used internet at home; 63% (n=98) used internet less than 3 hours/week; and 57% (n=103) didn't want their questions and answers to be published.

Conclusion: The young, single, well-educated, employed female used the majority of the virtual psychiatric

service. Among the known diagnoses, anxiety disorder and major depressive disorder are the most prevalent.

REFERENCES:

1. Huang MP, Alessi NE: The internet and the future of psychiatry. Am J Psychiatry 1996; 153 (7):861–869.
2. Chao-Cheng Lin, Chemg-Woei Song: A Survey of Psychiatric Resources on the Internet. Pro 35th Ann of the Soc of Psychiatry, R.O.C. (Taiwan) 1996: 116.

POSTER SESSION 5

Posters 138–170

Poster 138 **Saturday, October 13**
3:30 p.m.-5:00 p.m.

WORK STRESS AND EMOTIONAL HEALTH IN THE U.S. AIR FORCE

Steven E. Pflanz, M.D., *Chief, Mental Health Services, F.E. Warren Air Force Base, U.S. Air Force, 408 West First Avenue, Cheyenne, WY 82001*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand the relationship between occupational stress and psychiatric illness and how this applies to the military as a specific work environment.

SUMMARY:

Objective: One out of every ten American workers reports exposure to mental stress at work and 5% believe that their experience of work stress could be deleterious to their mental health. This study examined the incidence of occupational stress and its relationship to work stress in military personnel.

Methods: A total of 472 military personnel answered a 65-item survey that included items on the perception of occupational stress and reported life events. It incorporated the 43-item Schedule of Recent Experiences (SRE). By adding the weighted values assigned to the 43 items, each respondent was given an SRE score, which is a measure of overall stress and has been shown to be predictive of future illnesses.

Results: Significantly, more military personnel reported job stress than the general American working population ($p < .001$), with 26% suffering from significant work stress. Fifteen percent reported that work stress was causing them significant emotional distress, and 8% reported suffering from work stress that was so severe that it was believed to be damaging their emotional health. The average SRE score for all respondents was 160 reflecting increased risk for future illnesses. Generic work stressors were reported far more frequently than military specific stressors.

Conclusions: These results support previous research that indicates that work stress may be a significant occupational health hazard in the military. Using these data, interventions can be planned to mitigate the impact of stress caused by the military work environment on the mental health of military personnel.

REFERENCES:

1. Pflanz SE: Psychiatric illness & the workplace. Military Medicine 1999; 164(6): 401–406.
2. Pflanz SE, Skop B: Occupational stress and psychiatric illness in the military. Southern Medical Journal 1998; 91(10): S63.

TARGET AUDIENCE:

General psychiatry, occupational/organizational psychiatry

Poster 139 **Saturday, October 13**
3:30 p.m.-5:00 p.m.

CHRONIC BACK PAIN SUCCESSFULLY TREATED WITH PSYCHOEDUCATION

Adekola O. Alao, M.D., *Assistant Professor, Department of Psychiatry, State University of New York Upstate Medical University, 750 East Adams Street, Syracuse, NY 13210*; Ellen Faynberg, M.A., *Psychology Intern, State University of New York Upstate Medical University, 750 East Adams Street, Syracuse, NY 13210*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) recognize the impact of psychological functioning regarding the etiology and treatment of certain patients with chronic back pain, and (2) understand how psychoeducation as a form of treatment may achieve significant symptom reduction in certain individuals.

SUMMARY:

Chronic back pain is one of the most frequently encountered clinical diagnoses by a primary care physician. Despite the fact that the impact of psychological functioning is well recognized in the etiology and treatment of chronic back pain, most interventions are focused on pain reduction and surgical intervention.

This presentation describes an open-label study of five patients with chronic back pain. All patients were successfully treated with a structured program involving psycho-education.

Methods: Five patients with chronic low back pain that failed various surgical interventions were assessed at baseline, six months, and at one year. All patients

were examined to rule out any systemic illness such as a malignancy. They were assessed subjectively regarding their level of disability/impairment and with the visual analogue pain scale (VAS). They were started in a structured program of psychoeducation. This involved requesting all patients to identify present and past sources of rage, previous physical, sexual, or emotional abuse, and to review the list on a daily basis. The patients were encouraged to discontinue or limit treatment that was directed at a structural abnormality. However, they were allowed to continue with their pain medications. Lastly, they were encouraged to resume non-strenuous physical activities as the intensity of the pain subsided.

Results (Table 1 & 2)

All three females and two males have symptom reduction in their VAS with corresponding reduction in limitation after one year.

Case	Age	Sex	Stressor	Abuse history	Disability	VAS initial	VAS	% VAS reduction	Disability
1	55	F	+ve	E	Present	8	2	75	Imp
2	66	F	+ve	None	Present	9	3	67	Imp
3	28	F	+ve	E	Present	10	6	40	Imp
4	38	M	+ve	E	Present	9	1	89	Imp
5	24	M	+ve	S	Present	10	5	50	Imp

Key: +ve = positive, E = emotional, S = sexual, VAS = Visual analogue scale, Imp = Improved

Discussion and Conclusion: Psychological explanation of chronic pain may include fulfillment of unconscious needs for guilt and masochism, release of emotional pain, emotional suppression, idealization of relationships, strong work ethics, and emphasis on self-reliance. A structured psycho-educational program aimed at helping patients identify emotions and sources of stress and allaying the "fear of the fragile back" may be enough to achieve significant symptom reduction.

REFERENCES:

1. Gregory RJ, Berry SL: Measuring counterdependency in-patients with chronic pain. Psychosomatic Medicine 1999; 61:341–345.
2. Coen SJ, Sarno, JE: Psychosomatic avoidance of conflict in back pain. Journal of the American Academy of Psychoanalysis 1989; 17:359–376.

Poster 140 **Saturday, October 13**
3:30 p.m.-5:00 p.m.

RESPONSE TO RIVASTIGMINE TREATMENT IN KEY DOMAINS OF ALZHEIMER'S DISEASE

Novartis Pharmaceuticals Corporation

Martin Farlow, M.D., *Department of Neurology, Indiana University, 541 Clinical Drive, Suite 583, Indianapolis, IN 46203*; Richard D. Hartman, *Department of Medical Affairs, Novartis Pharmaceuticals Corporation, 59 Route 10-E, East Hanover, NJ 07936*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that a response in one domain of AD does not predict the response in another domain; determine the proportion of rivastigmine-treated patients who will experience benefit in any of three domains of AD.

SUMMARY:

Objective: In Alzheimer's disease, response to drug therapy may not be the same across different symptom domains. Using a multi-domain responder analysis, we determined the proportion of AD patients who responded to rivastigmine treatment in cognition, activities of daily living (ADL), or global functioning.

Method: Patients participated in one of three double-blind trials comparing rivastigmine with placebo. Analyses were performed on the U.S. trial and pooled trials. Cognition, ADL, and global functioning were measured with ADAS-Cog, PDS, and CIBIC-Plus, respectively. For this analysis, significant clinical improvement from baseline was defined as either ADAS-Cog $\geq$ 4-points, PDS $\geq$ 10% improvement, or CIBIC-Plus $<$ 4. Stabilization of disease was defined as ADAS-Cog $\geq$ 0-points, PDS $\geq$ 0% improvement, or CIBC-Plus $<$ 5.

Results: For the U.S. study (6–12 mg/d), clinically significant differences were observed in 25% for ADAS-Cog, 24% for CIBIC-Plus, and 26% for PDS. Overall, 54% demonstrated a clinically significant improvement in $\geq$1 domain. At week 26, stabilization was observed in 52% on ADAS-Cog, 60% on CIBIC-Plus, 45% on PDS, and 90% showed stabilization in $\geq$1 domain. Results from the pooled analysis were similar.

Conclusions: Patients respond to rivastigmine in different symptom domains. Since benefits in different domains appear substantially independent of each other, an overall rating of efficacy should take into account all domains.

REFERENCES:

1. Qizilbash N, et al: JAMA 1998; 280: 1777–1782.
2. Corey-Bloom et al: Int J Geriatr Psychopharmacol 1998; 1: 55–65.

TARGET AUDIENCE:

Geriatric psychiatrists

Poster 141 **Saturday, October 13**
3:30 p.m.-5:00 p.m.

MELATONIN TREATMENT FOR TARDIVE DYSKINESIA: A DOUBLE-BLIND, PLACEBO-CONTROLLED CROSS-OVER STUDY

Eyal Z. Shamir, M.D., *Director, Day Care Department, Abarbanel Mental Health Center, 15 KKL Street, Bat-Yam, Israel 59100*; Yoram Barak, M.D., *Director, Department of Psychogeriatrics, Abarbanel Mental Health Center, 15 KKL Street, Bat-Yam, Israel 59100*; Irena Shalman, M.D.; Nava Zisapel, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize melatonin as a new strategy in the treatment for tardive dyskinesia.

SUMMARY:

Background: Antipsychotics remain the mainstay of drug intervention in the management of schizophrenia. However, long-term treatment with antipsychotics is associated with a variety of movement disorders, the most disabling of which is tardive dyskinesia (TD) that occurs in up to 50% of chronically hospitalized patients with schizophrenia. The pathophysiology of TD is still unclear. Both dopamine receptors supersensitivity and oxidative stress-induced neurotoxicity in the nigrostriatal system are apparently implicated. TD has no definite treatment, although atypical antipsychotics and the antioxidant vitamin E were reported to reduce TD symptomatology. The pineal hormone melatonin is a potent antioxidant and attenuates dopaminergic activity in the striatum and dopamine release from the hypothalamus. Thus, it may have a beneficial effect for both the treatment and prevention of TD.

Methods: We evaluated in a double-blind placebo-controlled, cross-over study the efficacy of 10mg/day melatonin for six weeks in 22 patients with schizophrenia suffering from TD.

Results: Mean ± SD of decrease in Abnormal Involuntary Movement Scale (AIMS) score was 2.95 ± 2.14 for the melatonin and 1.0 ± 1.34 for the placebo treatment ($p = 0.0001$, MANOVA). A greater cumulative exposure to antipsychotics was associated with a better outcome. No adverse events or side effects were noted.

Conclusion: This is the first clinical evidence for efficacy of melatonin in the treatment of TD.

REFERENCES:

1. Feltner DE, Hertzman M: Progress in the treatment of tardive dyskinesia: theory and practice. Hosp Community Psychiatry 1993; 44:25–34.
2. Barak Y, Swartz M, Shamir E, Stein D, Weizman A: Vitamin E (alpha-tocopherol) in the treatment of tardive dyskinesia: a statistical meta-analysis. Ann Clin Psychiatry 1998; 10:101–5.

Poster 142 **Saturday, October 13**
3:30 p.m.-5:00 p.m.

HETEROGENEITY IN THE DIAGNOSIS AND TREATMENT OF DUAL DIAGNOSIS

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize prevalence of dual diagnosis and appreciate heterogeneity of diagnosis and treatment of dual diagnosis.

SUMMARY:

Dual diagnosis (DD) of mental illness (MI) and substance abuse (SA) poses a challenge for long-term recovery and has an economic impact of increased cost of its treatment. To assess the prevalence of DD and its treatment, records of patients enrolled into an SA treatment program for a minimum of 120 days were reviewed. There were 58 patients with a diagnosis of alcohol abuse/dependence (A), 38 with cocaine abuse/dependence (C), and 118 with opioid dependence (H). C were younger and H were older than A, but not significantly. 58.62% of A had MI as compared with 39.74% of C ($p < 0.05$), and 28.81% of H ($p < 0.001$). The MI was treated with anxiolytics (AX), antidepressants (DP), neuroleptics (NP), and mood stabilizers (MS). Most of the patients received one or two classes of drugs. But 29.41% of H received three classes of drugs as compared with 14.71% of A ($p < 0.005$), and to only 6.64% of C ($p < 0.001$). This may suggest more severity and/or complexity of MI among H. The DP were widely and commonly used, at 100% among C as compared with other drugs ($p < 0.001$). 55.88% of A received AX as compared with 20.00% of C ($p < 0.001$). On the contrary, only 14.71% received MS as compared with 33.33% of C ($p < 0.05$). These data show that there is a great heterogeneity in diagnosis and treatment of DD.

REFERENCES:

1. Regier DA, Farmer ME, Rae DS, et al: Comorbidity of mental disorders with alcohol and other drug abuse: results from the Epidemiological Catchment Area (ECA) study. JAMA 1990; 264:2511–2518.

2. Weiss RD, Mirin SM, Frances RJ: The myth of the dual diagnosis patients. Hospital and Community Psychiatry 1992; 43:107–108.

TARGET AUDIENCE:

Psychiatrists, psychologists, nurses, counselors

Poster 143 **Saturday, October 13**
3:30 p.m.-5:00 p.m.

PREDICTION AND ASSESSMENT OF SECLUSION IN AN ACUTE INPATIENT SETTING

Geetha Jayaram, M.D., *Associate Professor, Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street, Meyer 101, Baltimore, MD 21287-7101*; Gary Dunn, M.S.N.; Bernie Keenan, M.S.N.; Karin Taylor, M.S.N.; Donna Brannan, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) evaluate patients using a screening tool to predict seclusion use in the hospital, (2) apply regulatory requirements to the use of seclusion in severely ill patients, and (3) understand and successfully use less restrictive alternative to avoid secluding patients.

SUMMARY:

Background: New regulations promulgated by the Joint Commission on Accreditation of Hospitals (JCAHO) are onerous, requiring substantial changes in patient service systems. The Short Stay Service (SSS) in the Department of Psychiatry at Johns Hopkins Hospital devised multidisciplinary tools with a view to (1) guide appropriate use of seclusion per regulations, (2) encourage use of less restrictive measures, (3) collect patient related data for analyses to identify predictors of seclusion and assess the utility of the tools developed.

Method: Clinical data were collected on 229 consecutive admissions to the SSS in 2000. Potential for aggression was assessed at intake using a screening tool. Seclusion use was recorded on a newly devised form for each act of aggression. Demographics, case-mix severity, and outcomes were examined.

Results: Sixty-eight acts of verbal and physical aggression occurred among 22 patients, all of whom had been identified during screening. There were no gender or age differences between aggressive and nonaggressive patients. Significant differences between the groups were noted at the 0.004 and 0.006 levels for length of stay and cost of hospitalization, respectively, and at the 0.005 level for illness complexity. Details of interventions, outcomes, and successful resolution of unsafe behavior will be discussed.

REFERENCES:

1. The Joint Commission on Accreditation of Hospitals. Restraint and Seclusion Standards for Behavioral Health. Effective Jan 1, 2001
2. Crenshaw WB, Cain KA, Francis PS: An updated national survey on seclusion and restraint Psychiatric Services. 1997; 48(3): 395–397

Poster 144 **Saturday, October 13**
3:30 p.m.-5:00 p.m.

WHY ARE WEEKEND ADMISSIONS IMPORTANT?

Geetha Jayaram, M.D., *Associate Professor, Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street, Meyer 101, Baltimore, MD 21287-7101*; Gary Dunn, M.S.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) evaluate the complexity of patients and its impact on length of stay, and (2) understand the fiscal impact of admissions with respect to day of the week.

SUMMARY:

Background: Current hospital practice requires inpatient stays for severely mentally ill patients to be short and economical. Although we had previously reported on clinical and system variables that reduce length of stay, we had not examined the economic impact of admissions on weekdays as opposed to weekends. Our goal was to assess the differences between admissions on weekdays and weekends.

Method: We collected case-mix data for 10,810 admissions over a five-year period beginning fiscal year 1996. Patients admitted came through the emergency department and as elective admissions. Their diagnoses included schizophrenia, affective disorders, eating disorders, substance use disorders, and others. Case complexity was determined by use of Diagnostic Related Groups. Coders trained to concurrently review charts determined complexity ratings. Besides demographics, we used parametric and non-parametric tests to analyze data.

Results: We found highly significant differences between weekday and weekend admissions with respect to total charges, volume, length of stay, and case complexity. It is possible to be both efficient and economical by identifying, examining, and modifying those factors that negatively influence weekend admissions and to increase profits.

REFERENCES:

1. Joyaram G, Tien A, Sullivan P, et al: Elements of a successful short stay inpatient psychiatric service. Psychiatric Services 1996; 47(4):407–412
2. Mezzich JE, Coffman GA: Factors influencing length of hospital stay. Hospital and Community Psychiatry 1985; 36:1262–1264

Poster 145 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

EPILEPTIC MENTAL DISORDER AND SUICIDE BEHAVIOR

Zhihua Qin, M.D., *Department of Psychiatry, Mental Hospital of Henan Province, Jianshe Roal, Xinxiang City, China 453002*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will gain first-hand information collected in central China on suicide behavior and diagnosis during the last decade.

SUMMARY:

One hundred sixty-nine patients with epileptic mental disorder were hospitalized in our hospital from 1981 to 1990; 28 had suicidal behavior. The suicidal behaviors occurred for the most part in males (the ratio of the male to the female was 1.8:1). The ages of suicide below 40 years old accounted for 85.71%, the unmarried for 60. The suicide behaviors were related to such factors as: There were premonitory symptoms and it reached 67.87% in the paper. The mental symptoms were mainly hallucination and delusion, which accounted for 57.14%. The pessimistic and being world-weary accounted for 42.86%. Past suicide behavior accounted only for 10.71%. Suicide behavior occurred in each stage of epileptic mental disorder, mainly did within 3 years after falling sick. 39.29% had induced factors, mainly induced by emotional imbalance. 14.29% showed confusion which suggested the blindness of suicide behavior for partial patients. The suicide behavior mostly happened during the day, at home, the ways were varied and tools were at hand, which suggested difficulty of taking precautions.

REFERENCES:

1. Zhai Shu-tao: The psychiatry side of suicideology. Overseas Medicine, Psychiatry Book 1991;1: 1.
2. Rao Keming: The analyses of suicide death's cases during 10 years in residents of Xuhui district of Shanghai city. Shanghai Archieves of Psychiatry 1993; 1: 15.

TARGET AUDIENCE:

Psychiatrists

Poster 146 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

NEUROPSYCHIATRIC EFFECTS ASSOCIATED WITH INTERFERON THERAPY

Natalia Sartorius Calamai, M.D., *Psychiatrist, Hospital 12 de Octubre, Avenida de Andalucía, Km. 5400, Madrid, Spain 28041*; L. Estevez, M.D., *Psychiatrist, Hospital 12 de Octubre, Avenida de Andalucía, Km. 5400, Madrid, Spain 28041*; Corral I. Lopez; J. M. Misiego

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the neuropsychological effects of Interferon treatment.

SUMMARY:

Methods: 20 patients receiving interferon treated in a CHCM during the past year, were studied and followed during six months, due to the presence of psychiatric symptomatology.

Results: 11 men and 9 women from 25 to 59 years old, treated with interferon (underlying illness was chronic hepatitis C and melanoma), were sent to the CHCM.

85% had previous psychiatric history including personality disorder, substance abuse, disthimia, PSTD, and major depression.

Affective and anxiety disorders were the most common psychiatric problems, associated with interferon treatment; two patients had a delusional disorder.

Symptom presentation appeared in a range of four to 12 weeks after the beginning of interferon therapy (average nine weeks).

Most patients improved with psychopharmacologic treatment but premorbid status was not achieved.

Conclusions: Any patient treated with interferon is at risk of presenting neuropsychiatric symptoms.

Previous psychiatric illness and history of substance abuse are risk factors but not contraindication.

Psychiatric treatment improved patient clinical condition enough to avoid interferon discontinuation.

We recommend that all patients treated with interferon receive a psychiatric follow-up.

REFERENCES:

1. Dieperink F, Willenbring M, Ho S: Neuropsychiatric symptoms associated with hepatitis C and interferon alpha: a review. Am J Psychiatry 2000; 157:867–876
2. Trask PC, Esper P, Riba M, Redman B: Psychiatric side effects of interferon therapy: prevalence pro-

posed mechanisms, and futuro directions, J Clin Oncol 2000; 18 (11):2316–26.

TARGET AUDIENCE:

General psychiatrists

Poster 147 **Saturday, October 13**
3:30 p.m.-5:00 p.m.

PSYCHIATRIC INVESTIGATION TRENDS: EVOLUTION THROUGH INTERNATIONAL PUBLICATIONS IN THE LAST 15 YEARS

L. Estevez, M.D., *Psychiatrist, Hospital 12 de Octubre, Avenida de Andalucia, Km. 5400, Madrid, Spain 28041*; Natalia Sartorius Calamai, M.D., *Psychiatrist, Hospital 12 de Octubre, Avenida de Andalucía, Km. 5400, Madrid, Spain 28041*; E. Garcia-Bernardo, M.D.; J. M. Otin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be able to understand the dramatic evolution of psychiatric research trends in the last 15 years.

SUMMARY:

Objective: Different topics investigated in psychiatry in the last 15 years are described, shifting from a psychological and clinical interest focus to a genetic, molecular, and, specially, pharmacological one.

Material and Methods: The first 10 psychiatric publications, with highest impact factor in 1985, are reviewed, monitorized, and compared with the first 10 in 1999. Investigation articles contents are reviewed.

Results: Impact factor dramatically changes from 1985 to 1999. Contents of articles shifted from clinical and psychological interest to mollecular, genetic, and pharmacological.

Conclusion: Interests in psychiatric investigation trends have strongly changed in the last 15 years. Further studies are needed to assess the underlying reasons of this dramatic evolution.

REFERENCES:

1. Akil II, Watson SJ: Science and the future of Psychiatry. Archives General Psychiatric 2000 57(1):86–7.
2. Cami J: Impactolatria: diagnostico y tratamiento. Med Clin (Barc.) 1997; 109:515–524.

TARGET AUDIENCE:

General psychiatrists

Poster 148 **Saturday, October 13**
3:30 p.m.-5:00 p.m.

IMPACT OF A SMOKE-FREE POLICY ON MEDICATION USE IN A PSYCHIATRIC FACILITY

Norma C. Josef, M.D., *30901 Palmer Road, Westland, MI 48186-9529; Venkataramana S. Lingam, M.D., 30901 Palmer Road, Westland, MI 48186-9529*; Cynthia Quince, Pharm.D.; Patricia Camazzola, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able (1) to demonstrate the relationship between smoking and the utilization of cardiorespiratory and psychotropic medications in an inpatient facility, (2) gain awareness of the impact of smoking on the cost of the pharmacologic treatment of chronic psychiatric and co-morbid medical illnesses.

SUMMARY:

Cigarette smoking remains the most preventable contributor to health problems, disability, and health expenditures in the United States. The prevalence of cigarette smoking in the U.S. in 1994 was 25.5% in the normal population and as high as 50% in the psychiatric groups. According to the Federal Center for Disease Control, the approximately four million smoking-related deaths may decrease with the implementation of nonsmoking policies in public facilities. In March 1999, a nonsmoking campus policy was implemented in a Midwest state adult psychiatric inpatient facility. Concurrent chart review of 80 identified smoking patients at baseline (March), three months (June), and six months (September) post policy implementation, collected data on diagnosis, smoker status, cardiovascular and psychotropic medication use, and seclusion/restraints utilization. The results showed that the use of anxiolytics, antidepressant, antipsychotic, and cardiac and bronchodilator medications decreased during the six months post policy implementation, based on the facility's pharmacy expenditures, by as much as 25%. Seclusion/restraints measures remained constant. Based on the limitations of the study, it is difficult to determine if the nonsmoking policy independently caused the results, but it suggests a correlation that merits further exploration.

REFERENCES:

1. Appelbaum PS: Do hospitalized psychiatric patients have a right to smoke. Psychiatric Services 1995:46:653–654.
2. Pies R: Smoke, Schizophrenia and Cytochromes. Psychiatric Times Apr 1998:60.

TARGET AUDIENCE:

Psychiatric treatment teams, facility administrators

Poster 149 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

ACUTE EFFECTS OF VIDEO GAME VIOLENCE ON EMPATHY IN BOYS

Jonathan S. Kaplan, M.D., *Resident Psychiatrist, Hillside Hospital, 510 South 9th Street, New Hyde Park, NY 11040*; Michael N. Kessler, M.D., *Resident Psychiatrist, Hillside Hospital, 265-14 74th Avenue, Apt. B-1, Glen Oaks, NY 11004-1152*; Joseph Blader, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize the effects of acute video game violence on empathy in boys with and without behavioral disorders.

SUMMARY:

The effects of media violence on children and adolescents have been a controversial topic for the past few decades. Video games are one such medium for violence. The majority of video game studies concluded that children become more aggressive after either playing or watching a violent video game. The General Affective Aggression Model (GAAM) proposes that both short- and long-term exposure to aggression can decrease empathy in part by aggressive desensitization.

Nine 8- to 12-year-old boys with a diagnosis of oppositional defiant disorder or conduct disorder and nine controls were shown a violent and nonviolent video game for 15 minutes each. After each game, empathy was assessed by an empathy response task consisting of eight validated short stories of children in emotional situations.

Overall, results indicate that the control group had significantly higher empathy scores than the children with behavioral disorders regardless of the video game played. Also, the length of time in years playing video games and the category of video game played most often significantly affected empathy scores. Hence, violent video game playing does affect childhood empathy.

REFERENCES:

1. Griffiths M: Violent video games and aggression: a review of the literature. Aggression and Violent Behavior 1999;4:203–12
2. Anderson CA, Dill KE: Video games and aggressive thoughts, feelings, and behavior in the laboratory and in life. Journal of Pers & Social Psychology 2000;78:772–90

TARGET AUDIENCE:

Child and adolescent/forensic psychiatrists/psychologists

Poster 150 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

PREVALENCE OF CARDIOVASCULAR COMORBIDITY AND RISK FACTORS IN SEVERE AND PERSISTENTLY MENTALLY ILL PATIENTS

Terrance J. Bellnier, M.P.A., *Pharmacy Department, State University of New York at Buffalo, 36 Forest Meadow Trail, Rochester, NY 14624*; Adam Decatur, Ph.D., *Pharmacy Department, State University of New York at Buffalo, 36 Forest Meadow Trail, Rochester, NY 14624*; Anthony H. Labrum, M.D.; Shyam Karki, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the prevalence of comorbid cardiovascular disease and its risk factors in SPMI, and apply this knowledge to the selection of psychotropic drug treatment.

SUMMARY:

Objective: The severe and persistently mentally ill population have not been extensively studied concerning comorbidities and physical and behavioral risk factors of cardiovascular disease. We propose to determine the prevalence of these comorbidities and risk factors in this population.

Method: We conducted a chart review of all adult inpatients (N=179) of a state psychiatric hospital during July and August 2000. All subjects had a medical history, physical exam, screening blood tests, and ECG. The prevalence of cardiovascular disease in our population was compared with a control group matched for age and sex.

Results: Subject Characteristics: 47 ± 16 years; 113 male; 29% African American, 10% Hispanic. *Cardiovascular Disease Comorbidities:* 40% ECG abnormalities, 15% Hypertension, 10% Diabetes, 7% Thyroid Dysfunction, 6% CAD.

Physical and Behavioral Risk Factors: 69% overweight (BMI ≥ 30); 18% hyperlipidemia, 67% nicotine & 49% alcohol abuse, 35% chemically addicted.

Conclusion: 49% had cardiovascular disease comorbidities; 62% had multiple behavioral and physical risk factors for developing cardiovascular disease in their life time. The sample size limits our ability to make population inferences, yet an association between severe and persistently mentally ill patients and a increased risk

for cardiovascular disease exists in our group (T = 8.101, df=356,P<.00001).

REFERENCES:

1. Jeste DV, Gladsjo JA, Lindamer LA, Lacro JO: Medical comorbidity in schizophrenia. Schizophrenia Bulletin 1996;22,3:413–430.
2. Kitayama H, Kiuchi K, Nejima J, Kaoth T, Takano T: Long-term treatment with antipsychotic drugs in conventional doses prolonged QTc dispersion, but did not increase ventricular tachyarrhythmias in patients with schizophrenia in the absence of cardiac disease. Eur J Clin Pharmacol 1999;55:259–262

TARGET AUDIENCE:

Psychiatrists, mental health administrators, consumers

Poster 151 **Saturday, October 13**
3:30 p.m.-5:00 p.m.

CUE-ELICITED CRAVING AMONG INDIVIDUALS WITH SCHIZOPHRENIA AND COCAINE DEPENDENCE

David A. Smelson, Psy.D., *151 Knollcroft Road, Lyons, NJ 07939*; Miklos Losonczy, M.D., Ph.D., *151 Knollcroft Road, Lyons, NJ 07939*; Chris Kilker, B.A.; Jennifer Harter

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should develop a better understanding about diagnosing and treating cocaine addiction and craving in individuals dually diagnosed with schizophrenia and comorbid cocaine dependence.

SUMMARY:

Introduction: Cocaine abuse remains a serious public health problem in the United States among the psychiatric and nonpsychiatric population. In the psychiatric population, it is associated with increased hospitalizations, more relapses, and worse long-term outcomes. Because of the role of reinforcement in maintaining an addiction, we recently compared craving in schizophrenic and nonschizophrenic cocaine addicts. This study used a retrospective design, and found that the cocaine-dependent schizophrenics had significantly more craving than their nonschizophrenic counterparts (Carol et al, 2000). To extend this research, the present study used cue exposure to stimulate craving and compare cue-elicited craving in cocaine-dependent schizophrenics with nonschizophrenic cocaine addicts.

Methods: The sample was comprised of 89 schizophrenic and nonschizophrenic cocaine addicts who underwent a cue-exposure paradigm.

Results: The schizophrenic cocaine addicts (n = 33) had significantly more cue-elicited craving than nonschizophrenic cocaine addicts (n = 56) (mean −13.2 ± .8.5 vs .42 ± 12.3, t=5.6, df=87 p>.0001). After dichotomizing the data into responders and nonresponders, 97% of the cocaine-dependent schizophrenics were cue reactive compared with 43% of the nonschizophrenic cocaine addicts (chi = 23.7 df 1, P>.0001). Other data will also be reported.

Discussion: Future research should focus on targeting craving while treating the dual disorders.

REFERENCES:

1. Smelson DA, Roy A, Roy M, Santana S: Electroretinogram in withdrawn cocaine dependent patients: relationship to cue-elicited craving. British Journal of Psychiatry 1998; 172: 537–539.
2. Carol G, Smelson DA, Losonczy MF, Ziedonis D: Cocaine craving in individuals with Schizophrenia compared to cocaine addicts without schizophrenia. Poster presented at American Psychiatric Association in Chicago IL. May 2000.

Poster 152 **Saturday, October 13**
3:30 p.m.-5:00 p.m.

SUICIDES IN CHEMICAL DEPENDENCY PROGRAMS: PRELIMINARY DATA

Otto Kausch, M.D., *Department of Psychiatry, Case Western Reserve University, 10000 Brecksville Road, Brecksville, OH 44141*; Richard A. McCormick, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) recognize risk factors for suicide in chemical dependency programs, and (2) appreciate the difficulty of predicting suicide.

SUMMARY:

Completed suicides over a one-year period were reported from a nationwide survey of Department of Veteran Affairs medical centers. Of a total of 248 completed suicides, 11 occurred in outpatient substance abuse programs, and an additional five occurred among patients receiving combined outpatient substance abuse and psychiatric treatment. The majority of suicides were committed by males who had a primary alcohol addiction (63%). Thirty-eight percent had a comorbid mood disorder, and 38% had a comorbid personality disorder. There were no inpatient suicides. During this time, there were seven suicide attempts on inpatient units and 37 suicide attempts in outpatient chemical dependency treatment.

Three case studies, two completed suicides, and one attempted suicide are presented to illustrate the complexities of assessing chemical dependency patients for suicide potential while in treatment. Risk factors for suicide are reviewed.

REFERENCES:

1. Roy A: Suicide among alcoholics. Int Review of Psych 1992; 4: 211–216.
2. Lehman L, McCormick R A, McCracken L. Suicidal behavior among patients in the VA health care system. Psychiatric Services 1995; 46: 1069–1071.

TARGET AUDIENCE:

Chemical dependency treatment providers

Poster 153 **WITHDRAWN**

Poster 154 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

TOPIRAMATE IN THE TREATMENT OF BINGE EATING ASSOCIATED WITH OBESITY

Ortho-McNeil Parmaceuticals, Inc.

Susan L. McElroy, M.D., *Department of Psychiatry, University of Cincinnati College of Medicine, 231 Albert Sabin Way, P.O. Box 670559, Cincinnati, OH 45267*; Lesley M. Arnold, M.D.; Nathan A. Shapira, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the effects of topiramate in the treatment of binge eating disorder associated with obesity, including behavioral changes and weight loss associated with treatment.

SUMMARY:

Binge eating disorder (BED) is characterized by recurrent, uncontrollable episodes of excessive food consumption. Topiramate is an antiepileptic agent associated with weight loss in patients with epilepsy. This 14-week, placebo-controlled, double-blind trial of topiramate in BED included 61 randomized outpatients (53 female, 8 male) with BED and obesity. Fifty-eight patients received ≥1 dose of topiramate. Mean baseline weekly binge frequencies and weights were 6.3 and 123 kg, respectively (placebo) and 5.3 and 120 kg, respectively (topiramate). Topiramate was started at 25 mg/day and titrated slowly (25–50 mg/wk) to a maximum dose of 600 mg/day. Median topiramate dose was 213 mg/day (range 50–600). Compared with placebo, topiramate was associated with a significant reduction in binge frequency ($P < .001$), binge days ($P < .001$), YBOCS-BE score (P=.004), BMI (P=.003), and a significant increase in the CGI Improvement Scale (P=.012). For topiramate-treated completers mean weight loss was 5.9 kg (P=.005). Nine patients (3 placebo; 6 topiramate) discontinued due to adverse events. The most common reasons for discontinuing topiramate were headache (n=3) and paresthesias (n=3) and paresthesias (n=2). These results suggest that topiramate represents a potential new treatment for BED.

REFERENCES:

1. McElroy S I, et al: Open-label adjunctive topiramate in the treatment of bipolar disorders. Biol Psychiatry 2000;47:1025–33.
2. Shapira NA, et al: Treatment of binge-eating disorder with topiramate: a clinical case series. J Clin Psychiatry 2000;61(5): 368–72.

Poster 155 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

CLINICAL AND BIOLOGICAL PREDICTORS OF THE PLACEBO RESPONSE IN DEPRESSION

Robert H. Howland, M.D., *Associate Professor of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213*; Amy L. Fasiczka, M.A., *Data Coordinator and Analyst, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe various demographic, clinical, and biological variables that are associated with predicting a response to placebo in major depression.

SUMMARY:

The purpose of this study was to investigate various demographic, clinical, and biological predictors of a placebo response in depression.

A total of 139 outpatients with nonbipolar, nonpsychotic, nonchronic DSM-III-R major depression were enrolled in a four week, single-blind, placebo phase. Clinical measures included the 17-item Hamilton Depression Rating Scale (HRSD), Beck Depression Inventory (BDI), Global Assessment Scale (GAS), and the Pittsburgh Sleep Quality Index (PSQI). Cognitive measures included the Self-Control Schedule (SCS), Automatic Thoughts Questionnaire (ATQ), and Dysfunctional Attitude Scale (DAS). Biological data included two night sleep EEG studies and 24-hour urine cortisol collections. At the end of four weeks, subjects with a

HRSD score of <14 or who had >20% improvement in their HRSD were considered responders.

Thirty-nine subjects were responders. Responders had significantly lower pretreatment HRSD, BDI, DAS, and PSQI scores; higher GAS, SCS, and ATQ scores; longer depressive episodes; and were more likely employed. A significantly lower proportion of responders were severely depressed prior to treatment. Responders and nonresponders did not differ in age, gender, age of onset, number of previous episodes, education, marital status, sleep EEG, or cortisol.

These findings suggest that several demographic and clinical, but not biological, variables can be used to predict a placebo response.

REFERENCES:

1. Andrews G: Placebo response in depression: bane of research, boon to therapy. British Journal of Psychiatry 2001; 178:192–194
2. Quitkin FM: Placebos, drug effects, and study design: a clinician's guide. American Journal of Psychiatry 1999; 156:829–836.

TARGET AUDIENCE:

Psychiatrists, psychologists

Poster 156 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

COGNITIVE FUNCTIONING IN PERSONS WITH SCHIZOPHRENIA VERSUS COCAINE ABUSING PERSONS WITH SCHIZOPHRENIA

Chris Kilker, B.A., *Project Coordinator, VA New Jersey Healthcare Systems, 151 Knollcroft Road, Building 143, Lyons, NJ 07939*; Craig W. Davis, Psy.D., *Project Coordinator, VA New Jersey Healthcare Systems, 151 Knollcroft Road, Building 143, Lyons, NJ 07939*; David A. Smelson, Psy.D.; Valerie Johnson

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be better able to understand the differences in cognitive impairments that exist between non-cocaine-abusing schizophrenics and cocaine-abusing schizophrenics.

SUMMARY:

Introduction: Individuals with schizophrenia have cognitive deficits that negatively impact their psychosocial functioning. Cocaine abuse is also common among this population. While cognitive deficits have been examined in both schizophrenics and nonschizophrenic cocaine abusers, only recently has research focused on these comorbid conditions. Therefore, we were interested in completing a comprehensive neuropsychological battery to further understand the neurocognitive deficits among these patients.

Methods: Cocaine abusing schizophrenics and non-cocaine abusing schizophrenics (N = 33) were recruited from the VA and matched on age, race, socioeconomic status, and education. All participants were given a battery of neuropsychological tests focusing on processing speed, concentration, executive functioning, and motor skills.

Results: No differences were found between the groups in symptom severity, and the major distinction was their substance abuse. Preliminary findings indicate that the cocaine-dependent schizophrenics did better on tasks involving fine motor, visuo-motor, and processing speed (Range .02–.07). No significant differences were found on sustained attention, concentration, or executive functioning.

Discussion: Our results suggest that neurocognitive performance is multifaceted and deficits manifest differently in cocaine abusing schizophrenics versus non-abusing schizophrenics. These studies are important in helping to better understand the cognitive deficits and ultimately to match individuals to psychosocial interventions to remediate the deficits.

REFERENCES:

1. Smelson DA, Santana S, Engelhart C: Neuropsychological deficits in withdrawn cocaine dependent males American Journal of Drug and Alcohol Dependence 1999; 25(2). 377–381
2. Serper MR, Bergman A, Copersino ML, Chou JCY, et al: Learning and memory impairment in cocaine-dependent and comorbid schizophrenic patients. Psychiatry Research 2000; 93: 21–32

TARGET AUDIENCE:

Individuals working with schizophrenics and cocaine-abusing schizophrenics.

Poster 157 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

HIGH RESOLUTION BRAIN SPECT IMAGING IN ADHD USING STATISTICAL PARAMETRIC MAPPING

Eun-Young Oh, M.D., *5 Wonchon-dong Paldal-gu, Suwon Kyounggi-Do, South Africa*; Isaac Hwang, M.D., *5 Wonchon-dong Paldal-gu, Suwon Kyounggi-Do, South Africa*; Soek-Nam Yoon, M.D.; Young-Ki Chung, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that rCBF of left temporal area is significantly decreased in children with attention deficit hyperactivity disorder (ADHD) and ADHD with chronic tic disorder.

SUMMARY:

Objectives: We examined the abnormalities of regional cerebral blood flow(rCBF) in children with attention deficit hyperactivity disorder(ADHD) without comorbidity and ADHD with cronic tic disorder using statistical parametric mapping(SPM)method.

Method: Tc-99mECD brain SPECT was performed on 85 patients (M:F = 72:13, 10.03+2.5y) with the DSM-IV diagnosis of ADHD and seven normal controls (M:F = 6:1, 10.29 + 4.1y). ADHD group is divided into the following two groups, ADHD patients without comorbidity (M:F = 50:10, 10.35+2.6y), and ADHD patients with chronic tic disorder(M:F = 22:3, 9.89+2.29y). Using SPM methods, we compaired individual and patient group's SPECTs with those of seven control subjects and measured extent of the area with significant hypoperfusion($p<0.01$) in predefined 34 cerebral regions.

Results: (1) Left temporal area and left orbitofrontal area showed significant hypoperfusion in total ADHD patients(n = 85) as compared with control subjects(n = 7)($p<0.01$). (2) Only left temporal area showed significant hypoperfusion in ADHD patients without comorbidity (n = 60) as compared with control subjects (n = 7), (3) Left temporal area, left parietal area, left orbitofrontal area, and both basal ganglia showed significantly decreased rCBF in ADHD patients with chronic tic disorder (n = 35) as compared with control subjects(n = 7).

Conclusion: Left temporal area rCBF was decreased in ADHD group whether subjects have comorbidity or not, as compared with control groups. According to this result, the left temporal dysfunction may mediate ADHD symptoms in children.

REFERENCES:

1. Amen DG, Carmichael BD: Overview: high-resolution brain SPECT imaging in ADHD. Ann Clin Psychiatry 1997; 59(15):35–47.
2. Rubia K, Overmeyer S: Overview: hypofrontality in attention deficit hyperactivity disorder during higher-order motor control: a study with functional MRI. Am J Psychiatry 1999; 46:962–969.

Poster 158 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

DIVALPROEX SODIUM TREATMENT OF IMPULSE CONTROL DISORDERS

Abbott Laboratories

James A. Wilcox, Ph.D., *Professor, Department of Psychiatry, Texas Technical University, 4800 Alberta Avenue, El Paso, TX 79905-2709*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize impulsive control disorders and treat them with divalproex sodium.

SUMMARY:

In this study, 40 subjects with impulse control problems were treated with divalproex sodium and compared with 40 similar patients on other treatments, in a double-blind method. All subjects were adults. The subjects all suffered from impulse control disorders, with high Karolinska scores and DSM-IV diagnosis verified by objective criteria. Results were analyzed using student's t-test and multiple regression analysis. Scores were corrected using the revealed remarkable improvement in impulsivity for individuals treated with divalproex ($t = 8.79$, $p < .001$). Use of divalproex was the only variable that changed the mean improvement of the Karolinska impulsivity scores in a positive way ($F = 9.48$, $p < .0001$). We conclude that divalproex sodium is a very effective treatment for the reduction of impulsive behavior and explosive behavior.

REFERENCES:

1. Wilcox J: Divalproex sodium in the treatment of aggressive behavior. Annals of Clinical Psychiatry 1994; 6(1):17–20
2. Hollander E, Allen A, Lopez RP, Bienstock CA, et al: A preliminary double-blind, placebo-controlled trial of divalproex sodium in borderline personality disorder. J Clinical Psychiatry 2001; 62(3):199–203

Poster 159 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

IMAGES OF WOMEN IN PSYCHOTROPIC ADVERTISEMENTS OVER FIVE DECADES

Peggy E. Chatham-Showalter, M.D., *Consultation Psychiatrist, Raker Center, Good Shepherd Rehabilitation Center, 2430 Walbert Avenue, Suite 100, Allentown, PA 18103*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the portrayals of male and female patients in representative psychotropic medication advertisements since 1950.

SUMMARY:

Thorazine® advertisements first appeared in 1954, beginning the modern era of psychotropic advertisements. Initially advertisements targeted state hospital

psychiatrists who were prescribing Thorazine® to treat the most psychotically ill psychiatric patients. Advertisements and prescription patterns evolved in parallel for the major tranquilizer, antipsychotic, antidepressant, and sedative hypnotic groups. After state hospital psychiatrists, prescriptions and advertising encompassed outpatient psychiatrists, then internists, family practitioners, and other specialists. Most recently, antidepressants, anxiolytics, and hypnotics have been advertised directly to consumer/patients. Typical advertisements through the decades will be presented and reviewed. In the 1950s into the 1970s, advertisements frequently presented vignette scenes of clinical situations in which the promoted medication would be efficacious. Patient portrayals in these vignettes represented contemporary female and male role stereotypes of the decade. Male imagery is generally neutral or positive. Women portrayed as appropriate patients are generally not presented in a flattering manner. The female imagery easily could be viewed as indifferent, condescending, or sexist, especially in retrospect. Appearing more frequently in the 1980s are simple portraits of patients. Photographs of patient faces may be more universal and less likely to cause offense than a vignette presented to a diverse physician audience, which includes more women than in prior decades. Vignettes of the 1990s appear in a different format, in which it is not clear which people are the patients, family members, or friends. As the 1997 FDA Modernization Act regulates advertisement text but not images, advertising target audiences continue to need to be attuned for visual messages.

REFERENCES:

1. Lupton D: The construction of patienthood in medical advertising. Int J Health Serv 1993; 23:805–19
2. Quinn J, Nagle M, Casey PR: Analysis of psychotropic drug advertising. Psych Bull 1997; 21:597–599
3. Neill JR: A social history of psychotropic drug advertisements. Soc Sci Med 1989; 28:333–338

TARGET AUDIENCE:

Clinicians interested in psychotropic advertising

Poster 160 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

LONG-TERM PSYCHIATRIC EFFECTS OF CHEMICAL WEAPONS EXPOSURE

Saeed Momtazi, M.D., *Associate Professor of Psychiatry, Zanjan University of Medical Sciences, Beheshti Medical Center, ARG Square, Zanjan, Iran*; Haleh Hoseyny, M.D., *Department of Psychiatry, Zanjan University of Medical Sciences, Beheshti Medical Center, ARG Square, Zanjan, Iran*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize long-term psychiatric effects of chemical weapons exposure.

SUMMARY:

Objective: Thousands of Iranian veterans were injured by chemical weapons used by Iraq during eight years of Iran-Iraq war (1980–1988). As long-term psychiatric (and also other) effects of these agents are not clearly recognized, we wanted to find these effects about 15 years after exposure.

Design: We assessed mental health status of chemical injured soldiers, comparing with a control group.

Materials and Methods: Our case group was 40 33–50 year old men with a history of single or multiple chemical exposure during Iran-Iraq war to nerve agents and/or mustard. A control group was war veterans who had no chemical exposure or injury. We assessed both groups with a psychiatric symptoms checklist and also DSM-IV criteria for major depressive disorder. Assessments were done by a clinical psychologist blind to the study.

Results: DSM-IV criteria assessment revealed 27 of 40 (67.50%) of chemical injured group and 18 of 40 (45.00%) of control group had a diagnosis of major depressive disorder ($P<0.05$). Other symptoms significantly higher in chemical injured group were anxiety, hypervigilance, impaired concentration and memory, sensory hypersensitivity, headache, tremor, irritability, sleep disturbance, and diminished sexual desire.

Conclusion: Long-term mental problems are frequent consequences of chemical weapons exposure. These effects should be studied for different chemical agents separately.

REFERENCES:

1. Sidell FR: Nerve agents, in Medical aspects of chemical and biological warfare. Edited by Sidell FR, Takafuji ET, Franz DR. TNM Publications, Washington, 1997, pp 129–179
2. Lee EJ: pharmacology and toxicology of chemical warfare agents. Ann Acad Med Singapore 1997;26(1):104–107

Poster 161 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

QUETIAPINE TREATMENT IN PTSD: A PRELIMINARY OPEN TRIAL OF ADD-ON THERAPY

AstraZeneca Pharmaceuticals

Mark B. Hamner, M.D., *Director, Department of Psychiatry, Ralph H. Johnson VA Medical Center, and PTSD*

Clinic, 109 Bee Street, Charleston, SC 29403; S. E. Deitsch, M.D.; H. G. Ulmer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that quetiapine is well tolerated and may have efficacy in reducing PTSD symptoms in patients who have not had an adequate response to antidepressants.

SUMMARY:

Objective: This is a pilot study of adding quetiapine to existing antidepressant medications in patients with PTSD who still had a significant illness burden.

Methods: Combat veterans meeting DSM-IV criteria for PTSD (N = 20) were treated with quetiapine in a six-week, open-label trial. Starting dose was 25 mg hs, titrated based on tolerability and clinical response. Prior medications were maintained at a constant dose for at least one month prior to study entry and during the trial. Primary outcome was measured using the Clinician Administered PTSD scale (CAPS), and secondary assessments included PANSS and other. Safety evaluations included neurologic ratings and assessment of treatment-emergent side effects.

Results: Eighteen of the 20 patients completed six weeks of open-label treatment. There was a significant decrease in PTSD and positive and negative symptoms from baseline to endpoint. CAPS ratings declined from 89.8 ± 15.7 to 67.5 ± 21.0 ($t = 4.86$, $df = 18$, $P < 0.005$), and PANSS ratings declined from 76.2 ± 8.5 to 67.1 ± 14.1 ($t = 3.148$, $df = 18$, $P < 0.006$).

Conclusions: Quetiapine is well tolerated and may have efficacy in reducing PTSD symptoms in patients who have not had an adequate response to antidepressants. Larger, randomized, controlled studies are needed to better define the potential role of quetiapine in PTSD.

REFERENCES:

1. Hammer MB: Psychotic features and combat-associated PTSD. Depress Anxiety 1997;5:34–38.
2. The Expert Consensus Panels for PTSD: The expert consensus guideline series: treatment of posttraumatic stress disorder. J Clin Psychiatry 1999;60:3–76.

TARGET AUDIENCE:

Psychiatrists

Poster 162 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

DIFFERENTIAL INHIBITION OF ALPRAZOLAM METABOLISM BY FLUOXETINE AND CITALOPRAM

H. Lundbeck A/S

Claudio A. Naranjo, M.D., *2075 Bayview Avenue, Room F327, Toronto, ON Canada M4N 3M3*; Judith Hall; Beth A. Sproule; Nathan Herrmann, M.D.

SUMMARY:

In vitro and in vivo data show an inhibition of alprazolam metabolism by fluoxetine via CYP3A4. However, there is limited information regarding citalopram's effect on this isozyme in vivo. Therefore, we used a randomized, double-blind, placebo-controlled, within subject design to assess this potential drug interaction in humans. Twenty healthy volunteers attended a total of four study sessions: the first two (alprazolam/placebo) in the absence of SSRI, the last two sessions (alprazolam/placebo) while at steady-state with either citalopram 20 mg/day or fluoxetine 20 mg/day. At each session subjects received 1 mg alprazolam p.o. or placebo at 9:00 a.m. Blood samples for alprazolam concentrations were taken at baseline, 0.5, 1.0, 1.5, 2.0, 3.0, 4.0, 6.0, 6.0, 24.0, and 48 hours after administration.

Pharmacodynamic effects (sedation, Digit Symbol Substitution Test, and Manual Tracking) were measured at similar times.

We found that fluoxetine prolonged the $t_{1/2(\beta)}$ of alprazolam by 16% and increased the area-under-the-curve$_{(0-\infty)}$ of alprazolam by 32%. Citalopram did not affect these parameters, although the Tmax of alprazolam was prolonged by one-half hour. Neither SSRI significantly affected the pharmacodynamic profile of alprazolam. These findings suggest a differential effect, with fluoxetine producing more significant changes in alprazolam pharmacokinetics than citalopram.

REFERENCES:

1. Naranjo CA, Sproule BA, Knoke DM: Metabolic interactions of central nervous system medications and selective serotonin reuptake inhibitors. International Clinical Psychopharmacology 1999; 14(suppl. 2): S35–S47.
2. Hassan PC, Sproule BA, Naranjo CA, Herrmann N: Dose-response evaluation of the interaction between sertraline and alprazolam in vivo. Journal of Clinical Psychopharmacology 2000; 20:150–158.

TARGET AUDIENCE:

General psychiatrists, mood disorder specialists, psychopharmacologists

Poster 163 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

OLANZAPINE TREATMENT FOR TORTURE SURVIVORS WITH SEVERE PTSD: A CASE SERIES

Robert C. Stone, D.O., *Department of Psychiatry, University of Texas Southwestern Medical School, 1936 Amelia Court, Dallas, TX 75235*; Lisa Vinuesa, M.S.; David Urrate, M.D.

SUMMARY:

Posttraumatic stress disorder is a common psychiatric disorder with an 8% lifetime population prevalence in the U.S. Continued investigation into pharmacotherapy for PTSD is important given that up to half of patients studied in SSRI trials failed to respond significantly, especially those with intrusive, "parapsychotic" symptoms. Olanzapine was recently shown to be effective across the spectrum of symptoms in an open-label of veterans with PTSD. This case series reports on the treatment of eight survivors of severe torture from Central and Western Africa who presented to the Violence Intervention and Prevention Center at Parkland Hospital in Dallas for evaluation and treatment. All were experiencing severe PTSD symptoms, including nightmares and flashbacks, which had destroyed their quality of life and their ability to tolerate the legal asylum process. Diagnosis was confirmed by the MINI, and improvement was measured by the TOPS. Treatment consisted of 2.5-5 mg of olanzapine either as monotherapy or in combination with an SSRI. The average initial TOPS score of 31.6 improved to 10.0 (68%) after eight weeks of treatment. Transient sedation was the only reported side effect. The measured effects parallel subjective reports of return to near-normal life functioning and success in seeking political asylum.

REFERENCES:

1. Davidson JR, Rothbaum BO, van der Kolk BA et al: Multicenter, double-blind comparison of sertraline and placebo in the treatment of posttraumatic stress disorder. Arch Gen Psychiatry 2001; 58:485–92.
2. Cyr M, Farrar MK: Treatment for posttraumatic stress disorder. Ann Pharmacother 2000; 34:366–76.

TARGET AUDIENCE:

Psychiatrists and other mental health providers involved in the treatment of victims of violence and torture with PTSD.

Poster 164 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

GENERALIZED ANXIETY DISORDER IN PRIMARY CARE PATIENTS

Pfizer Inc.

William Korotitsch, M.A., *Psychology Intern, Brown University, Box G-BH Duncan Building, Providence, RI 02912*; Risa B. Weisberg, Ph.D., *Project Director, Department of Psychiatry, Brown University, 700 Butler Drive, Box G-BH, Providence, RI 02906*; Larry Culpepper, M.D.; Martin B. Keller, M.D.

SUMMARY:

Features of generalized anxiety disorder (GAD) are examined in primary care patients who were sampled from 15 general medical practices. Of the 474 participants meeting criteria for one of seven anxiety disorders assessed with the SCID-IV, 130 (27%) were diagnosed with GAD. Compared with primary care patients with other anxiety disorders, patients with GAD reported more negative perceptions of their overall mental health and evidenced high rates of comorbid anxiety disorders; 62% of the patients with GAD had at least one coexisting anxiety disorder as opposed to 46% of participants with other anxiety disorders (Chi-square = 9.19, $p < .01$). Additionally, GAD patients had a significantly greater number of coexisting psychiatric disorders ($z = 2.09$, $p < .05$). The age of onset for GAD was highly variable, with and average of 22.7 years. When a comorbid anxiety or depressive disorder was present, GAD typically had an earlier onset. These findings indicate that primary care patients with GAD may evidence greater levels of overall psychopathology compared with patients with other anxiety disorders. Implications of these findings for detection and intervention within primary care settings will be discussed.

PCAP is funded through an unrestricted grant from Pfizer Pharmaceuticals.

REFERENCES:

1. Roy-Byrne PP, Katon W: Generalized anxiety disorder in primary care: The modifier pathway to increased health care utilization. Journal of Clinical Psychiatry 1997; 58(Suppl 3):34–40.
2. Maier W, Gaensicke M, Freyberger H.-J, et al: Generalized anxiety disorder (ICD-10) in primary care from a cross-cultural perspective: a valid diagnostic entity? Acta Psychiatrica Scandinavica 2000; 101:29–36.

TARGET AUDIENCE:

Psychiatrists, psychologists, health care providers

Poster 165 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

SSRI-INDUCED APATHY: ITS PREVALENCE AND RESPONSIVENESS TO DONEPEZIL

Robert O. Morton, M.D., *Chief Resident, Department of Psychiatry, University of Oklahoma, 4502 East 41st Street, Tulsa, OK 74135*; William R. Yates, M.D., *Professor and Chairman, Department of Psychiatry, University of Oklahoma, 4502 East 41st Street, Tulsa, OK 74135*; Marilyn Davis, B.S.; Dalaina Joplin, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize apathetic consequences of SSRI therapy and the use of donepezil in treatment of this clinical state.

SUMMARY:

Apathy is a mood dimension of impaired motivation that has been shown to be a discernable neural construct in patients with head trauma, CVA, and neurodegenerative and dementing disorders. It has been described in case studies as a complication of serotonergically linked antidepressant therapy. We studied 386 mood-disordered outpatients (avg age 38) and found that clinically significant apathy (defined as Zung SDS index <60 and apathy index >50) was prevalent at 31% in SSRI-treated patients compared with 11% in untreated patients. Those taking atypical antipsychotics (AAS) with SSRIs had an apathy rate of 17%. Fifteen patients on SSRIs with minimal depression and moderate to elevated apathy were treated with donepezil for 60 days in an open-label trial as augmentation to their antidepressant regimen. Apathy levels were reduced from 59.3(5.8) to 44.9(7.0), $p = .0001$, while Zung depression scores were reduced only 56.9(10.8) to 51.3(10.5), $p = .018$. An increase in apathy scores was noted over 60 days in 18 patients receiving only SSRI medication from 48.6(4.7) to 52.4(5.3), $p = .05$. Apathy is a significant complication of antidepressant therapy and is responsive to cholinesterase inhibition. It is also less frequent in patients taking AASs with SSRIs. These findings implicate a pathogenesis resulting from altered neurotransmitter and/or receptor balance with resultant dysfunction expressed as diminished motivation in thought, emotion, and motor activity. The selective therapeutic response to donepezil supports the concept of apathy as a specific neural construct and suggests cholinergic desensitization as an important mechanism in its manifestation.

REFERENCES:

1. Marin RS, Firinciogullari S, Biedrzycki RC: Group differences in the relationship between apathy and depression. J Nerv Ment Dis 1994;182:235–239.
2. Cummings JL: Cholinesterase inhibitors: a new class of psychotropic compounds. Am J Psychiatry 2000; 157:4–15.

TARGET AUDIENCE:

Psychiatrists

Poster 166 **Saturday, October 13**
3:30 p.m.-5:00 p.m.

OPEN-LABEL TRIAL OF DONEPEZIL IN SSRI-TREATED OBSESSIVE-COMPULSIVE DISORDER PATIENTS

Robert O. Morton, M.D., *Chief Resident, Department of Psychiatry, University of Oklahoma, 4502 East 41st Street, Tulsa, OK 74135*; William R. Yates, M.D., *Professor and Chairman, Department of Psychiatry, University of Oklahoma, 4502 East 41st Street, Tulsa, OK 74135*; Michael Basso, Ph.D.; Fran Corona, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the potential for cholinergic system modulation in OCD.

SUMMARY:

Obsessive compulsive disorder (OCD) has been described as having components of cognitive impairments such as the relative inability to shift sets, nonverbal delayed memory recall, and visuospatial difficulties in visual memory and visual construction. Acetylcholine has been shown to have an important role in information processing and memory. Therefore the use of cholinesterase inhibition (donepezil 10 mg daily) was used in an open-label, 120-day, clinical trial. Multiple Y-BOC scores were obtained over the year preceding the study, which suggested maximal response to SSRI therapy had been achieved prior to beginning donepezil augmentation. Neuropsychological batteries were performed pre and post treatment with donepezil. Y-BOC scores were significantly reduced, 25.8(4.9) to 10.5(8.5) $p < 01$, with minimal reduction in HAM-D scores. Trails A and B and Stroop testing showed nonsignificant but generalized improvement. Four patients who had follow-up Y-BOC testing 60 days post donepezil showed an increase in scores, with movement toward pretreatment baseline values. These data suggest that altered cholinergic lone may play a role in the pathogenesis of OCD. Enhancement of attentional and memory systems are hypothesized to play a role in donepezil's efficacy. Double-blind, placebo-controlled trials appear to be indicated in order to confirm the ability of cholinesterase inhibitors to favorably augment and alter the clinical outcome OCD.

REFERENCES:

1. Hasselmo ME, Linster C: Acetylcholine and frontal cortex "signal-to-noise ratio", in The Human Frontal Lobes. Edited by Miller BL, Cummings JL. New York, Guilford Hess, 1999, 139–158.
2. Martinot JL, et al: OCD: a clinical, neuropsychological and positron emission tomographic study. Acta Psychiatr Scand 1990;82:233–242

TARGET AUDIENCE:

Psychiatrists

Poster 167 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

THE PREVALANCE OF PTSD AMONG SCHOOL CHILDREN AFTER THE EARTHQUAKE IN TAIWAN

Rong-Rong Huang, M.D., *Visiting Staff, Department of Child and Adolescent Psychiatry, Kaohsiung Kai-Suan Psychiatric Hospital, 130 Kai-Suan 2nd Road, Kaohsiung, Taiwan 802*; Wei-Tsuen Soong, M.D.; Yu-Chun Lee, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize that PTSD symptomatology can be reliably assessed through semi-structured interview and self-report measures.

SUMMARY:

Introductions and Purpose: An earthquake with a magnitude of 7.3 on the Richter scale struck middle Taiwan on September 21, 1999. The purpose was to study the psychiatric morbidity of school children at Yu-Chi township, three and six months after the quake.

Methods: A survey of 20 yes/no questions (Score 1/0) was constructed to screen for PTSD. All students in grades two through nine were asked to fill in the questionnaire. A school with 112 students was selected to study the cut-off point. A total of 40 students (9 scored 0–8, 14 scored 9–11, and 17 scored 12 and above) were given the second stage interview with the K-SADS-CM. Three child psychiatrists who were blind to the score made the diagnostic interview.

Results: The questionnaire has adequate test-retest reliability (ICC coefficient 675) and internal consistency (Cronbach alpha 842). In the first survey three months after the earthquake, 1,079 valid questionnaires were analyzed. Taking child psychiatrist's diagnosis as criteria cutoff point 11/12, the sensitivity is 0.85, specificity is 0.66 for DSM-IV criteria. It is estimated that 7.2% had DSM-IV PTSD. The students were again surveyed six months after the earthquake and 691 valid questionnaires were analyzed. The mean score decreased and the prevalence of PTSD is 4.2%.

Conclusions: The new questionnaire is adequate for screening PTSD associated with earthquake. The prevalence of PTSD among school children after the severe earthquake is decreasing with time, being 7.2% and 4.2%, three and six months respectively, after the disaster.

REFERENCES:

1. Giaconia RM, Reinherz HA, Silverman AB, Pakiz B, Frost AK, Cohen E: Traumas and posttraumatic stress disorder in a community population of older adolescents. J Am Acad Child Adolesc Psychiatry 1994; 34:1369–80.
2. Sharan P, Chaudhary G, Kavathekar SA, Saxena S: Preliminary report of psychiatric disorders in survivors of a severe earthquake. Am J Psychiatry 1996; 153:556–8.

TARGET AUDIENCE:

Child psychiatrist, psychiatrist

Poster 168 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

IMPROVED FUNCTIONING AND SATISFACTION IN PATIENTS USING ZALEPLON

Wyeth-Ayerst Laboratories

Thomas Roth, Ph.D., *Director of Research, Henry Ford Hospital, 2799 West Grand Boulevard, CFP-3, Detroit, MI 48202*; George J. Wan, Ph.D., *Associate Director, Wyeth-Ayerst Research Laboratories, 555 East Lancaster Avenue, St. Davids, PA 19087*; Paul Le Vine; Marc Cantillon, M.D.

EDUCATIONAL OBJECTIVES:

At the end of the presentation, the participant should be able to (1) understand the impact of physician-generated reports on insomnia patient functioning and satisfaction, and (2) recognize the importance of patient-reported outcomes in the management of patients with insomnia.

SUMMARY

Objective: To describe patient-reported symptoms, functioning, and satisfaction before and with zaleplon use.

Method: Prospective observational study of primary care insomnia patients. A total of 1,378 patients completed baseline (before zaleplon use) and follow-up (current zaleplon use) interactive voice response telephone surveys (January 2001 through May 2001). Participating physicians (n=1,437) were provided individual patient and aggregate reports.

Results: Most patients were female (77%), with a mean age of 58 years, and 62% reported difficulty sleeping on 15 or more nights per month. Patients using zaleplon reported on average decreased symptoms and better functioning compared with baseline ($P<0.001$). A significantly higher proportion of patients reported falling asleep sooner (30 minutes or less) at follow-up compared with baseline (66% vs. 30%; $P<0.0001$). A significantly higher proportion of patients indicated very good to fairly good quality of sleep at follow-up compared with baseline (79% vs. 25%; $P<0.0001$). Among

those who used a prior sleep medication (n=884), current zaleplon users reported significantly higher medication satisfaction compared with baseline (69% vs. 35%; P<0.001).

Conclusion: Symptoms, functioning, and satisfaction were positively impacted with zaleplon use. Findings were consistent with clinical trials. Data appear to indicate that physicians can promote best practices in insomnia treatment by incorporating direct feedback from patients about their treatment.

REFERENCES:

1. Fry J, Scharf M, Mangano R, Fujimori M: Zaleplon improves sleep without producing rebound effects in outpatients with insomnia. Zaleplon Clinical Study Group. Int Clin Psychopharmacol 2000; 15(3):141–152
2. Richardson GS: Managing insomnia in the primary care setting: raising the issues. Sleep 2000; 23(Suppl 1):S9–S12

TARGET AUDIENCE:

Psychiatrists, primary care physicians

Poster 169 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

MEDICAL-RELATED HOSPITALIZATION COSTS LOWER WITH VENLAFAXINE THAN SSRIS

Wyeth-Ayerst Laboratories

George J. Wan, Ph.D., *Associate Director, Wyeth-Ayerst Research Laboratories, 555 East Lancaster Avenue, St. Davids, PA 19087*; William H. Crown, Ph.D.; Ernst R. Berndt, Ph.D.; Stanley N. Finkelstein, M.D.; Davina C. Ling, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to evaluate the differences in treatment costs between venlafaxine and SSRIs and the potential economic benefits of using venlafaxine more as a first-line therapy.

SUMMARY:

Objective: Compare direct medical costs of venlafaxine (immediate and extended release) and SSRI treatment in depressed patients with/without anxiety.

Method: Six-month retrospective study of U.S. administrative claims of 2.3 million covered lives from MEDSTAT MarketScan (1994–1999). Patient selection based on new depressive episode with/without anxiety (within six months) using ICD-9 diagnostic codes and prescription claims.

Results: A total of 468 patients initiated on venlafaxine (314 immediate release, 154 extended release) and 8,625 on SSRIs (3,260 fluoxetine, 2,120 paroxetine, 3,003 sertraline, 102 citalopram, 140 fluvoxamine). Majority of patients were female (69%). Venlafaxine patients were slightly older (42 vs 41 yr; $P < 0.01$) with more frequent medical illnesses (0.85 vs 0.76; $P < 0.01$) and psychiatric-related hospitalizations (0.53 vs 0.29; $P < 0.05$) prior to treatment initiation vs SSRIs. Total medical and psychiatric health care expenditures not significantly different; however, venlafaxine had lower medical-related inpatient costs. No significant differences in medication costs, gap in treatment, and compliance rates (venlafaxine extended release vs SSRIs) noted.

Conclusion: Prior to therapy, patients given venlafaxine had more medical illnesses and psychiatric-related hospitalizations than SSRI patients. Although total costs for venlafaxine patients were expected to be higher, no significant differences were observed. More use of venlafaxine as first-line therapy could further lower overall costs.

REFERENCES:

1. Thase ME, Entsuah AR, Rudolph RL: Remission rates during treatment with venlafaxine or selective serotonin reuptake inhibitors. Br J Psychiatry 2001; 178:234–241.
2. Woods SW: Pharmacoeconomic studies of antidepressants: focus on venlafaxine. Depress Anxiety 2000; 12(suppl 1):102–109.

TARGET AUDIENCE:

Psychiatrists and clinicians

Poster 170 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

ZALEPLON SHOWN AS A MORE VERSATILE HYPNOTIC IN AN INSOMNIA PATIENT SURVEY

Wyeth-Ayerst Laboratories

Gary M. Levin, Pharm.D., *Associate Professor, Departments of Pharmacy Practice and Psychiatry, University of Florida, Box 100486, Gainesville, FL 32610*; George J. Wan, Ph.D., *Associate Director, Wyeth-Ayerst Research Laboratories, 555 East Lancaster Avenue, St. Davids, PA 19087*; Michael Tedeschi, R. Ph.; Marc Cantillon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to (1) understand that zaleplon is versatile enough to take at bedtime or later after patients have

tried to fall asleep on their own, and recognize the importance of patient-reported outcomes in the clinical management of patients with insomnia.

SUMMARY:

Objective: To describe patient-reported satisfaction with current sleep medications.

Method: A total of 352 patients [82 zaleplon (ZAL), 120 zolpidem (ZOL), 71 trazodone (TRZ), 79 benzodiazepines (BNZ)] were included in the analysis of newer (ZAL, ZOL) versus older (TRZ, BNZ) sedative hypnotics.

Results: Majority of patients were female (70%) with a mean age of 53 years, and 70% or more suffered from trouble falling asleep or middle-of-the-night awakening. A significantly higher proportion of patients used ZAL (18%) for middle-of-the-night awakening after experiencing difficulty sleeping compared with ZOL (7%), BNZ (6%), or TRZ (0%) ($p \leq 0.001$). A significantly higher proportion of patients had to consider morning alertness in their choice of ZOL (20%), BNZ (30%), or TRZ (33%) than ZAL (10%) ($p \leq 0.01$). A fewer proportion on ZAL (8%) reported a "drugged feeling" as a side effect compared with ZOL (16%), BNZ (23%), or TRZ (20%) ($p = 0.057$). No significant differences in "total sleep time" as a factor determining satisfaction with a sleep agent, medication effectiveness, overall satisfaction with current sleep medication, and occupational/activity performance the morning after use were observed between the newer or older agents.

Conclusion: ZAL may allow for a more flexible lifestyle relative to ZOL, BNZ, or TRZ.

REFERENCES:

1. Fry J, Scharf M, Mangano R, Fujimori M: Zalepton improves sleep without producing rebound effects in outpatients with insomnia. Zaleplon Clinical Study Group. Int Clin Psychopharmacol 2000; 15(3):141–152.
2. Richardson GS: Managing insomnia in the primary care setting: raising the issues. Sleep 2000; 23(Suppl 1):S9–S12.

TARGET AUDIENCE:

Psychiatrists, primary care physicians

Psychiatric Services Achievement Awards Session 1 **Thursday, October 11 8:30 a.m.-11:30 a.m.**

CREATING ACCESS: STRATEGIES FOR SERVING MULTIPLE ETHNIC POPULATIONS

Psychiatric Services Certificate of Significant Achievement Award

Kathy Lund, R.N., *Clinical Nurse Specialist, Community-University Health Care Center, 2001 Bloomington Avenue, South, Minneapolis, MN 55404;* Sy Vang Mouacheupao, *Bilingual, Bicultural Worker, Community-University Health Care Center, 2001 Bloomington Avenue, South, Minneapolis, MN 55404*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize how multidisciplinary mental health teams can effectively serve diverse populations and understand the role of bilingual/bicultural workers in providing culture-specific mental health services.

SUMMARY:

The purpose of this presentation is to familiarize psychiatrists and mental health providers with the Community-University Health Care Center's Model for providing culturally-competent mental health services to refugees, immigrants and the underserved. A clinical nurse specialist and bilingual/bicultural worker will present multicultural teaming and practical examples of how internal collaborations and external partnerships lead to effective mental health treatment. Both providers will discuss how services can reflect and integrate clients' world views and cultural perceptions of mental illnesses. Finally, the presenter will discuss how patient/provider dialogue and educational outreach has led to reduce stigma around mental illness in the communities served by the Community-University Health Care Center. On the cutting edge of social change, the Community-University Health Care Center offers practical strategies for serving multiple ethnic populations in a community clinic setting.

REFERENCES:

1. Kroll J, et al.: Medication compliance, antidepressant blood levels, and side effects in SE Asian Patients. J of Clinical Psychopharmacology 1990; 10-279-282.
2. Kroll J, et al.: Depression and posttraumatic stress disorder in SE Asian refugees. Am J of Psychiatry 1989; 146:1592-1597.

Psychiatric Services Achievement Awards Session 2 **Thursday, October 11 8:30 a.m.-11:30 a.m.**

PROVIDING EARLY CHILDHOOD MENTAL HEALTH SERVICES IN COMMUNITY SETTINGS

Psychiatric Services Certificate of Significant Achievement Award

Barbara L. Brady, M.S.W., *Administrator, Early Childhood Mental Health, Multnomah County, Portland, Oregon, 421 S.W. 6th Street, Suite 500, Portland, OR 97204;* Margie MacCleod, M.S.W., *Social Worker, Morrison Center, 310 S.W. 4th Avenue, Suite 910, Portland, OR 97204;* Nancy C. Winters, M.D., *Department of Psychiatry, Oregon Health Sciences University, 3874 N.E. Alameda Street, Portland, OR 97212-2818*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: (1) describe the early childhood mental health system of care model; (2) describe the early childhood consultation model; (3) identify community and client benefits to a community-based, service delivery system; (4) identify blended funding approaches to this delivery model; (5) describe two roles for the child psychiatrist in this system of care.

SUMMARY:

Increasingly, the concept of "system of care" has become the national standard against which children's mental health programs are measured. In the field of early childhood mental health, we now have 10 principles for designing a system of care to serve young children and their families, articulated by Jane Knitzer, Deputy Director of the National Center for Children in Poverty. Based on these principles and on models of early childhood mental health consultation, Multnomah County Oregon has, over the past 11 years, developed a system of services and supports, delivered within most of the major young child-serving organizations in the county. Services include on-site mental health consultation, on-site and in-home child and family interventions, enhanced outpatient services, and psychiatric evaluation and consultation. Mental health staff work in tandem with the staff and families of the early childhood community, creating a prevention through intervention early childhood system of care. Services are funded through a partnership of county and early childhood host organization contributions, and Medicaid reimbursement for direct services.

REFERENCES:

1. Mental Health Consultation in Early Childhood, Paul J. Donahue, Beth Falk, and Anne Gersony Provet. 2000 Paul H. Brookes Publishing Co., Baltimore.

2. "Early Childhood Mental Health Services: A Policy and Systems Development Perspective". Knitzer, Jane. In: J.P. Shonkoff and S.J. Meisels (Eds.), Handbook of Early Childhood Intervention, 2nd Edition, New York, NY; Cambridge University Press. 2000: 416–438.

Psychiatric Services Achievement Awards Session 3 **Thursday, October 11 8:30 a.m.-11:30 a.m.**

BALTIMORE CAPITATION PROJECT: SEVEN YEARS OF SUCCESS IN COMMUNITY INTEGRATION

Psychatric Services Certificate of Significant Achievement Award

Marta J. Hopkinson, M.D., *Medical Director, Capitation Programs, Baltimore Mental Health Systems, Inc., 7603 Central Avenue, Takoma Park, MD 20912;* Janet R. Farhie, M.D., *Senior Psychiatrist, Chesapeake Connections, A Division of the North Baltimore Center, 6021 Stanton Avenue, Baltimore, MD 21210-1203;* Gerard Gallucci, M.D., *Director of Community Psychiatry, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, Baltimore, MD 21224;* Barbara Harris, R.N., M.S., *Director, Chesapeake Connections, A Division of the North Baltimore Center, 2225 North Charles Street, Baltimore, MD 21218*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify challenges in treating and improving life quality of seriously mentally ill adults; recognize critical elements in a community integration program associated with positive outcomes; and learn how a correctly funded capitated program can be most effective while demonstrating improved psychosocial functioning.

SUMMARY:

Serious and persistent mental illness can be debilitating and devastating to the lives of individuals and their families. To address this the Maryland Mental Hygiene Administration in conjunction with Baltimore Mental Health Systems, Inc., created a flexibly funded program to encourage creative strategies to improve the clinical stability and psychosocial functioning of the highest utilizers of mental health services. This session will describe the finding and clinical structure of two programs charged with providing services to only the most severely mentally ill adults in Baltimore. Two clinical cohorts will be discussed the first cohort consists of state hospital patients discharged to the community after an average hospital stay of more than five years and the second cohort consists of adults from the community with more than four psychiatric hospitalizations in two years. Presenters will discuss the clinical and logistical challenges in community placement and maintenance of these institutionalized individuals and high service utilizers. Outcomes of both cohorts will be discussed including dramatic reductions in hospital days and significant improvements in psychosocial functioning and stability of both groups. Funding, administrative, and quality assurance mechanisms will be presented in a discussion of how other systems can replicate this model.

Summary: A viable model will be presented of a cost-effective and clinically proven method of improving community integration of the most severely mentally ill adults.

REFERENCES:

1. Agus D, Blan SK, Dugan ST: Building a Capitated Public Mental Health Service for the Seriously Mentally Ill Administration Policy in May 1995, 22 261–271.
2. Warner R, Huxley P: Outcome for People With Schizoprenia Before and After Medicaid Capitation at a Community Agency in Colorado. Psychiatr Serv 1998, 49 802–807.

Psychiatric Services Achievement Awards Session 4 **Thursday, October 11 8:30 a.m.-11:30 a.m.**

SHORT-TERM ACUTE RESIDENTIAL TREATMENT: THE SAN DIEGO MODEL

Psychiatric Services Gold Award

William B. Hawthorne, Ph.D., *Executive Director, Community Research Foundation, 1202 Morena Boulevard Suite 300, San Diego, CA 92110;* Linda C. Hammond, Ph.D., *President, Community Research Foundation, 1202 Morena Boulevard, Suite 300, San Diego, CA 92110;* James B. Lohr, M.D., *Chief, Department of Psychiatry, Veterans Hospital, 3350 La Jolla Village Drive, Code 116-A, San Diego, CA 92161-0002*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be aable to identify characteristics of an innovative alternative to acute psychiatric hospitalization with a patient-centered and psychosocial rehabilitation focus.

SUMMARY:

Short-Term Acute Residential Treatment (START) is a well-established alternative to acute psychiatric inpatient treatment in San Diego County. Six regionally-located facilities with 24-hour staffing range in size from 11 to 16 beds and offer brief intensive milieu-based

treatment in a home-like neighborhood setting. Most staff members have master's or doctoral level training in psychology, social work or nursing. Psychiatric care is provided on-site by the Department of Psychiatry, University of California, San Diego. The treatment philosophy is patient-centered and encourages each individual to be as involved as possible in his or her treatment, including treatment planning, tracking and meeting treatment goals. The treatment program includes individual, group, and community meeting interventions daily. The home-like setting also makes possible the inclusion of household responsibilities and meal preparation as a component of the treatment experience. This creates a less "institutional" atmosphere and provides more continuity with daily life outside of the treatment setting. Among patients successfully treated in the START model are those with severe mental disorders, including schizophrenia and major mood disorders. Suicidal ideation and psychotic symptoms are common presenting problems. START patients are frequently dually diagnosed with substance abuse and dependence and/or personality disorders, and many are also homeless.

REFERENCES:

1. Hawthorne WB, Green EE, Lohr JB, Hough R, Smith PG: Comparison of outcomes of acute care in short-tern residential treatment and psychiatric hospital settings. Psychiatric Services 1999, 50(3): 401–406.
2. Gerteis N, Edgman-Levitan S, Daley J, Delbanco TL (eds): Through the Patient's Eyes: Understanding and Promoting Patient Centered Care. San Francisco, CA, Jossey-Bass, 1993.

Psychiatric Services Achievement Awards Session 5

Thursday, October 11
8:30 a.m.-11:30 a.m.

THRESHOLDS ASSERTIVE COMMUNITY TREATMENT PROGRAMS AT COOK COUNTY JAIL

Psychiatric Services Gold Award

Jerry Dincin, Ph.D., *Executive Director, Thresholds, 4101 North Ravenswood Road, Chicago, IL 60613;* Thomas A. Simpatico, M.D., *Chief, Burrough of Chicago Network Manager, Chicago Read Mental Health Center, 4200 North Oak Park Avenue, Building K, Chicago, 60634*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the project, describe its results, and to open the floor to discussion of what types of interventions may be necessary to serve the mentally ill who are released from jail, and create new ideas needed to serve this population.

SUMMARY:

Cook County Jail, with over 10,000 inmates and with 1,000 of those persons taking daily psychiatric medication, has quietly become Illinois' largest psychiatric hospital. Aware of the problem and unable to obtain funding. Thresholds began its own demonstration project of "aftercare" services in January of 1997 with foundation and individual gifts. Upon approaching the jail with the idea, administrators within the Illinois Office of Mental Health, a dedicated hospital staff at Cook County Jail who knew the post-discharge system was not working, executed this project. They found a group of inmates who most overused the jail and psychiatric hospital. Those people were offered aggressive ACT services. The project has demonstrated major reductions of 80% in hospital days and jail days used as compared with prior year results.

Symposium 1 **Wednesday, October 10**
2:00 p.m.-5:00 p.m.

INTEGRATING RESEARCH INTO A COMMUNITY-BASED PSYCHIATRY SERVICE

Laurence Karper, M.D., *Vice Chair, Department of Psychiatry, Lehigh Valley Hospital, Muhlenberg, 400 North 17th Street, Suite 207, Allentown, PA 18104*

EDUCATIONAL OBJECTIVES:

To describe and understand various approaches to research in the community/hospital setting to facilitate improvement of clinical care.

SUMMARY:

In the managed care era, funding and developing a research component in a community hospital setting is both more difficult and more needed. Payors for care as well as regulatory agencies are focusing more and more on evidence based care for psychiatric patients. In order to improve clinical care and satisfy the regulatory and other requirements, developing a broad spectrum of community based research is not only advisable but essential for survival. This symposium seeks to present several different clinical community based research approaches to facilitate outcomes assessment, performance improvement, and to develop cost effective approaches to quality psychiatric care. In addition, the development of a research program may also provide funds for new and innovative approaches to care. The presenters of this symposium describe their own experiences with a variety of research projects as well as in seeking funding support. The aim of this symposium is to spark interest in and provide direction to those clinicians who are interested in enhancing the research component within their system of care.

No. 1A
INTEGRATING RESEARCH INTO A DEPARTMENT OF PSYCHIATRY

Gail Stern, M.S.N., *Administrator, Department of Psychiatry, Lehigh Valley Hospital, Muhlenberg, 400 North 17th Street, Suite 207, Allentown, PA 18104*

SUMMARY:

This presentation will highlight the importance and advantages of integrating research processes into a community network of psychiatric services. The development and design of specific types of data collection, analysis, research, and application of research will be explored. Types of research discussed will include pharmaceutical clinical trials, state/federally funded demonstration projects or research, foundation- or corporate-sponsored research, performance improvement research, and outcome measurement activities. Operational issues of resource allocation, ethics, and implementation of changes based on findings will be addressed. Finally, focused review of sources of funding and maintaining continuity of funding will be made to demonstrate how financial barriers to research can be remediated or removed.

REFERENCES:

1. Sederer LI, Dickey B, Hermann RC: The imperative of outcomes assessment in psychiatry. Outcomes Assessment in Clinical Practice 1996; 1–7.

No. 1B
USE OF RESEARCH TOOLS TO DOCUMENT EFFICACY

Gerald Rodriguez, L.S.W., *Vice Chairman, Department of Psychiatry, Lehigh Valley Hospital, Muhlenberg, 400 North 17th Street, Suite 207, Allentown, PA 18104*

SUMMARY:

Successful research strategies in a clinical outpatient setting must be both unobtrusive and clinically meaningful. We present data that document the effectiveness of two models for a structured, short-term group that use cognitive-behavioral approaches to improve mood and reduce hostility in men. We believe that it is critically important to document efficacy in order to remain competitive in the outpatient mental health market. In addition, the measuring of efficacy utilizing outcome measures provides managers with the information necessary to develop new and innovative programs. Data were collected on 58 men who started treatment in a structured men's group. Rating instruments included the Basis 32, Burns Anxiety Inventory, and Burns Depression Checklist. Subjects completed rating instruments prior to initiating the group and at the last session. There were large, clinically significant improvements in outcome measures in groups with both fixed entry times as well as rolling admissions. Admission Basis 32 scores were 1.03 and 1.45, and the discharge scores were 0.49 and 0.58, respectively. Attendance records show that the rolling admission group was more successful in terms of attendance, with 8.8 men attending each session compared with 4.25 in the fixed-ending-time group. In addition, it was found that subjects who completed four or more sessions had significant improvements in their anger, anxiety, and depression scores, whereas those who completed two or three sessions had no significant improvement in their symptoms.

REFERENCES:

1. Burns DD: Ten Days to Self-Esteem, The Leader's Manual. New York, Quill, 1993.

2. Eizen SV, Dillgraub MC: Reliability & Validity of a Brief Patient Report, Instrument for Psychiatric Outcome Evaluation. American Journal of Psychiatry 1991; 112:989–1004.

No. 1C
RESEARCH COLLABORATION BETWEEN A COMMUNITY HOSPITAL AND FAITH-BASED SUBSTANCE ABUSE TREATMENT CENTER FOR HOMELESS MEN

Laurence Karper, M.D., *Vice Chair, Department of Psychiatry, Lehigh Valley Hospital, Muhlenberg, 400 North 17th Street, Suite 207, Allentown, PA 18104*

SUMMARY:

The homeless population with comorbid mental illness and substance abuse disorders often require multiple intensive treatment episodes that traditionally are not integrated and rarely are coordinated. We have proposed a collaboration that seeks to produce a replicable model to improve the treatment for these patients in our community. This innovative research collaboration involves a faith-based drug treatment center for homeless men, a community hospital's department of psychiatry, and cooperation from county-based mental health clinics. The study evaluates the effectiveness of case management in this population. We plan to enroll 100 subjects over two years. Evaluations will occur at entry and at three-month intervals to assess treatment effects over time and at the end of the study. Rating instruments will include measures of alcohol and drug consumption, psychiatric symptoms, homelessness, and quality of life. This innovative collaboration was funded through a two-year grant supported by the Dorothy Rider Pool Healthcare Trust. The department of psychiatry at Lehigh Valley Hospital in collaboration with the Allentown Rescue Mission, a nonprofit, faith-based homeless shelter with a drug and alcohol program onsite, worked together to develop the study and seek funding. The study will also assess barriers to care and enhance collaboration among the public mental health system, community hospitals, and homeless shelters that serve this population.

REFERENCES:

1. Drake RE, Bartels JS, Teague GB, et al: Follow-up of substance abuse in severely mentally ill patients. J Nerv Men Dis 1993; 181:606–611.
2. Caton DLM, Wyatt RJ, Felix A, et al: Follow-up of chronically homeless mentally ill men. American Journal of Psychiatry 1993; 150:1639–1642.

No. 1D
GETTING YOUR PROJECT FUNDED: STRATEGIES IN WORKING WITH LOCAL GRANTMAKERS

Ronald Dendas, *1050 South Cedarcrest Boulevard, Suite 202, Allentown, PA 18103*

SUMMARY:

As grantmakers emphasize "venture philanthropy" over "giving money away," the relationship between grantmakers and grantees is also changing. The ability of applicants to develop meaningful relationships with local grantmakers plays an important role in securing local dollars, leveraging other private and public funds, successfully implementing projects, and getting future grants. Engaging local grantmakers in the process requires a deeper understanding of the mission, focus, and goals of both grantee and grantor and help create "win-win-win" situations for the two entities and the community they work in. This session will review several effective strategies that build meaningful, long-term relationships between clinicians/researchers and local grantmakers. The session will also give the participants the opportunity to hear more about the "venture philanthropy" role of a grantmaker.

REFERENCES:

1. Abelson BH: Research Funding. Science 1991; 252:625.
2. Lippmann S, Regan W: On making clinical research count. South Med J 1991; 74:349–352.

Symposium 2 **Thursday, October 11**
8:30 a.m.-11:30 a.m.

MENTAL ILLNESS IN THE DEVELOPMENTALLY DELAYED: A MULTIDISCIPLINARY APPROACH

Ramakrishnan S. Shenoy, M.D., *Consultant, Department of Psychiatry, Central State Hospital, 7803 Lancashire Place, Richmond, VA 23235-6729*; Donna K. Moore, Psy.D.

EDUCATIONAL OBJECTIVES:

At the end of this session, the participant should be able to recognize how to set up and work in a multidisciplinary team to treat patients with developmental delay who have serious mental illness. The participant will understand the role of each individual discipline and the way in which the disciplines interact to effect better treatment and discharge planning.

SUMMARY:

Providing appropriate assessment and treatment for individuals with mental retardation within the context of a traditional, medically-driven psychiatric institution may be challenging. A multidisciplinary consultation team provides specialty services to these individuals as an adjunct to their current psychiatric care. The mental retardation consultation team collaborates with already existing treatment teams to augment patient care for individuals with developmental disabilities. The team focuses on differential diagnosis, psychopharmacology, and individualized occupational, nursing, and functional assessments. Data can be charted on graphs, which include behavior symptoms, medication effects, and other variables. Development and implementation of skills training protocols, behavior support programs, and vocational programming will be reviewed. This symposium will present a collaborative model of care that can function efficiently within an already established system. An important role of an effective consultation team is to educate treatment team professionals on issues related to mental retardation to increase independent clinical decision making. Case illustrations, data, and reliability of intervention protocols will be presented. Results will be discussed in terms of strategies for collaboration, training, and system changes.

TARGET AUDIENCE(S):

Psychiatrists, psychologists, nurses, therapists who work in a psychiatric hospital setting

No. 2A
A MULTIDISCIPLINARY APPROACH: TRANSITIONING PATIENTS TO LESS RESTRICTIVE SETTINGS

Bethany A. Marcus, Ph.D., *Department of Psychiatry, Central State Hospital, 1411 Stratford Road, #B, Williamsburg, VA 23185*; Richard G. Doyle, M.S.; Bernadette A. Spruill, R.N.; Donna K. Moore, Psy.D.

EDUCATIONAL OBJECTIVES:

Recognize the importance of developing systematic protocols when transitioning patients into less restrictive environments. Additionally, the participant will understand that positive reinforcement and support will increase their chances of success.

SUMMARY:

A consultation team specialized to work with individuals with mental retardation developed data-based transition plans to move individuals from a maximum security psychiatric environment to a less-restrictive, civil psychiatric population. Data illustrating systematic transitions for three individuals who were housed in maximum security for 20 or more years will be presented. The consultation team provided comprehensive psychiatric, psychological, occupational, nursing, and behavioral assessment to develop a structured, reinforcement-based program to ease individuals into an environment that would include greater mobility and opportunities for vocational and community integration. Each of the individuals had histories of intense physical aggression and psychiatric instability. Data will demonstrate that the multiphase transition programs were effective (100% success for the three individuals, with only two incidents of problematic behavior during transition). Further, the procedures implemented illustrated a model of change for the system as a whole. Results will be discussed in terms of assessment and treatment implications when working with individuals with cognitive, behavioral, and psychiatric problems within the context of a traditional, medically driven framework.

REFERENCES:

1. Hansson L, Berglund M, Ohman R: The use of treatment contracts in short-term psychiatric care. Acta Psychiatr Scand 1984; 70:180–190.

No. 2B
TEAM TREATMENT OF INDIVIDUALS WITH DUAL DIAGNOSIS: THE PSYCHIATRIST'S ROLE

Ramakrishnan S. Shenoy, M.D., *Consultant, Department of Psychiatry, Central State Hospital, 7803 Lancashire Place, Richmond, VA 23235-6729*; Bethany A. Marcus, Ph.D.

EDUCATIONAL OBJECTIVES:

Recognize how psychiatric symptoms manifest in patients with developmental disabilities and learn how to work within a multidisciplinary team when treating this population.

SUMMARY:

The role of the psychiatrist within a multidisciplinary team for persons with developmental disorders and mental illness is complex. The primary role is to do a thorough psychiatric assessment, which leads to formulation, differential diagnoses, and medical and behavioral interventions. Diagnosis is made by obtaining a history from the chart and from family members, reviewing presenting complaints to include a functional assessment of behavior, identification of Axis I criteria for a mood or thought disorder, mental status examination, and formulation. By using systematic medication protocols, a psychiatrist can determine the indication and efficacy of selected psychopharmacology. Since the majority of diagnoses for persons with developmental disabilities are

disorders of behavior, it is imperative that the behavioral database drives medical decision making. It can also be used to differentiate whether a behavioral event is physiological in nature or is a conditioned response. Some cases will be presented about how to establish appropriate psychopharmacology, behavioral programming, and data-based decisions within a psychiatric environment.

TARGET AUDIENCE(S):

psychiatrists, psychologists, nurses, therapists who work in a psychiatric hospital setting

REFERENCES:

1. Hauser MJ: The role of the psychiatrist in mental retardation. Psychiatric Annals 1997; 27:170–174.
2. American Psychiatric Association Committee on Psychiatric Services for Persons with Mental Retardation and Developmental Disabilities: Psychiatry and Mental Retardation: A Curriculum Guide. Washington DC, Americant Psychiatric Association, 1995.

No. 2C
USING BEHAVIORAL GRAPHS TO MAKE CLINICAL DECISIONS

Victoria Swanson, Ph.D., *Director of Psychology, Southwest Louisiana Developmental Center, P.O. Box 218, Iota, LA 70543*; Terry Swanson, M.S.; Frankie Humbles, B.S.

EDUCATIONAL OBJECTIVES:

Understand and discuss the importance of using objective criteria and visual charts to evaluate treatment outcomes. Additionally, the participant will be able to develop and implement a data-based decision-making system.

SUMMARY:

Behavior analysts work with data as a primary tool. In order to document and quantify behavior change objectively, data are collected via direct and repeated measurement of behavior through deliberate, planned, and usually controlled observation. Interpretation of raw data can be confusing to team members. Behavior analysts maintain direct and continuous contact with the target behavior through the collected data. Accurately graphed, these data can be used by the multidisciplinary team to make important decisions (i.e., continue the present procedure, try something new, or reinstate a previous treatment). Behavior analysts can then assist teams by presenting a set of behavioral data in a format that displays visually the relationships among a series of measurements so that the meaningful features are more clearly evident. This presentation will review ways teams can use graphs to interpret and communicate behavior change. Examples will be given with behavior change graphed across symptoms of psychopathology, medication dose, and behavioral treatments. Implications for interpreted trends and patterns across cases, treatments, and systems will be explored.

TARGET AUDIENCE(S):

psychiatrists, psychologists, nurses, therapists who work in a psychiatric hospital setting

REFERENCES:

1. Pfadt A, Wheeler DJ: Control charts in a clinical setting. SPC INK 1993; 1–5.

Symposium 3 **Thursday, October 11**
8:30 a.m.-11:30 a.m.

MEETING THE TRAINING NEEDS OF COMMUNITY MENTAL HEALTH STAFF

Neil Pessin, Ph.D., *Director, Community Mental Health Services, Visiting Nurse Service of New York, 1250 Broadway, 3rd Floor, New York, NY 10001*; David C. Lindy, M.D., *Clinical Director and Chief Psychiatrist, Community Mental Health Services, Visiting Nurse Service of New York, and Associate Clinical Professor of Psychiatry, Columbia University, 1250 Broadway, 3rd Floor, New York, NY 10001*; Paula G. Panzer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should have an appreciation for some of the training needs of community mental health staff and some methods for meeting those needs.

SUMMARY:

As complex organizations with multiple constituencies, community mental health programs must provide a large variety of clinical services. Accordingly, there are many different kinds of demands placed upon staff. Services grow, roles change, problems emerge. An array of training needs arise, but responding to these needs can be very challenging for senior clinical and administrative staff.

The Visiting Nurse Service of New York's Community Mental Health Service (VNS) operates 24 programs throughout New York City spanning a wide range of clients and psychiatric disorders. Training needs are complicated by the outreach nature of all clinical services, raising difficult supervisory and logistical issues. This symposium will present four projects we have developed to address very different training needs. They include: (1) a counter-transference oriented training to enhance engagement of geriatric patients, (2) a program for the supervision of psychiatric nurse practitioners by

VNS psychiatrists with a focus on development of new roles, (3) a group for supervision of supervisors with a focus on psychodynamic process, and (4) the Community Mental Health Services University, a 12-part curriculum to designed to cover the essentials of clinical psychiatry for all mental health workers.

A discussant expert in training and community services will offer her thoughts on the issues raised and we hope the audience will actively contribute.

TARGET AUDIENCE(S):

CMH administrators, supervisors, and clinicians

No. 3A
TRAINING STAFF TO HELP ELDERLY PATIENTS ACCEPT MENTAL HEALTH TREATMENT

Leila B. Laitman, M.D., *Team Psychiatrist, Community Mental Health Services, Visiting Nurse Service of New York, 1601 Bronxdale Avenue, Bronx, NY 10462*; Rebecca Morales, C.S.W.

SUMMARY:

Many older people refuse a referral into the mental health system due to factors such as stigma, lack of mobility, finances, presence of cognitive deficits, medical comorbidity, and lack of social support, among others. This can lead staff to have feelings of frustration and hopelessness in constantly dealing with help-rejecting patients. They can become quick to cooperate with the patient's feeling that no additional services are necessary or lose faith in the efficacy of mental health linkage for geriatric patients. Training staff in specific techniques of interviewing and engagement that are appropriate for the geriatric population can address some of these difficulties.

The goal of the In-Home Geriatric Mental Health Program of the Visiting Nurse Service of New York is to assess people in their homes who have some kind of psychiatric symptom and link them with ongoing care by community resources within an eight-week period. The resources might be mental health treatment, medical treatment, social services, case management, home care, or even legal services, among others. During the course of developing a quality-improvement plan, it was discovered that only 14% of patients discharged from the service over a one-year period actually accepted a mental health treatment referral. A 12-session training program that focused on interviewing and engagement techniques intended to overcome patient and family resistances to ongoing mental health follow-up was developed. Countertransferential feelings of the workers were addressed as well. Dispositions were monitored, and the mental health referral acceptance rate was calculated throughout the course of training up through the following year. There was a 20% increase in mental health linkage compared with the year before the training.

This presentation will describe this educational program, which was very effective in teaching a multidisciplinary team better ways to deal with a homebound elderly population that often had complex psychiatric problems including cognitive deficits. Quality of service provided was improved as a result.

REFERENCES:

1. Pearlin LI, Skaff MM: Stressors and adaptation in late life, in Emerging Issues in Mental Health and Aging. Edited by Gatz M. Wash, D. C. American Psychological Association, 1995, pp. 97–123.
2. Kennedy G: Mental health consultation in the general hospital, home or nursing facility, in Geriatric Mental Health Care. New York, Guilford Press, 2000, pp. 248–281.

No. 3B
PSYCHIATRISTS TRAINING NURSE PRACTITIONERS IN A NURSING AGENCY

David C. Lindy, M.D., *Clinical Director and Chief Psychiatrist, Community Mental Health Services, Visiting Nurse Service of New York, and Associate Clinical Professor of Psychiatry, Columbia University, 1250 Broadway, 3rd Floor, New York, NY 10001*; Lawrence B. Jacobsberg, M.D., Ph.D.; Leila B. Laitman, M.D.; Ronald Goralewicz, R.N.

SUMMARY:

Although nurse practitioners (NPs) have practiced for over 30 years in some parts of the United States, approval of NP licensure is more recent in others, such as New York State. In part, this reflects the controversy still surrounding the appropriateness of the NP role. Although NPs often practice in rural areas, community mental health can also be a physician shortage area and "another pair of hands" with prescribing privileges can be sorely needed. However, training requirements for NPs vary from state to state, and even though they have their license and a collaborating physician, some NPs still desire further clinical supervision to function in their new role.

Perhaps unexpectedly, the Visiting Nurse Service of New York (VNS) has only recently started to use NPs in its clinical services. This presentation will describe the cultural shifts that accompanied the introduction of psychiatric NPs to VNS, the supervisory structure designed in which VNS psychiatrists supervised the NPs and functioned as their collaborating physicians, and the experience as it unfolded.

REFERENCES:

1. Caverly SE: The role of the psychiatric nurse practitioner. Nursing Clinics of North America 1996; 31:449–63.

No. 3C
THE SUPERVISION GROUP: GROUP PROCESS AS A WAY OF LEARNING ABOUT SUPERVISION

Neil Pessin, Ph.D., *Director, Community Mental Health Services, Visiting Nurse Service of New York, 1250 Broadway, 3rd Floor, New York, NY 10001*; David C. Lindy, M.D.

SUMMARY:

Supervisors of community-based mental health programs must frequently deal with complicated clinical situations, as well as challenging supervisees. They often feel isolated as they confront difficult decisions, worry that they are the only ones who find such situations difficult, and may be as reluctant to share these concerns with their supervisors as their staff are to share their concerns with them. In addition, it is easy for all of us to "lose the forest for the trees" and a sense of the dynamics at play over time when we get caught up in the urgencies of the moment.

Supervisors working for some of the 24 programs operated by the Visiting Nurse Service of New York's Community Mental Health Services (VNS) participated in a group organized to promote supervisory skills by learning about psychodynamic process. The group was co-led by the two clinical/administrative leaders of the service. A fascinating group process unfolded, leading to the institution of the subsequent groups run by former members of the first group. This presentation will discuss the benefits and dangers of this mode of supervision.

REFERENCES:

1. Freud S: Group Psychology and the Analysis of the Ego. The Standard Ed 1955; 18:67–143.

No. 3D
COMMUNITY MENTAL HEALTH SERVICES UNIVERSITY: THE PSYCHIATRIC ESSENTIALS FOR MENTAL HEALTH OUTREACH WORKERS

Howard Telson, M.D., *Associate Clinical Director, Community Mental Health Services, Visiting Nurse Service of New York, 1250 Broadway, New York, NY 10001*; Annette Cutrino, M.S.W.; David C. Lindy, M.D.; Neil Pessin, Ph.D.

SUMMARY:

Community mental health workers perform assessments and provide care for mentally ill individuals with complex clinical presentations in a variety of programs operated by the Visiting Nurse Service of New York. While some staff have professional degrees and training, others have quite limited education and experience. Interdisciplinary teams allow workers with different skills and perspectives to learn from each other, and ensure that cases are reviewed comprehensively. Nonetheless, over time it became clear that many staff could benefit from further formal instruction to understand and plan for the clinical care of psychiatric patients in the community.

The Community Mental Health Services University (CMHS U) is a 12-hour curriculum designed to educate field staff about core issues involved in their work. Topics include the mental status examination, psychiatric diagnosis and assessment, engagement, writing and presenting cases, safety in the field, and psychotropic medication. Courses are taught by a multidisciplinary faculty from within the agency and use didactic as well as interactive methods.

This presentation will describe the development of CMHS U since 1998. It will discuss methods used to assess the educational benefit of the program. It will also highlight its value in promoting staff cooperation and enhancing employee effectiveness and satisfaction.

REFERENCES:

1. Williams J, Swartz M: Treatment boundaries in the case management relationship: a clinical case and discussion. Community Mental Health Journal 1998; 134:299–311.

Symposium 4 **Thursday, October 11**
2:00 p.m.-5:00 p.m.

NEW RULES FOR WORKING IN THE COMMUNITY: ETHICS OF COMMUNITY-BASED TREATMENT

Ronald J. Diamond, M.D., *Clinical Professor, Department of Psychiatry, University of Wisconsin, 625 West Washington Avenue, Madison, WI 53703*; Alan Rosen, M.D.; Vivienne Miller, M.A., O.T.

EDUCATIONAL OBJECTIVES:

At the end of this symposium, participants will have a better understanding of the range of situations that raise ethical dilemmas for mental health clinicians working in the community, and have better tools for maintaining appropriate boundaries in complex situations.

SUMMARY:

Traditional psychiatric practice operates within boundaries defined by the walls of an office, scheduled appointments, and clear rules about acceptable behavior. Community-based mental health treatment often occurs while stopping by at the end of the day to visit a client at his work site, or going out to lunch with a client. Clear boundaries and ethical guidelines continue to be critically important, but traditional structures of where and when we meet no longer provide direction. How should the traditional injunctions not to socialize with clients be understood when clients get hired into staff positions? How do we handle the multiple roles when we serve on a planning committee with one of our own clients? What do we mean by a "collaborative relationship" with a consumer when we are controlling his money and telling him what medication he must take? How do we balance autonomy and paternalism when a client with many rehospitalizations says that she wants to risk living in her own apartment, when we feel that a more supervised residence would be more appropriate? What is the connection between taking risks and recovery, and how should these decisions get made? There are no simple answers to these questions.

TARGET AUDIENCE(S):

Clinicians working in community settings and their supervisors

No. 4A
ETHICS AND BOUNDARIES IN THE COMMUNITY

Ronald J. Diamond, M.D., *Clinical Professor, Department of Psychiatry, University of Wisconsin, 625 West Washington Avenue, Madison, WI 53703*

SUMMARY:

Most writing about psychiatric ethics focuses on "big" cases such as involuntary treatment and right to refuse. In contrast, most clinicians spend their time on "little" cases. Most ethical dilemmas come from "little cases"—decided by front line clinicians—often with little consultation or even realization that there are ethical issues involved. Is it coercive to continue to visit a client after he tells us to stay away? How much can we tell a landlord who asks about a client in one of his apartments? How do we balance our obligation to our client with concerns about neighbors or the rest of the community? When can we socialize with a client, and how do we handle the complication of being in multiple roles with a client who may also be on a committee with us or co-teaching a class. It is important to understand when ethical issues are present and how to reach some decision. This paper will discuss dilemmas commonly seen in community treatment settings and provide principles that are useful in guiding decisions of front-line staff.

REFERENCES:

1. Curtis LC, Hodger M: Ethics and boundaries in community support services: raising a dialogue, in Maturing Mental Health Systems: New Challenges and Opportunities New Directions in Mental Health Series No. 66. Edited by Stein L, Hollingsworth EJ. San Francisco, Jossey-Bass, p 1997, pp 43–60.

No. 4B
POWER AND COERCION IN COMMUNITY MENTAL HEALTH

Laurie C. Curtis, M.A., *83 Davy Road, Middlesex, VT 05602*

SUMMARY:

Community mental health service providers often find themselves in the middle of heated controversies about the appropriate and moral use of power in treatment of individuals with serious mental illnesses. While respecting values that support personal choice and self-determination, providers must also balance the legal, ethical, political, and economic factors that often intertwine with perceptions of risk and safety to complicate clinical decision-making. This paper will discuss the role of power in relationships from both provider and consumer perspectives, identify ways in which power dynamics are changing in recovery-oriented relationships, and introduce a "continuum of coercion" that helps to identify the various ways power is used—and sometimes misused—in community mental health practice.

REFERENCES:

1. Curtis LC. Diamond R: Power & coercion in mental health services, in Treatment Compliance and the Therapeutic Alliance. Edited by Blackwell B. Toronto, Canada, Harwood Academic Publishers, 1997, pp 97–122.

No. 4C
HIRING MENTAL HEALTH CONSUMERS IN A MAINSTREAM MENTAL HEALTH AGENCY

Eugene D. Johnson, M.S.W., *President and Chief Executive Officer, Meta Services, Inc., 2701 North 16th Street, #316, Phoenix, AZ 85006*

SUMMARY:

For the past five years META services has hired mental health consumers throughout the organization. The

issues META faced have created opportunities for transformation within a large mental health agency serving a metropolitan area of more than 3 million people. This discussion focuses on the challenges to our corporate culture, values, and behavior when mental health consumers are integrated into the organization as full partners. To succeed, consumers must have voice at all levels: governance, planning, service delivery, and monitoring. Otherwise, the consumer hiring initiative may dissolve in "tokenism." Hiring consumers has confronted our traditional hierarchical roles and offered opportunities to overcome stigma and increase mutuality. It has confronted our treatment models since consumers have become empowered to critique our practice strategies from the perspective of their experience. It has challenged our ethics, as beliefs about "professional boundaries," confidentiality, risk management, and credentials have required re-examination.

Our experience has confirmed the opinion stated by Soloman, et al., "Ultimately, we believe that hiring consumers as service providers is one of the most important trends to occur in the field of mental health in decades. We fully support this movement as one of the best ways to help consumers become empowered and to help nonconsumers see people with psychiatric disabilities as equals."

REFERENCES:

1. Soloman M, Jonikas J, Cook J, Kerouac, J: Positive Partnerships: How Consumers and NonConsumers Can Work Together as Services Partners. Chicago, National Research and Training Center on Psychiatric Disability, 1998.

No. 4D
THE ETHICS AND BOUNDARIES OF RISK IN A CONSUMER-OPERATED, RECOVERY-ORIENTED AGENCY

Jennifer Koberstein, President, *Soar Case Management, 1810 South Park Street, Madison, WI 53713*; Jennifer Branrs

SUMMARY:

As community mental health comes to include consumer-run services, the ethics and boundaries of taking risks is naturally changing. The most important risk is to create equity between consumer and professional. This risk, taken by both consumers and professionals, is the key to facilitating growth for both participants. We will examine different aspects of this changing power dynamic and how it affects a risk taking model. We will be discussing the progressive nature of fully identifying as a peer. We will also discuss the role of coercion in a recovery-oriented service.

An important area of risk taking is the willingness to evaluate, with the consumer, pressures that lead to the creation of a "professional consumer." A goal of shared risk taking is to allow people to grow out of our systems. This requires adopting the belief that people can and do heal completely. In the interest of full recovery, risks must be taken to assist individuals to move beyond their illness, to develop their own self definition and self direction. Real growth requires acknowledging that there is a lot to be afraid of for both consumers and providers, and that taking risks requires courage.

REFERENCES:

1. Crowley K: The Power of Procovery in Healing Mental Illness. Kennedy Carlisle Publishing Co, 2000.

Symposium 5 **Friday, October 12**
8:30 a.m.-11:30 a.m.

PUBLIC SECTOR MANAGED CARE: PAST, PRESENT, AND FUTURE?

American Association of Community Psychiatrists

Michael A. Hoge, Ph.D., *Associate Professor of Psychology, Yale University, 25 Park Street, 6th Floor, New Haven, CT 06519*; Kenneth M. Minkoff, M.D., *Medical Director, Choate Health Management, and Consultant and Trainer, Integrated Treatment Systems and Interventions for Co-Occurring Disorders, 500 West Cummings Park, Suite 3900, Woburn, MA 01801*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the national trends in public sector managed care and the factors that lead to success and failure in its implementation. Participants will also be able to describe provider, managed care organization, and state perspectives on the future of public sector managed behavioral health care.

SUMMARY:

Public-sector managed care has been implemented in almost every state in the nation and has had tremendous impact on the delivery of mental health services. This symposium is designed to enhance participants' understanding of the nature, impact, and uncertain future of managed care in the public sector. The first of five presentations will provide participants with a brief and somewhat irreverent overview of its evolution on a series of key dimensions. The following three presentations will revolve around the public-sector managed care demonstration in the Tampa, Florida area. A provider in this system will describe strategies that have been employed for surviving and thriving under managed care. A representative of a national managed care organization will

discuss the company's role in Florida, the models of public-sector managed care that it uses across the country, and concerns about the future of such initiatives. The dean of the Florida Mental Health Institute will discuss the outcomes of the Florida demonstration and the state's perspective on the future of behavioral health services. The final presentation will highlight the predictors of success and failure in implementing managed care as discerned from these "natural experiments" across the country. There will be two periods for questions, comments, and general discussion.

TARGET AUDIENCE(S):

Physicians, other professionals, and administrators in the public sector

No. 5A
A DECADE OF PUBLIC SECTOR MANAGED CARE: AN OVERVIEW

Michael A. Hoge, Ph.D., *Associate Professor of Psychology, Yale University, 25 Park Street, 6th Floor, New Haven, CT 06519*

SUMMARY:

Managed care in public-sector mental health has been vaguely defined and difficult to comprehend. Imported from the private sector, it has been rapidly evolving. This presentation is designed to clarify the nature of public-sector managed care. It will begin with an irreverent overview of the past decade of managed care in general, followed by a more detailed overview of managed care in the public sector. Topics to be covered include the historical roots of public-sector managed care, a working definition, and its varied forms and functions over the past decade. Ten key dimensions will be described that are useful to examine when trying to understand a managed-care initiative. The national trends in public-sector managed care on these key dimensions will be reviewed in order to increase participants' knowledge about this rapidly changing and controversial force in psychiatry.

REFERENCES:

1. Hoge MA, Jacobs S, Thakur NM, Griffith EEH: Ten dimensions of public-sector managed care. Psychiatric Services 1999; 50:51–55.
2. Hoge MA., Davidson L, Griffith EEH, et al.: Defining managed care in public-sector psychiatry. Hospital and Community Psychiatry 1994; 45:1085–1089.

No. 5B
PROVIDER PERSPECTIVE: SURVIVING FLORIDA MANAGED CARE

Kathy B. Hayes, M.S.W., *Behavioral Health Division, Winter Haven Hospital, 200 Avenue F, N.E., Winter Haven, FL 33881*

SUMMARY:

Winter Haven Hospital, Inc., (WHH) Behavioral Health Division (BHD) has not only survived but thrived in a managed-care environment in Florida. As a general acute care hospital in a small community in Florida, Winter Haven Hospital, Inc. has provided community mental health services since 1967. In 1996, when Florida decided to pilot a Medicaid carve-out Prepaid Mental Health Plan in a five-county area in Florida, the WHH decided to join a partnership with four community mental health centers and a national managed-care company to submit a proposal as the provider. That partnership was awarded the contract as the provider and continues to function as such.

In addition, BHD has had experience and learned to succeed in a commercial managed-care environment as well as Medicaid carve-in model with HMOs. Comparing and contrasting the differences between the carve-in and carve-out models and understanding their impact on our organization was a necessity in order to survive. Varying contract models have been undertaken as a means of reducing uncompensated care in the HMO model.

During the past four years, we have also been open to other possibilities such as mergers and affiliations as tactics to increase efficiency. Through attrition direct care staff have been reduced as we worked to increase our capacity and at the same time have maintained an unduplicated count of approximately 2,500 individuals served per month in the entire agency.

Surviving meant preparation, teamwork, training, and perseverance of all levels of staff throughout the organization and other stakeholders outside. This included clinical, support and clerical, information management, financial, and administrative. It took a coordinated effort of everyone working together and being open to making changes.

Clinical training of direct service staff included utilization management concepts, diagnosis-based treatment, and level of care guidelines and solution-focused therapy techniques as well as changes in forms to be more user friendly. An increased focus on accountability and enhanced service capacity were a must in order to meet access standards.

REFERENCES:

1. Lloyd D: How to Maximize Service Capacity. National Council for Community Behavioral Healthcare, Rockville, MD, 1998.

2. Thornton M: Ahead of the Game. National Council for Community Behavioral Healthcare, Rockville, MD, 2000.
3. Holahan J, Zuckerman S, Evans A, Rangarajan S: Medicaid managed care in thirteen states. Health Affairs 1998; 17(3):43–63.

No. 5C
FOR PROFIT MANAGED CARE ORGANIZATIONS IN THE PUBLIC SECTOR: ANSWER OR ANOTHER PROBLEM?

Robert H. More, M.S.W., M.B.A., *Executive Director, Association of Behavioral Health Care, Tampa Service Center, Value Options, Inc., 3014 North U.S. 301, Suite 1000, Tampa, FL 33619*

SUMMARY:

From Tennessee through Colorado, Arizona, Arkansas, Florida, and back to Massachusetts the message is mixed and confusing—Are for-profit MCOs in the public sector an answer or another problem. Some states have had good success using MCOs to improve care, others see the experiment as a disaster. When consumers are similar from state to state, why the different results?

This presentation will explore MCO models that have succeeded and failed, dynamics that have contributed to successes and failures, and recommendations for use of MCOs in the public sector.

No. 5D
OUTCOMES AND INCOMES: A STATE PERSPECTIVE ON THE FUTURE

David L. Shern, Ph.D., *Louis de la Parte Florida Mental Health Institute, 13301 North Bruce B Downs Boulevard, Tampa, FL 33612*; Julienne Giard, M.S.W.; Roger Boothroyd, Ph.D.; Paul Stiles, Ph.D.; Pat Robinson, M.S.W.; Mary Murrin, M.A.; Huey Chen, M.S.

SUMMARY:

In 1996, Florida initiated a demonstration in Tampa to test two alternative managed mental health care models (MCOs)—a carve in versus a carve out. We conducted an integrated study to document the characteristics of the managed-care models, their effects on access, cost, and outcomes of care. We identified several themes from our research. First, carve ins involving HMO vendors were, in fact, carve outs since HMOs subcapitated their mental health risk to managed behavioral health care organizations (BHOs). Strong competition among the BHOs for HMO business drove down subcapitation rates. Largely identical provider panels across the managed-care conditions frustrated consumer choice. All MCOs effectively reduced overall costs to the state, but HMO enrollees received significantly fewer mental health services than carve-out enrollees. Quality of care indicators were more positive in the carve out. Satisfaction outcomes favored the FFS condition, but no functional or clinical differences were obtained between all enrollees. We will discuss these results in terms of policy choices confronting states in improving services while containing costs, assuring adequate access and fixing responsibility for the most in need. While managed care arrangements have addressed some issues, many chronic organizational, financial, and clinical service delivery problems remain to be addressed.

REFERENCES:

1. Ridgely MS, Giard J, Shern D: Florida's Medicaid Mental Health Carve Out: lessons from the first years of implementation. The Journal of Behavioral Health Services & Research 1999; 26(4):400–415.
2. Holahan J, Zucherman S, Evans A, Rangarajan S: Medicaid managed care in thirteen states. Health Affairs 1998; 17(3):43–63.

No. 5E
PREDICTORS OF SUCCESSFUL SYSTEM OUTCOMES IN PUBLIC SECTOR MANAGED MENTAL HEALTH

Kenneth M. Minkoff, M.D., *Medical Director, Choate Health Management, and Consultant and Trainer, Integrated Treatment Systems and Interventions for Co-Occurring Disorders, 500 West Cummings Park, Suite 3900, Woburn, MA 01801*

SUMMARY:

As public managed care initiatives in behavioral health have proliferated throughout the country, we have had the opportunity to analyze the results of what constitutes a "natural experiment," and to identify factors that appear to contribute to success vs. failure in relation to system outcomes. These factors include:

(1) level of funding (in relation to target population)
(2) accountability (& structures to facilitate oversight)
(3) quality incentives (compared with financial incentives)
(4) advocacy (consumers, families, providers)
(5) carve out vs. carve in (especially for SPMI)
(6) behavioral health funding integration (MH & SA)
(7) adequate transition planning

These factors will be discussed in relation to a comparative analysis of various state managed care programs, and in relation to the programs presented in the sympo-

sium. Implications for future managed care contracting will be identified.

REFERENCES:

1. Minkoff K, Pollark B, (eds): Managed MH Care in the Public Sector: A Survival Manual. Halewood Acad Press, Amsterdam, 1997.

Symposium 6 **Friday, October 12**
2:00 p.m.-5:00 p.m.

NEW FINDINGS ON PSYCHIATRIC PRACTICE: QUALITY, ACCESS, AND PATTERNS OF CARE

John S. McIntyre, M.D., *Chair, Department of Psychiatry and Behavioral Health, Unity Health System, and Past President, American Psychiatric Association, 81 Lake Avenue, 3rd Floor, Rochester, NY 14608*; Joyce C. West, Ph.D., M.P.P., *Director, American Psychiatric Practice Research Network, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005;* Daniel A. Regier, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should have increase awareness of current trends in psychiatric practice related to quality, access, and patterns of care, including patterns of comorbidity and split versus integrated pharmacotherapy and psychotherapy.

SUMMARY:

This symposium will present new findings from the American Psychiatric Practice Research Network (PRN) on quality of care, access to care, and current patterns of psychiatric care in the United States. Nationally representative, clinically detailed data from the 1997 and 1999 PRN Study of Psychiatric Patients and Treatments will be presented to: (1) assess levels of quality of care as measured by conformance with evidence- and expert consensus-based treatment recommendations from the APA Task Force on Quality Care, (2) characterize the extent to which psychiatric patients receive split versus integrated pharmacotherapy and psychotherapy, (3) examine patterns of Axis I/Axis II comorbidities and treatment patterns, and (4) identify and describe patients with and without substance abuse disorders for whom financial considerations affect access to treatment. Practicing clinicians participating in the PRN will discuss these findings. Implications for clinical practice, policy and future research will be outlined.

TARGET AUDIENCE(S):

Mental health professionals, health services researchers

No. 6A
MEASURING QUALITY OF CARE IN ROUTINE PRACTICE

Lloyd I. Sederer, M.D., *Director, Division of Clinical Services, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005*

SUMMARY:

The set of indicators developed by the APA Task Force on Quality Indicators (1999) "is intended to serve as a tool for health care groups, including accrediting organizations; as an approach to evaluate care provided by health plans and organized systems of care; and as a source of direction for additional research and development of new indicators. Indicators address various aspects of care and are applicable to structure, process, or outcomes." From tested indicators, a "high confidence" set of indicators will then be selected for priority utilization by organized systems of care and by reviewing and accrediting organizations.

The APA Department of Quality Improvement and Psychiatric Services and the Committee on Quality Indicators have begun to field test the sample quality indicators already developed, utilizing the APA Practice Research Network (PRN) data. Using nationally generalizable, clinically detailed data from the 1997 and 1999 PRN Study of Psychiatric Patients and Treatments several of the task force's quality indicators have been operationalizable.

This presentation will provide an overview of the rates of conformance in the PRN sample with a number of the quality indicators including conformance with evidence-based practice guideline treatment recommendations. More specifically, rates of PRN conformance with quality indicators for the treatment of schizophrenia, substance abuse, borderline personality disorder, bipolar disorder, and major depression will be presented along with general quality indicators related to access to care and treatment of the severely mentally ill.

TARGET AUDIENCE(S):

Mental health professionals, health services researchers

REFERENCES:

1. APA Task Force on Quality Indicators: Report of the American Psychiatric Association Task Force on Quality Indicators, March, 1999.

No. 6B
TREATMENT OF BIPOLAR DISORDER IN ROUTINE PRACTICE

Joyce C. West, Ph.D., M.P.P., *Director, American Psychiatric Practice Research Network, American Psychiat-*

ric Association, 1400 K Street, N.W., Washington, DC 20005; Deborah A. Zarin, M.D.; David Kahn, M.D.; Steven C. Marcus, Ph.D.; Victoria Cosgrove, B.A.; Mark Townsend, M.D.

SUMMARY:

Objectives: The primary aims of this study were to: 1) characterize patterns of psychosocial and psychopharmacologic treatment for patients with bipolar disorder; 2) assess levels of conformance with key practice guideline recommendations; and 3) identify factors associated with non-conformance with key guideline recommendations.

Methods: Nationally representative, clinically detailed data from the *1999 American Psychiatric Practice Research Network (PRN) Study of Psychiatric Patients and Treatments* were used. Patterns of psychosocial and psychopharmacologic treatment for the 192 patients with a diagnosis of bipolar disorder in the acute phase of the illness were examined. In addition, factors associated with guideline non-conformance were assessed.

Results: 74.2% (SE=3.8) of the patients received a mood stabilizer; 67.0% (SE=4.3) received psychotherapy; and 97.4% (SE=1.6) received psychiatric management at the current visit or in the past 30 days. The most commonly prescribed mood stabilizer was valproate (43.6%, SE=4.1), followed by lithium (32.1%, SE=4.0) and carbamezapine (7.7%, SE=2.8). Other psychopharmacologic treatments that were provided included antidepressants (54.2%, SE=4.6), antipsychotics (40.3%, SE=4.3) and benzodiazepines (29.6%, SE=3.7).

Conclusions: Most patients in the sample received multiple treatment modalities and a significant proportion did not receive treatment that was consistent with key practice guideline treatment recommendations, including a quarter of the patients in the acute phase of their illness who did not receive a mood stabilizer. More research is needed to better understand reasons for guideline non-conformance and how it affects treatment effectiveness.

TARGET AUDIENCE(S):

Mental health professionals, health services researchers

REFERENCES:

1. Goldman W, McCulloch J, Cuffel B, Zarin DA, Suarez A, Burns BJ: Outpatient utilization patterns of integrated and split psychotherapy and pharmacotherapy for depression. Psychiatric Services 1998; 49:477–482.

No. 6C
AXIS I AND AXIS II COMORBIDITY IN PSYCHIATRIC PRACTICE

William E. Narrow, M.D., *Associate Director, Diagnosis and Classification, Division of Research, and Associate Director, Psychopathology Research Program, American Psychiatric Institute for Research and Education, American Psychiatric Association, 1908 Rookwood Road, Silver Spring, MD 20910-1730*; Diana J. Fitek, B.A.; Diane M. Herbeck, M.A.; Steven C. Marcus, Ph.D.

SUMMARY:

Objective: This study analyzed the reports of a nationally representative sample of psychiatrists on comorbid Axis II disorders among their patients with Axis I disorders.

Methods: The data were gathered from a sample of 1,843 psychiatrists participating in the Practice Research Network (PRN)'s 1999 Study of Psychiatric Patients and Treatments, conducted by the American Psychiatric Institute for Research and Education. Data were analyzed to ascertain the prevalence of Axis I and II disorders, comorbidity rates, and functional status and treatments.

Results: The most prevalent personality disorders were in Clusters B and C, found in 6% to 7% of the sample. Cluster A disorders were relatively rare. Overall rates of Axis II comorbidity with the mood, anxiety, and substance use disorders ranged from 17% to 19%. Lower Axis II comobidity rates were found in schizophrenia, schizoaffective disorder, and the adjustment disorders (5.5% to 9%). Demographic, functioning, and treatment characteristics will also be presented.

Conclusions: Personality disorders have a relatively high prevalence among persons with Axis I disorders. Knowledge of the relationships between Axis I and Axis II disorders and their functional impairments is important for planning effective treatment interventions and will be useful for future nosologic research.

TARGET AUDIENCE(S):

Mental health professionals, health services researchers

REFERENCES:

1. Oldham JM, Skodol AE, Kellman HD, Hyler SE, et al: Comorbidity of Axis I and Axis II disorders. Am J Psychiatry 1995; 152:571–578.

No. 6D
CHARACTERISTICS OF PATIENTS WITH SUBSTANCE USE DISORDERS AFFECTED BY FINANCIAL CONSTRAINTS

Farifteh F. Duffy, Ph.D., M.H.S., *Research Scientist, Office of Quality Improvement and Psychiatric Services, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005*; Steven C. Marcus, Ph.D.; Joyce C. West, Ph.D., M.P.P.; William E. Narrow, M.D.,

M.P.H.; Victoria Cosgrove, B.A.; Darrel A. Regier, M.D., M.P.H.

SUMMARY:

Objectives: The primary aims of this study were to: 1) characterize clinical features and treatment patterns for adult outpatients with major depressive disorder (MDD) treated by psychiatrists; and 2) assess levels of conformance with key evidence-based practice guideline treatment recommendations.

Methods: Nationally representative, clinically detailed psychiatrist-reported data from the *1999 American Psychiatric Practice Research Network (PRN) Study of Psychiatric Patients and Treatments* were used. Use of psychosocial, psychopharmacologic and ECT treatment for 416 adult outpatients with MDD were examined.

Results: The most common severity sub-type was moderate, followed by severe without psychotic features and severe with psychotic features. The majority had comorbid DSM-IV Axis I (49%), Axis II (21%) or Axis III (51%) disorders. A quarter had anxiety disorders; 15% had substance-related disorders. Sexual functioning (59%) and sleep (52%) problems were common. 91% were prescribed antidepressants; 42% anti-anxiety medications; and 11% antipsychotics. 76% received psychotherapy from the psychiatrist or another provider in the past 30 days. Less than one percent received ECT. Conformance rates for the key APA guideline recommendations (APA, 2000) studied ranged from 74% to 98%.

Conclusions: Most patients received multiple treatment modalities. A significant proportion received treatment that was not consistent with key practice guideline recommendations, including 26% of patients with psychotic depression. Longitudinal research is needed to determine if there is an empirically based clinical rationale for deviating from established treatment guidelines that includes an assessment of treatment effectiveness.

TARGET AUDIENCE(S):

Mental health professionals, health services researchers

REFERENCES:

1. Ridgely MS, Goldman HH, Willenbring M: Barriers to the care of persons with dual diagnosis: organizational and financing issues. Schizophr Bull 1990; 16:123–132.
2. Drake RE, Wallach MA: Dual diagnosis: 15 years of progress. Psychiatr Serv 2000; 51:1126–1129.

Symposium 7 **Friday, October 12**
2:00 p.m.-5:00 p.m.

MENTAL RETARDATION: DIAGNOSIS, RESEARCH, AND TREATMENTS

Michael M. Scimeca, M.D., *Associate Clinical Professor, Department of Psychiatry, Columbia University, 200 West 90th Street, #11-H, New York, NY 10024*; Harvey Stabinsky, M.D., J.D., *Department of Psychiatry, St. Vincent's Hospital, 15 Boulder Trail, Armonk, NY 10504-1008*; Susan Stabinsky, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify and diagnose mental retardation and recognize the comorbid psychiatric problems of the mentally retarded patient. The participant will understand techniques to identify syndromes, work with teams, and institute treatments.

SUMMARY:

Mental retardation is little studied and poorly understood among many clinicians. The goal of this symposium is to present an up-to-date picture of mental retardation and understanding of the treatments psychiatrists can provide. The symposium will offer an overview and definitions of the nature of retardation. This will be followed by reports on research on the treatment of depression (a common disorder) among mentally retarded patients. The symposium will then consider the experience and cases of senior clinicians in evaluating and treating the multiple comorbid conditions that affect these patients. Special attention will go to ways to decipher the symptom picture that may not be expressed in words. The need for collecting information from multiple observers, the obligation to make precise diagnoses so that treatments will be specific, and the importance of combining pharmacologic with behavioral interventions in a team approach will be emphasized. The education and participation of families and guardians will be urged. Throughout the symposium and at the end there will be opportunity for questions and discussion from the audience.

TARGET AUDIENCE(S):

General psychiatrists and other clinicians

No. 7A
DIAGNOSIS AND CLASSIFICATION IN MENTAL RETARDATION

Michael A. Bluestone, Ph.D., *Director, Psychological Services, Southern Maryland Regional Office, Developmental Disabilities Administration, 312 Marshall Avenue, Suite 500, Laurel, MD 20707*

SUMMARY:

Accurate diagnosis and classification in mental retardation and related developmental disabilities is critical to decision making involving treatment planning, the need for supports, optimal learning environments, and identification of the causes of problem behaviors and

psychiatric symtomatology. Recent research suggests that large numbers of individuals with mental retardation at all levels (mild, moderate, severe, profound) may be dually diagnosed, meeting DSM-IV diagnostic criteria for a mental disorder. These individuals may have the same range of mental disorders as the general population. Perhaps as many as one-third or more have a significant behavioral, mental, or personality disorder requiring mental health services. Additionally, individuals at all levels of mental retardation may have additional developmental, sensory, and neurological problems that affect their overall functioning. Individuals may meet diagnostic criteria as having a developmental disability (i.e. autism, pervasive developmental disorder, Asperger's) but not mental retardation per se. Therefore, accurate classification and differential diagnosis are critical. Psychological, neuropsychological, standardized, adaptive measures and a developmental history are essential tools. This symposium will provide a reliable method for achieving accurate diagnosis and classification in mental retardation.

REFERENCES:

1. American Association on Mental Retardation: Mental Retardation: Definition, Classification, and Systems of Supports (9th ed.), 1992.
2. Reiss S: Handbook of Challenging Behavior: Mental Health Aspects of Mental Retardation. Worthington, OH, IDS Publishing Corp, 1994.

No. 7B
DIAGNOSTIC ISSUES OF DEPRESSION IN PEOPLE WITH SEVERE AND PROFOUND MENTAL RETARDATION

John A. Tsiouris, M.D., *Associate Director, George Jervis Clinic, New York State Psychiatric Institute for Basic Research, and Clinical Assistant Professor, State University of New York Downstate Medical Center, 1050 Forest Hill Road, Staten Island, NY 10314-6399*

SUMMARY:

The underlying depressive disorder, although common, is not recognized and treated properly in people with severe/profound mental retardation and challenging behaviors.

A retrospective study and a prospective study were undertaken in a cohort of 350 consumers seen in a developmental center and a tertiary clinic. The studies were performed in order to elucidate whether DSM-IV observable characteristics of depression are enough to make the diagnosis or if depressive equivalents must be taken into account. Results suggest that although depressive equivalents (screaming, aggressive and self-injurious behavior) are common, they are not primary but mostly secondary characteristics and may be used only as indicators of the underlying psychopathology.

In another prospective study of 22 people with severe self-injurious behavior, diagnosis and proper treatment of the underlying psychiatric disorder (mainly unrecognized depression) significantly decreased the severity of self-injurious behavior. Unnecessary prescribed neuroleptics were either discontinued or the dosages were tapered by 50% to 75%.

Preliminary results from another ongoing study for identification of helpful biological markers/indicators of depression in people with severe/profound MR will be discussed, as well.

REFERENCES:

1. Marston GM, et al: Manifestations of depression in people with intellectual disability. J Intellect Disabil Res 1997; 41:476–480.
2. Myers BA: Major depression in persons with moderate to profound mental retardation: clinical presentation and case illustrations. Mental Health Aspects of Developmental Disabilities 1998; 1:57–68.

No. 7C
BEHAVIOR MODIFICATION: TECHNIQUES AND CASE STUDIES

Carl Siegel, M.A., *Applied Behavioral Science Specialist, 2658 East 21st Street, Brooklyn, NY 11235*; Michael M. Scimeca, M.D.

SUMMARY:

There is a significant need to provide clinical services to individuals with developmental disabilities and severe behavior disorders. This paper will review concepts of behavioral interventions that can be incorporated into treatment plans to minimize and decrease maladaptive behavior as well as increase socially appropriate behavior. Case studies will be presented to demonstrate how quality of life can be significantly improved when individualized behavioral modification programs are implemented successfully. An emphasis will be placed on a team approach with interaction with the behavioral specialist, psychiatrist, and RN so that there can be an integration of behavioral approaches with psychopharmacology.

REFERENCES:

1. Vollmer TR, Iwata BA: Differential reinforcement as a treatment for behavior disorders. Research in Development Disabilities 1992; 13, 393–417.
2. Axelrod S, Splent S, Berry B, Moyer L: A decision-making model for selecting the optimal treatment procedure, in Behavior Analysis and Treatment. Ed-

ited by Van Houton R, Axelrod S. New York, Plenum Press, 1993 pp 153–202.

No. 7D
RATIONAL PSYCHOPHARMACOLOGY IN MENTALLY RETARDED DUALLY-DIAGNOSED PATIENTS

Harvey Stabinsky, M.D., J.D., *Department of Psychiatry, St. Vincent's Hospital, 15 Boulder Trail, Armonk, NY 10504-1008*; Susan Stabinsky, M.D.

SUMMARY:

Until quite recently questions had been raised about the efficacy of specific psychiatric treatments, including psychotherapeutic and psychopharmacological interventions, for the mentally retarded and developmentally disabled. Most psychiatric treatments for this population were focused on decreasing aggression, and the primary therapeutic tool for decades was sedation.

We will review the rapidly growing focus on actually diagnosing and then appropriately treating a wide range of accompanying psychiatric disorders often affective in nature, in this population.

The difficulties in incorporating a significant MRDD population into an existing general psychiatric inpatient unit and the special needs of the co-existing outpatient population will be reviewed.

Finally the impact of counter-transferential factors in this treatment will be evaluated.

REFERENCES:

1. Masi G, et al: Psychiatric illness in mental retardation: an update on pharmacotherapy. Pan Minerva Medica, 1997; 39(4): 299–304.

No. 7E
MENTAL RETARDATION: WORK WITH TEAMS AND CARE OF PATIENTS

Michael M. Scimeca, M.D., *Associate Clinical Professor, Department of Psychiatry, Columbia University, 200 West 90th Street, #11-H, New York, NY 10024*; Carl Siegel, M.A.

SUMMARY:

Evaluation and treatment of challenging behaviors that often are signs of underlying comorbid psychiatric illness will be discussed. Particular attention will focus on methods of obtaining history, estimating realistic treatment according to the patient's habits and needs, working with (often) non-medical staff, communicating with family and guardians. Ambulatory, residential cases will be presented. Special use of certain medications will be mentioned. Discussion and questions will be welcome.

REFERENCES:

1. Bergman JD, et al: Mental retardation, in Comprehensive Textbook of Psychiatry. Edited by Kaplan H, Saddock B. Baltimore, Williams & Wilkins, 1995, pp 2207–2243.

Symposium 8 — Saturday, October 13 8:30 a.m.-11:30 a.m.

GAINING COMPETENCE IN EDUCATING CONSUMERS AND FAMILIES ABOUT MENTAL ILLNESS

Therapeutic Education Association

Cynthia C. Bisbee, Ph.D., *Clinical Director, Montgomery Area Mental Health Authority, 101 Coliseum Boulevard, Box 3223, Montgomery, AL 36109*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) describe mental illness educational content in the areas of medications, family issues, and coping skills; (2) demonstrate the technique of illness monitoring; (3) describe the role of the multidisciplinary team in mental illness education; and (4) name two emerging techniques in consumer and family education.

SUMMARY:

Consumer and family education/psychoeducation is becoming more and more an accepted part of the overall treatment and management plan for serious mental illnesses such as schizophrenia, bipolar disorder, and severe depression. In order to provide competent teaching of up-to-date information, clinician-educators of all disciplines must become competent and remain current in both the content and the process of educating consumers and families about mental illness. The purpose of this symposium is to provide information about emerging knowledge about mental illness education topics and about the techniques that are developing for the process of education. The sessions will begin with the role of the multidisciplinary treatment team in mental illness education. It will proceed then to give current knowledge about specific content areas such as effects and side effects of the new medications, emerging techniques of illness monitoring, the role of the family, and understanding family burden. It will then discuss techniques for teaching coping skills to consumers and families, and some of the latest techniques in mental illness education, including multimedia and the internet. The session will conclude with a substantial period of time for discussion

and sharing of participants' experiences in educating consumers and families about mental illness.

TARGET AUDIENCE(S):

Consumers, families, providers, and others interested in mental illness education

No. 8A
THE ROLE OF THE MULTIDISCIPLINARY TEAM IN MENTAL ILLNESS EDUCATION

Garry M. Vickar, M.D., *Chief of Psychiatry, Christian Hospital, 1245 Graham Road, Suite 506, Florissant, MO 63031*

SUMMARY:

The concept of an individual, didactic doctor/patient relationship in the treatment of schizophrenia and other major mental illnesses is probably obsolete, although there is no question that an individual relationship between the doctor and the patient must be established and nurtured. The nature of these chronic illnesses, however, requires that one view them also in the context of the family—not in the sense of causation, but in the sense of how others related to the patient are affected. For more than 15 years, we have had a structured, psychoeducation-based program for treating patients with schizophrenia. It has been successful, and we are in the midst of obtaining a grant to study its processes. We have learned an important lesson: As good as the physician may be and as wonderful as the newer medications are proving to be, nothing replaces the advantages of educating the patients and their families about the illness, about the medications, and about how to access a variety of needed services. This presentation will focus on the lessons learned from directing the program and working with the multidisciplinary team, and how these lessons can be applied in almost any public, private, or university setting.

REFERENCES:

1. Helping families cope with mental illness, Leffey & Wasow. Harwood Academic Pub, 1994.

No. 8B
WHAT TO TEACH CONSUMERS AND FAMILIES ABOUT MEDICATIONS

David P. Walling, Ph.D., *Vice President, Infoscriber Corporation, 10429 La Cebra Avenue, Fountain Valley, CA 92708*

SUMMARY:

Pharmacotherapy is often a central focus in managing the disease states that comprise serious mental illness. Psychoactive medications serve to alleviate or decrease symptoms for many consumers and are therefore seen as a central component of treatment. With newer medications reaching the market, and considerably more in development, it is increasingly important that consumers and their families receive the most current information available. However, many consumers receive little or no education about their medications, the potential side effects, and the role of medication in treatment. While the newer medications are designed to offer greater efficacy with fewer side effects, studies still show that a majority of clients discontinue their medications against medical advice and therefore experience a relapse of symptoms. Educating consumers about the role of medications in the treatment process can help to prevent medication noncompliance and thereby serve as an important tool in the relapse prevention process.

This presentation will focus on the provision of medication education to consumers and their support systems. The presentation will cover the essential material necessary to help professional and paraprofessional staff explain the current medications to their clients with a focus on translating the medical language to that which is understandable for the client.

REFERENCES:

1. Weiden P, Scheifler P, Diamond R, Ross R: Breakthroughs in Antipsychotic Medications: A Guide for Consumers, Families & Professionals. New York, W.W. Norton, 1999.

No. 8C
TEACHING ABOUT ILLNESS MONITORING

Cynthia C. Bisbee, Ph.D., *Clinical Director, Montgomery Area Mental Health Authority, 101 Coliseum Boulevard, Box 3223, Montgomery, AL 36109*; Humphry F. Osmond, M.D.

SUMMARY:

One of the major aspects of learning about management of serious mental illness is learning how to monitor illness symptoms, to predict the return of symptoms, and to respond to an impending relapse. By learning techniques of illness monitoring, consumers and families become more effective in maintaining a more constant level of stability. This presentation will discuss the concept of illness cycles and the idea that the waxing and waning of illness symptoms can be mapped and predicted. Two types of illness monitoring will be described and demonstrated—symptom monitoring, carried out by

the consumer, and behavioral monitoring, implemented by the family or by staff working with the consumer in a service setting. A specific type of symptom monitoring for mood disorders—the Mood Thermometer—will also be demonstrated. Examples of a relapse response plan based on the concept of illness monitoring will be described, including graphic presentation of the illness cycles and the plan for taking action in response to an observed increase in symptoms or behaviors. Also discussed will be examples of other systems of relapse prediction garnered from the literature and how they compare and contrast.

REFERENCES:

1. Bisbee C: Educating Patients and Families about Mental Illness. Birmingham, AL, Partnership for Recovery, 1991, 1995.

No. 8D
HOW TO TEACH ABOUT COPING SKILLS

Patricia L. Scheifler, M.S.W., *Director, Partnership for Recovery, 249 Lakewood Circle, Sylacauga, AL 35150*

SUMMARY:

Many patients with a serious and persistent mental illness spend years struggling to overcome a devastating illness but lack the knowledge and skills needed to achieve and sustain recovery. It is not unusual for patients to be in treatment for years without gaining a basic understanding of how to cope with their illness, how to recover, and how to prevent relapse. Knowledge acquisition and skill mastery can help many of our patients cope more effectively with their illness and can help facilitate recovery. However, in order to equip our patients to successfully navigate the road to recovery, we must use techniques and materials that are tailored to accommodate their special needs and cognitive deficits. Blending the roles of clinician, coach, and educator poses an interesting challenge for many professionals who realize the importance of broadening their services to meet the specialized needs of people with serious mental illness. This presentation will discuss the importance of coping skills training, identify key coping skills, describe effective skill building techniques, and provide a list of resource materials for practitioners.

REFERENCES:

1. Hognety GE, Flesher S: Practice principles of cognitive enhancement therapy for schizophrenia. Schizophrenia Bulletin 25(4):693–706.
2. Heinssen RK, Liberman RP, Kopelowicz A: Psychosocial skills training for schizophrenia: lessons from the laboratory. Schizophrenia Bulletin 26(1):21–46.

No. 8E
TAKING FAMILY BURDEN INTO ACCOUNT IN FAMILY EDUCATION

Victoria A. Conn, M.D., *8430 Germantown Avenue, Philadelphia, PA 19118*

SUMMARY:

Serious mental illnesses such as schizophrenia, bipolar disorder, and severe depression have devastating effects on all aspects of the lives of those affected. Moreover, the families of those with the illnesses are not spared. Families may experience substantial stress and burden in providing care and support for their ill relatives; thus they have service needs of their own apart from those of the person with the illness. Families also have tremendous strengths, resources, and a resilience that can be brought to bear on the treatment of the consumer. They can use these resources as well in their own learning to manage the illness and their response to it. Family education is an essential and vital part of any treatment program. Education must be delivered, however, in the context of support for the family, and timing is crucial. Families should be approached with a great deal of tolerance, in that the experiences they have had and stresses they face daily may interfere with learning and make it less efficient. Education must be clear, repetitious, and patiently delivered in a collaborative spirit that calls forth the strengths, resources, and resilience of the family.

REFERENCES:

1. Tessler R, Gamache G: Family Experiences with Mental Illness. Auburn House, Westport CT, 2000.

No. 8F
LATEST TECHNIQUES IN CONSUMER AND FAMILY EDUCATION

Kay J. McCrary, Ed.D., *Director, Patient and Family Education, Bryan Psychiatric Hospital, 220 Faison Drive, Columbia, SC 29203*

SUMMARY:

As the person on the panel who was trained as an educator, having earned a Doctor of Education degree in adult education with a psychology specialty, my contribution to this symposium is to discuss the latest techniques in consumer and family education. During my presentation, we'll primarily review the *process* of educating, touching lightly on content. We will examine the following:

- Multidisciplinary provision of education: teamwork for teaching—who should teach what when?

- What physical, mental capacity, emotional, and cultural factors need to be considered when evaluating learning readiness/potential learning barriers?
- What are the multiple pathways, various teaching modes, to effectively reach students?
- What is interactive teaching?
- What excellent teaching materials are readily available?
- What are the relevant standards by which these services should be evaluated?
- Documentation.

REFERENCES:

1. Educating Hospital Patients and Their Families, JCAHP.

Symposium 9 **Saturday, October 13**
8:30 a.m.-11:30 a.m.

CURRENT LEVEL OF CARE: ASSESSMENT TOOLS FOR PSYCHIATRIC AND SUBSTANCE DISORDERS

American Association of Community Psychiatrists

Kenneth M. Minkoff, M.D., *Medical Director, Choate Health Management, and Consultant and Trainer, Integrated Treatment Systems and Interventions for Co-Occurring Disorders, 500 West Cummings Park, Suite 3900, Woburn, MA 01801*

EDUCATIONAL OBJECTIVES:

The participant should be able to (1) describe the concept of independent de-linked dimensions of service intensity, and identify four such dimensions; (2) discuss the concept of multidimensional service intensity assessment, and identify six assessment dimensions for addiction patients and for psychiatric patients; (3) describe the current availability, utility, validity, and reliability of the ASAM PPC2R, the LOCUS, the CHOICE, and the CHOICE-Dual.

SUMMARY:

Despite the fact that there has been extensive controversy regarding managed care and concern that managed care reviewers may inappropriately deny access to intensive services, there has been surprisingly little available objective data on the process of utilization management and level of care determination. Fortunately, in recent years, this has begun to change, as there has been increasing development and investigation of more sophisticated instruments for assessment of level of care or service intensity requirements.

This symposium attempts to bring together in a single forum a presentation of the most up-to-date level of care assessment tools available in the public domain. The symposium begins with a presentation of general principles of utilization management, including the description of independent dimensions of service intensity and the concept of multidimensional service intensity assessment, and illustrates the application of these concepts to the development of utilization management manuals (CHOICE—the Choate Outline for Intensity of Care Evaluations) in managed care oriented service continuum. The symposium continues with a description of the latest version of the American Society of Addiction Medicine Placement Criteria (2R), which incorporates increased sophistication regarding assessment of comorbid psychiatric disorders in the addiction placement process. This presentation is followed by a presentation on the NIDA-funded ASAM Criteria Validity Study, which is attempting to demonstrate objective support for the ASAM PPC2.

The next section of the symposium focuses on the latest version of a level of care assessment tool that originated on the psychiatric side, (though also incorporating addressing comorbidity): LOCUS 2.001, developed by the American Association of Community Psychiatrists (AACP). The instrument will be described, along with current research supporting validity and reliability.

The final section of the symposium will emphasize audience participation in the level of care assessment process. Sample cases (one addiction focused, one psychiatric focused) will be distributed, and the audience will be invited to use ASAM 2R, LOCUS, and CHOICE-Dual to help determine appropriate level of care. The strengths and limitations of each instrument will then be discussed.

In total, the symposium will present the listener with an accurate portrayal of the current field of level of care assessment, and the directions of future research. This material will be invaluable for anyone involved, or planning to be involved in the development of, or delivery of service in, managed care systems.

TARGET AUDIENCE(S):

All clinicians

No. 9A
PRINCIPLES OF UTILIZATION MANAGEMENT AND LEVEL OF CARE ASSESSMENT

Kenneth M. Minkoff, M.D., *Medical Director, Choate Health Management, and Consultant and Trainer, Integrated Treatments Systems and Interventions for Co-Occurring Disorders, 500 West Cummings Park, Suite 3900, Woburn, MA 01801*

SUMMARY:

The presentation begins with an outline of basic principles of utilization management. This will include the concept of independent dimensions of service intensity, including biomedical, residential, treatment, and case management intensity, which lead in turn to the reconceptualization of "levels of care" as "matrices of service intensity." In this model, the independent dimensions are "de-linked" so that program models can vary flexibly across dimensional categories.

The second key concept is that of multidimensional service intensity assessment. Level of care instruments are based on identifying these dimensions, and connecting ratings on each dimension, separately and together, to the identification of patient service intensity requirements. Later talks in the symposium will illustrate how this is currently being done for individuals who present with substance disorders, psychiatric disorders (for adults), and child and adolescent psychiatric disorders.

The final component of this presentation will be the application of the above concepts to the creation of a behaviorally descriptive utilization management manual (CHOICE, CHOICE-DUAL) that has been utilized in a public-sector managed care case rate program in a vertically integrated continuum of care with a wide range of available service intensities.

REFERENCES:

1. Minkoff & Regner: Innovations in Dual Dx Treatment in MGD Care: The Choate Dual Dx Case Rate Program. J. Psychoactive Drugs, Jan-Mar 1999 RP 1–11.
2. Minkoff: Level of Care Determination for Individuals with Co-Occurring Psychiatric & Substance Disorders. J. Boult-Adrin, in press 2001.

No. 9B
UNDERSTANDING AND USING THE PATIENT PLACEMENT CRITERIA OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE

David Mee-Lee, M.D., *Assistant Clinical Professor of Psychiatry, University of California at Davis, 4228 Boxelder Place, Davis, CA 95616*

SUMMARY:

Clinicians involved in planning and managing care often lack a common language and systematic assessment and treatment approach that allows for effective, individualized treatment plans and level of care placement. The Patient Placement Criteria for the Treatment of Psychoactive Substance Used Disorders of the American Society of Addiction Medicine (ASAM), first published in 1991, provided common language to help the field develop a broader continuum of care. They were updated and the second edition (PPC-2) was published in 1996 and a revised second edition (PPC-2R) will be published in early 2001.

This presentation will explain the underlying principles that guided the original development and current edition of the ASAM Patient Placement Criteria (PPC). It will update participants about what changes and revisions were made in PPC-2R and inform participants about how to use the criteria in clinical practice.

REFERENCES:

1. American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised (ASAM PPC-2R). Chevy Chase, MD, The Society, in press, 2001.
2. Mee-Lee D: Use of patient placement criteria in the selection of treatment. 370, Section 5, in Overview of Addiction Treatment in Principles of Addiction Medicine, Second Edition. American Society of Addiction Medicine Inc., Chevy Chase, MD, 1998, pp 363–370.

No. 9C
PLACEMENT CRITERIA: ADVANCES AND OUTCOMES FOR SYSTEM-WIDE IMPLEMENTATION

David R. Gastfriend, M.D., *Associate Professor of Psychiatry, Harvard Medical School, 15 Parkman Street, Wall-812, Boston, MA 02114*

SUMMARY:

The ASAM Patient Placement Criteria have benefited from multiple research trials, to the point that a new, computerized tool offers comprehensive, reliable, feasible, and high resolution implementation. In prior research, an independent panel of the U.S. Center for Substance Abuse Treatment found sufficient face validity to recommend that states proceed with implementation and evaluation of criteria such as the ASAM criteria. A high degree of concordance of decisions between MCOs and the ASAM criteria has been reported. Support for concurrent validity and outcome comes from two trials in the ASAM Criteria Validity Study at the Massachusetts General Hospital and a third study at Roosevelt Hospital in New York City. In a VA hospital, naturalistic ASAM matching was associated with less subsequent service utilization than mis-matching. Standardization through the use of criteria seems likely to facilitate improved care and efficiency of addictions treatment. The result of this research is that a new computerized algorithm has been developed for clinician use that prompts

assessment via structured interview and provides quantitative, standardized scoring for routine use.

REFERENCES:

1. Gastfriend DR, Sharon E, Lu S: Patient Placement Criteria: Clinical Challenges and Technical Progress. Substance Abuse & Misuse, in press.
2. Gastfriend D: Patient Placement Criteria, in Textbook of Substance Abuse Treatment. second ed. Edited by Galanter M, Kleber HD. Washington, The American Psychiatric Press, 1999, pp 121–127.

No. 9D
THE LEVEL OF CARE UTILIZATION SYSTEM: A SIMPLE METHOD FOR LEVEL OF CARE DECISIONS

Wesley E. Sowers, M.D., *Medical Director, Allegheny County Office of Behavioral Health, and Clinical Associate Professor, Department of Psychiatry, University of Pittsburgh School of Medicine, 400 45th Street, Pittsburgh, PA 15201*

SUMMARY:

The Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) was developed by the American Association of Community Psychiatrists in 1995. The instrument attempts to assist in making level of care determinations while balancing the interests of maintaining quality with the demands for providing care in the most cost effective manner possible. It is designed to be easily understood and used by clinicians. A number of other principles were identified to guide the development of LOCUS: (1) integration of mental health and addiction variables, (2) dimensional and quantifiable assessment parameters, (3) levels of care defined flexibly in terms of resource intensity rather than rigidly defined program requirements, and (4) adaptable to the variety of circumstances encountered in behavioral health environments. LOCUS has been field tested over the past five years and has been revised to accommodate suggestions obtained from that process. Preliminary testing has shown it to be reliable and consistent with expert determinations for placement decisions. This workshop will discuss the practical applications of LOCUS and will use a case example to demonstrate its utility.

REFERENCES:

1. Sowers W: Level-of-care determinations in psychiatry. Harvard Rev Psychiatry 1998; 5:286–90.
2. Sowers W, George C, Thompson K: Level of care utilization system for psychiatric and addiction services (LOCUS): a preliminary assessment of reliability and validity. CMHJ 1999; 35(6):545–513.

Symposium 10 **Saturday, October 13**
2:00 p.m.-5:00 p.m.

ADOLESCENT VIOLENCE: RAGE IN REVIEW

American Orthopsychiatric Association

Judith E. Gerson, Ed.D., *Teacher and Counselor, Evergreen High School, Los Angeles Unified School District, 11824 G Moorpark Street, Studio City, CA 91604*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should acquire additional information about adolescent violence from three reference points: adolescent med., clinical/social service, and education. It is hoped a fresh perspective will be gleaned, and many part, will turn words to action.

SUMMARY:

This nation is engaged in a war against teenage violence. Although the problem is epidemic, the commitment to develop multidiscipline teams to combat it is insignificant. Unfortunately, many view this as a justice system problem. But this disease claims two victims: the person committing the violence and the one receiving it. The result of this is devasting to our nation.

Presentations will cover statistical impact from a public health concern, clinical view of the high at-risk youth, "red light" policies, and unique solutions to the problem. In addition, the voice of these youth will be relayed. At the end of the presentation a panel will be formed to answer questions and exchange ideas.

REFERENCES:

1. Gelles RJ: Family violence and adolescents. Adolescent Medicine: State of the Art Reviews 1990; 1:445–448.
2. Slaby RG, Stringham P: Prevention of peer and community violence: The pediatrician's role. Pediatrics 1994; 84(4):Supplement 608–616.
3. Garbarino J: Lost boys: Why our sons turn violent and how we can protect them. New York, Free Press/ Simon and Schuster, Inc., 1999.
4. Wodarski JS, Wodarski LA: Preventing Teenage Violence. New York, Springer Publishing Company, Inc., 1998.

No. 10A
VIOLENCE AMONG YOUTH: A MAJOR EPIDEMIC IN AMERICA

Hyman C. Tolmas, M.D., *Professor Emeritus, and Clinical Professor of Pediatric and Adolescent Medicine, Tulane University School of Medicine, 466 Crystal Street, New Orleans, LA 70124*

SUMMARY:

Violence has reached epidemic proportions among the youth of America and has become the leading cause of death in African-American adolescents and the second leading cause of death in adolescents overall. Because violence is the leading cause of mortality and morbidity among adolescents, it has gained recognition as the most important public health and social problem facing the United States. Violent injury and death disproportionally affect children, adolescents, and young adults. Some may question the designation of violence as a public health problem. However, one need only look at the devastating statistics relating to mortality, morbidity, and disability resulting from violent behavior to appreciate the impact of violence on both the health status of individuals and on our national health care delivery system. The ubiquitous nature of this problem makes it even more alarming.

No. 10B
PSYCHOLOGICAL AND SOCIAL FACTORS AFFECTING YOUTH WHO COMMIT VIOLENCE

Harriet Grazman, M.S.W., *Psychotherapist, Private Practice, 6-B Glen-Ed Professional Park, Glen Carbon, IL 62034*

SUMMARY:

This presentation will begin with a brief overview of normal psychological development with an emphasis on the importance of relatedness and a sense of connection. Focus will shift to personal, interpersonal, and social factors that may impact on youngsters' perception of self; how they fit in the world; and how this perception may put them at risk to commit violence.

Attention will be paid to some of the negative effects of the new "Zero Tolerance" policies that are currently being instituted in school systems throughout the United States.

No. 10C
THE BRIDGE PROGRAM: DIVERTING TEENS AT RISK FROM VIOLENCE

Judith E. Gerson, Ed.D., *Teacher and Counselor, Evergreen High School, Los Angeles Unified School District, 11824 G Moorpark Street, Studio City, CA 91604*

SUMMARY:

The presentation will point out the various needs and problems when teaching high at-risk teens in a special secondary school environment. Dropout, asocial, and gang youth who exhibit violent, disruptive, and/or apathetic behavior are ignored and pushed into the corners of education. They are "shadows" in the whir of the educational machine. If not attended to, they become the dropout and problem adults of our society. These youth will not disappear. They are a prominent factor in rising crime, a drain on the country's economy, and lessen technical advancement of the work force, sorely needed in an expanding technological world.

A view into the construction of multi-discipline programs that cut across the areas of medicine, mental health, juvenile justice system, and institutions of higher learning will be discussed. This team work is essential if we are to stem the increasing spread of the disease called "adolescent violence." A review of the Bridge Program, created in 1992 for high at-risk teens, shows how team effort is bringing a 70% to 80% success rate in diverting these teens from becoming dropouts and/or continuing a street life of violence.

Symposium 11 **Sunday, October 14**
8:30 a.m.-11:30 a.m.

TEACHING CULTURAL COMPETENCE AND DIVERSITY USING FILMS

American Association of Community Psychiatrists

Russell F. Lim, M.D., *Clinical Assistant Professor of Psychiatry, University of California at Davis, and Medical Director, Northgate Point, 601 West North Market Boulevard, #100, Sacramento, CA 95834*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the audience will be able to: (1) define cultural competence, (2) describe how cultural competence training differs from diversity training, (3) use films for both cultural competence training and diversity training by leading discussions following showings of "The Color of Fear," "Essential Blue Eyes," "Black and Blue," and other films.

SUMMARY:

The increasing cultural diversity of the United States, as shown by U.S. Census data, requires that clinicians understand how cultural differences affect diagnosis and treatment. From 1980 to 1990, the number of Asians in America increased by 100%, Hispanics by 53%, American Indians by 45% and African Americans by 14%, while Caucasians increased only by 7%. In addition, ACGME requirements for psychiatric residents now include a familiarity with cultural assessment. Finally, DSM-IV-TR has added new emphasis to the influence of culture on diagnosis by including an outline for cultural formulation and a glossary of culture bound syndromes.

Culturally diverse individuals have special needs and clinicians require special skills and knowledge to treat

them both appropriately and effectively. The symposium will present different methods of using films for training in cultural competence and diversity issues that can help residency training programs comply with the new regulations. Speakers will describe in detail how to use films such as "The Color of Fear," "Essential Blue Eyes," "Black and Blue," and other films, as well as show brief excerpts from those films. These films, showing either actual groups or therapy with actors, vividly portray emotional issues such as racism, prejudice, and discrimination that will stimulate discussion on diversity issues and cultural competence.

REFERENCES:

1. Gabbard G, Gabbard K: Psychiatry and the Cinema, Second Edition. American Psychiatric Press Inc., Washington, DC, 1999.
2. Summerfield, E: Crossing Cultures Through Film. Intercultural Press, Yarmouth, Maine, 1993.

No. 11A
USING FILMS TO FACILITATE DISCUSSIONS ABOUT RACE

Ronald J. Diamond, M.D., *Clinical Professor, Department of Psychiatry, University of Wisconsin, 625 West Washington Avenue, Madison, WI 53703*

SUMMARY:

It is usually extremely difficult to get people in the United States to talk frankly about issues of race. Euro-Americans are often concerned about saying the "right thing" and do not want to appear racist. People of color, in groups with Euro-Americans, are equally careful about what they say. The experience of people of color is often difficult for Euro-Americans to understand or accept without being defensive. The result is that groups that attempt to talk about race often end up in a mixture of uncomfortable silence broken by platitudes. A number of videos are now available that evoke powerful responses in almost any audience. These videos can serve to catalyze much deeper discussions that would naturally occur. The experience of using videos to facilitate discussion with both students and colleagues will be presented.

REFERENCES:

1. Web page on resources for using "The Color of Fear" for training Purposes.
2. *http://www.tcnj.edu/-kpearson/color/color.html*

No. 11B
BLACK AND BLUE

Annelle B. Primm, M.D., M.P.H., *Assistant Professor and Director, Community Psychiatry Program, Johns Hopkins University School of Medicine, 600 North Wolfe Street, Meyer 144, Baltimore, MD 21287-7180.*

SUMMARY:

A revised version of the educational videotape. Black and Blue: Depression in the African-American Community, will be presented and discussed. This videotape presents African-American consumers with histories of depression who discuss their personal experience with the illness. In addition, the videotape addresses culturally-based beliefs such as prayer alone being a cure for depression and antidepressant medication being addictive. Black and Blue offers the viewer an example of how videotape can be used to teach health professionals, trainees, and the general public about the syndromal nature and pathoplastic features of depressive illness. It also provides a culturally tailored, audiovisual tool that may be used in both health care and community settings to increase professional help-seeking for depression among African Americans.

REFERENCES:

1. Cooper-Patrick, L, Gonzales, JJ, Rost, KM et al: Patient preferences for treatment of depression. The International Journal of Psychiatry in Medicine 1998; 28:382–383.

No. 11C
CREATING A DOCUMENTARY LIBRARY FOR TEACHING CULTURAL ISSUES

Jacquelyn B. Chang, M.D., *341 Spruce Street, Suite C, San Francisco, CA 94118*

SUMMARY:

A wealth of documentaries exist that depict various aspects of culture; the dilemma seems to lie in figuring out how to use them to stimulate discussion to broaden awareness of cultural issues. Using funding from an APA Minority Fellowship in 1998, the presenter created a library of documentaries at the University of California, San Francisco, for use in teaching cultural issues. This presentation will explore the inception and development of the project, including the challenges in selecting choice documentaries, the development of discussion guides to facilitate use, and the applications possible in teaching.

Distributors for documentaries such as California Newsreel, National Asian-American Telecommunications Association (NAATA), New Day Films, and Women Make Movies will be highlighted as sources to consider in finding high-quality documentaries. Video clips from award winning documentaries such as "Girls Like Us" and "The Way Home" will be shown to demonstrate the richness and complexity of the docu-

mentary library holdings. Interested individuals can access more details on this project via the Internet at the website of the American Association of Directors of Psychiatric Residency Training (*www.aadprt.org*) under the heading "curriculum."

REFERENCES:

1. Summerfield E: Crossing Cultures Through Film. Intercultural Press, Yarmouth, Maine, 1993.

No. 11D
THE CROSS-CULTURAL THERAPEUTIC ALLIANCE

Irma J. Bland, M.D., *Clinical Professor, Department of Psychiatry, Louisiana State University Health Science Center, 1542 Tulane Avenue, New Orleans, LA 70112*

SUMMARY:

A distinctly positive experience between a patient and a therapist enhances compliance and is usually predictive of a favorable treatment outcome, regardless of the nature of the therapeutic intervention. This requires the development of a working therapeutic alliance. When the patient and therapist are of different racial/ethnic/cultural backgrounds, establishing this rapport may be a greater challenge. It does not, however, preclude the possibility of engagement, development of rapport, and an effective working alliance. It does require an understanding and acceptance of diversity, a thorough evaluation and empathic understanding of the patient in his/her cultural context and experience, awareness and working through one's own potential issues (across cultures), and the knowledge and skill in working through troubled transactions. This presentation utilizes and demonstrates the effectiveness of educational videotape as a format in teaching to demonstrate strategies and techniques for establishing an effective therapeutic alliance and working with patients in a cross-cultural context.

REFERENCES:

1. Bland IJ, Kraft I: The therapeutic alliance across cultures, in Clinical Methods in Transcultural Psychiatry. Edited by Okpaku SO. Washington, DC, APPI, Inc., 1998, pp 266–278.
2. Foulks EF, Bland IJ, Shervington D: Psychotherapy across cultures, in Annual Review of Psychiatry. Vol 14. Edited by Oldham JM, Riba M. Washington, DC, APPI, 1995.

Workshop 1 **Wednesday, October 10**
8:00 a.m.-9:30 a.m.

CATCHING THE BUS: SCHOOL-BASED PRIMARY PREVENTION AND MENTAL HEALTH

2000-2002 APA/Bristol-Myers Squibb Fellows

Nichole D. Grier, M.D., *2000-2002 APA/Bristol-Myers Squibb Fellow, and Resident, Department of Psychiatery, University of North Carolina School of Medicine, 111 Channing Lane, Chapel Hill, NC 27516-9153*; Craig A. Stuck, M.D., *2000-2002 APA/Bristol-Myers Squibb Fellow, and Resident, Department of Psychiatry, University of South Carolina School of Medicine, 216 West High Street, Winnsboro, SC 29180*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to discuss the utility of expanding mental health programming in schools, be able to identify practices critical to the success of these systems of care, and be familiar with available resources for current developments in this area.

SUMMARY:

School-based mental health services are an effective approach to the management of children who require treatment for mental illness. Most programs, however, offer only individual or small group interventions and thus do not interact directly with the majority of school-aged children. Comprehensive systems of care that integrate school-wide primary prevention and early after-onset interventions have been shown capable of improving mental health outcomes. Effective primary prevention can involve promoting self-esteem and fostering skills in responsible decision-making and social interactions and may be tailored to specific populations and issues. Many of these comprehensive approaches are still in the early phases of development and much research is still needed to evaluate effectiveness.

In this workshop, practices that have been shown to be integral to the success of expanded school-based mental health programs will be emphasized. Ideas for involving families, school personnel, and communities in programming will be presented. A research project conducted by the University of South Carolina, which teaches coping skills to third graders, will be used to highlight the development of new approaches and the challenges of measuring effectiveness.

There are no special background requirements for this workshop. The material should appeal to those interested in primary prevention with regard to mental illness, mental health care delivery systems, and working with children and adolescents in community settings.

REFERENCES:

1. Durlak LA, Wells AM.: Primary prevention mental health programs for children and adolescents: a meta-analysis review. American Journal of Community Psychology 1997; 25(2):115–52.
2. Tooman NA, Weier MD, et al: Toward the integration of prevention research and expanded school mental health programs. Children's Services: Social Policy, Research, and Practice 2000; 3(2): 97–115.

Workshop 2 **Wednesday, October 10**
8:00 a.m.-9:30 a.m.

A VACCINE FOR VIOLENCE: UNDERSTANDING THE SHAME RESPONSE TO REJECTION

National Center for Juvenile Justice

Abraham L. Halpern, M.D., *Professor Emeritus, Department of Psychiatry, New York Medical College, 720 The Parkway, Maroneck, NY 10543-4299*; Hunter Hurst III; Herbert E. Thomas, M.D.; James T. McLaughlin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) understand the pervasiveness of the shame response to rejection in our society, (2) understand that an intensely painful shame response can be a precursor to violence, and (3) understand the problems when those in authority, e.g., therapists, teachers, juvenile justice workers, ignore the physical consequences of rejection.

SUMMARY:

Our society exists with the understanding that when a person experiences rejection, especially by a significant other, she/he may become angry or even violent. However, there is another explanation in which rejection causes one to experience a primitive physiological response in one's body, viz. a shame response. If this physical response is sufficiently intense, it can be extremely painful and cause an intense psychic trauma. Several factors determine the intensity of the rejection: the significance to the person rejected of the one who rejects, the significance to the person rejected of those who witness the rejection, the rejected person's vulnerability to experiencing rejection, whether what is rejected is an aspect of one's self or of one's whole self, the degree of surprise associated with the rejection. The more intense the shame response, the more physically painful it is. Such painful experiences are cumulative. Hence, a slight rejection may release the energy associated with previous rejections and lead to violence. By deliberately ensuring that our posture toward others is one of acceptance, and not rejection we can help those

at risk from repeated painful experiences. Only by understanding the pervasiveness of acts of rejection can we diminish violence.

TARGET AUDIENCE:

All attendees.

REFERENCES:

1. Thomas H: Experiencing a shame response as a precursor to violence. Bulletin American Academy Psychiatry and Law 1995; 23:587–593.
2. Thomas HE: The shame response to rejection triggers primitive, physical reactions. The Brown University Child and Adolescent Behavior Letter 1998; 14(4).

Workshop 3 **Wednesday, October 10**
8:00 a.m.-9:30 a.m.

KENDRA'S LAW: TWO YEARS IN NEW YORK CITY

Michael S. Lesser, M.D., *Medical Director, New York City Department of Mental Health, 93 Worth Street, Room 414, New York, NY 10013-3412*; Daniel Garza, M.D., *Director, Assisted Outpatient Treatment Program, Elmhurst Hospital, 79-01 Broadway, Elmhurst, NY 11373*; Alexander Bardey, M.D.; Scott D. Rogge, M.D.; David A. Trachtenberg, M.D.; Isaac Monserrate, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to understand the basic concepts that include the behavioral and juridical systems complexities associated with the development and implementation of the New York State Assisted Outpatient Treatment "Kendra's Law" statue of 1999, for mandated treatment in a large urban city.

SUMMARY:

In 1999, New York State enacted legislation that provides for assisted outpatient treatment under court orders for certain people with mental illness who, in view of their treatment history and present circumstances, are unlikely to survive safely in the community without supervision. This new law is commonly referred to as "Kendra's Law."

The New York City Mental Health Assisted Outpatient Treatment Teams workshop will focus on the experiences and the two years of clinical, legal issues, and outcomes of the implementation of Kendra's law.

TARGET AUDIENCE:

Hospital inpatient services, community mental health center, mental health professionals, lawyers

REFERENCES:

1. Miller RD: Commitment to outpatient treatment: a national survey. Hospital Community Psyc. 36:265–267, 1985.
2. Swartz MS, Burns BJ, et al.: New directions in research on involuntary outpatient commitment. Psychiatric Services 1995; 46(4):381–385.

Workshop 4 **Wednesday, October 10**
10:00 a.m.-11:30 a.m.

WHAT IS THE PATIENT SAYING? THE PSYCHIATRIC INTERVIEW THROUGH AN INTERPRETER

2000–2002 APA/Bristol-Myers Squibb Fellows

Steven B. Rudin, M.D., *2000–2002 APA/Bristol-Myers Squibb Fellow and Resident, Department of Psychiatry, Columbia University College of Physicians and Surgeons, 1051 Riverside Drive, Box 106, New York, NY 10032*; Priyamvada Narayanan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop participants should be able to (1) identify common errors that occur in the translation process and acquire practical skills to minimize these, (2) familiarize themselves with policies regarding the use of interpreters, (3) develop an understanding of the transcultural and psychodynamic nuances involved in working with patients through an interpreter.

SUMMARY:

According to the 1990 census, almost 14 million people who live in the United States have limited English proficiency. Thus, training psychiatrists are frequently called upon to interview patients with limited English skills. Unless the psychiatrist is bilingual, he/she must use an interpreter. Unfortunately, many psychiatrists do not receive formal training in this area. The literature suggests that psychiatric residents find interviewing through an interpreter unsatisfying, time consuming, and cumbersome. In addition, studies indicate the results of language barriers often include poor compliance, inappropriate follow-up, and patient dissatisfaction.

The Civil Rights Act of 1964 requires that funded health programs offer patients with limited English skills equal access to care. The regulation of this act, however, provides little guidance regarding the use and implementation of interpreter services. Furthermore, funding for trained interpreters is scarce. The result is a haphazard system where interviewers are often compelled to ask an untrained individual such as a hospital employee or family member to translate. Ineffective interpretation may compromise psychodiagnosis, treatment informed consent, and confidentiality.

This workshop will explore the use of interpreters in the psychiatric interview. Emphasis will be placed on the clinical encounter. We will describe the most common types of errors and provide practical recommendations. Clinical material will be included to illustrate house policies, psychodynamics, and transcultural factors.

TARGET AUDIENCE:

Residents and other mental health professionals who work with underserved populations.

REFERENCES:

1. Marcos LR: Effects of interpreters on the evaluation of psychopathology in non-English-speaking patients. Am J Psychiatry 1979; 136: 171–174.
2. Woloshin S, Bickell NA, Schwartz LM, et al: Language barriers in medicine in the United States. JAMA 1995; 273: 724–728.

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

WHAT NOT TO MISS: HERBS IN WOMEN, HIV PATIENTS, AND ETHNIC MINORITIES

APA Center for Mental Health Services
AstroZeneca Minority Fellows

Margaret T. Lin, M.D., *Resident Physician, Department of Psychiatry, UCLA Medical Center, Harbor, 1000 West Carson Street, Box 495, Torrance, CA 90509*; Ikwunga Wonodi, M.D.; Margaret W. Fang, M.D.; Victor Hong, M.D.; Khakasa H. Wapenyi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the basics of psychotropic drug metabolism by the P450 system, recognize common herbal medications used by certain minority groups, and be aware of potential drug-herb interactions.

SUMMARY:

According to the NEJM (Jan. 1993), the use of alternative medicine in the U.S. is common, with 34% of participants surveyed using at least one "unconventional" therapy in the preceding year. In particular, the use of herbs by psychiatric patients has become an important consideration for psychiatrists due to increasing evidence of drug-herb interactions affecting the metabolism and hence the efficacy and toxicity profiles of these medications. This workshop will provide an overview of the cytochrome P450 system as it relates to the metabolism of psychotropic medications and then focus on the use of herbs in specific minority populations, including ethnic minority groups, as well as the use of herbs by women and by people living with HIV and AIDS. The pattern of use by these specific groups and the importance for psychiatrists to recognize potential drug-herb interactions will be emphasized.

TARGET AUDIENCE:

Mental/general health care providers interested in cultural/ethnic minority issues. No specific background requirements.

REFERENCES:

1. Schultz HT: Rational Phytotherapy. Berlin, Heidelberg, New York; Springer 1999.
2. Eisenberg DM, Kessler RC, Foster C, et al: Unconventional medicine in the U.S. Prevalence, costs, & patterns of use. New Engl J Med 1993; 328(4), 246–52.

Workshop 6 **Wednesday, October 10**
10:00 a.m.-11:30 a.m.

HELPING ELDERLY PATIENTS ACCEPT MENTAL HEALTH TREATMENT

Leila B. Laitman, M.D., *Team Psychiatrist, Community Mental Health Services, Visiting Nurse Service of New York, 1601 Bronxdale Avenue, Bronx, NY 10462*; Lawrence B. Jacobsberg, M.D., Ph.D.; Rebecca Morales, C.S.W.; Melanie M. Murphy, C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand issues involved in getting older patients to accept mental health treatment as well as implement appropriate engagement and interviewing techniques.

SUMMARY:

Many older people refuse a referral into the mental health system, despite its benefits. They prefer to be treated with medication by their primary physicians rather than psychiatrists and avoid psychotherapy altogether. Reasons for this are multiple: stigma, lack of mobility, finances, presence of cognitive deficits, medical comorbidity, and lack of social support, among others. The goal of the In-Home Geriatric Mental Health Program (IHGMHP) of the Visiting Nurse Service of New York (VNSNY), is to assess people in their homes who have some kind of psychiatric symptom and link them with ongoing care by community resources within an eight-week period. The resources might be mental health treatment, medical treatment, social services, case management, home care, or even legal services, among others. When dispositions of patients discharged from our service over a one-year period were collated, it was found that only 14% actually accepted mental health treatment. A 12-session training program that focused

on interviewing and counseling techniques intended to overcome patient and family resistances to ongoing mental health follow up was developed. Clinicians who participated in the training were able to increase the rate of patient's acceptance of referrals by approximately 20% over the following year.

This workshop will focus on helping the audience to understand issues involved in getting older patients to accept mental health treatment as well as to implement appropriate engagement and interviewing techniques. To highlight the issues, the experiences of another VNSNY program that did not have the benefit of the training but provides psychiatric consultation to elderly patients who are receiving medical home care from the agency will be described. By comparison, the experiences of the IHGMHP will then be described. Finally, the clinician who actually performed the training will describe the curriculum. Problems and successes in implementation will be discussed. The audience will be encouraged to participate by discussing experiences and problems from their own settings.

TARGET AUDIENCE:

Professionals providing mental health services to geriatric patients.

REFERENCES:

1. Pearlin LI, Skaff MM: Stressors and adaptation in late life, in Emerging Issues in Mental Health and Aging. Ed. by Gatz M. Wash, DC American Psychological Association, 1995, pp. 97–123.
2. Kennedy G: Mental Health Consultation in the General Hospital, Home or Nursing Facility in Geriatric Mental Health Care. NY, Guilford Press, 2000, pp 248–281.

Workshop 7 **Wednesday, October 10**
1:30 p.m.-3:00 p.m.

HOW MUCH DOES IT COST? AN ETHICAL APPROACH TO THE PHARMACEUTICAL INDUSTRY

2000–2002 APA/Bristol-Myers Squibb Fellows

Daralynn Deardorff, D.O., *2000–2002 APA/Bristol-Myers Squibb Fellow, Liaison, APA Institute Scientific Program Committee, and Resident, Department of Psychiatry, University of Texas Southwestern School of Medicine, 5323 Harry Hines Boulevard, Dallas, TX 75390-9070*; Daniel P. Dickstein, M.D.; Pamela E. Swedlow, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to demonstrate an understanding of the spectrum of influence of the pharmaceutical industry on current psychiatric practice.

SUMMARY:

The pharmaceutical industry is partner in an important relationship with the profession of psychiatry. This working partnership may place interests of patients in direct conflict with financial interests of drug companies with physicians placed in the role of arbiter of this conflict. The relationship between the psychiatrist and the pharmaceutical industry presents many potential ethical dilemmas, which are too frequently left unaddressed. In training, psychiatric residents interact frequently with pharmaceutical detailers (PD) during the course of their educational programs and patient care duties. The presence of PD in academic training programs appears to have increased in recent years, but the effects of this type of exposure have not been studied or documented in psychiatry. Residents were surveyed as to their attitudes about the presence of PD in and around their training sites, as well as the perceived influences on prescribing practices. In this workshop, we will review the results of this survey and discuss ways in which residents and faculty members may consider these attitudes within the context of an ethical framework.

TARGET AUDIENCE:

Residents, medical students, faculty of psychiatry training programs

REFERENCES:

1. Blake R: Patient's attitudes about gifts to physicians from pharmaceutical companies. Journal of the American Board of Family Practice 1995; 8(6): 457–464.
2. Thompson D: Understanding Financial Conflicts of Interest. The New England Journal of Medicine 1993; 329 (8):573–576.

Workshop 8 **Wednesday, October 10**
1:30 p.m.-3:00 p.m.

TREATMENT OF SEXUAL DYSFUNCTION BY PSYCHIATRISTS

Troy L. Thompson II, M.D., *Professor of Psychiatry, Jefferson Medical College, 833 Chestnut Street, East, Suite 210, Philadelphia, PA 19107-5005*

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, participants should be able to better recognize, diagnose, and treat sexual dysfunction associated with psychiatric conditions and medications.

SUMMARY:

Group discussion will focus on the four phases of sexual functioning (i.e., libido, excitement, orgasm, and resolution) and how to assess each during evaluation and at follow up. Assess the four phases separately because psychiatric and medical conditions and many medications may affect the phases differently and different treatments are indicated for dysfunctions in each phase. For example, sildenafil is not indicated for many types of sexual dysfunction.

Sexual topics are so personal that even psychiatrists may feel some discomfort in directly asking the questions necessary for a good evaluation. Also, questions may be asked in such a way and with nonverbal cues that make an affirmative reply uncomfortable for patients, such as physicians asking, "You aren't having any sexual problems, are you?" while shaking their head. Such indirect and negative approaches indicate to patients that their psychiatrist is not comfortable discussing, evaluating, and treating such problems and, thereby, make it more difficult for many patients to initiate discussion of their sexual concerns and questions.

A change in sexual functioning also may be a sensitive indicator of incipient problems in intimate relationships. A decrease in sexual functioning may be quite stressful to a partner and, thereby, catalyze further deterioration in the relationship, creating a vicious cycle. Also, improving sexual functioning may foster improvement in the relationship with the partner, which often has positive psychological effects on both, including more interest in pursuing other treatment recommendations.

REFERENCES:

1. Levine SB: Sexuality in Mid-Life. New York, Plenum Press, 1998.
2. Rothchild AJ: Sexual side effects of antidepressants. J Clin Psychiatry 2000; 61 (suppl 11): 28–36.

Workshop 9 **Wednesday, October 10**
1:30 p.m.-3:00 p.m.

TELEPSYCHIATRY AND FORENSIC PRACTICE

Tracy D. Gunter-Justice, M.D., *Director, Forensic Evaluation Service, Hall Institute, 10 Harvest Ridge Drive, Columbia, SC 29229*; R. Gregory Lande, D.O.; Mark Fitzgibbon

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate an understanding of the use of telemedicine in the practice psychiatry and recognize the complexities of setting up a viable telepsychiatry program.

SUMMARY:

Over the last 30 years, the use of telemedicine has grown dramatically. The available technology has become less expensive, more reliable, and of better resolution, allowing for more applications in general and forensic psychiatry. The application of telemedicine to the practice of psychiatry has resulted in easier access to expertise and cost reduction, while maintaining high-quality patient assessment and care of geographically isolated persons, such as incarcerated individuals. This workshop will provide an orientation to the available technology and will focus on the process of establishing a telemedicine site from a maximum security psychiatric hospital providing pre-trial evaluations, case consultation, clinical assessments, and educational opportunities to the state detention centers and mental health centers. The target audience for this presentation includes anyone interested in telepsychiatry. There are no specific background requirements for participants. A basic understanding of the nature of a psychiatric evaluation and experience with telephone and fax machine technology is preferable.

REFERENCES:

1. Bear D, Jacobson G, Aaronson S, et al: Telemedicine in psychiatry: making the dream a reality. Am J Psychiatry 1997; 154:885.
2. Brodley B, Claypoole K, et al: Satisfaction of forensic psychiatric patients with remote telepsychiatric evaluation. Psychiatr Serv 2000; 51:1305–1307.

Workshop 10 **Wednesday, October 10**
3:30 p.m.-5:00 p.m.

THE HISTORY OF MENTAL HEALTH PROFESSIONALS IN THE JUVENILE JUSTICE SYSTEM

2000-2002 APA/Bristol-Myers Squibb Fellows

Kamlyn R. Haynes, M.D., *2000–2002 APA/Bristol-Myers Squibb Fellow, and Child and Adolescent Fellow, Department of Psychiatry, University of Massachusetts Medical School, Worcester, MA 01655*; Marc E. Dalton, M.D., M.P.H., *2000–2002 APA/Bristol-Myers Squibb Fellow and Resident, Department of Psychiatry, Medical University of South Carolina, 822 Williamsburg Lane, Charleston, SC 29414*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to appreciate the complexities of the interface between mental health professionals and the juvenile justice system, identify the unmet mental health needs of juveniles and with this knowledge think constructively of ways for better collaboration.

SUMMARY:

From their beginnings, the fields of juvenile justice and mental health have maintained ambivalent closeness. At times they have informed each other's understanding of conduct problems in children, sometimes they are rivals in intervention, often they subvert one another, and occasionally they have worked together effectively. These fields have maintained an historically fascinating and complex interdependency for the past 100 years.

Due to the relative paucity of published information on this very relevant and timely topic, we have created a structured interview that gathers the opinions of the senior mental health experts in the field of juvenile justice. We will present the data compiled by our literature review and the results of our interviews to try and reach an historical understanding of why the fields have worked together so differently at separate periods of time in our country. We will also present epidemiologic statistics of juveniles with mental health issues as a way of illustrating the importance of collaboration.

TARGET AUDIENCE:

Forensic and child psychiatrists

REFERENCES:

1. Neumeyer M: Juvenile Delinquency in Modern Society. 3rd edition. Princeton, NJ: D. Van Nostrand Company, LTD, 1961.
2. Glueck S, Glueck E: One Thousand Juvenile Delinquents: Their Treatment by the Court and Clinic. Cambridge, Ma, Harvard University Press, 1934.

Workshop 11 **Wednesday, October 10**
3:30 p.m.-5:00 p.m.

MULTIDISCIPLINARY ROLES IN ASSERTIVE COMMUNITY TREATMENT

Jaak Rakfeldt, Ph.D., *Professor, School of Professional Studies, and Professor, Department of Psychiatry, Yale University, Lang Social Work Center, Southern Connecticut State University, 101 Farnham Avenue, New Haven, CT 06515*; Kenneth S. Thompson, M.D.; Margaret A. Bailey, M.S.W.; Monica A. Kalacznik, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to identify the complex role relationships that are inherent in multidisciplinary assertive community treatment situations, as well as to be more sensitive to the evolving relationship between psychiatry and other disciplines, and will integrate these concepts into their clinical practice.

SUMMARY:

The workshop will explore the impact that more assertive community support services have had on the complex role relationships that are inherent in multidisciplinary assertive community treatment situations, as well as be more sensitive to the evolving relationship between psychiatry and other disciplines. In particular, the emerging new role relationships of having consumers as colleagues and service providers will be explored. Relevant literature will be reviewed, and an analysis of current practices will be provided. The workshop will feature a dialogue between psychiatrists and a supervisor of case management services. They will discuss their efforts to grapple with complex multidisciplinary role relationships. The lessons that consumer/providers, and case managers can teach psychiatry and vice versa will be emphasized. Workshop participants will be encouraged to join in this discussion, and thus, will share their own clinical experiences with these issues.

TARGET AUDIENCE:

Mental health professionals, consumers, family members.

REFERENCES:

1. Rakfeldt J, Sledge WH, Bailey, MA, Anderson C: A two-tiered approach to case management. Continuum: Developments in Ambulatory Mental Health Care 1996; 3 (1):45–57.
2. Sledge WH, Astrachan B, Thompson K, Rakfeldt J, Leaf P: Case management in psychiatry: an analysis of tasks. The American Journal of Psychiatry, 1995; 152 (9): 1259–1265.

Workshop 12 **Wednesday, October 10**
3:30 p.m.-5:00 p.m.

DO I NEED AN M.B.A. TO TRANSFORM MY CAREER?

Arthur L. Lazarus, M.D., M.B.A., *Vice President of Behavioral Health, Humana Incorporated, 6830 Windham Parkway, Prospect, KY 40059*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the importance of graduate business education for aspiring clinician executives and evaluate the advantages and disadvantages of an executive MBA program.

SUMMARY:

Behavioral health administration promises to be an area of growth and opportunity for many clinicians, including psychiatrists, psychologists, and social work-

ers. Increasingly, clinician executives are turning to graduate level business training to learn effective management skills. Executive MBA programs, which can be completed in less than two years, offer clinicians an opportunity to obtain an MBA degree without interrupting their career.

The workshop leader will discuss a typical executive MBA curriculum, the MBA "lifecycle," and the resources needed to complete such a program. In addition, workshop participants will have a chance to learn about marketplace opportunities for clinician executives. The careers of clinicians who recently graduated from executive MBA programs will be profiled. There will be ample time to ask questions and discuss personal experiences to help plan for a career in behavioral health administration.

TARGET AUDIENCE:

Psychiatric residents, psychology interns, early and mid-career psychiatrists, and psychologists

REFERENCES:

1. Lazarus A: The educational needs of physician executives: why an MBA? Physician Executive 1997; 23(8):41–45.
2. Lazarus A (ed): MD/MBA: Physicians on the New Frontier of Medical Management. Tampa, Florida, American College of Physician Executives, 1998.

Workshop 13 **Thursday, October 11 8:00 a.m.-9:30 a.m.**

SELF-DESTRUCTIVENESS IMPLICATIONS FOR HIV DISEASE

2000–2002 APA/Bristol-Myers Squibb Fellows

Esther J. Dechant, M.D., *2000–2002 APA/Bristol-Myers Squibb Fellow, and Resident, Department of Psychiatry, Harvard Medical School, Cambridge Hospital, 1493 Cambridge Street, Cambridge, MA 02139*; Marshall Forstein, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the psychological underpinnings of self-destructive behavior to work with patients to reduce risk taking.

SUMMARY:

This workshop reviews the psychoanalytic literature on self-destructiveness and applies the concepts to behaviors that increase the risk of contracting HIV disease. Clinical examples will be presented.

TARGET AUDIENCE:

Clinicians with patients at risk for HIV disease.

REFERENCES:

1. Kernberg OF: Clinical dimensions of masochism. J Am Psychoanal Assoc 1988;36(4):1005–29.
2. Flavin DK, Frances RJ. Risk-taking behavior, substance abuse disorders, and the acquired immune deficiency syndrome. Adv Alcohol Subst Abuse 1987;6(3):23–32.
3. Gala C, Pergami A, Catalan J, Riccio M, Durbano F, Musicco M, Baldeweg T, Invernizzi G: Risk of deliberate self-harm and factors associated with suicidal behavior among asymptomatic individuals with human immunodeficiency virus infection. Acta Psychiatr Scand 1992;86(1):70–5.

Workshop 14 **Thursday, October 11 8:00 a.m.-9:30 a.m.**

MULTIDISCIPLINARY ROLES IN THE DEVELOPMENT OF A CONTINUUM OF CASE MANAGEMENT SERVICES

Paul J. Cornely, Ph.D., *Director of Community Services, University of Pittsburgh, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Room E-508, Pittsburgh, PA 15213*; Kenneth S. Thompson, M.D.; Michelle M. Barwell, M.D.; Susan Coyle, M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant should be able to (1) recognize and discuss the roles of multidisciplinary team members in planning a population-based intervention (case management community treatment teams), and (2) demonstrate how team members and consumers are catalysts for change in the evolution and evaluation of service delivery.

SUMMARY:

This workshop will discuss the multidisciplinary roles of professionals and patients (consumers) in the development of a continuum of case management services provided across the lifespan and to specialty populations. This workshop will be interactive and will encourage participation by registrants as they respond to data-driven clinical examples to develop a continuum of case management services to meet the needs of various special needs populations including forensic, high utilizers of inpatient and emergency levels of care, homeless, children and adolescents, older adults, dual diagnosis (MISA), etc. Special attention will be paid to the roles of the multidisciplinary team in planning, implementing, and evaluating service delivery. This workshop is appropriate for psychiatrists, other professionals in the health

and human services professions, consumers, and family members, and is appropriate for clinical and administrative staff.

The frame of reference will be the "enhanced case management" services provided to over 1,000 individuals and families. Services have evolved from a strength-based model to a rehabilitative/recovery model. Benchmarked outcomes data will be presented to summarize the impact of the enhanced case management model.

TARGET AUDIENCE:

Psychiatrists, professionals, consumers/family members.

REFERENCES:

1. Meisler N, Gonzales MC: Medicaid financing, in S.W. Henggeler 7 AB Santos (eds.) Innovative Approaches for Difficult to Treat Populations (pp 395–410) Washington: American Psch. Press, 1997.
2. Essock SM, Kontos N: Implementing assertive community treatment teams. Psychiatric Services 1995; 46: 679–683.

Workshop 15 **Thursday, October 11**
8:00 a.m.-9:30 a.m.

THE SAFETY AND VIOLENCE EDUCATION CURRICULUM: SAFETY TRAINING AND VIOLENCE PREVENTION FOR MENTAL HEALTH PROFESSIONALS

Robert L. Weisman, D.O., *Assistant Professor of Psychiatry, University of Rochester, and Co-Director of Project Link, 28 Cobblecreek Road, Victor, NY 14564-8935*; J. Steven Lamberti, M.D., *Associate Professor of Psychiatry, Strong Ties, University of Rochester, and Director of Project Link, 240 Hampton Way, Penfield, NY 14526-1531*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to recognize the prevalence of violence against practitioners in the mental health field, identify various options to safety approach a violent client, describe a novel approach toward safety training of mental health workers in the community.

SUMMARY:

Violence inflicted by the mentally ill toward health care workers has received national notoriety. Though violent incidents are relatively infrequent, they inspire horror and reactive responses. Prevention of such events is a challenge to all mental health workers who assist their clients in the community, and poses a particular challenge for those educating and supervising mental health workers. A safety training curriculum developed for Project Link, recipient of the American Psychiatric Association's 1999 Gold Achievement Award, will be presented. The Safety and Violence Education (SAVE) curriculum teaches prevention strategies, including how to identify warning signs of impending violence, and methods for safety approaching patients in community settings. Utilizing the SAVE curriculum, Project Link has successfully transitioned high-risk mentally ill individuals from the criminal justice system into the community with no assaults or suicide attempts to date. This presentation will discuss an overview of the SAVE curriculum and its development. Results of recent SAVE program evaluations will also be discussed.

TARGET AUDIENCE:

This workshop will be of interest to mental health administrators and all mental health professionals and trainees working with severely mentally ill persons.

REFERENCES:

1. Lamberti JS, Weisman RL, Schwarzkopf SB, Mundondo-Ashton R: Prevention of jail and hospital recidivism among outpatients with schizophrenia. Schizophrenia Research 1999; 36: 344.
2. Zitrin A, Hardesty AS, Burdock EI, Drossman AK: Crime and violence among mental patients. American Journal of Psychiatry 1976; 133: 142–149 APA Practice Guidelines (534).

Workshop 16 **Thursday, October 11**
10:00 a.m.-11:30 a.m.

DESIGNING AND IMPLEMENTING A COMPREHENSIVE VIOLENCE PREVENTION PROGRAM IN A STATE HOSPITAL

Abraham R. Frenkel, M.D., *Department of Psychiatry, University of Illinois at Chicago, College of Medicine, 5407 North University, #C, Peoria, IL 61614*; S. Atezaz Saeed, M.D., M.S., *Chair, Department of Psychiatry and Behavioral Medicine, University of Illinois College of Medicine at Peoria, 5407 North University, Suite C, Peoria, IL 61614-4736*; Robert Vyverberg, Ed.D.; Linda L. Hughes, R.N.; Sally Davidson, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to describe the necessary components of an effective violence prevention program, and to describe the processes involved in designing such a program in an inpatient public psychiatric hospital.

SUMMARY:

Violence is a major occupational hazard for mental health professionals. The rate of patient-related injuries is particularly high among direct care staff, exceeding those in other at-risk occupations, such as correctional officers. Psychiatric hospitals and inpatient units must address the safety concerns of their staff, while insisting on delivery of high-quality care. They need to balance the need for a safe milieu with patients' rights for the least restrictive interventions and environment. This workshop will present a comprehensive violence prevention initiative that was developed and implemented at Zeller MHC, a 95-bed, acute-care, state-operated, inpatient psychiatric facility affiliated with the UIC College of Medicine at Peoria. A panel of psychiatric administrators will describe the principles, methods, and the processes involved in designing and implementing this program. Participation from the workshop participants and input about their own experiences and insights will be strongly encouraged. Initially, specific data are gathered and specific variables associated with occurrence of violent episodes are identified. After staff survey and literature search, procedures are written. Assessment and monitoring procedures are implemented along with continuous outcome monitoring. Needed safety features are installed. A two-day intensive training workshop for staff follows.

TARGET AUDIENCE:

Mental health professionals and psychiatric administrators.

REFERENCES:

1. Bensley L, Nelson N, Kaufman J, Silverstein B, et al: Injuries due to assaults on psychiatric hospital employees in Washington State. American Journal of Industrial Medicine 1997; 31: 92–99.
2. Torrey EF: Violent behavior by individuals with serious mental illness. Hospital and Community Psychiatry 1994; 45: 653–662.

Workshop 17 **Thursday, October 11**
10:00 a.m.-11:30 a.m.

CULTURAL FACTORS IN AGING ASIAN-INDIAN IMMIGRANTS IN THE U.S.

Nalini V. Juthani, M.D., *Professor of Psychiatry, Albert Einstein College of Medicine, 1276 Fulton Avenue, 4 South, Bronx, NY 10456*; Jyotsna Kalavar, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop (1) the participants will recognize cultural differences in aging South Asian immigrants and will learn about struggles these elderly citizens face in family and community, and (2) participants will recognize the need for developing culturally sensitive senior citizen programs for South Asians.

SUMMARY:

Asian Indian elderly represent ten percent of total South Asian immigrants. According to the 1990 census these 150,000 senior citizens reside primarily in California, Texas, Illinois, Pennsylvania, New York, New Jersey, Florida, Ohio, and Michigan. The post-1965 wave of South Asian immigrants are turning 65, and the parents and siblings of these immigrants constitute this elderly group. Changing family structure, intergenerational differences, and cultural values are some of the conflicts faced by these seniors. In this workshop, the authors will describe findings of their study of these cultural factors in aging South Asians. With audience participation, issues of quality of life, role reversal, limited social network, language barrier, and ignorance about resources available in the United States will be discussed. Culturally sensitive community-based development of senior citizen programs will be explored.

TARGET AUDIENCE:

Psychiatrists, residents, psychologists, and social workers

REFERENCES:

1. Kalavar J: The Asian Indian Elderly in America. Garland Publisher, 1998.
2. Kuo WH: Prevelance of depression among Asian Americans. Journal of Nervous & Mental Diseases 172:449–457.

Workshop 18 **Thursday, October 11**
1:30 p.m.-3:00 p.m.

CONTINUUM OF CARE FOR YOUTH IN THE JUVENILE JUSTICE SYSTEM

Debra M. Katz, M.D., *Medical Director, Child and Adolescent Services, Mental Health and Mental Retardation Administration, Harris County, 2850 Fannin Street, Houston, TX 77002*; Regenia Hicks, Ph.D.; Philip L. Farley, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the need for mental health services for the juvenile justice population, identify specific treatment strategies for the juvenile justice population who have psychiatric disorders, and identify methods of effective collaboration between community-based child care agencies.

SUMMARY:

This workshop will describe the development of collaborative service for youth and families who are at risk for involvement in the juvenile justice system and for those youth that are currently involved in the juvenile justice system. The interagency program to be explored is in Harris County, Houston, Texas.

The service array includes the TRIAD Prevention Program, which integrates funding streams from Juvenile Probation, Mental Health, and Child Protective Services. This component includes emergency shelter care, court liaisons, assessment, and family support. The First Time Offender Program, funded by Mental Health, provides psychiatric assessment and counseling services for youth diagnosed as SED who are at risk for further penetration in the juvenile justice system. These outpatient services are also incorporated with the Juvenile Probation Pre-Adjudication Team that connect youths at the point of court referral to appropriate care. The Juvenile Justice Alternative Education Program is an alternative school that utilizes resources from the various child serving agencies for youth being released from correctional facilities and those youth who are status and felony offenders.

The Juvenile Forensic Services integrates court ordered assessments, referrals, and facility-based services provided by the mental health system. These services also include a psychiatrist stabilization unit, site-based psychiatric care, and after care services. Information detailing the demographics, DSM-IV diagnoses, and treatment intervention strategies will be presented. Information will also be provided on principles of effective collaboration in the current system, and the developing challenges in implementing of appropriate care for children and families of color who are over-represented in juvenile justice and client-related outcomes. Following the brief presentation by panel members, an interactive discussion with the audience will be facilitated exploring innovative programs, treatment strategies, and barriers to the continuum of care for youth in the juvenile justice system nationwide.

TARGET AUDIENCE:

Child and adolescent psychiatrists, mental health workers in the juvenile justice system, general psychiatrists, and child care workers

REFERENCES:

1. National Coalition for the Mentally Ill: Responding to the mental health needs of youth in the Juvenile Justice System, November, 1992.
2. Hodges S, Nesman T, Hernandez M: Systems of Care. Promising Practices in Children's Mental Health, U. S. Dept. of Health and Human Services, Volume VI, 1998.

Workshop 19 **Thursday, October 11**
1:30 p.m.-3:00 p.m.

WHITHER RESIDENCY TRAINING AMIDST CORPORATIONS, UNIONS, MERGERS, AND CLOSURES?

APA Division of Education, Minority and National Programs

Avram H. Mack, M.D., *Member-In-Training Trustee, APA Board of Trustees, and Resident, Department of Psychiatry, Harvard Longwood Program, Brigham Women's Hospital, 81-A Wendell Street, Cambridge, MA 02138*

EDUCATIONAL OBJECTIVES:

To discuss ways in which graduate education in psychiatry must maneuver around effects of financial and corporate pressures on American health care.

SUMMARY:

Residents and fellows in psychiatry increasingly have to cope with effects of the volatile corporate "takeover" of American medicine. Hospital and medical school closings and mergers, managed care guidelines, mental health carveouts, and the influences of the pharmaceutical industry may all disrupt education in psychiatry in various ways. How can the trainee cope? Are there actions to take? To whom or which institution is a trainee ultimately responsible? To whom does the patient "belong?" What good are unions to trainees working for multihospital programs? These topics and others will be discussed in what promises to be a lively meeting that features a panel of trainees and educators who have dealt with such issues.

TARGET AUDIENCE:

Residents, fellows, educators.

REFERENCES:

1. Ginzberg E: The monetarization of medical care. New England Journal of Medicine 1984; 310:1162–65.
2. Anders TE, Neufeld J, Hales RE, Callahan EJ: The behavioral health center: a model for academic managed care. Psychiatric Services 2000; 51:861–64.

Workshop 20 **Thursday, October 11**
1:30 p.m.-3:00 p.m.

PSYCHIATRIC ILLNESS AND THE WORKPLACE

Steven E. Pflanz, M.D., *Chief, Mental Health Services, F.E. Warren Air Force Base, U.S. Air Force, 408 West First Avenue, Cheyenne, WY 82001*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the relationship between work stress and mental health and the role of the psychiatrist in minimizing the impact of job stress on the emotional health of workers.

SUMMARY:

Increasingly, both industry and mental health professionals are recognizing that work stress is a major factor in determining the mental health of employees. Psychiatrists and other mental health professionals are often faced with patients suffering from emotional distress that is attributed to job stress. Importantly, 15% of American workers experience at least one episode of psychosocial disability every year. Mentally ill workers exhibit decreased productivity, increased workforce turnover, higher absenteeism, and increased medical care utilization. These combined factors cost industry $150 billion annually. The relationship between the work environment and the mental health of employees has received little research attention. Nonetheless, 10% of American workers report exposure to mental stress at work and 5% believe that their experience of work stress could be deleterious to their mental health. At work, both exposure to sudden traumatic events and to chronic daily stress can produce or exacerbate psychiatric symptoms. In this workshop, we will discuss the complex relationship between the work environment and mental health. We will examine the common sources of job stress and the mechanisms by which work stress can lead to psychiatric illness. Lastly, we will explore how the mental health professional can forge a partnership with patients and employers to reduce work stress and ameliorate or eliminate psychiatric illness in working patient populations.

TARGET AUDIENCE:

General psychiatry, occupational, and organizational psychiatry

REFERENCES:

1. Pflanz SE: Psychiatric illness & the workplace. Military Medicine 1999; 164 (6): 401–406.
2. Pflanz SE, Skop B: Occupational stress & mental illness in the military. Southern Medical Journal 1998; 91 (10): S63.

Workshop 21 **Thursday, October 11**
1:30 p.m.-3:00 p.m.

PUBLIC AND ACADEMIC PARTNERSHIPS TO ENHANCE SERVICES IN PENNSYLVANIA

Paul J. Cornely, Ph.D., *Director of Community Services, University of Pittsburgh, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Room E-508, Pittsburgh, PA 15213*; Jerry Kopelman, M.S.W., *DPW/OMHSAS, P.O. Box 2675, 2nd Floor, Beechmont Building, Harrisburg, PA 17105*; Donna McNelis, Ph.D.; William Milchak, M.S.W., C.A.C.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to:

(1) Recognize the strengths and limitations of a partnership between statewide mental health authority (OMHSAS) and three academic centers to provide training and technical assistance in public and private/non-profit sector.

(2) Demonstrate knowledge of the link between competency based training and improved quality and scope of psychiatric services delivery.

(3) Implement distance education and clinical consultation strategies in community and hospital settings in large geographic area.

SUMMARY:

This workshop will describe a unique public-academic partnership to improve the quality and scope of behavioral health (psychiatric and substance abuse) services in Pennsylvania through training and technical assistance. The Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) works with three academic psychiatric institutes to provide competency-based training and technical assistance throughout the state hospital system and the private, nonprofit community-based system. The academic partners include the Eastern Pennsylvania Psychiatric Institute (EPPI) of Habnemann University, Central Pennsylvania Psychiatric Institute (CPPI) of Hershey Medical Center (Pennsylvania State University), and Western Psychiatric Institute and Clinic (WPIC) of the University of Pittsburgh Medical Center Health System.

This workshop will be interactive and will be appropriate for individuals working in the public mental health sector, academic health centers and those involved in psychiatric training programs. The effects of training and technical assistance and how they act as a catalyst for change will be documented and discussed. Examples of specific topics include: The use of statewide curriculum to assure competence and to guide program change and evolution for Intensive Case Management (ICM), the use of distance education (telemedicine, web-based training, local on-site training) to improve access to lifelong learning opportunities for diverse staff, the role of training and technical assistance in the development and implementation of a statewide initiative to provide services in PA.

REFERENCES:

1. Petti TA, Cornely PJ, McIntyre A: A consultative study as a catalyst for improving mental health ser-

vices for rural children and adolescents. Hospital & Community Psychiatry 1993; 44:262–265.
2. Petti TA, Cornely PJ, Sonis M, et al: State-university collaborations to enhance public psychiatric services in western Pennsylvania. Hospital & Community Psychiatry 1992; 43:996–1000.

Workshop 22 **Thursday, October 11**
1:30 p.m.-3:00 p.m.

HOW TO KEEP "ER" VIEWERS OUT OF THE EMERGENCY ROOM: A MULTIMEDIA APPROACH TO PREVENTION

Alan M. Langlieb, M.D., *Department of Psychiatry, Johns Hopkins University School of Medicine, and Former APA/Bristol-Myers Squibb Fellow, 6808 Cherokee Drive, Baltimore, MD 21209*; Geetha Jayaram, M.D.

EDUCATIONAL OBJECTIVES:

Participants in this session will have an opportunity to explore how several psychiatric topics have been covered on "ER" and to develop an understanding of how mass media shape the image of psychiatry. In addition, "Following ER" will be dissected as a model for developing strategic partnerships between physicians and the media in order to improve the public's general medical knowledge and advance public health.

SUMMARY:

The media are the public's leading source of information about medical research, diagnosis, and treatment and thus serve as a common reference point in the doctor-patient relationship. In addition to medical news, fictional television also shapes the public's opinion about doctors and doctoring. For the last five years, the most watched television drama has been NBC's "ER." Roughly 60 medical (and psychiatric) plots and hundreds of medically-related themes are portrayed each season.

In an effort to harness the power and reach of "ER," a syndicated feature called "Following ER" was developed and is broadcast nationally each week by local TV stations during the late news after "ER." The goal of these segments is to educate and motivate viewers to take action on a series of important health topics dramatized on "ER." Viewers are instructed to access additional information and resources via the Internet and by calling a toll-free phone number using Interactive Voice Response (IVR) Technology.

In addition to forging links between prime-time TV and local news, "Following ER" creates new opportunities for medical professionals to work with the media. The value of this access is staggering; during the 1997–98 viewing season, "Following ER" reached an estimated 36 million viewers in 75 metropolitan regions.

TARGET AUDIENCE:

Community leaders, public health experts, media

REFERENCES:

1. Langlieb AM, Cooper CP, Gielen A: Linking health promotion with entertainment television. AJPII 1999;89:1116.
2. Cooper CP, Roter DI, Langlieb AM: Using prime-time TV to build a context for prevention news stories, Prev Med 2000; 31(3):225–31.

Workshop 23 **Thursday, October 11**
3:30 p.m.-5:00 p.m.

TREATMENT PROGRAMS FOR CIVILLY COMMITTED SEX OFFENDERS

Alan Q. Radke, M.D., M.P.H., *State Medical Director, Minnesota Department of Human Services, 444 Lafayette Road North, St. Paul, MN 55155-3826*; Thomas W. Hester, M.D.; Joseph Parks, M.D.; Rupert R. Goetz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant should understand the ramifications of civilly committing sex offenders to state mental health agencies; the principles for treatment, public safety, and patient rights; and the key "lessons learned" by state-operated sex offender treatment programs.

SUMMARY:

The practice of civilly committing persons to state mental health agencies for treatment under sexually violent predator statutes following completion of their criminal sentences was upheld by the 1997 U.S. Supreme Court decision in Kansas v. Hendricks. In light of this precedent, a growing number of states have created programs for the treatment of persons civilly committed under sexually violent predator statutes. Emerging case law (e.g., Turay v. Seling) further clarifies the mandate for state mental health agencies to provide adequate treatment for sexually violent predators, to carefully define terms and conditions for their continuing confinement, and to make thoughtful release decisions for this population. As new treatment programs are developed, it can be expected some of them will be subjected to legal tests to determine the appropriateness and effectiveness of their treatment and the adequacy of their discharge criteria and processes. It can also be expected that the fiscal impact of such programs on states will continue to increase.

REFERENCES:

1. National Association of State Mental Health Program Directors, 1999. "NASMHPD Medical Directors' Council: Development and Implementation of Programs for Persons Civilly Committed for Treatment Under Sexually Violent Predator Statutes". Alexandria, Virginia.
2. Grossman LS, Martis BM, Fichtner CG: Are sex offenders treatable? A research overview. Psychiatric Services 1999; 50 (3), 349–361.
3. National Association of State Mental Health Program Directors, NASMHPD Policy Statement of Laws Providing for the Civil Commitment of Sexually Violent Criminal Offenders. Alexandria, Virginia, 1997.
4. NASMHPD Medical Directors Council: Development and Implementation of Programs for Persons Civilly Committed for Treatment Under Sexually Violent Predator Statutes. National Association of State Mental Health Program Directors, Alexandria, VA, 1999.

Workshop 24 **Thursday, October 11**
3:30 p.m.-5:00 p.m.

FAMILY AS A TREATMENT TEAM MEMBER

Katherine G. Levine, M.S.W., *Program Director, Community Mental Health Services, Visiting Nurse Service of New York, 450 East 149th Street, 3rd Floor, Bronx, NY 10455*; David C. Lindy, M.D., *Clinical Director and Chief Psychiatrist, Community Mental Health Services, Visiting Nurse Service of New York, and Associate Clinical Professor of Psychiatry, Columbia University, 1250 Broadway, 3rd Floor, New York, NY 10001*; Augusto Torres, M.S.W.; Marisol Collazo, B.A.; Paul Gray, A.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) describe three strategies for teaching families how to be members of the treatment team, and (2) describe three specific advantages for including family members on the treatment team.

SUMMARY:

The Visiting Nurse Service of New York's Community Mental Health Service operates a Mobile Community Support Team (MCST) in the Mott Haven Section of the South Bronx. The MCST seeks to prevent the psychiatric hospitalization of youth through use of a family-driven, home-based crisis program. Family members are asked to be members of the treatment team. This program will first describe how the family is taught to become a member of the treatment team. A brief video of this process and of a family-based treatment team meeting will be shown. This will be followed by a brief discussion of outcome data comparing 20 cases using this approach with 20 cases drawn from another home-based crisis team serving similar youngsters but using the more traditional treatment team approach. Outcomes to be examined will include dropout rate, consumer satisfaction, reduction of risk rate, hospitalization rates, length of service, and success of linkage to follow-up services. This will be followed by a case presentation and discussion.

TARGET AUDIENCE:

Psychiatrists, residents, crisis team members

REFERENCES:

1. James B: Treating Traumatized Children. Lexington, MA, Lexington Press, 1989.
2. Madsen WC: Collaborative Therapy With Multi-Stressed Families. New York, NY, Guilford Press, 1999.

Workshop 25 **Thursday, October 11**
3:30 p.m.-5:00 p.m.

ELEMENTS IN A MEANINGFUL CONTINUUM OF CARE AND HOW TO GET FROM HERE TO THERE

Marilyn Seide, Ph.D., *Division Chief, Los Angeles Department of Mental Health, 1925 North Daly Street, 2nd Floor, Los Angeles, CA 90031*; Richard A. Miller, M.D.; Carol Wilkins, M.P.P.; Suzanne Wagner, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the obstacles in negotiating residential continuums of care and how to address them as well as understand the elements essential to have in place in order to develop permanent supportive housing as a desired goal for chronically mentally ill clients.

SUMMARY:

This presentation will describe an initiative of the Los Angeles Department of Mental health that looks at the residential care system for mentally ill/dually diagnosed adults. Part of the initiative called for an assessment of the appropriateness of placement of the client as well as the ability of the system to move clients through the various levels of care (sometimes referred to as the plumbing problem) to more permanent supportive housing programs. The workshop will include descriptions of some of these supportive housing programs and the services essential to have in place in order that clients may maintain such placement. The presentation will also offer guidance in how to develop such settings—what

collaborations must be in place and what agreements are essential to facilitate their development and ensure the most desirable and stable outcomes for mentally ill/dually diagnosed clients. Topics covered should be of interest and relevant to the concerns of those responsible for effecting longer-term placement solutions for this population.

TARGET AUDIENCE:

Clinicians and policymakers dealing with long-term placement of chronic mentally ill/dually diagnosed clients

REFERENCES:

1. American Assn of Community Psychiatrists: Level of Care Utilization System (LOCUS), 1998.
2. Grob GN: From Asylum to Community. Princeton N.J., Press, 1991.

Workshop 26 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

STRESS OF INCARCERATION: THE CRUCIAL ROLE OF TRANSITIONS

Erik J. Roskes, M.D., *Chief Psychiatrist, Patuxent Institution, P.O. Box 700, Jessup, MD 20794*; Sharon M. Lipford, M.S.W., *Administrator, Adult Mental Health Services, Baltimore County Department of Health, Bureau of Mental Health, One Investment Place, Suite 310, Towson, MD 21204*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate an understanding of stress and adjustment theories and their application to forensic clinical practice.

SUMMARY:

The incarceration experience is known to be difficult, yet little effort has been expended on examining the role of the various transitions during this process. This workshop will focus on transitions experienced by the individual from the time of initial contact with the criminal justice system through the prison and release process. The presenters will bring to this discussion theories of stress and adjustment to stress found in the literature. These theories will include examinations of captives and their adaptations to stress, as well as studies focusing on incarcerated individuals. Special emphasis will be placed on the ways in which the criminal justice system is experienced by individuals with mental illness or otherwise impaired coping skills.

TARGET AUDIENCE:

Psychiatrists, mental health clinicians, parole agents, and administrators

REFERENCES:

1. Toch H, Adams K, Grant JD. Coping: Maladaptation in Prisons. New Brunswick, NJ: Transaction Publishers, 1989.
2. Rahe RH, Genender E: Adaptation to and Recovery From Captivity Stress. Military Medicine 1983; 148:577–585.

Workshop 27 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

CORE COMPETENCIES FOR ASSUMING MULTIDISCIPLINARY ROLES IN THE 21ST CENTURY

Arthur L. Lazarus, M.D., M.B.A., *Vice President of Behavioral Health, Humana Incorporated, 6830 Windham Parkway, Prospect, KY 40059*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to articulate the "new" role of the behavioral health practitioner and define the core competencies required for successful practice in the future.

SUMMARY:

At no point in the history of organized medicine has there been a greater need for behavioral health clinicians to assume roles other than primary caregiver. Managed care and integrated delivery systems are profoundly altering the way psychiatrists and psychologists relate to the rest of the health care system, and in turn, how the rest of the system interacts with specialty providers of behavioral health care. Those specialists possessing an eclectic array of clinical, management, and leadership competencies will be best endowed to navigate into the future.

The "new" clinician is embodied in terms like change agent and boundary spanner. As new roles necessitate new competencies, best practices will have to be identified to ensure clinicians possess the required skills. Emerging best practices include developing on-site managed care and business education training programs, implementing mentoring programs, and obtaining graduate degrees in business administration or public health.

Clinicians may find it difficult, however, to find time or gain support for the innovative changes for which they are responsible. As a result, health care systems and current leaders should plan carefully to access the most seamless transition to a clinician's new role.

TARGET AUDIENCE:

All practitioners, especially those with some administrative responsibilities.

REFERENCES:

1. Guthrie MB: Challenges in developing physician leadership and management. Frontiers of Health Services Management 1999;15(4):3–26.
2. Yedidia MJ, Gillespie CC, Moore GT: Specific clinical competencies for managing care: views of residency directors and managed care medical directors. JAMA 2000;284:1093–1098.

Workshop 28 **Friday, October 12**
8:00 a.m.-9:30 a.m.

USING A MULTIDISCIPLINARY TEAM TO TREAT DUALLY DISORDERED OUTPATIENTS

Charles R. Goldman, M.D., *Director, Public Psychiatry Training Program, William S. Hall Psychiatric Institute, and Professor, University of South Carolina School of Medicine, 3555 Harden Street Extension, Suite 104A, Columbia, SC 29203*; Patricia Hicks, R.N.; Thomas Mercer, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) demonstrate understanding of value of an outpatient multidisciplinary team approach to clients with severe disability, (2) describe obstacles to the survival of a team over many years in a mental health service service system, (3) describe factors that define and promote the success of a team over time.

SUMMARY:

The workshop presenters are part of a multidisciplinary treatment team that has been operating for over 12 years. The team constitutes a specialized intensive case management program within a large community mental health center and serves approximately 50 severely mentally ill clients with substance use disorders. Clients are not admitted unless they have had multiple hospitalizations and have not responded to less intensive outpatient treatment. Three members of the team, a psychiatrist, a nurse, and a psychologist, will discuss how the team functions, what obstacles have been overcome, and ongoing challenges. Although this program has served as a model program and is a teaching site for medical students and residents, its primary function over the years has been serving the most difficult to treat clients in the service system. Team building exercises and retreats have been an integral part of the program for over ten years. Recruiting and training new staff has been a team effort. Grieving the loss of staff and clients has also been an important part of the group process. These and other issues will be presented in order to encourage open discussion with the participants in the workshop.

TARGET AUDIENCE:

Mental health clinicians and program managers.

REFERENCES:

1. Munetz MR, Birnbaum A, Wyzik PF: An integrative ideology to guide community-based multidisciplinary care of severely mentally ill patients. Hosp Community Psychiatry 1993; 44:551–555.
2. Yank GR, Barber JW, Hargrove DS, Whitt PD: The mental health treatment team as a work group; team dynamics and the role of the leader. Psychiatry 1992; 55:250–264.

Workshop 29 **Friday, October 12**
8:00 a.m.-9:30 a.m.

WOMEN WITH MENTAL ILLNESS AND TRAUMA: PILOT OUTCOMES

Cordula T. Holzer, M.D., *Medical Director, Horizon House, Inc., 120 South 30th Street, Philadelphia, PA 19104*; Ava Atzram, B.S.W., *Staff Trainer, Horizon House, Inc., 120 South 30th Street, Philadelphia, PA 19104*

EDUCATIONAL OBJECTIVES:

At the end of the presentation, the participants will be able to identify the sx of complex trauma and the implications for treatment, assess treatment appropriateness, identify alternative funding sources, understand the TREM program, design a training program, ensure a trauma informed system, and formulate realistic outcome expectations.

SUMMARY:

This workshop is a follow up to the workshop presentation at the APA meeting in October 2000 titled "A Community Pilot: Treating Women With Mental Illness and Trauma." This workshop will review the Trauma Recovery and Empowerment Model (TREM), will review why and how our agency chose this model of treatment, how we financed the program, and the training and referral process. This workshop will update the participants with outcome data, and update as to how our agency has addressed the possibility of citywide Trauma Informed Services, through collaboration with other city organizations. Some research has addressed the frequency of histories of physical and sexual trauma among women with chronic mental illness and co-occurring disorders, who are disenfranchised and receiving services through the community mental health system. Un-

der the direction of Maxine Harris, Ph.D., Community Connections in Washington, D.C. has developed TREM to address histories of trauma survived by female consumers. This workshop will be geared to providers of community- and hospital-based mental health services and will introduce the concept of trauma identification, treatment, and recovery for women. We will provide a model for treatment implementation within their community institutions, and present our outcome data as a basis for expectations of outcomes in their own organizations.

TARGET AUDIENCE:

Providers of community and hospital based mental health services.

REFERENCES:

1. Van der Kolk BA: Psychological Trauma. Am Psych Press, Wash., D.C., 1987.
2. Harris M: Trauma Recovery and Empowerment: A Clinician's Guide For Working With Women In Groups. The Free Press, New York, N.Y., 1998.

Workshop 30 **Friday, October 12**
8:00 a.m.-9:30 a.m.

COMMUNITAS: FUTURE ROLE OF THE PSYCHIATRIST IN URBAN PLANNING FOR THE POOR

Mario Cruz, M.D., *Clinical Assistant Professor and Associate Head of Clinical Services, Department of Psychiatry, University of Arizona, 1501 North Campbell Avenue, Tucson, AZ 85724*; Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute and Clinic, Assistant Professor of Psychiatry, University of Pennsylvania Medical Center; and Former APA/Bristol-Myers Squibb Fellow, 3811 O'Hara Street, Room E-516, Pittsburgh, PA 15213*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate an understanding of the social and environmental conditions within communities for the poor that promote medical and psychiatric disturbances. The participant will also demonstrate an awareness of the potential role for psychiatric consultation in urban planning.

SUMMARY:

In the United States, our modern "post-industrial" economy has increased the disparity in social, political, and financial advantages afforded middle class and wealthy citizens versus the poor. Economic decline and political disempowerment occurring in poor communities has resulted in social conditions that perpetuate behavioral disorders in community members with mental illness. Although impoverished social conditions are recognized as catalysts for disease promotion and dissemination, little emphasis is placed on these issues in psychiatric education and training. These disease promoting social conditions warrant the development of additional skills for future community psychiatrists to be effective in the treatment of behavioral disorders. Specifically, community psychiatrists must become active participants in urban planning and development. The chair and panelist, two community psychiatrists with more than 20 years of combined experience working with marginalized populations, will summarize the present literature on environment and health, share their views on this topic, and provide examples from their experiences.

TARGET AUDIENCE:

Mental health providers—community psychiatrists

REFERENCES:

1. Book-Smedley BD, Syme SL (eds): Promoting Health: Intervention Strategies from Social and Behavioral Research. Institute of Medicine. National Academy Press, Washington, D.C., 2000.
2. Mohai P, Bunyan B: Race, poverty and the environment. EPA Journal 1992; 18(1): 6–8.

Workshop 31 **Friday, October 12**
10:00 a.m.-11:30 a.m.

COMMUNITY ACADEMIC COLLABORATIONS FOR MENTAL HEALTH

Annelle B. Primm, M.D., M.P.H., *Assistant Professor and Director, Community Psychiatry Program, Johns Hopkins University School of Medicine, 600 N. Wolfe Street, Meyer 144, Baltimore, MD 21287-7180*; Diane Cabot, M.S.W.; Adrian Mosley, M.S.W.; Karen L. Swartz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe the critical elements of effective community academic partnerships, understand three models of mental health educational outreach involving community academic collaborations, engage the faith community and schools in mental health education and screening efforts.

SUMMARY:

This presentation will showcase initiatives that provide mental health education and screening to the general public through the use of partnerships between the com-

munity and academic institutions. Through sharing of resources and expertise, individuals from academic and community settings collaborate to design and implement programs that perform effective educational outreach. The initiatives presented will highlight strategies for providing communities and underserved groups with mental health information by training lay people to perform mental health screening and by reaching out to community institutions such as churches and schools. The target audience for this presentation will be mental health professionals of a variety of disciplines as well as community-based mental health advocates.

REFERENCES:

1. Hirshfeld RMA, Keller MB, Panico S: The NDMDA Consensus Statement on the Undertreatment of Depression. JAMA 1997; 277: 333–340.
2. Levine, DM. Becker, DM, Bone, IR.: Narrowing the gap in health status of minority populations: a community-academic medical center partnership. American Journal of Preventive Medicine 1992; 8(5):319–323.

Workshop 32 **Friday, October 12**
10:00 a.m.-11:30 a.m.

UPDATE ON PRACTICE GUIDELINES: SUICIDE MANAGEMENT

APA Steering Committee on Practice Guidelines

John S. McIntyre, M.D., *Chair, Department of Psychiatry and Behavioral Health, Unity Health System, and Past President, American Psychiatric Association, 81 Lake Avenue, 3rd Floor, Rochester, NY 14608*; Douglas G. Jacobs, M.D.

EDUCATIONAL OBJECTIVES:

To provide an update concerning the overall progress of the APA practice guidelines effort and obtain feedback on a wide variety of issues relating to the development of the Suicide Management Guideline.

SUMMARY:

The APA practice guidelines project has published 11 guidelines using an evidence-based process resulting in documents that are both scientifically sound and clinically useful to practicing psychiatrists. The Steering Committee on Practice Guidelines has begun work on a practice guideline on suicidal behaviors. Suicide cuts across every diagnostic category and affects patients in all clinical settings. Although this guideline is not disorder specific as are the other APA practice guidelines, we are proceeding because of the seriousness of these behaviors and the importance of identifying clinically useful strategies. Workshop panelists will discuss the overall development process of practice guidelines and the content and outline of the developing practice guideline on suicide management. Persons attending the session are invited to comment on the broad array of issues relating to this guideline including the specific content of the guideline, implications for the field, and dissemination and evaluation strategies.

REFERENCES:

1. Hirschfeld RM, Russel JM: Assessment and treatment of suicidal patients. N Engl J Med 1997; 337:910–5.
2. The Harvard Medical School Guide to Suicide Assessment and Intervention. Edited by Jacobs DG. Jossey-Bass, San Francisco, 1999.

Workshop 33 **Friday, October 12**
10:00 a.m.-11:30 a.m.

THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS TECHNICAL REPORT ON SECLUSION AND RESTRAINT

Rupert R. Goetz, M.D., *State Medical Director, Office of Mental Health, Salem, Oregon, 2575 Bittern Street, N.E., Salem, OR 97310*; Alan Q. Radke, M.D., M.P.H., *State Medical Director, Minnesota Department of Human Services, 444 Lafayette Road North, St. Paul, MN 55155-3826*

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant should know reasons for the increasing attention given the reduction and elimination of seclusion and restraint; should be able to apply a model of primary, secondary, and tertiary prevention to this clinical practice; and should recognize at least one lesson that specific special populations teach.

SUMMARY:

A series of articles in the 1998 Hartford Courant highlighted the potentially deadly results of inappropriate use of seclusion and restraint (S&R). Since then, HCFA has promulgated Interim Final Rules and the JCAHO has issued new standards, both aimed at reducing possible harm from these clinical practices. The National Association of State Mental Health Program Directors' (NAMSHPD) Medical Directors Council held two colloquia on the reduction and elimination of the use of S+R that were published as technical reports. They take the position that S&R should be seen not a treatment interventions, but as a safety measures of last resort. The first report suggests a public health model of primary prevention (preventing and reducing the need

for S&R), secondary prevention (using early and least-restrictive interventions to de-escalate situations), and tertiary prevention (quality improvement steps to decrease the harm S&R can cause). The second report examines issues that arise in five special populations: children, elderly, substance abuse/dependent, developmentally disabled, and forensic. Lessons can be learned from each of these populations. Use of a developmental model, multidisciplinary approaches, viewing behavior as communication, considering the capacity for self-control and addressing public safety concerns can all be helpful.

TARGET AUDIENCE:

Psychiatrists, other mental health professionals, and administrators who are examining their practices seclusion and restraint practices in psychiatric facilities.

REFERENCES:

1. Medical Directors Council: Reducing the Use of Seclusion and Restraint: Findings, Strategies and Recommendations. National Association of State Mental Health Program Directors, Alexandria, VA, 1999.
2. Medical Directors Council: Reducing the Use of Seclusion and Restraint in Special Populations: Findings, Strategies and Recommendations. National Association of State Mental Health Program Directors, Alexandria, VA, 2001.

Workshop 34 **Friday, October 12**
10:00 a.m.-11:30 a.m.

DISASTER RESPONSE: THE DISASTER PSYCHIATRY OUTREACH EXPERIENCE

Anand Pandya, M.D., *Clinical Instructor, Department of Psychiatry, New York University, 215 East 24th Street, #322, New York, NY 10010-3804*; Craig L. Katz, M.D., *Department of Psychiatry, Mt. Sinai Hospital, 118 East 93rd Street, #5-A, New York, NY 10128-1663*; Anthony T. Ng, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: (1) identify disorders that are more common in the wake of disasters, (2) treat disaster victims and disaster response workers, (3) alter their therapeutic approach for the unique milieu of disaster sites, and (4) identify areas of future research needed in disaster psychiatry.

SUMMARY:

In recent years, hurricanes, terrorist bombings, and mass shootings have drawn the attention of clinicians and the mass media to the large toll of disasters. This has given rise to a growing psychiatric literature that assesses the psychological responses and the long-term outcome of individuals exposed to disasters. These data can allow us to plan evidence-based interventions for future disasters that utilize preliminary outcome studies and our understanding of the pathophysiology of abnormal trauma response.

To explore the elements of such interventions, we shall discuss the experiences of Disaster Psychiatry Outreach, a volunteer organization for psychiatrists who wish to aid at disaster sites. Presenters will describe their experiences responding to the crash of Swissair Flight 111 in 1998 and the crash of Egypt Air Flight 990 in 1999. The literature on disaster psychiatry will be reviewed focusing on epidemiology and treatment. Finally, the presenters will discuss the unique clinical challenges of preparing appropriate psychiatric services in case of disasters. Audience members with experience in trauma work and in systems issues will be encouraged to add their comments on how such clinical services can be designed in other parts of the country.

TARGET AUDIENCE:

Psychiatrists with interest in trauma-related disorders, community psychiatrists, child psychiatrists

REFERENCES:

1. Ursano RJ, et al: Psychiatric dimensions of disaster: patient care, community consultation, and preventive medicine. Harvard Review of Psychiatry 1995; 3:196–209.
2. North CS, et al: Psychiatric disorders among survivors of the Oklahoma City bombing. JAMA 1999; 282:755–762.

Workshop 35 **Friday, October 12**
1:30 p.m.-3:00 p.m.

MAKING PROGRAM EVALUATION A USER-FRIENDLY MANAGEMENT TOOL

Susan M. Deakins, M.D., *Associate Director, Public Psychiatry Fellowship, New York State Psychiatric Institute, 1051 Riverside Drive, Box 111, New York, NY 10032*; Rajesh A. Parekh, M.D.; Juliana I. Ekong, M.D.; Silviu M. Burcescu, M.D.; Jules M. Ranz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop participants will learn why it is important for psychiatrists and other clinicians serving as program managers to initiate program evaluations. They will also learn how clinician managers, without extra resources, can design and carry out useful program evaluations.

SUMMARY:

Few clinical program managers find evaluations by either inside (CQI) or outside (JCAHO) surveyors to be programmatically productive or relevant. They are often not consulted when determining the parameters of most evaluations and experience the process as being done "to" rather than "by" the program.

Clinical program managers can take charge of the CQI or JCAHO survey process by initiating program evaluations that use measures that accurately reflect the particular program's goals and are meaningful to the program's operations and outcomes. By being proactive in this manner they can create the necessary data to use the survey process to support program development.

The Columbia University Public Psychiatry Fellowship has developed a strategy to address this issue. The program requires fellows to design and carry out program evaluations at their field placements and encourages them to continue this process after completing their fellowship. Several alumni of the fellowship will present program evaluations designed and carried out at their field placement or current agencies.

TARGET AUDIENCE:

Psychiatrists, especially medical directors, and other clinicians with management responsibility in mental health organizations

REFERENCES:

1. Posavec EJ: Toward more information uses of statistics: alternatives for program evaluators. Evaluation and Program Planning 1998; 21:243–254.
2. Rossi PH, Freeman HE, Lipsey MW: Evaluation—A systematic Approach, Sixth Edition. Thousand Oaks, Sage Publications, 1999, pp 29–33.
3. Ranz JM, Rosenheck S, Deakins S: Columbia University's Fellowship in Public Psychiatry. Psychiatric Services 1996; 47:512–516.

Workshop 36 **Friday, October 12**
1:30 p.m.-3:00 p.m.

THE GOOD, THE BAD, AND THE UGLY: HOLLYWOOD'S PORTRAYAL OF PSYCHIATRISTS

Fuat Ulus, M.D., *Psychiatrist, Assertive Community Treatment Programs, 406 Rockhill Circle, Bethlehem, PA 18017-1702*; Eda Ulus, B.S.

EDUCATIONAL OBJECTIVES:

To become aware of and identify stereotypy as well as realistic portrayals of psychiatrists in movies throughout the decades; demonstrate, teach, and share this information with others in educational/discussion circles to address stigma in various venues; and apply this knowledge to counter stigma in the therapeutic setting.

SUMMARY:

The format of the workshop will begin with a presentation of graphs and statistical data about psychiatrists in movies, such as the percentage of American films in which the psychiatrists are portrayed as the "good," the "bad," or the "ugly." "Good" is defined as a caring and effective psychiatrist; "bad" as an incompetent clinician likely to cause more harm than good; and "ugly" as psycho/sociopathic and Hannibal-like. A series of movie scenes depicting good, bad, and ugly psychiatrists will then be shown. Next, experiential activities such as role-playing will occur based upon the presentation content and the movies. For example, the presenter will ask, "What would you do if you were the psychiatrist in this situation?" or "How does this movie scene affect the public's perception of mental illness and ultimately the therapeutic outcome of those who are stigmatized?" All audience members are strongly urged to participate and exchange ideas among themselves, to create a lively discussion.

TARGET AUDIENCE:

The target audience for this workshop includes psychiatrists, psychologists, psychiatric nurses, social workers, hospital chaplains, pastoral counselors, and all other health care professionals who are willing to enjoy the movies.

REFERENCES:

1. Clara A: The image of the psychiatrist in the movies. Acta Psychiatr Belg 1995; 95: 7–15.
2. Schneider I: Images of the mind: psychiatry in the commercial film. Am J Psychiatry 1977; 134: 613–20.

Workshop 37 **Friday, October 12**
1:30 p.m.-3:00 p.m.

HOUSE CALLS TO THE HOMELESS: PROVIDING ON-SITE TREATMENT TO THE HOMELESS

Katherine Falk, M.D., *Assistant Clinical Professor of Psychiatry, Columbia University, President and Founder, Project for Psychiatric Outreach to the Homeless, Inc., New York State Psychiatric Institute, 141 East 88th Street, New York, NY 10128*; Regina Y. LeVerrier, M.D.; Cathy Treiber, C.S.W.; Marilyn A. Kneeland, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the unique treatment needs

of homeless, mentally ill persons, and understand the benefits and challenges of designing a program to provide on-site psychiatric treatment that addresses those needs.

SUMMARY:

The Project for Psychiatric Outreach to the Homeless, Inc. (PPOH) is a not-for-profit organization in New York City that was designed to meet the unique treatment needs of homeless, mentally ill persons. PPOH recruits and trains psychiatrists to go on-site to social service programs for homeless persons to provide psychiatric outreach and treatment in partnership with caseworkers and other agency staff. This model of treatment makes use of existing resources and is appropriate for replication in other communities.

This workshop will describe PPOH's development from a volunteer organization to a city-wide agency that also serves as an educational program for psychiatry residents and fellows. In addition, techniques for engaging homeless persons and providing psychiatric treatment in a "nontraditional" setting will be explored. Finally, the administrative and supervisory aspects of such a program will be discussed.

TARGET AUDIENCE:

This workshop is targeted to mental health professionals (psychiatrists, social workers, psychologists) who are interested in innovative solutions to the problem of providing accessible psychiatric treatment to homeless persons.

REFERENCES:

1. Susser E, et al: Preventing recurrent homelessness among mentally ill men: a 'critical time' intervention after discharge from a shelter. American Journal of Public Health 87: 256–261.
2. Susser E: Working with people who are mentally ill and homeless: the role of a psychiatrist in homelessness: A Prevention-Oriented Approach. Edited by Jahiel R. Baltimore, Johns Hopkins Univ. Press, 1992, pp. 207–217.

Workshop 38 **Friday, October 12**
3:30 p.m.-5:00 p.m.

PRACTICING PSYCHIATRY IN PRIMARY CARE SETTINGS: OPPORTUNITIES AND PITFALLS

Matthew R. Schneider, M.D., *Attending Psychiatrist, Department of Psychiatry, Montefiore Medical Center, 2600 Netherland Avenue, #1625, Bronx, NY 10463*; Robert J. Rothenstein, M.D., *Attending Psychiatrist, Department of Psychiatry, Montefiore Medical Center, 111 East 210th Street, Bronx, NY 10467*

EDUCATIONAL OBJECTIVES:

To recognize the growing role of psychiatrists practicing in primary care settings, better understand the benefits of providing care to patients in primary care settings, appreciate pitfalls that may arise to psychiatrists in these settings.

SUMMARY:

Even the busiest of psychiatric practices pales in comparison with regard to the volume of patients treated in a typical primary care setting. Within these large volumes of patients comes a significant number who have mental illnesses and would benefit from psychiatric services. There is an increasing realization that providing psychiatric care within the primary care office can improve patient care by allowing mental health access to patients who would not otherwise seek it, as well as other accompanying advantages.

The psychiatrist working in a primary care setting must perform multiple tasks—curbside consultation, crisis intervention, as well as typical evaluation and management. The ability to shift gears depending on the clinical situation is but one challenge. Other challenges are more particular to the setting and are borne from the differing "cultures" of primary care medicine and psychiatry.

The workshop will examine in an interactive format the opportunities and pitfalls of practicing psychiatry in a primary care setting. A clinically-oriented, "real-life" perspective will be utilized, including the discussion of examples that illustrate issues.

TARGET AUDIENCE:

Psychiatrists currently or considering practicing in a primary care setting.

REFERENCES:

1. Katon W, et al: Stepped collaborative care for primary care patients with persistent symptoms of depression. Arch Gen Psychiatry 1999; 56: 1109–1115.
2. Kroenke K: Discovering depression in medical patients: reasonable expectations. Ann Intern Med 1997; 126: 463–464.

Workshop 39 **Friday, October 12**
3:30 p.m.-5:00 p.m.

PSYCHODYNAMIC ASPECTS OF MULTIDISCIPLINARY ROLE RELATIONSHIPS

American Academy of Psychoanalysis

Mariam C. Cohen, M.D., *Faculty, Institute of Behavioral Medicine, Good Samaritan Regional Medical Center,*

4810 East Andora Drive, Scottsdale, AZ 85254-3514; Ian E. Alger, M.D.; Sheila Hafter Gray, M.D.

EDUCATIONAL OBJECTIVES:

To evaluate their role relationships with other health professionals and to develop at least one model of practice that meets the needs of individual patients in a complex setting.

SUMMARY:

As we enter the 21st century psychiatrists are confronted equally with the need to share their traditional roles and expertise with members of other health care professions and with pressures toward intraprofessional subspecialization. We intend to help participants explore ways that psychodynamic theory can help psychiatrists work with the shift from hierarchical multidisciplinary mental health teams composed of highly specialized clinicians to models of practice in which leadership roles and professional contributions may be diffuse and overlapping. The question of who prescribes medication will provide a special focus for the discussion because it reflects the full spectrum of psychosocial and economic forces ranging from social attitudes toward physicians through the psychology of the psychiatrist to cost and quality of health care for individual patients. Is the 21st century psychologist or nurse specialist any less competent to manage psychopharmacological treatment than was the ordinary 20th century general psychiatrist? Are 21st century general psychiatrists as competent to do psychotherapy as their psychologist or social worker colleagues? Must appropriate subspecialization within psychiatry lead to loss of basic skills in other areas? Is psychodynamic medical psychotherapy a relic of the past or a model for the future?

TARGET AUDIENCE:

Psychiatrists who work in mental health systems and in private practice.

REFERENCES:

1. Gray SH: Quality Assurance and Utilization Review of Individual Medical Psychotherapies, Manual of Psychiatric Quality Assurance Review. Edited by MR Mattson APA Press, Washington DC.
2. Gutheil TG: The psychology of psychopharmacology. Bull Menninger Clinic 1982; 46:321–30.

Workshop 40 **Friday, October 12**
3:30 p.m.-5:00 p.m.

CROSS-CULTURAL ADAPTATION IN A CHANGING PSYCHIATRIC WORLD

APA Committee on International Medical Graduates

Gopalkrishna K. Upadhya, M.D., *9 Overhill Road, Scarsdale, NY 10583-5307*; Josie L. Olympia, M.D., *Buffalo Psychiatric Center, 400 Forest Avenue, Buffalo, NY 14213-1207*; Renato D. Alarcón, M.D., M.P.H.; Chowallur D. Chacko, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to appreciate the two-way road that biology and culture create for better understanding of psychiatric symptoms, syndromes and diseases, learn about different responses to medications across various ethnic groups, understand the role of family and natural community supports in treatment planning and delivery, identify standards and develop various strategies in acquiring cultural competency.

SUMMARY:

Numerous changes have occurred in the way that psychiatric services are delivered in the past few decades. With America's rapidly growing diverse population, there has been an increasing demand from consumers, advocates, and third-party payers for care that is culturally sensitive and cost-effective. The first part of the workshop will address bicultural connections in psychopathology and clinical implications for treatment of patients with various ethnic backgrounds. The second part of the workshop will encourage discussion on how providers, themselves coming from different cultural backgrounds, can more effectively deliver culturally competent care.

TARGET AUDIENCE:

Mental health professionals caring for diverse patient populations in public and private health care settings whether in rural or urban areas of the United States.

REFERENCES:

1. Alarcon RD, et al: Clinical relevance of contemporary cultural psychiatry. Journal of Nervous and Mental Disease 1999; 187:465–471.
2. Flashend JH, Hu L: Relationship of ethnicity to psychiatric diagnosis. Journal of Nervous and Mental Disease 1992; 18: 296–303.

Workshop 41 **Saturday, October 13**
8:00 a.m.-9:30 a.m.

BETWEEN SOUTH-ASIAN GENERATIONS AND COUNTRIES: A PSYCHOTHERAPEUTIC MORASS

Anand Pandya, M.D., *Clinical Instructor, Department of Psychiatry, New York University, 215 East 24th Street, #322, New York, NY 10010-3804*; Linda Chokroverty, M.D., *Child Fellow, Department of Psychiatry, Albert Einstein College of Medicine, 118 East 93rd Street, #5-*

A, New York, NY 10128; Abdullah M. Hasan, M.D.; Juhi Chawla, M.D.; Nalini V. Juthani, M.D.

EDUCATIONAL OBJECTIVES:

To appreciate the conflicts between two or more generations within South Asian families residing in a Western dominant culture; acquire knowledge and develop clinical skills to address psychiatric symptoms brought forth by such conflicts within family members.

SUMMARY:

The discord that arises between adolescents and young adults with their parents is an ancient notion of childhood development. When the complex issues surrounding immigration of parents and family development are introduced, an ever-more-daunting task awaits the therapist who is asked to provide mental health treatment in cases where these themes predominate. This workshop will examine the nature of intergenerational conflicts that arise in the South Asian community that has re-established itself in a Western setting. Using film clips from two contemporary movies, East is East and Bhaji on the Beach, and parallel clinical case examples, the workshop will explore the issues of sexuality, racism, domestic violence, and loss of cultural identity among two distinct generations of South Asian immigrants.

The presenters and participants will then engage in a discussion of treatment strategies for symptoms of depression, bereavement, and anxiety that may result from such family situations. Finally, an approach for fostering dialogue between the generations will be developed by the workshop members.

TARGET AUDIENCE:

Mental health professionals: trainees and advanced practioners from the fields of psychiatry, psychology, and social work; educators, members of the clergy, and art/music therapists.

REFERENCES:

1. Canino IA, Spurlock J (ed.): Culturally Diverse Children and Adolescents, Assessment, Diagnosis and Treatment. New York, The Guilford Press, 2000.
2. Ahktar S, Kramer S (ed.): The Colors of Childhood. Northvale, N.J., Jason Aronson Inc., 1998.

Workshop 42 **Saturday, October 13 8:00 a.m.-9:30 a.m.**

CHALLENGES IN EMERGENCY PSYCHIATRIC CARE

Avrim B. Fishkind, M.D., *Medical Director, The Neuropsychiatric Center of Houston, and Southern Region Coordinator, American Association for Emergency Psychiatry, 2850 Fannin Street, Houston, TX 77002*; Rochelle Kibert, Ph.D.; Mende Snodgress, J.D., L.M.S.W.; Debra M. Katz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the retarded individual present with in psychiatric crisis; recognize managed care companies as potential payees for the PES.

SUMMARY:

These are interesting times for modern psychiatric emergencies services (PES). Across the world, PESs are facing many challenges in the medical field and in legal and economic spectrums. In addition, the American Association of Emergency Psychiatry (AAEP) is expanding leadership in the field through multiple academic venues. In this workshop, participants will get a chance to discuss topics of interest to crisis and emergency psychiatry workers. The following four topics will certainly provide for lively and interactive audience participation: (1) providing medical care and medical clearance in a free standing psychiatric emergency service. (2) If you build it they will come: building a front door to your PES and providing effective gatekeeping. (3) I'm a psychiatrist.... I don't treat MR: a discussion on the challenges that emergency psychiatrists face in the treatment of patients with mental retardation. (4) Managed care and the PES: behavioral health care organizations as a revenue stream for the PES.

TARGET AUDIENCE:

All psychiatrists, emergency room mental health providers, psychotherapists

REFERENCES:

1. Carreis G: New Development in Everyday Medical, Legal and Economics. Jossey-Bass Publishers, San Francisco, 1999.
2. Kleespies PM: Emergencies in Mental Health Practice Evaluation and Management. The Guilford Press, New York, 1998.

Workshop 43 **Saturday, October 13 8:00 a.m.-9:30 a.m.**

IMPROVING EFFICIENCY AND QUALITY OF CARE IN A COMMUNITY MENTAL HEALTH CENTER

Michael A. Hoge, Ph.D., *Associate Professor of Psychology, Yale University, 25 Park Street, 6th Floor, New Haven, CT 06519*; Simie Rosenthal-Whalen, M.S.W.; Nancy L. Anderson, M.S.N.

EDUCATIONAL OBJECTIVES:

To identify at least five practical strategies for increasing staff productivity and the appropriateness of treatment services delivered in the public sector through community mental health centers.

SUMMARY:

Reductions in state grant support and third-party reimbursement have led to a need for community mental health centers to function with improved efficiency. Simultaneously, managed care and the recent focus on practice guidelines have created increased pressure for these organizations to implement "best practices" and to enhance the appropriateness of care delivered. This workshop will provide an overview of practical strategies that were employed to achieve these objectives in an urban mental health center. The interventions designed to improve efficiency focused on increasing staff productivity, providing improved administrative support to clinical teams, streamlining paperwork through computerization, and building the management skills of team leaders. The interventions designed to improve quality of care focused on the use of treatment guidelines to shape practice patterns and the implementation of level of care guidelines and internal utilization review procedures to match patients to appropriate treatments. The design, implementation, and impact of these interventions will be discussed. Special attention will be given to the challenge of creating and sustaining change in these provider organizations.

TARGET AUDIENCE:

Administrators and clinical supervisors.

REFERENCES:

1. Dassori AM, Chiles JA, Swenson-Britt E: Implementing best-practice guidelines for schizophrenia in a public-sector institution. Psychiatric Services 2000; 51:972–974, 979.
2. Lehman AF, Steinwachs DM: Translating research into practice: the schizophrenia patient outcomes research team (PORT) treatment recommendations. Schizophrenia Bulletin 1998; 24:1–10.

Workshop 44 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

WHAT ETHICAL PRINCIPLES DOES ONE FOLLOW AS A PSYCHIATRIC ADMINISTRATOR?

American Association of Psychiatric Administrators

S. Atezaz Saeed, M.D., M.S., *Chair, Department of Psychiatry and Behavioral Medicine, University of Illinois College of Medicine at Peoria, 5407 North University, Suite C, Peoria, IL 61614-4736*; Steven H. Moffic, M.D.; Marc D. Feldman, M.D.

EDUCATIONAL OBJECTIVES:

To recognize and effectively process ethical dilemmas that psychiatric administrators often face.

SUMMARY:

When functioning as a psychiatric administrator, what ethical principles, if any, does one follow? Does one keep the mission statement of the organization in mind or does one always keep the needs of an individual patient primary? Or does one try to do some combination of both? If so, which principle may dominate in a given situation? The ethical challenge for a psychiatric administrator is to help optimize the potential benefits and reduce risks of treatment and/or rehabilitation, while considering the costs, likely outcome, and alternatives unique to psychiatry. While different approaches could be taken, a time-tested one would be to use the principles of medical ethics. Just as APA added annotations to these principles, the American Association of Psychiatric Administrators has suggested annotations especially applicable to psychiatric administrators.

This workshop will focus on ways of looking at ethical dilemmas psychiatric administrators often face in various settings. A panel of psychiatrist administrators will present scenarios from public, private, and academic settings to stimulate discussion and participation. While talking about ethical quandaries for psychiatrist-administrators in insurance and managed care companies, the panel members will draw on their own experiences working in these areas. Input from participants about their own experiences and insights will be strongly encouraged.

TARGET AUDIENCE:

Psychiatric administrators and educators.

REFERENCES:

1. American Psychiatric Association: Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry. Washington DC, American Psychiatric Association, 1985.
2. Moffic S: Ethical principles for psychiatric administrators: the AMA principles of medical ethics, with annotations especially applicable to psychiatric administrators. American Association of Psychiatric Administrators Newsletter Summer 2000, pp. 5–9.

Workshop 45 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

ENSURING MENTAL HEALTH SERVICES FOR ALL AMERICANS

National Mental Health Association

Michael M. Faenza, M.S.S.W., *President and Chief Executive Officer, National Mental Health Association, 1021 Prince Street, Alexandria, VA 22314-2971*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the strength and importance of the psychiatrist's role as a public policy advocate; identify messages to focus public leadership and political capital on mental health and related issues; determine multiple opportunities to meet their advocacy responsibilities within their own field and community; target key social institutions, including child protective services and criminal justice, for system partnership and change.

SUMMARY:

Organized psychiatry is often the central professional voice that brings the science of mental and behavioral health to policy makers and opinion leaders; therefore, the issues the profession chooses to focus on and advocate for carry great weight. This workshop will help psychiatrists amplify their advocacy voice to promote a new public health vision for mental health and to create the moral, economic, and political imperative necessary to make mental health central to all public health endeavors. Participants will learn to better leverage their professional influence to strategically focus public attention on the prevention, treatment and rehabilitation needs of individuals with mental health and substance use disorders, and to effectively advocate for high-quality, accessible mental health and substance abuse services.

REFERENCES:

1. Faenza MM: Taking issue: mental health services for all Americans. Psychiatric Services 2000; v. 51.
2. Faenza M, Steel E. Mental health care coverage for children and families, in Children's Health Care: Issues for the Year 2000 and Beyond. Edited by Gullotta T, Hamptor R. Thousand Oaks, CA, Sage Publications, 1999.

Workshop 46 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

METHADONE AND LEVOMETHADYL ACETATE TREATMENT: CLINICAL, OUTCOME, AND PATIENT MANAGEMENT ISSUES

Andreas Evdokas, Ph.D., *Psychologist, Department of Psychiatry, Albert Einstein College of Medicine, 3100 Third Avenue, Bronx, NY 10451*; John B. Osei-Tutu, M.D., *Chief of Chemical Depression, Bronx Lebanon Hospital Center, 1276 Fulton Street, Bronx, NY 10456*; Diane Fine, M.A.

EDUCATIONAL OBJECTIVES:

To demonstrate increased awareness of issues relating to ORLAAM treatment of opioid dependence.

SUMMARY:

As new treatments for opioid dependency become available it is important to be able to offer patients individualized treatment options that will increase their chances of success. An analysis of in-house clinical outcome data suggests that both methadone and levomethadyl acetate (ORLAAM) can be effective treatments. However, it is becoming increasingly clear that success rates can be improved when matching the treatment to the patient. To this end, attention has to be directed toward various aspects of treatment. The goal of this interdisciplinary workshop is to increase awareness of the multitude of issues, to provide specific suggestions to those considering providing it as a treatment option, and to encourage further consideration of such issues. The topics include an overview of pharmacological properties and guidelines of treatment; the use of in-house treatment outcome data to monitor effectiveness; patient selection, education, and preparation; managing the transition from methadone to ORLAAM; managing dually diagnosed patients; administrative issues regarding scheduling and dosing; clinical and organizational issues such as staff reaction and challenges to ORLAAM; and patient subjective accounts of ORLAAM treatment. The presentations will be interactive, and participants are particularly encouraged to share their thoughts and experiences. A discussion period will conclude the session.

TARGET AUDIENCE:

Clinical and administrative staff

REFERENCES:

1. Johson RE, Chutuape MA, Strain EC, et al: A comparison of levomethadyl acetate, buprenorphine and methadone for opioid dependence. N Engl J Med 2000; 343:1290–7.
2. Ling W, Charuvastra C, Kaim SC, Let CJ: Methadyl acetate and methadone as maintenance treatments for heroin addicts: a Veterans Administration cooperative study. Arch Gen Psychiatry 1976;33:70–2.

Workshop 47 **Saturday, October 13**
1:30 p.m.-3:00 p.m.

INDO-AMERICAN PSYCHIATRIC SERVICES: AN OUTPATIENT MENTAL HEALTH CLINIC

Indo-American Psychiatric Association

Manoj R. Shah, M.D., *Medical Director, Department of Psychiatry, Schneider Children's Hospital, 269-01 76th Avenue, Suite 135, New Hyde Park, NY 11040-1433*; Seetharaman Vivek, M.D.; Dinshaw D. Bamji, M.D.

EDUCATIONAL OBJECTIVES:

To become sensitive to the issues faced by immigrants from a different culture, learn to develop services for these groups, and develop strategies to provide quality service at a low cost, negotiating with various health care delivery systems.

SUMMARY:

The number of uninsured is steadily increasing. Among new immigrants (after 1996) there is the added burden of not being eligible for Medicaid. The immigrants from the Indian subcontinent have to adapt to the new culture and society, which leads to stress-related conditions. The major psychiatric disorders are also equally prevalent. There is a greater degree of stigma associated with seeking psychiatric help in this community. There is a vast body of literature that suggests that a culturally competent system of care is needed to provide the needed services to these groups. The Indo-American Psychiatric Services is an innovative program that provides free or low-cost service to this population. Flushing Hospital, which has its own mental health clinic and which is located in an area where this population resides agreed to provide the space on Saturdays to run the program. The Indo-American Psychiatric Association enlisted its members to provide free psychiatric consultation and treatment. Dr. Vivek will discuss the art of negotiating with the hospital for the space and the legal issues involved. Dr. Shah will discuss the enlistment of volunteer psychiatrists and raising funds for ancilliary expenses. Dr. Bamji will discuss the day-to-day running of a high-quality, low-cost program.

TARGET AUDIENCE:

Psychiatrists, administrators, psychologists, social workers

REFERENCES:

1. Isaacs MR, Benjamin MP: Towards a culturally competent system of care. CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown, University Child Development Center, 1991.
2. Viswanathan R, Shah M, Ahad A: Asian-Indian Americans, in Cultural Issues in the Treatment of Anxiety. Edited by Friedman S. New York, The Guilford Press, 1997, pp. 175–195.

Workshop 48 **Saturday, October 13**
1:30 p.m.-3:00 p.m.

MENTAL HEALTH AND CRIMINAL JUSTICE CONSENSUS PROJECT

American Association of Community Psychiatrists

Jacqueline M. Feldman, M.D., *Patrick H. Linton Professor, Department of Psychiatry, University of Alabama at Birmingham, and President, American Association of Community Psychiatrists, 4-CCB 908 20th Street, South, Birmingham, AL 35294*; Fred C. Osher, M.D.; Hunter L. McQuistion, M.D.

EDUCATIONAL OBJECTIVES:

To demonstrate an understanding of the issues related to the interface between systems of corrections and mental health, and the importance of the process of the mental health/criminal justice consensus project.

SUMMARY:

A consensus project has been developed in association with the Consortium of State Governments (CSG), the National Association of State Mental Health Program Directors (NASHMHPD), and the Police Enforcement Research Foundation (PERF). The development of the project was predicated on the staggering statistics of increasing involvement with the utilization of the criminal justice system by persons with mental illness (PMI). Acknowledging the precarious sequelae for both PMIs and their communities when criminal justice systems are compelled to become involved, a project has evolved to foster a consensus approach to research, problem solve, and formulate solutions related to PMIs and the criminal justice system. Three "tracks" were developed (mental health and law enforcement, mental health and the judiciary, and mental health and corrections). Representatives from state and local executive, legislative, and judicial branches of government, as well as representatives from law enforcement and corrections served on these three committees as did representatives of mental health providers. The presenters of this workshop are the three psychiatrists who served on these committees and who were also part of the umbrella Mental Health Advisory Group. The workshop will focus on the process of the project and the recommendations for public policy development that have evolved as part of the project.

TARGET AUDIENCE:

Mental health professionals who treat consumers who also interface with the criminal justice system (law enforcement, judiciary, jails, and prisons); no specific background requirements.

REFERENCES:

1. Position statement on post-release planning by the Committee on Persons with Mental Illness Behind Bars of the American Association of Community Psychiatrists. Community Psychiatrists 2000; 14:4–6.
2. Thorburn KM: Health care in correctional facilities. Western Journal of Medicine 1995; 163:560–564.

Workshop 49 **Saturday, October 13**
1:30 p.m.-3:00 p.m.

BIPOLAR GUIDELINES WILL MAKE YOUR PRACTICE BETTER

APA Steering Committee on Practice Guidelines

John S. McIntyre, M.D., *Chair, Department of Psychiatry and Behavioral Health, Unity Health System, and Past President, American Psychiatric Association, 81 Lake Avenue, 3rd Floor, Rochester, NY 14608*; Roy H. Perlis, M.D.; Karen D. Wagner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to provide an update concerning the overall progress of the APA practice guidelines effort and obtain feedback on a wide variety of issues relating to the project in general and the development of the Bipolar Guideline.

SUMMARY:

Since the publication of the last APA bipolar practice guideline in 1995, there have been many new developments in the treatment and management of bipolar disorder. New findings on existing mood stabilizers have been published. Several new anticonvulsants and atypical neuroleptics have emerged as effective treatments for bipolar disorder.

The aim of the APA practice guidelines project is to produce a document that is both scientifically sound and clinically useful to practicing psychiatrists. The revised bipolar disorder practice guideline focuses on the evaluation, selection and application of both pharmacologic interventions and psychosocial treatments and provides a framework for clinical decision making.

The foundation for treatment of each disorder is psychiatric management, which is combined with specific treatments in order to optimize patient outcome. Formulating and implementing a treatment plan utilizing psychiatric management in conjunction with specific pharmacologic and psychosocial treatments will be discussed in the context of bipolar disorder. Workshop panelists will present the latest draft of the revised bipolar disorder practice guideline. Emphasized in this presentation will be the new parts of this revised guideline which reflect significant recent advances especially in the area of psychopharmacology.

Persons attending the session are invited to comment on the broad array of issues relating to practice guidelines including guideline content, overall development procedures, dissemination and evaluation strategies, future guideline topics, and implications for the field.

REFERENCES:

1. Sachs GS, Printz DJ, Kahn DA, Carpenter D, Docherty JP: The expert consensus guideline series: medication treatment of bipolar disorder, 2000.
2. American Psychiatric Association: Practice Guideline for the Treatment of Patients with Bipolar Disorder. Am J Psychiatry 1994; 151:12 (suppl).

Workshop 50 **Saturday, October 13**
1:30 p.m.-3:00 p.m.

IMPROVING ACCESS TO MENTAL HEALTH SERVICES FOR THE DEAF AND HARD OF HEARING IN ILLINOIS

Thomas A. Simpatico, M.D., *Chief, Burrough of Chicago Network Manager, Chicago Read Mental Health Center, 4200 North Oak Park Avenue, Chicago, IL 60634*; Bruce Munro-Ludders, L.C.S.W.

EDUCATIONAL OBJECTIVES:

To demonstrate an understanding of some of the aspects of deafness and deaf culture that challenge the ability to provide effective mental health care; be familiar with some of the strategies Illinois is using to develop its statewide system of care for the chronic mentally ill who are deaf and hard of hearing.

SUMMARY:

This workshop will describe how a system of care for the deaf and hard of hearing mentally ill is rapidly evolving in Illinois. In describing the evolutionary steps of this system, panel members will point out obstacles that are commonly encountered by mental health providers working with deaf and hard-of-hearing patients. Clinical vignettes will illustrate problem situations that commonly occur, and easy to implement solutions will be suggested. The benefits of creating a system of support for mental health care providers working with the deaf will be described. Several such systems will be discussed, including the statewide system that is rapidly developing in Illinois. The description of these systems

will emphasize: (1) key elements any system for working with the deaf mentally ill should have, (2) avoidable obstacles to access of services commonly encountered by the deaf mentally ill; (3) the need to have a working knowledge of deaf culture in order to provide effective mental health care to the deaf. All elements of the presentations will be designed to promote general discussion. Particular attention will be paid to what might be effective strategies for audience members to use in their areas of practice.

REFERENCES:

1. Hindley P: Psychiatric aspects of hearing impairments. Journal of Child Psychology and Psychiatry 1997; 38:101–177.
2. Myklebust HR: The Psychology of Deafness. New York, Grune & Stratton, 1960.

Workshop 51 **Saturday, October 13**
3:30 p.m.-5:00 p.m.

THE CLINICAL EVALUATION OF COGNITIVE DYSFUNCTION

Raymond A. Faber, M.D., *Professor of Psychiatry and Neurology, University of Texas Health Science Center, San Antonio, and Chief of Neuropsychiatry, Audie Murphy VA Hospital, 7400 Merton Minter, 116-A, San Antonio, TX 78284*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to efficiently assess the nature and extent of cognitive dysfunction in psychiatric and neuropsychiatric patients.

SUMMARY:

This workshop will present the essential elements that comprise the clinical evaluation of cognitive functioning. The organization of cognitive functioning will be explained. This is best understood as a hierarchy starting with the fundamental foundations of consciousness and attention then ranging to specialized abilities such as language and visuospatial skills. Practical methods of easily assessing cognitive functions will be demonstrated. Particular emphasis will be given to the assessment of memory and executive functions as understood from recent research. Two very practical batteries will be presented in detail. These are the "Cognistat" exam and the "7 minute Screen" for Alzheimer's disease. The advantages of these instruments over the better-known Mini-Mental Status Exam will be highlighted. This workshop is intended for clinicians who must efficiently determine the nature and extent of cognitive dysfunction in patients with psychiatric and neuropsychiatric disorders. No special background is required.

TARGET AUDIENCE:

Psychiatrists; other mental health professionals.

REFERENCES:

1. Solomon PR, Hirsckoff A, Kelly B, et al: A 7-minute neurocognitive screening battery highly sensitive to Alzheimer's disease. Arch Neurol 1998; 55:349–355.
2. Kiernan RJ, Mueller J, Langston JW, et al: The Neurobehavioral Cognitive Status Examination: a brief but quantitative approach. An Intern Med 1987; 107:481–485.

Workshop 52 **Saturday, October 13**
3:30 p.m.-5:00 p.m.

ONE STRIKE AND YOU'RE OUT: A STRIKE'S IMPACT ON A COMMUNITY MENTAL HEALTH CENTER

American Association of Community Psychiatrists

Jeffrey L. Geller, M.D., M.P.H., *Professor of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue, North, Worcester, MA 01655-0002*; Marie H. Hobart, M.D.; Jeffrey G. Stovall, M.D.

EDUCATIONAL OBJECTIVES:

To demonstrate an understanding of the potential effects of a labor strike on patients and the psychiatric staff of a community health center.

SUMMARY:

Tremendous organizational and economic upheavals have pressured community mental health centers (CMHCs) in recent years—reductions in reimbursement rates, privatization of public services, for-profit managing of Medicaid, and escalating health care costs of employees. CMHCs have entered into mergers and affiliations with other health care organizations in an attempt to survive economically. Within this context, one CMHC endured a protracted labor dispute with its employees, a dispute that led to a 30-day strike by 40 percent of the employees.

The workshop will: (1) review relevant literature including previous findings of strikes adverse effects on individual with chronic illnesses and those from a lower socioeconomic status, (2) review the strike's impact upon patients of the CMHC as reflected in consumer satisfaction surveys and outpatient service utilization data, and (3) discuss the impact of the strike upon the role of psychiatrists at the CMHC, particularly upon psychiatrist leadership functions.

TARGET AUDIENCE:

The workshop is intended to benefit participants who work in community mental health or who administer or regulate community services.

REFERENCES:

1. Norman R, Malla A: The effect of a mental hospital strike on general hospital psychiatric services. Psychogical Medicine 1984;14:913–921.
2. Abdelkader M, Macmillan JF: The effect of a nurses' industrial action on psychiatric hospital admissions. Social Psychiatry Psychiatric Epidemiology 1990;25:154–158.

Workshop 53 **Saturday, October 13**
3:30 p.m.-5:00 p.m.

ELECTRONIC MEDICINE: PROMISES AND PITFALLS

APA Council on Psychiatry and the Law

Jagannathan Srinivasaraghavan, M.D., *Professor of Psychiatry, Southern Illinois University School of Medicine, and Medical Director, Choate Mental Health and Development Center, 1000 North Main Street, Anna, IL 62906*; Patricia R. Recupero, M.D., J.D., *Department of Psychiatry, Brown University, Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906*; Philip T. Merideth, M.D., J.D.; Robert Hurst

EDUCATIONAL OBJECTIVES:

To understand the issues concerning electronic medical records, data collection, on-line therapies, and telemedicine.

SUMMARY:

Electronic medicine provides novel opportunities for clinician-patient interaction and documentation. Its predecessors—telephone, fax, and telemedicine provide some models for ethical and legal decision making in this new era. However, electronic records, "beaming prescriptions" to pharmacies, use of PDA (personal desk accessories), communication by e-mail with patients and colleagues, medical education via Web sites, and on-line therapy bring many new benefits and raise uncharted legal and ethical considerations. This workshop will describe the use of electronic medical communication and explore the potential liabilities and limitations associated with each. Dr. Srinivasaraghavan will outline the proliferation of the use of electronics in the practice of medicine and speak on threats to confidentiality and privacy issues posed by electronic medical records. The role of electronic media in health services research will also be explored. Dr. Recupero will discuss issues related to e-mail communication with patients including licensure, credentialing, confidentiality, informed consent, timeliness of response, and liability risks. Dr. Meredith will explain uses of telemedicine in clinical practice and medical and patient education. Mr. Hurst will describe how clinicians can get the best out of the burgeoning information technology and useful sites for education and research. There will be ample time for audience participation.

TARGET AUDIENCE:

Practicing clinicians and mental health professionals

REFERENCES:

1. Kane B, Sands D: Guidelines for the clinical use of electronic mail. JAMA 1998; 5:104–111.
2. Terry NP: Cyber-malpractice: legal exposure for cybermedicine. American Journal of Law & Medicine 1999; 25:327–66.

Workshop 54 **Saturday, October 13**
3:30 p.m.-5:00 p.m.

MAKING VERY BRIEF GROUP PSYCHOTHERAPY THERAPEUTIC

Roger Peele, M.D., *Member, APA Board of Trustees, and Clinical Professor of Psychiatry, George Washington University School of Medicine, 2150 Pennsylvania Avenue, N.W., Washington, DC 20037*; Michael D. Barnett, M.D.; David Alt, M.D.; Keith A. Shebairo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants will have an understanding of how daily group therapy of only a few days can benefit the patients.

SUMMARY:

Can daily group therapy be useful to patients only hospitalized for only a few days? Yes. Very much so.

The panel will summarize group therapy on a typical general psychiatric admission ward in which the majority of patients are on the ward less than a week, including the results of the group work as perceived by the patients. After the very brief overview, the panel will lead the workshop attendees through a discussion of the following topics: for which patients is group therapy indicated, for which patients is group therapy contraindicated, for which patients is group therapy used with caution, what are the techniques used in this brief form of therapy, and what are the typical themes one addresses in this brief form of therapy.

TARGET AUDIENCE:

All clinical professionals doing group work.

REFERENCES:

1. Yalom ID: The Theory and Practice of Group Psychotherapy. New York, Basic Books, 1985.
2. MacKenzie KR: Time-Limited Group Psychotherapy. Washington, DC, American Psychiatric Press, 1990.

Workshop 55 **Sunday, October 14 8:00 a.m.-9:30 a.m.**

CRIMINAL JUSTICE AND MENTAL HEALTH COLLABORATIONS IN COOK COUNTY, ILLINOIS

Thomas A. Simpatico, M.D., *Chief, Burrough of Chicago Network Manager, Chicago Read Mental Health Center, 4200 North Oak Park Avenue, Chicago, IL 60634*; Carl J. Alaimo, Psy.D.; Ronald Simmons, Psy.D.

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

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

REFERENCES:

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

Workshop 56 **Sunday, October 14 8:00 a.m.-9:30 a.m.**

THE ROLE OF CINEMA IN PSYCHIATRIC EDUCATION

Erika Wojciuk, M.A., *Department of Psychiatry, State University of New York Health Science Center at Brooklyn, 71 8th Street, Apt. 2-A, Brooklyn, NY 11217*; Babak Mirin-Babazadeghan M.D., Michael Berzofsky, Ph.D.; and Adam Stein, M.S.F.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the importance of films in psychiatric training.

SUMMARY:

The cinema represents a largely untapped resource in the education of psychiatric residents, medical students, and other health care professionals. While an innovative and enjoyable teaching tool, the cinema also represents a hotly debated source of knowledge in the field.

Several scholars have published works on the psychoanalytic study of film, promoting film as a valuable, but neglected educational medium. Through the cinema, individuals may practice and explore psychoanalytic methodologies, understand popular images of the mind and of the psychiatrist, shape their conduct as emerging professionals, and tap trends of cultural thought on notions such as family, violence, religion, race, and gender, to name just a few examples.

Nevertheless, the use of the cinema in medical education has its disadvantages. The motion picture industry has been a notorious source of *mis*information on mental illness and the psychiatric profession. Films such as Hitchcock's *Psycho* have conjured up some of the most enduring, frightening, and misleading images of mental illness in contemporary Western culture. Portrayals of psychiatrists in motion pictures have largely been limited to the thoroughly evil, the innocuously mad, or the unrealistically perfect. The implications of these depictions are significant and have been shown to negatively affect the doctor-patient relationship.

Participants of this workshop will be introduced to these current debates, assess the value of the cinema as a teaching tool, and discuss the role of psychiatrists in reconciling the constraints and considerations of filmmakers with ethical concerns and public accountability.

TARGET AUDIENCE:

Medical students, residents, and other mental health professionals

REFERENCES:

1. Schneider I.: The theory and practice of movie psychiatry. American Journal of Psychiatry 1987; 144(8):996–1002.
2. Gabbard GO, Gabbard K: Psychiatry and the cinema. Washington, DC, American Psychiatric Press, 1999.

Workshop 57 **Sunday, October 14**
10:00 a.m.-11:30 a.m.

CONSUMER-PROVIDER DIALOGUES IN QUALITY IMPROVEMENT PROCESSES

American Association of Community Psychiatrists

Wesley E. Sowers, M.D., *Medical Director, Allegheny County Office of Behavioral Health, and Clinical Associate Professor, Department of Psychiatry, University of Pittsburgh School of Medicine, 400 45th Street, Pittsburgh, PA 15201*; Kenneth S. Thompson, M.D.; Penny Pearlman

EDUCATIONAL OBJECTIVES:

To recognize alternative methods for consumer-provider interaction that foster greater understanding and collaboration in treatment planning, and to discuss how the dialogue process may be applied to quality-improvement activities.

SUMMARY:

Quality improvement processes often attempt to use client satisfaction measures to identify opportunities for improvement and to monitor outcomes of care. The value of these data is often limited by a lack of direct communication between the consumer of services and the provider. Misinterpretation of the meaning of such data is almost inevitable without direct connection and understanding. Consumer-provider dialogues are a method of enhancing and humanizing the relationship between these two groups and removing them from the context of power in which they normally occur. These dialogues foster a mutual understanding of each party's respective predicament and allow a greater level of understanding and collaboration to occur. In this workshop one group's experience in the development of consumer-provider dialogues on a regional basis will be described, and the evolution of these interchanges will be analyzed. Extending the dialogue process in the form of focus groups for use in quality-improvement activities in a regional public behavioral health delivery system and the barriers to doing so will then be considered. Participants will be encouraged to discuss their experiences in these processes.

REFERENCES:

1. Hannigan B, Bartlett H, Clilverd A: Improving health and social functioning: perspectives of mental health service users. Journal of Mental Health 1997; 6:613–619.
2. Conners NA, Franklin KK: Using focus groups to evaluate client satisfaction in an alcohol and drug treatment program. Journal of Substance Abuse Treatment, 2000; 18:313–320.

Workshop 58 **Sunday, October 14**
10:00 a.m.-11:30 a.m.

PERSONALITY DISORDERS IN HOMEBOUND AIDS PATIENTS

Lawrence B. Jacobsberg, M.D., Ph.D., *Team Psychiatrist, Community Mental Health Services, Visiting Nurse Service of New York, 220 East 63rd Street, New York, NY 10021*; Thomas Laverack, M.S.W.; Karen Decher, M.S.N.; David C. Lindy, M.D.; Neil Pessin, Ph.D.

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

Patients with HIV/AIDS are often homebound as a result of their illness. The Visiting Nurse Service of New York supports HIV-Mental Health Consultation Teams to provide consultation and liaison to the medical home care services of these patients. Formulation and execution of a treatment plan is often complicated by the presence of concurrent personality disorders, which often impede intervention with the patient.

We will review the systematically assessed Axis II diagnoses of 200 homebound AIDS patients referred to the HIV-Mental Health Consultation Teams over a two-year period. The problems experienced by medical staff related to the patients' Axis II diagnosis will be discussed as will the medical staff's looking to the consultation-liaison program to "fix" the immediate problem at hand. The presentation will contrast the home-care professional's perspective with that of the consultant, and the audience will be enlisted to provide supplementary examples from their own experiences of such "difficult patients".

By engaging a varied audience of caregivers, each of whom has unique clinical experiences, the presentation will expand the treatment repertoires of all participants.

TARGET AUDIENCE:

Psychiatrists, psychiatric nurses, and clinical social workers.

REFERENCES:

1. Jacobsberg L, Frances A, Perry S: Axis II diagnoses among volunteers for HIV testing and counseling. Am J Psychiatry 1995; 152:1222–4.
2. Perkins DO, Davidson EJ, Leserman J et al: Personality disorder in patients infected with HIV: a controlled study with implications for clinical care. Am J Psychiatry 1993; 150:309–15.

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