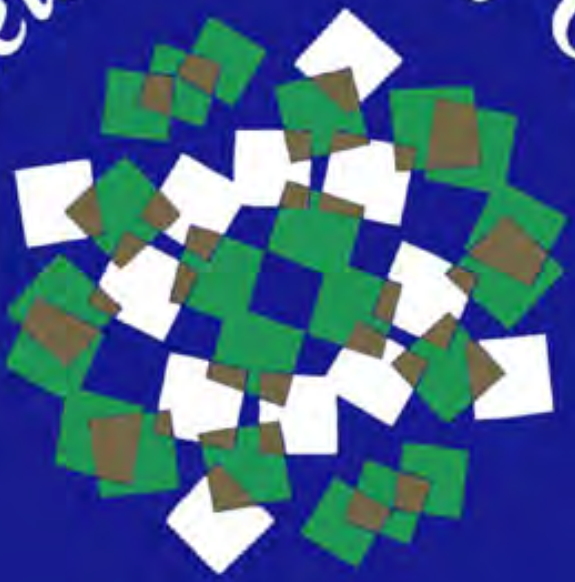
Kaleidoscope of Care



Clinical Advances
and
Research and Educational Excellence

50th Institute on Psychiatric Services

1998 Syllabus and Proceedings Summary

October 2-6, 1998 ◆ Los Angeles, CA

American Psychiatric Association

CERTIFICATE OF ATTENDANCE

This certificate provides verification of your completion of educational activities at the 1998 Institute on Psychiatric Services.

This is to certify that

_____

Attended the 1998 Institute on Psychiatric Services of the American Psychiatric Association
October 2-6, 1998
Los Angeles, CA

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

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Rodrigo A. Muñoz, M.D.
APA President

Steven M Mirin MD

Steven M. Mirin, M.D.
Medical Director

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

The APA designates this educational activity for up to 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 50th INSTITUTE ON PSYCHIATRIC SERVICES, OCTOBER 2–6, 1998, LOS ANGELES, CA

NOTE: 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 1998 INSTITUTE

The American Psychiatric Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education (CME) for physicians. The APA certifies that the continuing medical education activities designated as Category 1 for the 1998 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 which are 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, Lectures, Medical Updates, Multimedia Sessions, Symposia, and Workshops. Other Sessions, designated for Category 2 credit, include: 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 scientific sessions. To document that credit, participants should record the session(s) attended on the back page of the **Certificate of Attendance found on page ii, in the front of this book.** This Certificate is for your personal records and may be forwarded to other organizations requiring verification. Documentation of all CME credit is based on the honor system.

* * * * * * * * *

CME REQUIREMENTS FOR APA MEMBERS

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

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

In December 1983 the Board of Trustees ratified 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 California, Delaware, Florida, Georgia, Hawaii, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nevada, New Hampshire, New Mexico, Ohio, Rhode Island, or Utah, you may demonstrate that you have fulfilled your APA CME requirements by *sending the APA a copy of your reregistration of medical license.* These states have CME requirements for licensure that are comparable to those of the APA. Your APA certificate will be valid for the same length of time as the reregistration.

(Continued)

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

If you hold a current CME certificate from a state medical society having CME requirements comparable with those of the APA, you may receive an APA CME certificate by *sending the APA a copy of your state medical society CME certificate*. The APA will issue a CME certificate valid for the same period of time. The state medical societies currently having CME requirements comparable to those of the APA are 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, NW, Washington, DC 20005 or call (202) 682-6179 or filed electronically via the APA Home Page.

APA REPORT FORM

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

CATEGORY 1:

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

CATEGORY 2:

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

EXEMPTIONS

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

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

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

CONTINUING MEDICAL EDUCATION

SYLLABUS AND PROCEEDINGS SUMMARY

FOR THE

50th

INSTITUTE ON PSYCHIATRIC SERVICES

October 2–6, 1998

Los Angeles, CA

The American Psychiatric Association
Institute on Psychiatric Services
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Clinical Advances
and
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American Psychiatric Association

50th Institute on Psychiatric Services

October 2-6, 1998 ◆ Los Angeles, CA

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Course 1 **Friday, October 2**
8:00 a.m.-12 noon

HOW TO MEASURE OUTCOMES WITHOUT BREAKING THE BANK

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

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

This course is for mental health professionals wishing to learn about cost-effective outcomes 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, these are financially prohibitive for most clinicians. 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. No prior knowledge of this topic is required. The presentation is divided into four sections. The first, Basic Concepts, will outline quality improvement notions such as cycle of quality, efficacy, effectiveness, dimensions, motivation, methodology and outcome theory. The second section, Adult Outcome Tools, will review scales used to measure health/ function status (HSQ-12, GAS), symptoms (SCL-90, BPRS, Beck) and satisfaction (CSQ). The third section, Child Outcome Tools, will describe scales utilized with youngsters to determine general functioning (CBCL) and specific symptomatology (Conners, CDI). The purpose of the final section, Practicum, is to provide the audience an opportunity to apply principles learned during this course. This is a repeat of a course given last year. Format will include lecture and small-group discussion.

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. *Behav Health Tomorrow* 5:3;73-75, 1996.
2. Hunkeler EM, Westphal JR, Williams M: Developing a system for automated monitoring of psychiatric outpatients: a first step to improve quality. *HMO Pract* 9:4;162-167, 1995.

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

INTEGRATED MODELS FOR TREATMENT OF DUAL DIAGNOSIS

Kenneth Minkoff, M.D., *Medical Director, Choate Health Management, and Medical Director, Arbour-Fuller Hospital, 92 Montvale Avenue, Suite 3200, Stoneham, MA 02180*

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 disorder, and vice versa; 4) describe and implement a rational strategy for prescribing psychotropic medication to dual-diagnosis patients; 5) become familiar with clinical techniques to engage mentally ill patients to address substance disorder; and 6) describe integrated program models for treatment of dual diagnosis and the specific populations addressed by each model.

SUMMARY:

This course provides a brief overview of the problem of dual diagnosis, with specific emphasis on substance abuse and dependence among the seriously mentally ill. Barriers to the development of integrated treatment are described, which are followed by the presentation of an integrated disease and recovery model for both disorders that addresses those barriers. This model is then used to organize a structured approach to assessment, diagnosis and treatment. In this model, clinical interventions for this population can be individualized based on phase of recovery, diagnosis and level of acuity, severity, disability and motivation for treatment for each comprehensive dual-diagnosis system of care. Individual strategies of psychotherapeutic intervention, and integrated program models are described for each phase of recovery. Specific attention will be paid to the issue of psychopharmacologic management strategies for psychiatrically symptomatic patients who are also using substances.

Participants will be encouraged to discuss clinical and programmatic case problems to illustrate application of those principles. This is a repeat of a course given last year. Format will include lecture and discussion.

REFERENCES:

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

Course 3 **Friday, October 2**
1:00 p.m.-5:00 p.m.

COMPUTER SURVIVAL GUIDE '98

Robert S. Kennedy, M.A., *Director of Computer Operations, Department of Psychiatry, Albert Einstein College of Medicine, 1300 Morris Park Avenue, Room 402, Bronx, NY 10461;* Thomas A.M. Kramer, M.D., *Arkansas Mental Health Research and Training Institute, 4301 West Markham, Slot 766, Little Rock, AR 72205-7101*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should: 1) be familiar with the latest hardware and software as they meet the needs of the contemporary psychiatrist and 2) be able to identify and know the function of each of the physical components of computer hardware.

SUMMARY:

This course is designed as a primer in computers for the psychiatrist of the 20th and 21st centuries. The course will be organized into several segments. After a brief introduction to the use, power and future of computers in psychiatry and medical education, the course will include: 1) a review of the basics of hardware, the various components, and the most basic elements to the sophisticated interaction of hardware and software, including multimedia and virtual reality; 2) telecommunications via computer with discussion and a demonstration of the Internet, World Wide Web and other aspects of computer communications; and 3) the importance of software and how it can help the busy psychiatrist, including a demonstration of various software packages and a review of commercially available software, such as word processing and databases, and how today's psychiatrist can take advantage of them. The participants will also review some of the software programs available in psychiatry.

Format will include lecture and demonstrations with state-of-the-art computer hardware and software and a printed guide to computers. The course will be geared to the beginner but it will offer basic as well as sophisticated concepts to allow participants to address issues at their particular level of sophistication.

REFERENCES:

1. *Psychiatric Annals,* Using computers in psychiatry, 24:1, January 1994.
2. Baskin D: *Computer Applications in Psychiatry and Psychology.* Clinical and Experimental Psychiatry Monograph No. 2 Ed, Brunner/Mazel, New York, 1990.

Course 4 **Saturday, October 3**
8:00 a.m.-12 noon

COGNITIVE THERAPY FOR SEVERE MENTAL DISORDERS

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) utilize cognitive therapy (CT) interventions for inpatients; 2) apply cognitive therapy techniques to symptoms of psychosis and bipolar disorder; and 3) address treatment adherence problems using a cognitive therapy approach.

SUMMARY:

In recent years, cognitive therapy methods have been developed to meet the special needs of patients with chronic and severe psychiatric symptomatology. This course presents these newer cognitive therapy applications for the treatment of inpatients, individuals with bipolar disorder and those experiencing psychotic symptoms. Cognitive-behavioral conceptualizations and specific treatment procedures are described for these patient groups. Several modifications of standard cognitive therapy techniques are suggested for the treatment of severe or persistent mental disorders. Participants in this course will learn how to adapt cognitive therapy for patients with problems such as psychomotor retardation, paranoia, hypomania and nonadherence to pharmacotherapy recommendations. Cognitive therapy procedures are illustrated through case discussion, role plays, demonstrations and videotaped examples. Worksheets that can facilitate application of cognitive therapy techniques will be provided. Participants will also have the opportunity to discuss application of cognitive therapy for their own patients. This is a repeat of a course given last year. Format will include didactic presentations, workshop experiences including videotape illustrations. This is an

intermediate course. Participants should have completed an introductory cognitive therapy course.

REFERENCES:

1. Basco MR, Rush AJ: *Cognitive Behavioral Therapy for Bipolar Disorder.* New York, Guilford Press, 1996.
2. Basco MR, Rush AJ: Compliance with pharmacotherapy in mood disorders. *Psychiatric Annals* 25:269-279, 1995.

Course 5 **Saturday, October 3**
8:00 a.m.-12 noon

BRIEF PSYCHODYNAMIC PSYCHOTHERAPY: THE CORE CONFLICTUAL RELATIONSHIP THEME (CCRT) METHOD

Howard E. Book, M.D., *Director, Brief Psychotherapy Training Program, University of Toronto, Coordinator, Brief Psychotherapy Training Program, Clarke Institute, and Associate Professor, University of Toronto, 2900 Yonge Street, Suite 101, Toronto, Ontario, Canada M2H 2L7*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) list defining characteristics of brief psychodynamic psychotherapy (BPP); 2) differentiate BPP from emergency, crisis and long-term psychotherapies concerning goals, frequency, duration and therapist activity; 3) list inclusion criteria for brief psychodynamic psychotherapy; 4) develop a core conflictual relationship theme focus for any patient; and 5) summarize the defining charac-teristics of the beginning (sessions 1-4), middle (sessions 5-11) and termination (sessions 12-16) phases of the 16 session CCRT method of BPP.

SUMMARY:

This interactive, participant-oriented course offers psychotherapists an in-depth introduction to the CCRT method of brief (16 sessions) psychodynamic psychotherapy (BPP). Initially articulated and researched by Professor Lester Luborsky, the CCRT method of BPP has as its goals symptom relief and limited but significant character change. The course begins with comparing and contrasting BPP with other time-limited psychotherapeutic interventions: crisis, emergency and long-term psychotherapies. It then defines BPP with respect to goals, frequency and duration of sessions and time limit, and then underlines the crucial importance of developing a circumscribed area of a patient's interpersonal difficulties on which treatment will focus. The major component of this course emphasizes an easily operationalized, step-by-step method of developing the CCRT. Participants have an opportunity to develop CCRTs from typed patient transcripts, audiotapes of a patient's psychotherapy session and videotapes of a (simulated) patient interview. The final section of this course illustrates how the CCRT focus is psycho-therapeutically addressed during the beginning, middle and termination phases of the 16 session BPP. Format will include lecture, clinical vignettes, small-group discussion, audio and videotaped transcripts, and handouts.

REFERENCES:

1. Anderson EM, Lambert MJ: Short-term dynamically-oriented psychotherapy: a review and meta-analysis. *Clinical Psychology Review* 15, 503-514, 1995.
2. Book HE: *How to Practice Brief Psychodynamic Psychotherapy: The CCRT Method.* Washington, D.C., American Psychological Association, 1997.

Course 6 **Saturday, October 3**
9:00 a.m.-4:00 p.m.

ASSESSING THREATS AND VIOLENCE AT HOME AND WORK

James R. Missett, M.D., *Department of Psychiatry, Stanford University, 1187 University Drive, Menlo Park, CA 94025*; Paul S.D. Berg, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) identify elements of a threat; 2) distinguish among obligations to the threatener, harasser or domestic abuser to the victim and employer in the case of workplace threats; 3) understand the legal ramifications of any actions taken by the psychiatrist; and 4) competently assess, treat and consult in domestic and workplace violence situations.

SUMMARY:

Psychiatrists are seeing increasing numbers of patients who report being the victims of threats or violence at home and work. Alternatively, psychiatrists may be asked to evaluate, treat or consult about the person accused of threatening and/or violent behavior. Each of these assessments, treatments and consulting situations present special professional, ethical and legal considerations. This course focuses on practical strategies for the individual psychiatrist to use in approaching such evaluation, treatment or consulting situations. A psychologist will review, through a slide presentation, various ways to approach assessing, treating or consulting about individuals who are the victims of threats and violence at home or at work. A forensic psychiatrist will discuss the legal ramifications of evaluation in, and consulting about, threats and violence. A detailed review

of the various elements involved in an assessment of verbal threats and actual dangerousness will be done. The course will conclude with a class analysis of various case studies to put the points previously covered into practice. Handouts will accompany each presentation and be keyed to each topic. Format will include lectures, slides, videotapes, question-and-answer sessions and case presentations.

REFERENCES:

1. Ammerman R, Hersen M: *Assessment of Family Violence.* New York, John Wiley & Sons, 1992.
2. Ammerman R, Hersen M: *Treatment of Family Violence.* New York, John Wiley & Sons, 1990.

Course 7 **Saturday, October 3**
1:00 p.m.-5:00 p.m.

MANAGING MANAGED CARE IN PUBLIC HOSPITALS

Donna M. Moores, M.D., *Vice Chairperson and Chief of Psychiatry, Boston Medical Center, ACC 4S, One BMC Place, Boston, MA 02118*; Douglas H. Hughes, M.D., E. Samuel Rofman, M.D., Peggy L. Johnson, M.D., Janet E. Osterman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) understand the clinical, financial and political forces that have driven the move to managed behavioral health care; 2) assess the impact of managed care on public hospitals; 3) anticipate changes in local public systems of behavioral health care; 4) prepare services and staff for such changes; and 5) implement strategies to promote excellent clinical care while meeting the guidelines put forth by managed care entities.

SUMMARY:

Managed care has significantly altered clinical practices and the way behavioral health services are provided in the private sector. Increasingly, it is also affecting the way these services are provided at the city, county, state and federal levels. This course will provide rich background material describing the forces that have led to these changes both in the private and public sectors. Data will be presented regarding: 1) trends in privatization of public hospitals; 2) increased use of diversionary services and closing of inpatient beds, 3) costs of care and shifting payer streams, 4) external monitoring of treatment; and 5) implementation of treatment guidelines such as InterQual standards. Practical implementation techniques, general policies and procedures, service and staff management approaches, and service design will be presented. Faculty will also share both positive and negative experiences in dealing with these challenging changes in public hospitals and systems of care. Format will include audiovisual-enhanced lectures and group discussion.

TARGET AUDIENCE:

Administrators, program managers and clinicians in public hospitals providing behavioral health services.

REFERENCES:

1. Bachman, SS: Why do states privatize mental health services? six state experiences. *Journal of Health Politics, Policy and Law* 21:807-824, 1996.
2. Bachrach LL: The state of the state mental hospital in 1996. *Psychiatric Services* 47:1071- 1077, 1996.

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

COMPUTER-ASSISTED DIAGNOSTIC INTERVIEW

Paul R. Miller, M.D., *Associate Clinical Professor of Psychiatry, Valley Care Olive View Medical Center, 14445 Olive View Drive, Sylmar, CA 91342-1495*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, participants should be able to use the Computer-Assisted Diagnostic Interview (CADI) program to: 1) conduct an initial diagnostic interview that collects a database sufficient to evaluate all major adult diagnostic groups; 2) process the database so that all declared diagnoses meet DSM-IV algorithmic requirements; 3) perform a complete differential diagnosis; 4) use the computer or associated hardcopy protocols to assist in all the above; and 5) evaluate how the CADI can be used in clinical work and research.

SUMMARY:

CADI uses the computer to assist and enhance the collection of a database sufficient to achieve accuracy and completeness and then processes the database automatically for DSM-IV diagnosis. The course will 1) show the need for CADI, and describe research findings that demonstrate how the traditional diagnostic interview frequently makes incorrect or incomplete diagnoses; 2) review the operation, advantages and disadvantages of computer assistance in diagnostic interviewing; 3) demonstrate a live CADI interview/assessment of a patient (role-played by a colleague) as participants simultaneously evaluate and record their findings; and 4) analyze and discuss the process and the participants' findings in the CADI interview.

Format will include discussions prompted by slides and a simulated interview. Participants are encouraged to use a laptop computer or a hardcopy of the protocols will be provided. (Please use battery as no electricity will

be available.) Software and protocols will be provided by the presenter. This is an intermediate course. Participants should be familiar with DSM-IV and interviewing techniques. No special computer knowledge or skills are required.

REFERENCES:

1. American Psychiatric Association. *Diagnostic and Statistical Manual, 4th ed.* Washington, D.C., American Psychiatric Association, 1994.
2. American Psychiatric Association. *DSM-IV Sourcebook, Volume I.* Washington, D.C., American Psychiatric Association, 1994.

Course 9 **Sunday, October 4**
8:00 a.m.-12 noon

TREATMENT ISSUES FOR WOMEN IN MINORITY GROUPS

Joint Session with the California Psychiatric Association

Susan R. Downs, M.D., *Assistant Clinical Professor, Department of Psychiatry, University of California at San Francisco, 1537 Bonita Avenue, Berkeley, CA 94709*; Michelle O. Clark, M.D., Ellen Haller, M.D., Elisabeth C. Small, M.D., Eleanor Valdes Dwyer, M.S.W., L.C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be more sensitive to the multiple issues encountered when dealing with women who are members of minority groups.

SUMMARY:

There will be four presentations in this course. The first presentation, *Diagnostic and Treatment Issues for African-American Women,* will describe key issues in the prevalence, presentation and perception that affect diagnosis of major psychiatric illnesses in African-American women. Factors impacting treatment will be discussed, including the combined impact of gender and ethnicity on psychopharmacology. The second presentation, *Issues in Psychotherapy for Asian Women,* will discuss the Asian attitudes toward mental disorders, coupled with racial and ethnic discordance between therapist and patient, which can lead to resistance and noncompliance, and hinder the psychotherapeutic process. The third presentation, *Hispanic/Latinas,* will address gender roles and expectations commonly encountered. Clinical strategies will be presented that will allow the clinician to elicit the particular values of the patient and discuss ways in which these values are molded by the forces of socioeconomic class, gender preference, age, acculturation and the individual woman's psychosocial reality. The final presentation, *Unique Issues for Lesbians and Bisexual Women,* will discuss the coming-out process, relationship dynamics unique to same sex couples and parenting issues for lesbians and bisexual women. Format will include lectures and small-group discussions.

TARGET AUDIENCE:

Psychiatrists and mental health professionals.

REFERENCES:

1. Cass V: Homosexual identity formation: a theoretical model. *J. Homosex* 4:219-235, 1979.
2. Sorensen L, Roberts SJ: Lesbian uses of and satisfaction with mental health services: results from Boston lesbian health project. *J. Homosex* 33:35-49, 1997.

Course 10 **Sunday, October 4**
9:00 a.m.-4:00 p.m.

ASSESSMENT AND TREATMENT OF PATIENTS WITH MENTAL RETARDATION

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to arrive at accurate and comprehensive psychiatric diagnosis (or diagnoses) for persons with developmental disabilities, and devise successful comprehensive treatment plans that use a wide variety of treatment modalities.

SUMMARY:

Persons with developmental disabilities (mental retardation, autism and others) present a complex, fascinating and potentially rewarding challenge for psychiatrists, mental health professionals and the system. This course will illustrate methods of accurate psychiatric diagnosis, comprehensive medical and behavioral assessment and updated information on pharmacologic and nonpharmacologic treatments. Principles of successful rehabilitation require a team-oriented multidimensional approach, which will be emphasized. Material discussed will be relevant to any setting. Videotapes, case examples and review of relevant literature will be included. Audience examples, questions and discussion are strongly encouraged. This is a repeat of a course given last year.

REFERENCES:

1. Aman MG: Drugs and learning in mentally retarded persons. *Advances in Human Psychopharmacology,*

JAI Press (delete Breuning studies; have been retracted), 1984.
2. Carter G, et al: Mortality in the mentally handicapped: a 50 year survey at the Stroke Park group of hospitals (1930 - 1980). *The Journal of Mental Def Research* 27:143-156, 1983.

Course 11 **Sunday, October 4**
1:00 p.m.-5:00 p.m.

PROMOTING STAFF DEVELOPMENT AND AVOIDING BURNOUT

Lily Awad, M.D., *Assistant Professor of Psychiatry, Department of Psychiatry, Boston University School of Medicine, 150 Huntington Avenue, # 12C, Boston, MA 02130*; Domenic A. Ciraulo, M.D., Douglas H. Hughes, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) identify signs of professional burnout in their faculties; 2) have an appreciation of possible ameliorating measures; and 3) identify means to promote the academic and nonacademic careers of their staff.

SUMMARY:

This course will focus on various means to promote staff development and discuss situations and stressors that can adversely affect staff performance. Dr. Hughes will review the literature and practical guidelines to help managers identify and address staff burnout. Interventions that enhance workgroup autonomy and provide opportunities for professionals to use their skill while developing their competence may help reduce burnout. Dr. Ciraulo will discuss how substance abuse may contribute to or possibly be a symptom of emotional burnout in staff. Traditionally this has been a highly sensitive area to even discuss, much less confront in the workplace environment. Some subtle signs of substance abuse and measures to address them gently, but effectively, will be reviewed. Format will include lectures with slide presentations, discussion and question-and-answer session.

REFERENCES:

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

Course 12 **Monday, October 5**
8:00 a.m.-12 noon

EVALUATING COMPETENCE IN THE ELDERLY

David Naimark, M.D., *Assistant Clinical Professor, Department of Psychiatry, University of California at San Diego, 220 West Broadway, Room 1003, San Diego, CA 92101*; Ansar M. Haroun, M.D., *Associate Professor of Psychiatry, University of California at San Diego, 5475 Bragg Street, San Diego, CA 92122-4103*; Marc Hankin, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) evaluate, report and testify in civil and criminal geriatric cases involving competencies and dangerousness; 2) utilize an empirically-based approach to geriatric forensic evaluations; and 3) be familiar with common pitfalls that can sabotage effective work with the elderly.

SUMMARY:

As the population ages, geriatric psychiatrists will perform an increasing number of civil and criminal evaluations on older persons. This course (taught by a geriatric psychiatrist and a forensic psychiatrist) will teach the participant an advanced method of evaluating, reporting and testifying in forensic geropsychiatric cases. The first section of the course will focus on civil issues. The *Due Process in Competence Determinations Acts (SB 730)* will be presented. This legislation puts scientific standards into the law for the determination of who is competent to consent to medical treatment, enter into contracts, sign trust agreements, make gifts, sign wills, marry and perform other acts. We will clarify the "data sets" and "cognitive pipes" required for assessment of these competency issues. The audience will learn how to translate the results of the evaluation into an empirically-based report. In an interactive fashion, the class will analyze two forensic reports for their strengths and weaknesses. A discussion of common pitfalls in expert testimony during geriatric cases will help ensure that the course participants may always "sparkle on the stand." The second section of the course will focus on criminal issues. The audience will be introduced to an instrument used in conducting an evaluation of dangerousness in the older felon. This instrument integrates key biological, psychological and social issues in the elderly. The audience will analyze key biological, psychological and social issues in the elderly. Criminal topics to be covered include prediction of dangerousness, disagreement around dangerousness assessments, causes of dangerousness and synthesis of data into a forensic formulation. Format will include lectures and exercises analyzing clinical vignettes and actual forensic reports.

TARGET AUDIENCE:

General psychiatrists, geriatric psychiatrists and forensic psychiatrists

REFERENCES:

1. Grossberg GT, Zimny GH: Medical legal issues. *Comprehensive Review of Geriatric Psychiatry II.* Edited by Sadavoy J, Lazarus LW, Jarvik LF. Washington D.C., American Psychiatric Press Inc., 1996.
2. Rosner R, Wiederlight M, Harmon RB, Cahn DJ: Geriatric offenders examined at a forensic psychiatry clinic. *Journal of Forensic Services* 36:1722-1731, 1991.

Course 13 **Monday, October 5**
8:00 a.m.-12 noon

CLINICAL MANAGEMENT OF VIOLENT PATIENTS IN THE EMERGENCY ROOM

American Association for Emergency Psychiatry

Janet S. Richmond, M.S.W., *Director of Psychiatry Emergency Service, Boston Veterans Affairs Medical Center, 150 South Huntington Avenue, 116A, Boston, MA 02130*; Rachel L. Glick, M.D., Karen K. Milner, M.D., Michael H. Allen, M.D., James R. Hillard, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) treat a variety of violent and threatening patients safely within an acute setting and 2) obtain practical clinical strategies and theory pertaining to the management of these patients.

SUMMARY:

Violence can be an unpredictable event in an acute setting and puts patients and staff at risk for physical and emotional trauma. This course is intended for the clinician who works in such an acute setting. The course will offer practical clinical strategies for early detection and acute clinical management of the violent patient. Since aggression may occur in a variety of psychiatric conditions, ranging from the psychoses to nonpsychotic disorders, attention will be paid to general behavioral methods that can lead to successful deescalation for a variety of violent patients. A theoretical review will be provided as well as discussion of psychopharmacologic interventions, including the use of the new-generation antipsychotics in the management of violence. Legal considerations regarding restraint and civil commitment will be examined. Format will include lecture and small-group discussion.

TARGET AUDIENCE:

Front-line clinical staff in emergency rooms and other acute settings.

REFERENCES:

1. Anderson AA, Ghali AY, Bansil RK: Weapon carrying among patients in a psychiatric emergency room. *Hospital and Community Psychiatry* 40(8):845-847, 1989.
2. Blumenreich PE, Lewis S: Managing the violent patient: a clinician's guide. New York, *Brunner/Mazel, Inc.*, 1993.

Course 14 **Monday, October 5**
9:00 a.m.-4:00 p.m.

LEARN TO BUILD ELECTRONIC MEDICAL RECORDS

Daniel A. Deutschman, M.D., F.A.P.A., *Medical Director of Behavioral Health, SW General Health Center, Cleveland, OH, and Associate Clinical Professor, Case Western University School of Medicine, 7255 Old Oak Boulevard, Middleburg Heights, OH 44130*; Beth A. O'Toole, M.A., Victoria White, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to understand: 1) how electronic medical records can enhance quality of care and office efficiency; 2) how they are designed and built; 3) what elements should be present; 4) where to get assistance in building such systems; and 5) how building your own personal electronic medical records allows continuous iteration and improvement.

SUMMARY:

This course will teach psychiatrists having no computer sophistication how to begin to build electronic medical records (EMR) or use them with their patients. The instructor, a practicing psychiatrist, developed such a system in 1995. The database has since grown to include more than 10,000 records from clinical visits with patients. The EMR facilitates assessment, diagnosis, treatment and research. It improves practice management and the quality of clinical records. Participants will learn the fundamentals of designing and building EMR. They will learn to build tables, queries, data entry forms and look-up tables. Developing prescriptions, lab test requests and medication trial reports will also be discussed. The format will be interactive, with ample time for questions and answers. A mature electronic medical record system will be demonstrated. Costs for software, hardware and time to program the EMR will also be discussed. Instructional resources will be described

which will allow participants to develop electronic medical record systems on their own. Clinicians learning to build EMR are in a position to continually upgrade and strengthen their systems which further enhances the quality of patient care. Format will include lecture, workshop and videotapes. This is a basic course.

TARGET AUDIENCE:

Practicing physicians.

REFERENCES:

1. Allen SI, Johannes RS, et al: Prescription-writing with a PC. *Computer Methods and Programs in Biomedicine* 22:127-135, 1986.
2. Modai I, Rabinowitz J: Why and how to establish a computerized system for psychiatric case records. *Hosp Community Psychiatry* 44:1091-1095, 1993.

Course 15 **Monday, October 5**
1:00 p.m.-5:00 p.m.

DEALING WITH RESISTANCE IN ADDICTION PATIENTS

David Mee-Lee, M.D., *DML Training and Consulting, 3725 Lillard Drive, Davis, CA 95616-5071*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) understand how clinicians can improve their method of dealing with resistance in addiction patients; 2) learn new skills in the assessment and treatment of resistance; and 3) identify ways to transform programs and policies to improve treatment effectiveness and efficiency.

SUMMARY:

Denial and resistance are expected features of many addiction patients' presentations. Yet the strategies to deal with resistance have traditionally been education, confrontation and intensive, inpatient services. As the number of individuals under managed care grows, reimbursement and funding increasingly emphasize outpatient treatment. This compels the field to rethink how to deal with patient resistance and engage a person into treatment and recovery in an environment of shrinking resources, greater security and more accountability. This course is designed to help clinicians and care managers improve assessment and treatment of resistance in addiction patients and become better acquainted with models of 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 also discuss the changes needed to reconfigure treatment services to better match patients' readiness to change. This course will review the staff and program changes needed to better develop specific matching of treatment site and plan. Format will include lecture, slides and overheads, role play, discussion and question-and-answer sessions.

TARGET AUDIENCE:

Clinicians, care managers, clinical supervisors and medical directors.

REFERENCES:

1. American Society of Addiction Medicine. *Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition (ASAM PPC-2). Chevy Chase, MD, American Society of Addiction Medicine, 1996.*
2. *Assessing Alcohol Problems - A Guide for Clinicians and Researchers.* Eds. Allen JP, Columbus M. National Institutes on Alcohol Abuse and Alcoholism, Treatment Handbook Series 4. National Institutes of Health Publication No. 95-3745, 1995.

Course 16 **Tuesday, October 6**
8:00 a.m.-12 noon

PSYCHIATRY AND PRIMARY CARE: SHARING CARE

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) understand the role of the family physician in delivering community mental health care and the principles underlying shared care and 2) work collaboratively and effective 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 presents 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 reviews the prevalence, presentation and management of mental health problems in primary care and problems in the relationship between psychiatry and primary care. It outlines principles to guide shared mental health care and presents three different sets of implementation strategies aimed 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 are discussed. Finally, the course offers 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. This is a repeat of a course given last year. Format will include small-group workshops.

TARGET AUDIENCE:

Mental health providers, especially psychiatrists.

REFERENCES:

1. Coyne J, Fechner-Bates S, Schwenk T: Prevalence, nature and comorbidity of depressive disorders in primary care. *General Hospital Psychiatry* 16(3):267-276, 1994.
2. Craven M, Kates N: Assessment of family physicians' knowledge of social and community services. *Can Fam Physician* 36:443-447, 1990.

Debate 1 **Saturday, October 3**
8:00 a.m.-9:30 a.m.

SHOULD CLINICAL TRAINING IN LONG-TERM PSYCHODYNAMIC PSYCHOTHERAPY BE MANDATORY IN RESIDENCY TRAINING?

Harvey Bluestone, M.D., *Member, Institute Scientific Program Committee, and Professor of Psychiatry, Albert Einstein College of Medicine, 1285 Fulton Avenue, Bronx, NY 10456-3401;* Norman A. Clemens, M.D.; Arthur T. Meyerson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to explore the rationale for the requirement of clinical experience in psychoanalytic therapy; and prove that the rationale is flawed and that alternative approaches to training residents would better serve them and the field.

NEGATIVE SUMMARY:

The question of whether or not clinical experience in psychoanalytic psychotherapy should be a requirement of residency hinges on several related questions. Has long-term dynamic therapy sufficiently proven itself a valid medical treatment? Do residents graduate with this skill at a level suitable to practice? If not, why not? Does the experience provide residents with an essential set of tools that is generalizable to all treatment (an assertion often made by proponents)? Finally, why, given the poverty of sustainable intellectual evidence to support the requirement, do so many still argue for its inclusion or expansion? The negative case will be compellingly made.

AFFIRMATIVE SUMMARY:

Long-term psychodynamic psychotherapy is a fundamental skill of psychiatric practice. Psychiatric residents must have the opportunity to work with patients once or twice a week for a year or more, using free-associative interview techniques in a relatively open-ended structure, paying close attention to transference and countertransference phenomena. Only thus can they gain more than a cursory intellectual knowledge of unconscious mental processes, the impact of early life experiences, ego defenses and adaptations, and the force of instincts and the superego in a longitudinal view of the person. Crucially, residents must experience and learn to manage constructively the emotional impact of an in-depth treatment relationship.

Experience in long-term psychotherapy is the foundation for skill in flexible, short-term, individualized psychotherapy. It allows discerning assessment and focused treatment planning based on a rich awareness of psychodynamic processes. Psychodynamic principles influence the conduct of cognitive-behavioral and interpersonal psychotherapies, which were originated by therapists with a psychodynamic foundation. In-depth psychodynamic experience provides guidance and direction when patients fail to respond to time-limited methods or personality variables complicate treatment.

Psychiatric psychotherapy without this experiential foundation is comparable to psychiatric psychopharmacology without knowledge of neurotransmitters and pharmacodynamics. The pressures of managed care and a busy, fractionated residency curriculum must not be allowed to undermine the fundamentals.

REFERENCES:

1. Essentials and Information Items, ACGME, American Medical Association 1997-98; p 266.
2. Kaplan HI, Sadock BJ: The comprehensive textbook of Psychiatry/VI. Williams and Wilkins 1995; Chapter 53, p 2784.

Debate 2 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

DISSOCIATIVE IDENTITY DISORDER: IS IT TIME TO PULL THE PLUG?

Louis Jolyon West, M.D., *Professor of Psychiatry, University of California at Los Angeles School of Medicine, 760 Westwood Plaza, Los Angeles, CA 90024-8300;* Stephen S. Marmer, M.D.; John I. Hochman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand the nature of dissociative disorders and their prevalence worldwide. Dissociative identity disorder, under present or prior terminology, has appeared in every DSM edition. This long-standing, chronic post-traumatic adaptation to trauma, with ongoing validity today, was one of the earliest mental illnesses to be studied scientifically.

NEGATIVE SUMMARY:

Dissociative identity disorder (DID) was first described in 1781, two hundred years before borderline personality disorder was introduced. Among those writing about DID were Benjamin Rush, Morton Prince, Charcot, Janet, Breuer, and Freud. DID has been reported in North America, Asia, Pacific Islands, Turkey, the Netherlands, and the Caribbean. DID, under its present or prior terminology, has appeared in every edition of the DSM. Straw man arguments will not take away from the fact that dissociation is a psychological defense mechanism, and that DID is a chronic, post-traumatic adaptation to early trauma. Why is DID, a condition with one of the longest continuous histories of any men-

tal illness, singled out for attack on the grounds of whether one "believes" in it or not? We should instead remain within a scientific perspective to understand mental phenomena, whether they make us comfortable or not.

AFFIRMATIVE SUMMARY:

Dissociative identity disorder is an artifact, and not a mental disorder that occurs "in nature." The recent "epidemic" of DID is due to a combination of media influence, social (including therapist) expectation, and aggressive use of suggestive techniques (i.e., hypnosis). This "epidemic" has resulted in unneeded suffering by thousands of DID patients (mostly women).

REFERENCES:

1. Piper A: Multiple personality disorder. Br J Psychiatry 1994; 164(5):600-12.
2. Merskey H: The manufacture of personalities. The production of multiple personality disorder. Br J Psychiatry 1992; 160:327-40.
3. Putnam HW: Dissociation in children and adolescents: a developmental perspective, The Guilford Press New York, 1997.
4. West LJ: Dissociative reaction, in Comprehensive Textbook of Psychiatry, Chapter 23.3:885-899. Edited by Freedman A, Kaplan: The Williams & Wilkins Company, Baltimore, Maryland, 1967.

Full-Day Session 1 **Friday, October 2**
8:30 a.m.-5:00 p.m.

PSYCHIATRIC ASPECTS OF HIV/AIDS AMONG WOMEN

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

Francine Cournos, M.D., *Professor of Clinical Psychiatry, Columbia University, 722 West 168th Street, Unit 12, New York, NY 10032*; Marshall Forstein, M.D.; Joyce Hunter, D.S.W.; Meg Kaplan, Ph.D.; Rich Herman, M.A.; Vivian Brown, Ph.D.; Tom Donohoe, M.B.A.; Cynthia J. Telingator, M.D.; Helen Rodriquez-Trias, M.D.; Mari Radzik, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the epidemiology of HIV among women; recognize women's HIV risk factors; identify appropriate interventions; and diagnose and treat HIV-related complications within the context of mental health care.

SUMMARY:

The sub-epidemic of AIDS among women continues to grow. According to the Centers for Disease Control and Prevention, from 1985 through 1996, the proportion of adolescent/adult women reported with AIDS increased steadily each year, from 7% to 20% of reported cases. Currently, AIDS is the third leading cause of death among women ages 25-44. This program will review all facets of HIV/AIDS among women and present ways to stem the epidemic and treat those affected by it.

The morning plenary includes an overview of HIV/AIDS epidemiology and risk behavior among women, research-based findings concerning prevention models and HIV among women with severe mental illness, and an HIV + consmer's perspective on treatment and service options and access to health care. The plenary will be followed by small-group workshop sessions that will provide participants with state-of-the-art, hands-on skills in specific areas including medical and neuropsychiatric manifestations of HIV in women, multicultural aspects, HIV prevention for women in psychiatric settings, services for HIV-infected women and HIV-infected families, and prevention and treatment strategies for substance using women.

Presenters include nationally recognized experts in mental health manifestations of HIV/AIDS who will share their experiences and the most up-to-date information and resources available.

TARGET AUDIENCES:

Mental health care providers, students, consumers, caregivers.

REFERENCES:

1. Fauthfull J: HIV+ and AIDS-infected women, *American Journal of Orthopsychiatry*, Jan 1997; 67(1): 144–51.
2. Hackl KL, et al: Women living with AIDS, Health Social Work, Feb 1997, 22(1):53-62.
3. Lechky O: Multiculturalism and AIDS, *Canadian Medical Assoc. Journal*, May 15, 1997; 156(10): 1446.
4. Moneyham L, et al: Perceptions of stigma in women infected with HIV. *AIDS Patient Care and STDS*, June 1996; 10(3): 162–67.

Full-Day Session 2 **Sunday, October 4**
8:30 a.m.-5:00 p.m.

SYSTEMS OF CARE: FUTURE OF CHILD MENTAL HEALTH

American Association of Community Psychiatrists and the American Academy of Child and Adolescent Psychiatry.

Andrés J. Pumariega, M.D., *Professor and Chairman, Department of Psychiatry and Behavioral Sciences, James H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70567, Hillrise Hall, Johnson City, TN 37614-9567*; Nancy C. Winters, M.D.; Mary Jane England, M.D.; Graeme Hanson, M.D.; Larry S. Marx, M.D.; Theodore Fallon, M.D.; Katherine E. Grimes, M.D.; Andrea J. Eberle, M.D.; Michael M. Faenza, M.S.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) understand the application of the community-based system of care model of children's mental health in public systems of care; (2) help participants define the role of child and adolescent psychiatrists in such systems of care; (3) be familiar with the principles of community-based systems of care for children's mental health in managed behavioral health, systems for youth in the juvenile justice system, and integrated primary care/mental health systems; and (4) to assist participants in applying concepts of outcome evaluation and critical pathways in such systems of care.

SUMMARY:

The rapid change in community mental health from a traditional clinic-and-outreach model to community-based systems bypassed much of child and adolescent psychiatry. This left its practitioners at a loss on how they

can re-integrate themselves into these rapidly evolving systems. Managed behavioral health care is adopting aspects of the community-based systems model in its development of private and public service systems as the next step in the evolution of mental health services. Therefore, child and adolescent psychiatry and child mental health in general need to become conversant in this model in order to ensure its relevance into the 21st century. We will present the conceptual framework for the community systems of care model and its increasing application in managed behavioral health care, community clinical practice, training, and research. Additionally, we will present applications of this model in critical areas facing mental health professionals and society at large, including consumer and family needs, youth violence, and the integration of physical and mental health services. If child psychiatrists embrace this model and develop their roles and functions within these merging systems, our relevance and centrality as a clinical and scientific specialty will be secured into the 21st century.

REFERENCES:

1. Small, B., Friedman, R: *Community-Based Sys of Care for SED Children.* Wash, DC–CASSP Tech Com. 1986.
2. Pumariega, AJ, et al: *Best Principles for Managed Medicaid RFP's*, Wash, DC—AACAP, 1996.
3. Pumariega, AJ, et al: *Guidelines for Training C&A Psych in Sys of Care.* Wash, DC—AACAP, 1996.
4. Waters, N, et al: *Best Princples for Outcome Eval for Managed Medicaid*, Wash, DC, AACAP, In press.
5. Pumariega, AJ, et al: Community-Based Systems of Care. J. Am Assoc Acad Min Phys. Oct. 1997.

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

LIVES OF LESBIANS AND GAY MEN: WHAT YOU MUST KNOW

Southern California Psychiatric Society and the Assocation of Gay and Lesbian Psychiatrists

Daniel E. Fast, M.D., *Assistant Clinical Professor, Department of Psychiatry and Biobehavioral Science, University of California at Los Angeles, and Chairman, Department of Psychiatry, Saint John's Health Center at Santa Monica, 2901 Wilshire Boulevard, #431, Santa Monica, CA 90403-4903*; Diana C. Miller, M.D.; Norman B. Hartstein, M.D.; Judd Marmor, M.D.; Stanley E. Harris, M.D.; Larry Sperber; Lynette Sperber; Mary Andres, Psy.D.; Pat Alford-Keating, Ph.D.; John R. Sealy, M.D.; Robert Paul Cabaj, M.D.; Duane E. McWaine, M.D.; Gene A. Nakajima, M.D.; Keith W. Young, M.D.; Thomas F. Newton, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will demonstate a working knowledge of the issues facing gay, lesbian, and bisexaul patients, from adolescence through adulthood, including developmental, family, cultural, and ethnic minority issues; substance abuse; biological theories of homosexuality; effects of the HIV epidemic; and sexually compulsive behavior.

SUMMARY:

As psychiatry re-examines itself at the end of the 20th century, increasing attention is being paid to the developmental and psychological differences of previously little-studied groups. This full-day session will increase your knowledge and skills in working with gay, lesbian, and bisexual (GLB) patients. Our faculty of experienced clinicians will present in lectures, videotapes, panels, and small groups with time for interaction and questioning of specific practical issues.

Attendees will develop greater understanding of the following: Developmental stages of awareness of sexual orientation ("coming out") in adolescence and young adulthood. Concepts of "heterosexism." "homophobia," and their societal (external) and psychological (internal) manifestations. Early attitudes of children toward sexual orientation. Results and implications of current biological research into theories of the etiology of homosexuality. The impact of substance abuse on GLB individuals and their community as well as appropriate interventions. Special challenges facing bisexual individuals. Countertransference and problematic assumptions in working with GLB patients. Additional burdens faced by GLB members of ethnic, racial, and cultural minorities. The "gayby" boom of GLB parenting and new types of families. The epidemic of sexually compulsive behavior among gay men. The tremendous impact of the HIV/AIDS epidemic on the GLB community.

TARGET AUDIENCE:

Practicing psychiatrists and psychotherapists.

REFERENCES:

1. Cabaj, R, Stein, TS, Eds: *The Textbook of Homosexuality and Mental Health.* Appl, 1996.
2. Seidman, SN, Rieder, RO: *A Review of Sexual Behavior in the United States.* Am J Psych 1994; 151: 330–341.
3. Gender & Psychoanalysis. Int'l. Univ. Press (quarterly).
4. Journal of Gay and Lesbian Psychotherapy. Haworth Medical Press (quarterly).

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

DIAGNOSIS AND TREATMENT ADVANCES IN MANIC DEPRESSION

Supported by Abbott Laboratories

Hagop S. Akiskal, M.D., *Professor, Department of Psychiatry, University of California at San Diego, 9500 Gilman Drive, La Jolla, CA 92093-0603*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to develop clinical understanding of new research in the diagnosis and treatment of the bipolar spectrum.

SUMMARY:

Manic-depressive illness, originally described as a psychotic disorder, is now renamed bipolar disorder in DSM-IV and ICD-10 to emphasize that it refers to a broad spectrum of clinical presentations that include both hospitalized and ambulatory forms. Thus, bipolar I, bipolar II, and bipolar NOS have become official clinical subtypes. Indeed, the prevalence of the disorder classically reported at 1%, is now being challenged to include these ambulatory forms, with recent estimates of up to 5%. In addition, complex forms of the illness have been described such as mixed states and rapid cyclers that defy lithium carbonate, the classical treatment for this illness. A large array of anticonvulsant mood-stabilizing agents have been introduced during the past decade for clinical use, and atypical neuroleptics have been added to our clinical armamentarium. There is now also a compelling need to help patients and their families through psychoeducation and practical psychotherapeutic approaches to deal with the disruptions of the illness in their social lives. Dr. Akiskal will cover advances in diagnostic approaches and Dr. McElroy will discuss advances in clinical management. This will be followed by a question-and-answer period with the two presenters.

No. 1A
THE NEW BIPOLAR SPECTRUM: CLINICAL PRESENTATIONS

Hagop S. Akiskal, M.D., *Professor, Department of Psychiatry, University of California at San Diego, 9500 Gilman Drive, La Jolla, CA 92093-0603*

SUMMARY:

Lithium, originally discovered in Australia and later tested for safe methods of clinical use in Denmark, was until recently the gold standard in the acute and prophylactic treatment of bipolar disorder. However, at least 50% of bipolar patients have been shown to have suboptimal responses to lithium salts. These include, in particular, rapid-cycling and mixed states. Also, of the "new" forms of bipolar disorder included in DSM-IV, the response of bipolar II to lithium salts has not always been optimal, especially since this subtype has high comorbidity with substance abuse and temperamental or Axis II pathology. The last decade has witnessed tremendous advances in treatment approaches to the entire spectrum of bipolar disorders. Valproate, originally developed in France, has led to a landmark U.S. study and is now approved by the FDA as an effective mood stabilizer; it is particularly useful in nonclassical bipolars, who are commonly seen in clinical practice. Carbamazepine, lamotrigine, and gabapentin also have varying levels of clinical research support as mood stabilizers. Finally, such atypical neuroleptics as olanzapine and risperidone, can be used in the psychotic forms. Psychoeducation has also emerged as an important component of the overall clinical management of bipolar patients.

No. 1B
EMERGING TREATMENTS FOR BIPOLAR DISORDER

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

SUMMARY:

Manic-depressive illness was classically defined as a psychotic disorder. Classical authors also described milder forms of it among the relatives of hospitalized patients. As psychiatry has moved into the outpatient arena, clinicians have encountered these subpsychotic forms in great numbers. This led the author to propose the concept of a bipolar spectrum that subsumes the overlapping clinical presentations of bipolar I, bipolar II, and bipolar III. Types I and II are now officially recognized in both American and international classifications of mental disorders, type III is roughly equivalent to bipolar NOS in DSM-IV. The hallmark of bipolar I is the manic episode, though depressive episodes of varying severity are also quite common; recent observations have indicated that as many as 40% of bipolar is largely women, who suffer from dysphoric mixed manic episodes with the simultaneous presence of manic and depressive symptoms. The hallmark of bipolar III is recurrent depression with history of hypomania; because many of these people are cyclothymic by temperament, the course of this subtype is often tempestuous and 20%, especially women, develop rapid cycling. Bipolar III includes depressions with pharmacological hypomania, bipolar family history, and/or hyperthymic temperament

(persistent cheerfulness, high energy and confidence). These clinical subtypes have important therapeutic implications.

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1. Perugi G, Akiskal HS, Micheli C, et al: Clinical subtypes of bipolar mixed states: validating a broader European definition in 143 cases. J Affect Disord 1997; 43:169-180.
2. Swann A, Bowden C, Morris D, et al., Depression during mania: treatment response to lithium or divalproex. Arch Gen Psychiatry 1997; 54:37-42.
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Industry-Supported Symposium 2 — **Friday, October 2 7:30 p.m.-10:30 p.m.**

ATYPICAL ANTIPSYCHOTICS IN SELECTED PATIENTS

Supported by Janssen Pharmaceutica and Research Foundation

Prakash S. Masand, M.D., *Professor, Department of Psychiatry, SUNY Health Sciences Center, 750 East Adams Street, Syracuse, NY 13210*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to identify patients who are candidates for an atypical antipsychotic based on psychiatric diagnosis and risk factors; to list issues related to efficacy and cost to consider in the selection of an antipsychotic; to describe steps for converting a patient from a conventional to an atypical antipsychotic; and to list factors to consider when incorporating an atypical antipsychotic into a patient care plan.

SUMMARY:

The advent of the atypical antipsychotics over the past few years has had a significant impact on the management of patients with a variety of psychiatric disorders. Their use has also resulted in much discussion regarding their appropriate role compared with conventional antipsychotics. This debate is a result of considerable differences in side effects and costs and, to some degree, clinical efficacy. To help define the role of the atypical antipsychotics, several case studies will be discussed in depth focusing on patient selection and clinical use. Each case will be constructed to allow for discussion of different concepts including the advantages and disadvantages of the different antipsychotics.

No. 2A
CLINICIAN'S OVERVIEW OF ANTIPSYCHOTICS

Robert R. Conley, M.D., *Department of Psychiatry, University of Maryland, P.O. Box 21247, Baltimore, MD 21228*

SUMMARY:

There are now many atypical antipsychotics available to the clinician. Since the re-introduction of clozapine in 1990, risperidone, olanzapine, and quetiapine have become available; sertindole and ziprazidone are likely to be marketed soon. Are these drugs more beneficial to patients in real-world care settings? None of these drugs are yet available generically. Is the higher cost of these agents justified? Can they be used effectively in the clinic? While these drugs have some similarities in their clinical effects, there are marked differences in their dose potency, pharmacokinetics, drugs interactions, and side effects. These differences will be important as these drugs find their place in clinical psychiatry. In this seminar, a clinical overview of these antipsychotics will be presented. Particular emphasis will be placed on their role in special populations such as young, elderly, first-break, affective, refractory and substance abusing populations. Practical information regarding the safe use of these agents and converting patients from one drug to another will be reviewed. The effectiveness of these drugs in reducing relapse rates will be compared. Case presentations will be used to present information in actual clinical situations.

No. 2B
USE OF ATYPICAL ANTIPSYCHOTICS IN NONSCHIZOPHRENIC CONDITIONS

Prakash S. Masand, M.D., *Professor, Department of Psychiatry, SUNY Health Sciences Center, 750 East Adams Street, Syracuse, NY 13210*

SUMMARY:

Atypical antipsychotics are drugs of choice in schizophrenia and many other indications due to their superior efficacy and better side effect profile compared with conventional antipsychotics. Atypical antipsychotics have been found to be effective in bipolar disorder, major depression, obsessive-compulsive disorder, dementia, delirium, and mental retardation. Atypical antipsychotics are often useful and safe in children and adolescents with autistic and other disorders. Medically

ill populations can also benefit from atypical antipsychotic pharmacotherapy. Clinicians should be familiar with drug-drug interactions when using atypical antipsychotics in the nonschizophrenic population.

No. 2C
CLINICAL CHALLENGES: CASE STUDIES IN PERSPECTIVE, PART A

Gary S. Sachs, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-812, Boston, MA 02114*

SUMMARY:

This presentation will use cases to illustrate the clinical decision-making process proceeding from diagnosis to development of treatment plans for patients with psychotic symptoms. In formulating a treatment plan, psychiatrists must weigh safety, cost of care, potential adverse effects, and differential efficacy of available treatment modalities.

Since many patients will benefit from multiple treatment modalities and will require adjustments over time, some conceptual guidelines can improve clinical outcomes. The cases presented offer a systematic "menu of reasonable choices approach" coupled with division of treatment into acute, continuation, maintenance, and discontinuation phases. In each of these phases, therapeutic choices can be made based on the specific goal of treatment defined for that phase. Life cycle and diagnosis-specific issues will also be considered.

No. 2D
CLINICAL CHALLENGES: CASE STUDIES IN PERSPECTIVE, PART B

William Wirshing, M.D., *Department of Psychiatry, West Los Angeles Veterans Affairs Medical Center, 11301 Wilshire Boulevard (B151-H), Los Angeles, CA 90073*

SUMMARY:

The controlled data in treatment responsive subjects strongly suggest that the newer so-called "atypical" antipsychotic medications mediate their efficacy through different mechanism(s) of action than conventional medications. If true, this implies that they may have heightened efficacy in both treatment-refractory and treatment-intolerant populations (e.g., the elderly). In addition, the lower rate of treatment-emergent neurotoxicity and decreased rate of adjunctive anticholinergics (compared with conventional compounds) also hint that they may have superior efficacy in certain symptom complexes historically unresponsive to conventional treatment (e.g., neurocognitive performance and hostility/violence). While the newer agents unarguably have lower acute extrapyramidal toxicity than their conventional counterparts, they are not without other toxicities. Some of these other liabilities (e.g., weight gain or cardiotoxicity) are problematic in certain subpopulations. This presentation will discuss the relative benefits and limitations of the newer agents in both refractory and elderly populations. The data presented will be culled predominantly from the controlled trials done in experimental settings. However, the discussion will be almost exclusively clinical.

REFERENCES:

1. Conley RR, Buchanan RW: Evaluation of treatment resistance in schizophrenia. Schizophr Bull, in press.
2. Sachs GS: Treatment refractory bipolar depression: In Psychiatric Clinics of North America, Amsterdam J, and Rohan M (Eds), Philadelphia, W.B. Saunders, 1996
3. Sachs GS: Bipolar mood disorder: practical strategies for acute and maintenance-phase treatment, J. Clin Psychopharm (suppl) 1996; 16:32s-47s.
4. Wirshing DA, Marder SR, Wirshing WC, et al: Atypical antipsychotics: a practical review, Medscape 1997; http://www/medscape.com [article-Internet journal].
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Industry-Supported Symposium 3 — **Saturday, October 3 6:30 a.m.-8:00 a.m.**

AN ATYPICAL LOOK AT TYPICAL NEUROLEPTICS

Supported by Watson Laboratories, Inc.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to to define the various dimensions of atypical neuroleptics; to recognize the aspects of "atypicality" for individual antipsychotic agents; to apply these concepts not only to the newly marketed agents, but to older, classical drugs; to demonstrate that "atypi-

cality'' exists across a spectrum, and that some older drugs exhibit some aspects of atypical neuroleptics.

SUMMARY:

This symposium will feature a review and analysis of antipsychotic agents, both old and new, by debating concepts of how to define an atypical neuroleptic and how individual antipsychotic drugs measure up to these various ideas. Although some concepts clearly separate the newer agents from the older agents, it may also be possible to define a spectrum that differentiates both among the newer agents and among the older agents. The format is a dialogue between the psychopharmacology perspective (Dr. Stahl) and the clinical perspective (Dr. Glazer). The symposium will be conducted as a ''mini-course'' with didactic explanations of these concepts applying instructional design that utilizes an audience response system enhanced with visualizations of drug actions through animations.

No. 3A
WHAT IS AN ATYPICAL NEUROLEPTIC?

Stephen M. Stahl, M.D., Ph.D., *Department of Psychiatry, University of California, San Diego, 8899 University Center Lane #130, San Diego, CA 92122-1009*

SUMMARY:

Innovative therapeutic agents for the treatment of schizophrenia are entering psychiatry at a rapid pace. ''Typical'' neuroleptics are sometimes defined as those with limited efficacy for negative and cognitive symptoms as well as unfavorable side effects. ''Atypical'' neuroleptics can be defined in many ways: by pharmacology (i.e., serotonin/dopamine antagonism), by efficacy profile (i.e., helpful for negative symptoms), by improved tolerability (i.e., fewer extrapyramidal side effects, less hyperprolactinemia, less tardive dyskinesia), by the ability to treat those refractory to other agents, by cost (expensive), and by marketing hype.

Using an interactive format, Dr. Stahl will present data supporting the notion that pharmacological mechanism of action can help define all antipsychotics across a spectrum and that the notion of ''atypical'' may be a continuum. Not only do the new agents differ among each other (e.g. risperidone, olanzapine, quetiapine, ziprasidone, sertindole, iloperidone) but the older agents also have comparative differences (e.g. haloperidol, chlorpromazine, molindone, ioxapine). Dr. Glazer will review whether the predictions from psychopharmacology are demonstrable as clinical differences across the spectrum from typical to atypical and from old to new.

No. 3B
IS THERE CLINICAL EVIDENCE FOR ATYPICAL PROPERTIES AMONG THE CLASSICAL NEUROLEPTICS?

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

SUMMARY:

The ultimate value of the concept of ''atypical'' antipsychotic is how well these ideas translate into clinically useful differentiation of one antipsychotic drug from another. In earlier days, the idea of ''high potency'' versus ''low potency'' among the classical antipsychotics had some value in differentiating tolerabilities among the typical drugs. The newer concept of atypical antipsychotic is also demonstrating clinical applicability, specifically in terms of extrapyramidal side effects.

This presentation will review the classical and atypical antipsychotics, specifically in terms of how well pharmacological concepts are demonstrable in clinical practice. Emphasis will be placed on extrapyramidal side effects, tardive dyskinesia, and hyperprolactinemia, and how various antipsychotics have differential ability to cause these problems. Discussion of enhanced efficacy for negative symptoms and for refractory positive symptoms among the classical and atypical antipsychotics will derive from the pharmacological presentation of Dr. Stahl.

REFERENCES:

1. Stahl SM: ''Awakening'' from schizophrenia: intramolecular polypharmacy and the atypical antipsychotics. J Clin Psychiatry 1997; 58: 381-382.
2. Stahl SM: Essential Psychopharmacology, Cambridge University Press, New York, 1996.
3. Richelson E: Preclinical pharmacology of neuroleptics: focus on new generation compounds. J Clin Psychiatry 1996; 57(S11):4-11.
4. Stahl SM: What makes an antipsychotic atypical? J Clin Psychiatry, in press.

Industry-Supported Symposium 4 — **Saturday, October 3, 12 noon-1:30 p.m.**

NEW RESEARCH FINDINGS AND TREATMENT STRATEGIES FOR RECURRENT AND CHRONIC DEPRESSION

Supported by Bristol-Myers Squibb

A. John Rush, M.D., *Betty Jo Hay Distinguished Chair in Mental Health, Rosewood Corporation, Chair in Biomedical Science, and Professor of Psychiatry, University*

of Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, MC-9086, Dallas, TX 75235-9086

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to list the risk factors that increase the probability of a patient having a recurrent major depressive episode; and outline pharmacologic strategies for treating sexual dysfunction and insomnia secondary to SSRI use.

SUMMARY:

The NIMH Collaborative Depression Study has demonstrated that depression is a chronic and recurrent disorder with a 87% cumulative probability of recurrence after 15 years. Patients who have had three or more episodes of depression have a 90% probability of recurrence. Dr. Keller will review research findings on chronic and recurrent depression and will present for the first time initial results of the Serzone Chronic Depression Study, which involved 660 patients enrolled at 11 sites throughout the U.S. and investigated the efficacy of three treatment groups for depression: nefazodone, cognitive behavioral therapy (CBT-M), and nefazodone plus CBT-M.

Since depression is a chronic and recurrent illness, physicians need current information on the practical management of common treatment-emergent side effects such as sexual dysfunction and insomnia from newer antidepressants, especially the SSRIs. Dr. Dunner will review the latest strategies for managing these side effects and will provide guidance on add-on therapies for reducing these symptoms. He will also summarize common side effects associated with nefazodone and mertazapine.

No. 4A
NEW RESEARCH FINDINGS IN THE COURSE AND TREATMENT OF RECURRENT AND CHRONIC DEPRESSION

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

SUMMARY:

Lifetime rates of depression were reported by the National Comorbidity Study at between 17% and 19%. Evidence that depression is a chronic and recurrent condition has emerged consistently from the National Institute of Mental Health Collaborative Depression Study (CDS). Data from the CDS indicate that duration of the episode prior to entering the study ranged from two to 526 weeks, with a median duration of 24 weeks. The cumulative probability of the patient recovering from a major depressive episode in one year is 67%, after two years it is 84%, after five years it is 88%, and after 10 years it is 93%. After 15 years, 6% of subjects still had not recovered.

Before the CDS, the rate of recurrence following recovery for unipolar depression had been estimated at between 30% and 50%. However, using a subset of 378 unipolar depressive patients, the CDS data show that five years after recovery the cumulative probability of recurrence is 62%, after 10 years the rate is 75%, and after 15 years the cumulative probability of recurrence is 87% (Keller et al., unpublished data). The number of prior episodes is the strongest predictor of future recurrence. Two prior episodes of depression predict a 50%-90% probability of recurrence, and three or more prior episodes indicate a greater than 90% probability of recurrence. Other predictors of recurrence include double depression, a family history of affective disorder, poor symptom control during continuation therapy, and a comorbid disorder or substance abuse.

Maintenance studies of between two and five years' duration will be presented on the efficacy of treatment with imipramine, lithium, and interpersonal psychotherapy (IPT). Data from continuation studies of between six month's and one year's duration will be presented on fluoxetine, paroxetine, sertraline, and nefazodone.

No. 4B
SELECTING AN ANTIDEPRESSANT FOR THE LONG-TERM TREATMENT OF DEPRESSION

David L. Dunner, M.D., *Center for Anxiety and Depression, University of Washington Medical Center, 4225 Roosevelt Way N.E., Suite 306, Seattle, WA 98105-6099*

SUMMARY:

There are four depressive conditions that require long-term treatment: chronic major depressive disorder, dysthymic disorder, recurrent major depressive disorder, and bipolar disorders. The purpose of this paper is to discuss the principles a clinician might utilize in selecting a long-term treatment for depression. The principles include selecting medication that will show short-term efficacy and continuing that antidepressant at the same dose for maintenance therapy. The antidepressant selected for initial therapy thus should be efficacious and well tolerated. Furthermore, short-term side effects of the medication should be tolerable enough so that the patient is willing to continue the medication. Long-term side effects should not interfere with function of the patient. Important long-term side effects, which will be discussed, include sleep disruption and sexual dysfunction. Other factors such as ease of administration, need

for dose titration, single versus multiple daily dosing, cost of the medication and cost of additional medication used to counteract side effects are all factors that should be taken into account in the selection of an antidepressant.

REFERENCES:

1. Keller MB, Klerman GL, Lavori PW, et al: Treatment received by depressed patients. JAMA 1982; 248:1848-1855.
2. Keller MB, Lavori PW, Mueller TI, et al: Time to recovery, chronicity and levels of psychopathology in major depression: a 5-year prospective follow-up of 431 subjects. Arch Gen Psychiatry 1992; 49:809-816.
3. Pages KP, Dunner DL: Focus on dysthymic disorder and chronic depression in Dunner DL and Rosenbaum JF eds. The Psychiatric Clinics of North America: Annual of Drug Therapy, W.B. Saunders Co., Philadelphia, 1997, pp. 91-109.
4. Dunner DL: Mood disorders, in Raykel RE, ed. Conns Current Therapy, W.B. Saunders Co. Philadelphia, 1998, pp. 1141-1148.

Industry-Supported Symposium 5 **Saturday, October 3 12 noon-1:30 p.m.**

EMERGING CONCEPTS FOR THE TREATMENT OF DEMENTIA

Supported by Janssen Pharmaceutica and Research Foundation

Dilip V. Jeste, M.D., *Professor of Psychiatry and Neurosciences, San Diego Veterans Affairs Medical Center, 3350 La Jolla Village Drive, San Diego, CA 92161-0001*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to: 1) list the differential diagnosis, 2) identify signs and symptoms that differential dementia and depression, 3) describe the overall pharmacologic and nonpharmacologic management approach, 4) identify the role of psychosocial treatment, 5) Describe the role of antipsychotics in treatment, 6) compare the conventional and atypical antipsychotics in terms of efficacy and safety, and 7) list legal and management issues.

SUMMARY:

Dementia will continue to be a growing psychiatric problem in the U.S. with the progressive increase in life expectancy. Unfortunately, dementia is frequently misdiagnosed and often mistreated. There is generally an inadequate understanding of the differences between dementia and depression, with consequent mismanagement of patients. The optimal treatment of dementia is necessarily multifaceted. Psychosocial management plays a critical role in the overall therapeutic plan. New pharmacologic treatment strategies for improving cognition are emerging but are still quite limited in efficacy. Noncognitive behavior problems such as psychosis, severe agitation, and depression are often amenable to pharmacologic treatments, but these agents have their own side effects. Finally, as the disease enters its last stage there are important legal and end-of-life issues that need to be addressed. This symposium will deal with recent advances in the diagnosis and management of dementia.

No. 5A
DIAGNOSING DEMENTIA

Lon S. Schneider, M.D., *Department of Psychiatry, University of Southern California School of Medicine, 1975 Zonal Avenue, KPM-400, Los Angeles, CA 90033-1071.*

SUMMARY:

Although dementia, including Alzheimer's disease, is common in the elderly, its recognition and differential diagnosis can be challenging clinical problems. The essential cognitive deficits, including memory impairment, apraxia, aphasia, and agnosia, may not be easily detected early in the illness. Sometimes, minimal cognitive impairment is not distinguished from age-related cognitive decline. Similarly, patients with deliria may be unrecognized or misidentified as having dementia or behavioral syndromes. Depression, delusions, and aggression may develop throughout the course of a dementing illness. Often, behavioral signs and syndromes may mask the cognitive deficits. Some patients may present with anxiety or depressive symptoms or disorders. Recognition and accurate differential diagnosis of the dementia and its associated symptomatic behaviors is essential for developing multidisciplinary treatment approaches. This presentation will discuss an effective differential diagnostic approach to patients with cognitive deficits, with or without behavioral symptoms, that can form the basis for subsequent effective treatment planning.

No. 5B
PRACTICAL PHARMACOLOGIC MANAGEMENT

Dilip V. Jeste, M.D., *Psychiatry Service, San Diego Veterans Affairs Medical Center, #116-A-1, 3350 La Jolla Village Drive, San Diego, CA 92161-0001*

SUMMARY:

The pharmacologic strategies for the symptomatic treatment of dementia can be broadly divided into those

for possible cognitive enhancement and those for noncognitive behavioral problems. Although there is still no useful long-term treatment for cognitive deficits, medications such as tacrine and donepezil have limited short-term value in early stages of certain dementias. A number of experimental drugs are currently being studied and are likely to improve the course of dementia in the near future. Better treatments are currently available for treating noncognitive behavioral problems such as psychosis, severe agitation, and depression in dementia. The newer agents for treating these psychiatric symptoms are generally superior to the older ones in terms of greater efficacy and fewer side effects. For example, the newer atypical antipsychotics have a lower risk of extrapyramidal side effects and possibly of tardive dyskinesia than the conventional ones. Nonetheless, these drugs also have their own adverse reactions and need to be used in considerably lower dosages compared with those for younger adults. This presentation will focus on practical issues of pharmacotherapy such as the appropriate daily dosages; initiation, maintenance, and discontinuation strategies; and use of concomitant medications.

No. 5C
PSYCHOSOCIAL TREATMENT

George T. Grossberg, M.D., *Department of Psychiatry and Human Behavior, St. Louis University School of Medicine, 1221 South Grand Boulevard, Suite 202, St. Louis, MO 63104-1016*

SUMMARY:

Dementing disorders present with a variety of problem behaviors. Among the most common are agitation, mood disorders, psychotic symptoms, sleep disturbance, and wandering. Psychosocial evaluations and treatment play a valuable role in identifying and ameliorating potential triggers for problem behaviors. Common precipitants include stress among caregivers (family or professional), environmental changes or losses, and inability to communicate internal needs such as pain, hunger, fear, or a need to void. Psychosocial treatment alone may alleviate problem behaviors. Often, a combination of psychosocial and pharmacologic therapies may be needed.

Psychosocial interventions of proven value in dealing with demented patients include increased physical activity, optimal sensory input, environmental changes, caregiver education, and the role of structure and routine.

No. 5D
LEGAL AND MANAGEMENT ISSUES

Prakash S. Masand, M.D., *Department of Psychiatry, State University of New York Health Sciences Center, 750 East Adams Street, Syracuse, NY 13210*

SUMMARY:

Legal and management issues are an extremely important, but often underlooked area in the management of patients with dementia. Loss of competency is an inevitable consequence of Alzheimer's disease and other progressive dementias. The assessment of competency poses a special challenge to psychiatrists since it has important social, ethical, philosophical, and clinical implications. Furthermore, the level of competency needed to make decisions may vary with the risk-benefit ratio. A significant number of older individuals with dementia have an impaired ability to make and communicate their own choices about personal and financial matters, including the ability to consent to medical treatment and to research, self-care, guardianship issues, ability to sign out of the hospital, among others. The talk will address the legal, ethical, and management issues involved in taking care of patients with dementia and discuss some public policy implications.

REFERENCES:

1. Schneider LS, Tariot PN: Treatment of dementia. In, Clinical Geriatric Psychopharmacology: Third Edition. Edited by Salzman C. Williams and Wilkins, Baltimore, 1997, pp. 510-542.
2. Porsteinsson A, Tariot PN, Schneider LS: Mood disturbances in Alzheimer's disease. Seminars in Clinical Neuropsychiatry, 1997; 2:265-275.
3. Zayas EM, Grossberg GT: Treating the agitated Alzheimer's patient. J Clin Psychiatry, 1996; 57(suppl. 7):46-51.
4. Blacker D, Cummings JL, Goldberg RJ: Managing behavioral problems in AD. Patient Care, 1996; 84-107.
5. Jeste DV, Rockwell E, Harris MJ, et al: Conventional versus newer antipsychotics. Am J Geriatric Psychiatry (in press, 1997).
6. Masand PS, Bouckoms AJ, Fischel SV, et al: A prospective multi-center study of competency evaluations by psychiatric consultation services. Psychosomatics (in press).
7. Marson DC, Schmitt FA, Ingram KK, et al: Determining the competency of Alzheimers patients to consent to treatment and research. In Alzheimer Disease and Associated Disorders, Vol 8, Raven Press, NY, 1994, pp 5-18.

Industry-Supported Symposium 6 — **Saturday, October 3, 7:00 p.m.-10:00 p.m.**

THERAPEUTIC STRATEGIES FOR ALZHEIMER'S DISEASE

Supported by Novartis Pharmaceuticals Corporation

George T. Grossberg, M.D., *Department of Psychiatry and Human Behavior, St. Louis University School of*

Medicine, 1221 South Grand Boulevard, Suite 202, St. Louis, MO 63104-1016

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to list the recent advances in the management of Alzheimer's disease; and describe the current therapies used in Alzheimer's disease to treat cognitive impairment and behavioral disorders.

SUMMARY:

Alzheimer's disease is the most common disorder causing cognitive decline in older age. This symposium will present the new pharmacologic and nonpharmacologic approaches available for the management of these patients. Most of the presentations will be done in a case-study format and will provide practical recommendations to the psychiatrist on patient management. Dr. Grossberg will start with a 15-minute overview on the diagnosis and assessment of Alzheimer's disease. This will then be followed by three 25-minute presentations on the practical management of Alzheimer's patients: Dr. Lon Schneider will present the pharmacologic therapies for cognitive impairment, Dr. Gary Small will address the management of associated behavioral disorders, and Dr. Murray Raskind will discuss the "alternative" agents currently being investigated and often mentioned by the patients to treat Alzheimer's disease. Finally, a 30-minute panel discussion will address the audience questions.

No. 6A
DIAGNOSIS AND ASSESSMENT OF ALZHEIMER'S DISEASE

George T. Grossberg, M.D., *Department of Psychiatry and Human Behavior, St. Louis University School of Medicine, 1221 South Grand Boulevard, Suite 202, St. Louis, MO 63104-1016*

SUMMARY:

This presentation will briefly review the diagnosis and assessment issues associated with Alzheimer's disease. Alzheimer's disease is the most common dementing disorder and affects an estimated 4 million people in the United States. Unfortunately, the diagnosis of Alzheimer's disease is often missed because it is underreported by the patients or their families and is unrecognized by the physicians in the early stages. The diagnosis of the disease is primarily one of inclusion and can usually be made using standardized clinical criteria. Adequate assessment involves a careful clinical examination and informant interview. The Functional Activities Questionnaires and the Revised Memory and Behavior Problems Checklists are two useful informant-based instruments. The physical examination should include a brief neurological and mental status evaluation (e.g., MMSE). Standardized rating scales are recommended for initial screening. Common laboratory tests and structural imaging studies (e.g., CT, MRI) are performed for differential diagnosis. Functional studies (PET, SPECT) may confirm clinical impressions.

No. 6B
PHARMACOLOGIC MANAGEMENT OF ALZHEIMER'S DISEASE

Lon S. Schneider, M.D., *Department of Psychiatry, University of Southern California School of Medicine, 1975 Zonal Avenue, KPM-400, Los Angeles, CA 90033-1071*

SUMMARY:

Improving central cholinergic neurotransmission is the only currently marketed treatment for the cognitive impairment of Alzheimer's disease. Two cholinesterase inhibitors, tacrine and donepezil, are already approved in the United States for the treatment of Alzheimer's disease, and by the time of the meeting, other cholinesterase inhibitors will become available. This presentation will provide the attendees with practical recommendations on how to use these drugs in the elderly population and will focus on particular factors such as concomitant medications and medical and psychiatric comorbidities.

No. 6C
MANAGEMENT OF BEHAVIORAL DISORDERS

Gary W. Small, M.D., *Department of Psychiatry, University of California, Los Angeles, Neuropsychiatric Institute, 760 Westwood Plaza, Los Angeles, CA 90024-8300*

SUMMARY:

Behavioral symptoms in patients with Alzheimer's disease include depression, agitation, and psychosis. They are a stressful aspect of caregiving for family members, representing a common referral for the practicing psychiatrist. Several pharmacologic agents and psychosocial techniques may provide relief for behavioral disorders associated with dementia. The pharmacologic management of depressive symptoms includes newer agents without anticholinergic effects as first-line therapy. Psychosocial strategies should also be considered to enhance quality of life for the patients and their family. Antipsychotic drugs including the atypical antipsychotics are generally used to treat agitation and psychosis. Other agents, such as anticonvulsants, are also being investigated for the treatment of behavioral disorders

in dementia. Finally, the role of the caregiver and the nonpharmacologic approaches will be discussed.

No. 6D
UPDATE ON ALTERNATIVE THERAPIES IN ALZHEIMER'S DISEASE

Murray A. Raskind, M.D., *Department of Psychiatry, Veterans Affairs Puget Sound, 1660 South Columbian Way, Seattle, WA 98108*

SUMMARY:

This presentation will present alternative pharmacologic options currently "proposed" for Alzheimer's disease. Because over-the-counter products are increasingly more popular among Alzheimer's patients and their families, physicians should know their pharmacology and eventual use in the disease. These agents include vitamin E, botanical agents such as ginkgo biloba, and DHEA. Although the evidence of clinical benefit is inconclusive at this time, some of these agents are currently being investigated to assess whether or not they can improve cognitive function. Finally, the effect of other pharmacologic agents, including estrogen and anti-inflammatory agents, on cognitive function will be discussed.

REFERENCES:

1. Small G, et al: Diagnosis and treatment of Alzheimer's disease and related disorders: consensus statement of the American Association for Geriatric Psychiatry, the Alzheimer's Association, and the American Geriatrics Society. JAMA 1997; 278:1363-1371.
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Industry-Supported Symposium 7 — **Saturday, October 3 7:00 p.m.-10:00 p.m.**

DEPRESSION AND ITS IMPACT ON THE BODY AND MIND

Supported by U.S. Pharmaceuticals, Pfizer Inc

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to enhance participants' knowledge of how depression impacts psychosocial function, physical illness, and aging; to teach effective strategies for managing these complications and for achieving better outcomes.

SUMMARY:

This symposium will discuss issues relevant to developing effective strategies for managing depression as it relates to psychosocial function, physical illness, and aging.

John Rush, M.D., will examine the impairment of interpersonal, marital, and occupational role functions as they are affected by depressive disorders. The role of psychotherapy in restoring psychosocial function alone or in combination with medication will be discussed. Ranga Krishnan, M.D., will review data from a clinical research center for depression in the elderly and from a study of patients with cardiac disease to illustrate the effect of depression on physical illness. George Grossberg, M.D., will describe the prevalence and differential diagnosis of depression in the elderly population, including comorbidity, and then focus on current treatment approaches to the management of late-life depression.

No. 7A
THE IMPACT OF DEPRESSION ON PSYCHOSOCIAL FUNCTION

A. John Rush, M.D., *Betty Jo Hay Distinguished Chair in Mental Health, Rosewood Corporation Chair in Biomedical Science, and Department of Psychiatry, University of Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, MC-9086, Dallas, TX 75235-9086*

SUMMARY:

Depressive disorders, even so-called "minor" depressions, cause substantial impairment in all role functions (e.g., interpersonal, marital, occupational). The levels of disability equal or exceed those found with most other chronic general medical conditions. Three questions will be addressed in this presentation: (1) If symptoms are reduced or entirely eliminated, does function return to normal? (2) When should clinicians anticipate functional restoration in the course of treatment response? and (3) Is a more chronic course of illness associated with greater functional impairment or with a reduced capacity to recover functionally when symptom reduction or remission does occur? Data from the Texas Medication Algo-

rithm Project, from a large acute and maintenance trial of two antidepressants, and from other trials in the literature will be presented to address these questions. The role of psychotherapy in accomplishing functional restoration alone or in combination with medication will be discussed.

No. 7B
THE IMPACT OF DEPRESSION ON PHYSICAL ILLNESS

K. Ranga Rama Krishnan, M.D., *Department of Psychiatry, Duke University Medical Center, Box 3018, Durham, NC 27710-0001*

SUMMARY:

The impact of depression on physical illness has not been well studied. Most of the data on the impact of depression come from cardiovascular literature. Nancy Frasure Smith of Montreal has shown that following myocardial infarction the presence of depression, even at low levels, increases the risk of dying in the follow-up period. Similar data are now available in patients diagnosed with coronary artery disease. We're in the process of collecting data on the effect of depression on hospitalization, mortality, and other events in patients with congestive heart failure. Depression in patients with stroke is also reported to reduce recovery and increase the risk of death.

Data from these studies have led to further studies to evaluate whether treatment of depression is feasible and potentially useful in patients with a cardiac illness such as following myocardial infarction. Two such trials are underway SADHEART, which is a trial of sertraline and placebo inpatients following MI and ENRICHD, which is a trial of CBT inpatients with post-MI depression or lower social support.

Besides the effect of depression on morbidity and mortality, depression also affects activities of daily living. Data from the clinical research center for depression in the elderly and from a study of patients with cardiac disease will be presented to illustrate the effect of depression. The studies demonstrate that depression does not affect basic functions but affects instrumental functions. Basic activities of daily living are more likely to be affected by the medical illness itself.

The studies clearly suggest that depression should be identified and treated in patients with physical illness. Treatment of the depression is likely to affect the overall outcome and quality of life in these subjects. More studies are clearly needed in this area.

No. 7C
THE IMPACT OF DEPRESSION ON THE ELDERLY

Sanford I. Finkel, M.D., *3127 Greenleaf Avenue, Wilmette, IL 60091-2080*

SUMMARY:

Individuals over the age of 65 constitute 13% of our population and those over 85 constitute the most rapidly growing segment. Though the prevalence of major depression may decline with age, minor depression and depressive signs, symptoms, and equivalents seem to increase significantly. Even major depression is much more common among elderly in nursing homes and in acute hospital environments. We looked at nearly 200 geriatric patients with a primary mood disorder treated in the Division of Geriatric Psychiatry at Saint Louis University School of Medicine inpatient unit over the past decade. Trends in treatment, length of stay, acuity level, comorbidity, concomitant medications, and cost were studied. Results of this study will be discussed in the context of current treatment approaches to the management of late-life depression.

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

THE USE OF ANTIPSYCHOTICS IN THE MANAGEMENT OF BIPOLAR DISORDER

Supported by Eli Lilly and Company

Paul E. Keck, Jr., M.D., *Department of Psychiatry, University of Cincinnati, P.O. Box 610559, 231 Bethesda Avenue, Cincinnati, OH 45267*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to recognize the indications for antipsychotic medications in the treatment of patients with bipolar disorder and their risks and benefits, to understand the potential advantages and thymoleptic properties of new agents.

SUMMARY:

Prior to the advent of lithium, conventional antipsychotics were frequently used in the management of acute mania and as maintenance treatment in patients with bipolar disorder. In studies of acute mania, conventional antipsychotics were found to be more rapidly effective than lithium in ameliorating psychomotor agitation but less effective in reducing core manic symptoms. Despite the availability of several mood-stabilizing agents (e.g., lithium, divalproex, carbamazepine), recent studies indicate that conventional antipsychotics continue to be commonly used in both acute and maintenance treatment. The arrival of new antipsychotics (e.g., olanzapine, risperidone, quetiapine) with unique pharmacologic properties has led to increasing interest in the role of these agents in the treatment of patients with bipolar disorder. This interest is in part related to the putative thymoleptic as well as antipsychotic activities associated with these medications.

In this symposium, the efficacy of conventional and new antipsychotics in the treatment of acute mania will be discussed. Data regarding the role of antipsychotics in the maintenance treatment of patients with bipolar disorder will be reviewed. Finally, the potential risks as well as benefits of conventional and new antipsychotics will be discussed.

No. 8A
ANTIPSYCHOTICS IN BIPOLAR MAINTENANCE TREATMENT

Michael J. Sernyak, M.D., *Department of Psychiatry, Yale University, 1950 Campbell, 116 A, West Haven, CT 06516*

SUMMARY:

This talk will present what is known about the use of antipsychotic medications in the maintenance treatment of bipolar disorder. The patterns of use in this patient population will be described, and the implications of chronic neuroleptic exposure as an element of the maintenance treatment of bipolar disorder will also be addressed. The possibilities presented by the newer antipsychotic medications will also be examined.

No. 8B
ANTIPSYCHOTICS IN ACUTE MANIA: NEW FINDINGS

Paul E. Keck, Jr., M.D., *Department of Psychiatry, University of Cincinnati, P.O. Box 610559, 231 Bethesda Avenue, Cincinnati, OH 45267;* Susan L. McElroy, M.D.; Stephen M. Strakowski, M.D.

SUMMARY:

Psychotic symptoms occur during the manic, mixed, and depressive episodes of bipolar disorder. Every type of psychotic symptom, including mood-incongruent, bizzare, and schneiderian first-rank symptoms, has been reported to occur in patients with mania. Not surprisingly, conventional antipsychotics are frequently used in the treatment of acute mania. In more than 15 randomized controlled trials, conventional antipsychotics produced comparable efficacy compared with mood stabilizers (e.g., lithium, divalproex, carbamazepine). However, the use of conventional antipsychotics in acute mania is associated with a number of limitations including possible exacerbation of depressive symptoms, neurological side effects (EPS, akathisia, tardive dyskinesia), and confounding of interpretation of response to mood-stabilizing agents.

New antipsychotic agents and clozapine appear to exert not only antipsychotic but also thymoleptic activity. However, these agents differ pharmacologically and may have different thymoleptic profiles. New findings regarding the efficacy and safety of clozapine and newer antipsychotics (e.g., olanzapine) in the treatment of acute mania will be presented. The relative advantages and disadvantages of newer antipsychotics in the treatment of acute mania will be discussed. Potential drug-drug interactions between mood stabilizers and new antipsychotics will also be discussed.

No. 8C
ATYPICAL ANTIPSYCHOTIC DRUGS: THE CURRENT LIMITATIONS AND FUTURE PROMISES

Diana O. Perkins, M.D., *Department of Psychiatry, University of North Carolina, Chapel Hill, CB#7600, Neurosciences Hospital, Chapel Hill, NC 27599-7160*

SUMMARY:

The advent of neuroleptic drugs was one of the great breakthroughs in pharmacotherapeutics in the 20th century. Antipsychotic drugs have proven efficacy in alleviating psychotic symptoms and preventing their recurrence in idiopathic and drug-induced psychotic disorders. However, more than 40 years of experience with these compounds has clearly revealed their limitations. These include that: 1) neuroleptics are not effective in all patients with psychosis, 2) they do not exert therapeutic effects against all domains of morbidity; 3) they have an extensive side-effect profile. The thrust of new drug development has been to identify new compounds that have enhanced antipsychotic efficacy and reduced side effects compared with standard neuroleptic compounds. In addition to more favorable side-effects profiles, atypical antipsychotic drugs offer the promise of superior efficacy that may be reflected in various measures of disease morbidity as well as provide new insights into the pathophysiological basis of psychosis. Emerging data suggest that these new agents may not only exert antipsychotic effects, but may also possess thymoleptic activity. Data regarding the potential pharmacologic mechanisms underlying putative thymoleptic properties of these agents will be reviewed. These data also suggest that the thymoleptic properties of the new antipsychotics may also differ among agents. The challenge for investigators, clinicians, and patients is to determine the full extent of the therapeutic benefits, risks, and cost effectiveness of these compounds and develop a rational policy for their optimal utilization.

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Industry-Supported Symposium 9 **Sunday, October 4 12 noon-1:30 p.m.**

MANAGING SEXUAL SIDE EFFECTS OF ANTIDEPRESSANTS

Supported by Organon Inc.

Troy L. Thompson II, M.D., *Scientific Program Committee Member, and The Daniel Lieberman Professor, Department of Psychiatry and Human Behavior, Jefferson Medical College and Hospital, 841 Chestnut Street, Suite 1001, Philadelphia, PA 19107-4414*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to know the prevalence of sexual dysfunction in depressed patients and to know which antidepressants have fewer of these side effects and how to avoid and manage these side effects.

SUMMARY:

Clinical depression is often accompanied by sexual dysfunction. This often includes a decrease in libidinal drive and in excitatory (engorgement and lubrication or erectile) functions. Approximately 70% of depressed patients experience some variant of sexual dysfunction, as compared with about 20% of the nondepressed population. Sexual dysfunction associated with depression may also include altered expressions of sexual drive, such as atypical promiscuity, which is often associated with a compensatory desire for closeness and amelioration of dejected feelings.

In evaluating sexual dysfunction secondary to depression, it is important for the clinician to have a good understanding of the anatomy and physiology of sexual dysfunctions as well as an understanding of the range of normal human sexual responses. It is also important for the physician to determine a baseline sexual history from the patient so the clinician can differentiate between premorbid (before depression and before antidepressant use) sexual functioning and behaviors and symptoms that may arise from the depression and antidepressants or other medications. The physician should also discriminate between sexual dysfunctions arising from transient episodes of emotional stress or from medical conditions, such as prostatitis and vaginitis.

Since antidepressants have become a key treatment modality of depression, dysthymia, panic disorders, and OCD, one needs to understand that many antidepressants often cause sexual problems. The selective serotonin reuptake inhibitors (SSRIs) in particular have a high prevalence (probably about 70%) of adverse effects on sexual function, as manifested by altered libido, excitement, orgasm, and resolution stages. SSRIs may effectively treat premature ejaculation, but pathologically delay or eliminate ejaculation and orgasm in patients who previously were normal in these areas and who are otherwise responding well with improvement in depressive symptoms. SSRIs may also decrease libido in those for whom it is effective in delaying ejaculation, so a paradox may develop.

Spontaneous resolution of antidepressant-induced sexual dysfunction rarely occurs after a few weeks. Reduction to the lowest effective antidepressant dose may be an initial step to correcting dysfunction. Several

newer antidepressants (mirtazapine, bupropion SR, nefazodone, venlafaxine XR, and citalopram) have a much lower prevalence of sexual dysfunction than the SSRIs and are equalling efficacious to the SSRIs. (Citalopram is a new, more selective SSRI; it may be released during the next year.) Switching to one of these agents or combinations of these with the "offending" agent class may also be effective. Other adjunctive agents might then be tried.

The overall challenge is to bring relief to depressed patients while avoiding or eliminating the sexual adverse effects of the antidepressant being used to alleviate the mood disorder. This series of presentations will also summarize the sexual side effects of a number of other medications, hormones, and other agents. Recent research will be reviewed in a clinically useful way to assist physicians' awareness of drug-related sexual complications. Some older approaches, e.g., testosterone and vacuum devices, and newer approaches, e.g., an oral tablet, urethral suppository, and penile injections, to treat erectile dysfunction, which may be effective if the above measures fail, will also be discussed.

No. 9A
SEXUAL SIDE EFFECTS OF HORMONES AND OTHER AGENTS

Theresa L. Crenshaw, M.D., *Director, Crenshaw Clinic, 3750 Riviera Drive, Apt. 1, San Diego, CA 92109-6658*

SUMMARY:

Drugs that have adverse sexual side effects often produce noncompliance, which can result in serious consequences—morbidity, mortality, and liability. Sophisticated prescribing that takes into account sexual ramifications of medications can avoid or minimize these casualties and in some cases can improve a patient's sexual function, e.g., in treating depression. The pharmacologic (including sexual) response to a particular drug often varies according to whether the patient is male or female and if other medical conditions and medications are present.

Many psychotropic drugs have extensive adverse effects on sexual function. Because reduced libido and sexual responsiveness are common symptoms of depression, as well as common complications in the medical management of depression, new drugs are being used singly and in combination to treat depression without producing undesirable sexual consequences. While many of the medications commonly in use and some hormones and other agents may affect sexual function in a negative way, some have been identified as having favorable sexual properties.

This presentation will summarize information about the sexual side effects of a number of medications, hormones, and other agents. Current research will be interpreted in a clinically useful way to increase physicians' awareness of drug-related sexual complications. The interrelationships between sex, disease, and depression will be discussed, with a specific focus on antidepressant drugs that are contraindicated when certain sexual symptoms preexist and a number of medications that may enhance some sexual functioning.

No. 9B
CORRECTING SEXUAL DYSFUNCTION DUE TO ANTIDEPRESSANTS

Troy L. Thompson II, M.D., *Scientific Program Committee Member, and the Daniel Lieberman Professor, Department of Psychiatry and Human Behavior, Jefferson Medical College, 841 Chestnut Street, Suite 1001, Philadelphia, PA 19107-4414*

SUMMARY:

Sexual dysfunction of various types affects 10% to 27% of the nondepressed general population, and up to 70% of depressed patients. Therefore, a careful baseline history gives essential information about whether depression or antidepressants initiated a dysfunction or exacerbated or had no effect on an existing condition. Decreased libido and other sexual dysfunctions are among the most common symptoms of depression, and many antidepressants frequently produce sexual dysfunction as a side effect, often creating a vicious cycle of noncompliance and relapse. Anxiety (independently, as a symptom of depression, or as an antidepressant side effect) also often produces sexual dysfunction. A thorough biopsychosocial evaluation and careful follow up on such symptoms at subsequent appointments are the keys to diagnosis and effective treatment of sexual dysfunction associated with depression and antidepressants.

Tricyclic and serotonin-reuptake inhibiting medications frequently inhibit sexual function. Up to 70% of patients taking SSRIs develop sexual dysfunction in libido, excitement, orgasm, and resolution stages. The related "good news" is that SSRIs often effectively treat premature ejaculation; the "bad news" is that they may prevent or greatly interfere with libido and orgasm or ejaculation in patients who otherwise are responding well with improvement in depression symptoms.

Spontaneous resolution of antidepressant-induced sexual dysfunctions rarely occurs after a few weeks. Unless the patient is already on the minimal effective dose, dosage reduction should be the initial approach to determine whether the side effect might subside while the therapeutic effect is maintained. Drug holiday strategies may produce serotonin withdrawal syndrome in short half-life SSRI agents and increase the risk of de-

pression relapse. Paradoxically, the more effective the holiday, the more common noncompliance becomes, frequently leading to relapse. Next, try other agents with a low prevalence of sexual dysfunction side effects (e.g., mirtazapine, bupropion SR, nefazodone, venlafaxine XR, citalopram). Citalopram is a new, second generation SSRI, which is reported to be more selective and cause much less sexual dysfunction and adverse drug-drug interactions than current SSRIs. It may be released during the next year.

Other counterbalancing, adjunctive agents for antidepressant-induced sexual dysfunction include psychostimulants, trazodone, buspirone, yohimbine, cyproheptadine, amantidine, and ginkgo. Some approaches to treating erectile dysfunction will be reviewed including: vacuum devices, a new tablet (sildenafil), penile injections, and a urethral suppository.

Psychiatrists can play a key role in effectively treating and consulting with other physicians and educating patients and the public about recent advances related to avoiding and treating sexual dysfunction due to depression and antidepressants.

REFERENCES:

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Industry-Supported Symposium 10 — **Sunday, October 4 12 noon-1:30 p.m.**

SCHIZOPHRENIA: CHARTING A COURSE THROUGH MENTAL ILLNESS

Supported by U.S. Pharmaceuticals, Pfizer Inc

S. Charles Schulz, M.D., *Professor and Chairman, Department of Psychiatry, Case Westen Reserve University, 11100 Euclid Avenue, Cleveland, OH 44106-2602*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to demonstrate knowledge of the lifelong course of schizophrenia, incorporating new findings and recognizing which phases of illness are critically important; evaluate new versus older antipsychotic treatments and psychological interventions across the course of psychotic illness; and diagnose and treat affective symptoms associated with psychotic disorders.

SUMMARY:

The course of schizophrenia is lifelong, characterized by many remissions and exacerbations. Recent clinical and neuroscience advances have contributed to the development of new antipsychotic agents and new empirically derived psychosocial interventions that offer effective integrated treatment for psychotic patients. This symposium will focus on evaluating and selecting treatments appropriate for each phase of psychosis from preillness to prodroms, first psychotic break, and maintenance treatment. Discussion will highlight work characterizing the neuropsychological and functional characteristics of premorbid schizophrenics. From there, the emphasis will shift to a description and evaluation of an identified early psychosis prevention and intervention program, focusing on outcomes, research findings, and identified treatment strategies. Early identification and intervention, both pharmacologic and psychosocial, reduce future morbidity. The next discussion will characterize the patients themselves and management issues faced with first-episode schizophrenics and review treatment decisions early in the disease course. The fourth presentation will describe challenges posed in treating schizophrenia by residual affective and negative symptoms, focusing on recognition and diagnosis, followed by medication strategies for these symptoms. The symposium will conclude with a discussion of overall management issues in maintenance treatment throughout the course of illness, such as relapse prevention and side-effects management.

No. 10A
THE COURSE OF SCHIZOPHRENIA

S. Charles Schulz, M.D., *Professor and Chairman, Department of Psychiatry, Case Western Reserve University, 11100 Euclid Avenue, Cleveland, OH 44106-2602;* Lee Friedman, Ph.D.; Robert L. Findling, M.D.

SUMMARY:

The early stages of schizophrenia represent an important phase of illness for research and treatment. The research group at Case Western Reserve University has been utilizing MRI imaging, neuropsychiatry of both schizophrenia and bipolar patients whose onset occurs before age 18. In addition, our group has conducted an open-label trial of an atypical antipsychotic agent to examine its safety and efficacy in this age group.

Results of the MRI data will be presented and will show that both patient groups have similar brain volume indices as the community-based control group. This finding is consistent with a neurodevelopmental hypothesis not only of schizophrenia but also of bipolar illness when onset occurs during adolescence. Neuropsychological test results show deficiencies in the teenage schizo-

phrenic patients, a finding that may have importance in treatment planning. In addition, results of our open-label risperidone study will show a reduction in both positive and negative symptoms of schizophrenia. In teenagers with schizophrenia, in our opinion, the medication also showed great acceptability.

No. 10B
EARLY INTERVENTION IN SCHIZOPHRENIA

Alan J. Mendelowitz, M.D., *Department of Psychiatry, Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004*

SUMMARY:

Early intervention in patients with schizophrenia has been a focus of clinical research over the last several years. In studying first-episode schizophrenic patients, we have been interested in the correlation between the duration of their symptoms prior to treatment and subsequent clinical course. The duration of illness before treatment was found to be associated with the time to remission of symptoms.

As a result, a new focus of early intervention in patients prior to the onset of illness is an area of clinical attention.

We are attempting to identify, evaluate, and treat a cohort of patients with a constellation of behavioral symptoms, neuropsychological findings, and symptoms of psychosis who fail to meet criteria for schizophrenia but who are felt to be at risk for the illness.

The question of the efficacy of treatment in this cohort and its effect on their clinical course will be discussed.

No. 10C
EMERGENCY INTERVENTIONS AND TREATMENT OF PSYCHOSIS

David G. Daniel, M.D., *Clinical Studies, L.T.D., 6066 Leesburg Pike, 6th Floor, Falls Church, VA 22041;* Fuad Issa, M.D.; Mary R. Lee, M.D.

SUMMARY:

Currently available pharmacological interventions for emergency treatment of psychotic agitation are limited by incomplete efficacy and by side effects. The mainstays of treatment are intramuscular formulations of conventional neuroleptics and benzodiazepines. The former are often poorly tolerated due to extrapyramidal and dysphoric side effects; none are currently commercially available in parenteral formulations. This presentation will describe the available options, their advantages and disadvantages, and newer investigational approaches on the horizon. Results of recent clinical trials with an investigational intramuscular preparation of the atypical antipsychotic, ziprasidone, will be included.

No. 10D
LONG-TERM MANAGEMENT OF SCHIZOPHRENIA: THE ROLE OF NEW ANTIPSYCHOTICS

Paul E. Keck, Jr., M.D., *Department of Psychiatry, University of Cincinnati, P.O. Box 610559; 231 Bethesda Avenue, Cincinnati, OH 45267*

SUMMARY:

The key to the long-term successful treatment for patients with schizophrenia is prevention of relapse. Lack of compliance with antipsychotic medication is the major factor in psychotic relapse. New data suggest that psychotic relapses may have a cumulative effect and accentuate a downhill course. A frequent reason for patients discontinuing antipsychotic medication is the occurrence of uncomfortable pseudo-parkinsonian symptoms, akathisia, and other side effects. Compliance can be enhanced by selecting agents with characteristics most likely to reduce patient-specific side effects. A model using receptor affinities will be presented to rationally select the optimal neuroleptic treatment with the least side effects for each patient. Optimizing dose, slow titration, and rational use of adjunctive agents, are important factors in maintenance long-term pharmacological treatment. Providing psychoeducation to patients and their families, with emphasis on medication compliance, identification of early signs of illness, and problem solving techniques, are important aspects of maintenance. Flexibility to intervene when necessary with community-based programs, such as Assertive Community Treatment, can be useful, especially when medication compliance is at issue. A rehabilitation model, combined with optimal psychopharmacology, is the key to successful maintenance treatment.

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Industry-Supported Symposium 11 **Sunday, October 4 7:00 p.m.-10:00 p.m.**

DEPRESSION AND ITS SUBTYPES: A TREATMENT UPDATE

Supported by Glaxo Wellcome Inc.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to recognize, diagnose, and treat major depressive subtypes including atypical, hostile, anxious, and bipolar. In addition, the attendees will become familiar with new antidepressant modalities and mechanisms of action.

SUMMARY:

Depression is a heterogeneous disorder varying in its presentation by onset, course, severity, comorbidities, and symptom clusters. Prediction of outcome, selection of therapies, and identification of genetic determinants of the disorder, however, require further efforts by clinical researchers to define specific subtypes of mood disorders among the general population of patients with major depression. Specific and well studied depressive subtypes with characteristic symptom patterns, prognostic significance, and treatment implications are "atypical," "anxious," "hostile," and "bipolar" depressions. In this symposium, Dr. Jerrold Rosenbaum will review general psychopathological and treatment implications of subtyping depressive syndromes. Dr. Andrew Nierenberg will define and present data on the course and treatment of atypical depression. Dr Bruce Lydiard will describe the anxious depressive subtype. The hostile depressive with the prominent features of anger attacks will be the focus of Dr. Maurizio Fava's presentation, and Dr. William Potter will review data on the bipolar depressive. Each presentation will offer new data as well as discussion of pharmacological treatments. Dr. Steven Stahl will describe new antidepressant pharmacotherapies, mechanisms of action, and their implications for these depressive subtypes.

No. 11A
COURSE AND TREATMENT OF ATYPICAL DEPRESSION

Andrew A. Nierenberg, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114-3117*

SUMMARY:

Atypical depression is the most common form of depression in outpatients, but little is known about its comorbidity, course, and treatment compared with melancholia. Beyond the well-characterized constellation of symptoms that define atypical depression (mood reactivity, hypersomnia, leaden paralysis, hyperphagia, and rejection sensitivity), specific Axis I and II comorbid conditions may differentiate atypical from other depressed patients. Similarly, age of onset, duration of episodes, frequency of relapses and recurrences, and frequency of complete remission in atypical depression may be different. It has not even been established if atypical depression is a stable subtype or if it is just one of several forms of depression that an individual may express during a lifetime of recurrent depressions. MAOIs are superior to TCAs for the treatment of atypical depression, but no studies have compared MAOIs to the newer generation of antidepressants (SSRIs, bupropion, venlafaxine, nefazodone, and mirtazapine). Because of the favorable benefit/risk ratio, clinicians tend to use these newer antidepressants for all outpatients, including those with atypical depression, even though the literature is limited. A review and critique of the relevant literature on atypical depression will be presented.

No. 11B
ANXIOUS DEPRESSION: CLINICAL CHARACTERISTICS AND TREATMENT OPTIONS

R. Bruce Lydiard, M.D., Ph.D., *Department of Psychiatry, Medical University of South Carolina, 171 Ashley Avenue, Charleston, SC 29425-0001*

SUMMARY:

Depression and anxiety co-occur frequently in depressed patients. Studies indicate that over half of patients presenting with major depression may have a concomitant anxiety disorder. An additional percentage have subdiagnostic anxiety symptoms that are clinically significant. The most commonly observed anxiety disorders detected in patients seeking treatment for depression include generalized anxiety disorder, panic disorder, and social phobia. The literature regarding optimal treatment of patients with comorbid major depression and anxiety disorders is scant. However, it is clear that when major

depression co-occurs with anxiety disorders, treatment resistance is unfortunately common. In the long term, there is increased risk for psychosocial impairment, financial disability, and suicide for these unfortunate individuals. Because comorbidity of anxiety and depression is extremely common, optimal treatment is essential.

Following an overview of the existing literature, potential treatment strategies will be presented, and remaining questions will be discussed.

No. 11C
DEPRESSION AND ANGER ATTACKS

Maurizio Fava, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114*

SUMMARY:

Major depressive disorder is frequently accompanied by irritability, hostility, and anger attacks. This presentation will focus on depression with anger attacks (hostile depression), which is characterized by the presence of sudden spells of anger associated with general irritability and autonomic arousal symptoms such as tachycardia, sweating, flushing, and a feeling of being out of control. Hostile depression was first introduced by John Overall, who identified this subtype as being characterized by high levels of hostility, suspiciousness, somatic symptoms, and anxiety. We have subsequently replicated Overall's findings in two separate studies of depressed outpatients with anger attacks. Depressed patients with anger attacks tend to present with more pathologic behaviors than depressed patients without anger attacks, and anger attacks subside in most patients following antidepressant treatment. Although there is anecdotal evidence that TCAs may be less effective than SSRIs in treating this subtype of depression, a recent double-blind, placebo-controlled study found similar response rates to sertraline and imipramine among depressed patients with anger attacks.

No. 11D
BIPOLAR DISORDER: SPECIAL TREATMENTS?

William Z. Potter, M.D., Ph.D., *Department of Neuroscience, Lilly Research Laboratories, Lilly Corporate Center, DC-0532, Indianapolis, IN 46285*

SUMMARY:

To date, no treatment has been *specifically* developed for the treatment of the depressed phase of manic-depressive illness. Many reports indicate that at least in some patients drugs indicated for unipolar depression may precipitate mania and/or worsen the long-term course of the illness. An example of this phenomenon is the association of rapid cycles with the use of tricyclic antidepressants (TCAs).

There are clinical reports for non-TCA antidepressants—MAOIs, SSRIs, bupropion—suggesting superiority over TCAs for bipolar depression. Systematic controlled studies, however, are not available to test these possibilities. Most recently, it has been suggested that compounds as disparate as selective alpha-2 adrenoreceptor antagonists and novel antiepileptics (eg., lamotrigine) may have special efficacy. These various pharmacologic approaches to bipolar depression will be reviewed in terms of what is known about the distinguishing biochemical actions of each drug class. Since no common pattern emerges, it will be argued that agents with novel actions be more systematically assessed in the treatment of bipolar depression. The importance of finding a "maintenance antidepressant" for some patients who do not respond to lithium monotherapy will be emphasized with a critical evaluation of the potential of newer drugs.

No. 11E
NEW ANTIDEPRESSANT MECHANISMS AND IMPLICATIONS OF DEPRESSIVE SUBTYPES

Stephen M. Stahl, M.D., Ph.D., *Department of Psychiatry, University of California, San Diego, 8899 University Center Lane, #130, San Diego, CA 92122-1009*

SUMMARY:

Five new pharmacological classes of antidepressants have been introduced since the tricyclic antidepressants and the monoamine oxidase inhibitors. These include the selective serotonine reuptake inhibitors, a norepinephrine dopamine reuptake inhibitor, a serotonin norepinephrine reuptake inhibitor, and serotonin-2 antagonist/reuptake inhibitor. Most recently introduced is mirtazapine, an alpha-2 antagonist with several additional pharmacological actions, sometimes referred to as a NASSA (noradrenergic, antihistaminergic, and specific serotonergic antidepressant).

Mirtazapine is the first alpha-2 antagonist marketed in the U.S. By blocking alpha-2 receptors on noradrenergic (NE) neurons, NE release is enhanced. By similarly blocking alpha-2 heteroreceptors on serotonin (5-HT) neurons, NE release is enhanced. A second mechanism acts to enhance 5-HT release, namely the increase of NE at excitatory postsynaptic alpha-1 receptors on 5-HT neurons. Such actions increase both NE and 5-HT, not unlike dual reuptake inhibitors, but by an entirely separate and unique mechanism.

Although the evidence for one antidepressant acting in any given depressive subtype (more effectively than another) requires further study, it is evident from some differences already observed, (MAOIs vs. TCAs in atypical depression), that different mechanisms of action may well have relevance for enhanced therapeutic efficacy in particular subtypes of depression. Certainly, different mechanisms of action are associated with different side-effect profiles.

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2. Comorbidity of Mood and Anxiety Disorders. Edited by Maser JD, Cloninger CR. American Psychiatric Press, Inc. Washington DC, 1990.
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Industry-Supported Symposium 12 — **Sunday, October 4, 7:00 p.m.-10:00 p.m.**

VIOLENCE AND MENTAL ILLNESS: AN OVERVIEW

Supported by Eli Lilly and Company

W. Walter Menninger, M.D., *The Menninger Clinic, 5800 S.W. 6th Street, Topeka, KS 66606*

SUMMARY:

Violence is a significant problem in psychiatry—40% of psychiatrists and 48% of psychiatric residents report being assaulted by a patient. Over the past decade, studies report a prevalence of violent behavior ranging from 6% to 40% in mentally ill patients requiring hospitalization, with a median prevalence of 15% prior to hospitalization and 25% being violent on mental hospital wards. Drawing on NIMH Epidemiological Catchment Area study data, Swanson et al found the prevalence of violence in persons meeting the criteria for a DSM-III Axis I diagnosis to be 11% to 13%, more than five times the rate among persons not diagnosable (2%). Diagnoses most associated with violence were schizophrenia, major depression, mania/bipolar disorder (all between 11% and 13%), alcoholism (25%), and drug abuse (35%). Violence was most likely to occur in young, lower class males with a diagnosis of substance abuse or a major mental disorder. In psychiatric settings, four social variables predict much of the violence: history of violence, coercion, length of hospitalization, and a bipolar diagnosis. Commonly, mentally ill persons are violent over issues of power and control, similar to persons who are not mentally ill.

No. 12A
VIOLENT PATIENTS: ASSESSMENT, MANAGEMENT, TREATMENT

W. Walter Menninger, M.D., *The Menninger Clinic, 5800 S.W. 6th Street, Topeka, KS 66606*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify new developments in the prevalence, treatment, and management of aggressive and violent patients, discuss risk management and assessment of potential violence, examine new developments in the legal requirements for warning or protecting third parties, and specify psychopharmacological interventions and countertransference issues.

SUMMARY:

Violence on the part of patients is second only to patient suicide as a situation that provokes anxiety in clinicians. Clinicians are confronted not only with the challenge of appreciating the true incidence of violence in relation to mental illness, but they must have reasonable approaches in the assessment of a potential for violence and in techniques for managing and treating the violent patient. This symposium offers an update of knowledge drawn from work with violent patients to:

- Establish a solid understanding of violence and its relation to mental illness,
- Be presented an approach for assessing potential violence that can be used in risk management,
- Be updated with the latest legal decisions that obligate the clinician to warn or protect third parties from violent patients,
- Identify the potential psychopharmacological interventions used to reduce aggression and violence,
- Recognize countertransference issues in working with violent patients, and
- Establish an effective overall approach to the management of the violent and aggressive patient.

No. 12B
RISK MANAGEMENT: ASSESSING POTENTIAL VIOLENCE

Prudence Baxter, M.D., *Cambridge Court Clinic, 40 Thorndike Street, Cambridge, MA 02141;* Jonathan M. Silver, M.D.

SUMMARY:

This presentation will offer a conceptual framework that will assist the clinician in delineating factors in both the patient and his/her environment that will increase or decrease the patient's risk of violence. Risk management of potentially violent patients requires, among other things, an orderly process of assessment. A thorough assessment includes (1) an analysis of the violent episode or set of circumstances—such as threats—that led to concerns about a patient's potential for violence; (2) a review of any past history of violence; (3) an assessment of the patient's insight into his or her behavior; and (4) knowledge of the patient's medical status. Because violence does not exist in a vacuum, this presentation will teach the clinician to identify situational, interpersonal, and biological/diagnostic/mental status factors associated with violence specific to the patient being evaluated.

No. 12C
DELUSIONS AND VIOLENCE

Phillip J. Resnick, M.D., *Department of Psychiatry, University Hospital, 11100 Euclid Avenue, Cleveland, OH 44106-1736*

SUMMARY:

This presentation will cover the relationship between delusions and violence. Recent research on characteristics of delusions relevant to risk assessment will be delineated. In particular, threat control-override delusions will be contrasted with more benign delusions. Special attention will be given to assessing persecutory delusions.

Paranoid psychotic patients are relatively more likely to be violent in the community than in hospital settings. The importance of weapon movement in persons with paranoid delusions will be emphasized. Acute delusions are more dangerous than chronic delusions. The specific propensity for violence in erotomanic delusions, misidentification delusions, and delusions of infidelity will be explicated. The affects of fear and anger increase the likelihood of acting on delusions. Delusions in stalkers will also be discussed. Finally, the likelihood of acting on command hallucinations with hallucination-related delusions will be covered.

No. 12D
NEW DEVELOPMENTS IN THE "DUTY TO PROTECT"

James C. Beck, M.D., *Department of Psychiatry, Cambridge Hospital, 1493 Cambridge Street, Cambridge, MA 02139*

SUMMARY:

The duty to protect continues to vex psychiatrists, particularly in the public sector where psychiatrists increasingly see patients who have been violent. Psychiatrists should know the current state of the law and its clinical implications.

Review of recent legal cases suggests two contrasting themes. The good news is that several state courts have rejected the duty to protect altogether. The bad news is that California courts have extended the duty to criminal cases, raising potentially serious problems for patient/therapist confidentiality in that state.

Lastly, I will review the clinical implications of the legal duty, giving concrete suggestions on how to evaluate and manage potential violence and on how to document effectively. These suggestions are designed to be clinically sound and to protect the clinician against potential liability if violence should occur.

No. 12E
PSYCHOPHARMACOLOGICAL TREATMENTS FOR VIOLENCE

Stuart C. Yudofsky, M.D., *Department of Psychiatry and Behavioral Sciences, Baylor College of Medicine, One Baylor Plaza, Room 115D, Houston, TX 77030-3411*

SUMMARY:

Violent and aggressive behaviors are highly prevalent among psychiatric patients and people who suffer from organic brain disorders. Elliott reported that 94% of 286 patients with histories of recurrent uncontrolled range attacks with little or no provocation had evidence of developmental or acquired brain deficits. Aggressive episodes related to organic brain disorders may range from verbal expressions to physical outbursts and severe injury. Each year in the United States over 400,000 people suffer from brain injury secondary to trauma. Irritability and aggressiveness occur in up to 70% of people who suffer from traumatic brain damage. Irritability and aggressiveness—as opposed to physical deficits—are often the major source of disability to victims and of stress to their families. This presentation will focus on assessment and treatment of these difficult

patients. Pharmacologic treatment of these aggressive disorders will be explored.

No. 12F
ASSESSMENT AND MANAGEMENT OF THE VIOLENT PATIENT

Carl C. Bell, M.D., *President and Chief Executive Officer, Community Mental Health Council, Inc., Clinical Professor of Psychiatry, University of Illinois School of Medicine, and Clinical Professor, Illinois School of Public Health, 8704 South Constance Avenue, Chicago, IL 60617-2746*

SUMMARY:

Staff attitudes and affects will be discussed as impediments or strengths in appropriately assessing and managing the violent patient. The need to explore staff's prior experience with violence will also be discussed. The different types of violence will also be highlighted as different types of violence call for different staff responses. The amount of time available to respond to violence determines the response, and as such, time is the main principle for managing violence and differentiates violence into potential, urgent, and emergent situations. Each of these situations will be discussed and appropriate interventions will be given for each situation.

REFERENCES:

1. Menninger WW: Management of the aggressive and dangerous patients. Bulletin of the Menninger Clinic, 1993; 57(2):208-217.
2. Borum R, Swartz M, Swanson J: Assessing and managing violence risk in clinical practice. Journal of Practical Psychology Behavioral Health 1996; 205-215.
3. Link BG, Stueve CA: Psychotic symptoms and the violent illegal behavior of mental patients compared to community controls, in Violence and Mental Disorder: Developments in Risk Assessment. Edited by Monahun Steadman H. Chicago, University of Chicago Press, 1994.
4. Curry J, Beck JC: Current status of the duty to protect. Practical Psychiatry and Behavioral Health 1997; 3:203-211.
5. Yudofsky SC, Silver JM, Jackson M, Endicott J, Williams D: The Overt Aggression Scale: an operationalized rating scale for verbal and physical aggression. Amer J Psychiatry 1986; 143:35-39.
6. Tupin JP: The violent patient: a strategy for management and diagnosis. Hospital & Community Psychiatry 1983; 34:37-40.

Industry-Supported Symposium 13 — **Monday, October 5 6:30 a.m.-8:00 a.m.**

PRACTICAL ASPECTS TO IMPROVING OUTCOMES IN SCHIZOPHRENIA

Supported by Zeneca Pharmaceuticals

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to translate the current advances in psychosocial and psychopharmacologic treatment of schizophrenia into a model for clinical practice.

SUMMARY:

Despite better psychosocial and psychopharmacologic treatments, long-term outcomes in schizophrenia have remained disappointing. This symposium, "Practical Aspects of Improving Outcomes in Schizophrenia," will present practical information that mental health clinicians can use to enhance the long-term outcomes for their clients with schizophrenia. Because individuals with schizophrenia have so many difficult problems, clinicians must begin by establishing a primary focus of treatment.

The symposium will use a hierarchical model of treatment priorities; that is, first comes stability, then quality of life, and finally, recovery. This model assumes that relapse prevention is a cornerstone to improving other outcome areas. The presentations will follow this model. The first two presentations will focus on relapse prevention from the perspectives of psychopharmacologic and psychosocial interventions. The next two presentations will focus on ways of improving patients' quality of life after stabilization: the first will focus on how to decrease the burden of medication side effects and the second on the psychosocial management of quality of life for patients who are recovering from schizophrenia.

No. 13A
RELAPSE PREVENTION: HOW TO GET MORE FROM MEDICATIONS

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

SUMMARY:

Relapse prevention is a cornerstone of improving the treatment outcome for persons with schizophrenia. While the newer antipsychotic medications offer hope of better outcomes, the proper use of these medications must be based on an understanding of the fundamentals

of relapse prevention psychopharmacology. In addition, clinicians need to consider how to adapt the use of maintenance medication to common complications seen during the long-term treatment of schizophrenia. These complications include comorbid substance abuse and medication noncompliance and nonresponse. These complicating factors affect the initial selection of an antipsychotic, as well as impact on a variety of other medication management decisions.

Some of the more common medication management decisions affecting a person's chance of relapse include (1) the recommended duration of maintenance therapy, (2) the evaluation of medication nonresponse and the timing of the use of newer "atypical antipsychotics," (3) the evaluation of a patient's likelihood of becoming noncompliant and his or her need for depot medication, (4) medication management when there are episodes of active substance abuse, and (5) switching methods from one antipsychotic to another.

Recently developed practice guidelines and the findings from publications based on "outcome research" have addressed the topics listed above. These guidelines and findings will be reviewed and ways of implementing the recommendations as they apply to community settings will be discussed.

No. 13B
HOW TO MAKE PSYCHOEDUCATION REALLY EFFECTIVE

Patricia L. Scheifler, M.S.W., *Director, Partnership for Recovery, P.O. Box 55053, Birmingham, AL 35255*

SUMMARY:

Many clients spend years revolving in and out of hospital and community programs without mastering the knowledge and skills needed to overcome some of the barriers to stability. To be effective, a psychoeducation program has to be presented in a way that truly facilitates learning. Methods for teaching clients about their illness and its treatment will be discussed as well as ways of teaching clients to master the skills needed to lead a fuller, more productive life. The goal of a psychoeducation program is to develop a partnership between the client and treatment team that will ultimately reduce relapse and promote recovery. Specific case examples will be given to illustrate key points.

No. 13C
MEDICATION SIDE EFFECTS AND QUALITY OF LIFE: HAS THE PARADIGM CHANGED?

Sharon G. Dott, M.D., *Department of Psychiatry, University of Texas Medical Branch, 1114 Graves Building, Room D28, Galveston, TX 77555-0428*

SUMMARY:

The conventional antipsychotics have a wide array of central nervous system and peripheral system side effects that often lead to problems in patient management. With the recent introduction of atypical antipsychotics, considerable progress has been made with respect to the adverse motor side effects. The lack of prolactin elevation associated with some of these newer agents has also reduced the incidence of menstrual irregularities and sexual dysfunction. The new agents have greatly improved the treatment of psychosis by increasing effectiveness, reducing drug-induced morbidity, enhancing medication compliance, and increasing the quality of life of our patients. This presentation will review how to properly identify side effects and how to select medications to match patient needs and concerns.

No. 13D
QUALITY OF LIFE: WHAT DO CLIENTS TELL US?

Ronald J. Diamond, M.D., *Department of Psychiatry, University of Wisconsin, 6001 Research Park Boulevard, Madison, WI 53718*

SUMMARY:

Improving clients' quality of life has become a major treatment goal when working with persons with schizophrenia. The problem has been to agree on what quality of life actually means. Clinicians used to feel they knew when a client was "getting better" and that they knew more than the client. It is now clear that clients' views often differ from those of their clinicians. What is important to the clinician may not be as important to the client and vice versa. Symptom reduction and community stability are typically the most important goals for clinicians, whereas, getting an apartment and a job are often of more importance to the client. Further, clients and clinicians often assess the costs and benefits of a medication differently. Therefore, at the very least, clinicians need to acknowledge a quality-of-life gap between perspectives.

The next step beyond acknowledging the differences in viewpoints is to take the patient's concerns seriously. When we do, all aspects of our treatment from the initial treatment plan, to how we use medication, to what we count as indicators of improvement tend to change. By taking the client's perspective seriously, it may require that we work with varying points of view that may be incompatible with our own. At the same time, listening to our clients' perspectives about quality of life can lead to more effective treatment as defined by both clients and clinicians.

REFERENCES:

1. Practice Guidelines for the Treatment of Patients with schizophrenia, Am J Psychiatry 1997; 154:1-62.
2. Kissling W: Compliance, quality assurance and standards for relapse prevention in schizophrenia. Acta Psychiatrica Scand 1994; 89(Suppl 382):16-24.
3. Bisbee CC: Educating Patients and Families about mental illness. Birmingham: Partnership for Recovery, 1995.
4. Casey DE: Side effect profiles of new antipsychotic agents. J Clin Psychiatry 1996; 57(Suppl II):40-45.
5. Sainfort F, Becker M, Diamond R: Judgments of quality of life of individuals with severe mental disorders: patients' self-report versus provider perspectives. Am J Psychiatry 1996; 4:497-502.

Industry-Supported Symposium 14 — **Monday, October 5, 12 noon-1:30 p.m.**

INTERVENTION FOR REFRACTORY BIPOLAR DISORDER

Supported by Glaxo Wellcome Inc.

Gary S. Sachs, M.D., *Department of Psychiatry, Harvard Medical School, and Massachusetts General Hospital, 15 Parkman Street, WACC-812, Boston, MA 02114*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will be able to offer better treatment to patients with treatment refractory-bipolar depression, mania, and rapid cycling; understand the role of cognitive behavioral interventions for managing bipolar mood disorder; recognize potential adverse consequences of antidepressant medications for bipolar patients; and understand the role of practice guidelines in the management of refractory bipolar patients.

No. 14A
MANAGEMENT OF TREATMENT-REFRACTORY BIPOLAR DEPRESSION

Gary S. Sachs, M.D., *Department of Psychiatry, Harvard Medical School and Massachusetts General Hospital, 15 Parkman Street, WACC-812, Boston, MA 02114*

SUMMARY:

The high risk of suicide in depressed bipolar patients presents a compelling need for antidepressant treatment, but risk of poor outcome is high. Response rates to standard antidepressant medications appear substantially lower in bipolar patients than in unipolar depression. Furthermore standard antidepressant medications may worsen the course of bipolar illness. Use of antidepressants is complicated by the risk of mania during the course of treatment and during withdrawal of treatment. In addition, Altshuler et. al. have shown antidepressant medications may accelerate cycling even without induction of abnormal mood elevation. Therefore, clinicians treating bipolar depression face a dilemma as they balance the risks and benefits of treatment with antidepressant mediation.

This presentation will offer guidelines for management of refractory bipolar depression, which use four principles to manage the risk of antidepressant medication: (1) Initiate acute phase treatment with mood stabilizing agents. (2) If necessary offer standard antidepressant medications proceding stepwise from agents with lower risk (bupropion) to higher medications (tricyclics). (3) Minimize antidepressant exposure by attempting a gradual taper after appropriate continuation phase treatment, and (4) Offer ECT for patients at immediate risk of self-harm or unable to tolerate pharmacological interventions.

No. 14B
OPTIONS FOR TREATMENT-REFRACTORY RAPID RECYCLING

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

SUMMARY:

The rapid-cycling variant of bipolar disorder appears to account for 13% to 20% of all patients with bipolar disorder and as many as 72% to 82% of these patients exhibit a poor response to lithium. Dunner and Fieve (1976) first coined the term rapid cycling in a landmark paper that summarized double-blind, placebo-controlled data designed to evaluate clinical factors associated with lithium prophylaxis failure; Kukopulos (1980) and colleagues replicated and extended these findings in 1980. Rapid cycling is now viewed as a phenomenon that modifies or specifies the natural history or course of bipolar disorder and is believed to be associated with a greater mortality and morbidity. In recent studies, it has been noted that bipolar rapid cycling is often accompanied by comorbidity on Axis I (substance abuse and anxiety disorders), Axis II (borderline personality disorder), and Axis III (hypothyroidism). The phenomenon of rapid cycling tends to appear late in the course of the disorder when cycles have become circular, and occurs more frequently among females. This presentation will review various treatment options for refractory rapid cycling, including data regarding the spectrum of efficacy of lamotrigine in treatment-refractory bipolar rapid cycling.

No. 14C
COGNITIVE BEHAVIORAL STRATEGIES FOR BIPOLAR PATIENTS

Noreen A. Reilly-Harrington, Ph.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114*

SUMMARY:

Historically, bipolar disorder has been conceptualized as a biologically driven form of mental illness. Therefore, the majority of research on bipolar disorder has explored genetic and biochemical diatheses and pharmacological treatments. However, limitations to pharmacotherapy alone are indicated by a five-year relapse rate of 73% for even patients with favorable acute responses to medication and adequate maintenance treatment. Furthermore, a growing number of studies suggest that life stressors and psychological variables, such as negative cognitive styles, contribute vulnerability to bipolar mood episodes. Cognitive-behavioral therapy (CBT) is a structured, active, and present-oriented psychotherapy that has the potential to augment the efficacy of pharmacotherapy, improve quality of life, and lower rates of relapse. This presentation will focus on adjunctive, cognitive-behavioral techniques for the control and management of treatment-refractory hypomania and depression. Specialized strategies for modifying dysfunctional thinking and behavior, identifying and coping with triggers for relapse, and improving medication compliance will be discussed. Suggestions for regulating activities, minimizing circadian rhythm disruptions, charting mood fluctuations, and recognizing early warning signs of episodes will also be presented. The importance of psychoeducation and family involvement will be addressed and recent data supporting the application of adjunctive CBT will be reviewed.

REFERENCES:

1. Sachs GS: Treatment refractory bipolar depression, in Psychiatric Clinics of North America. Edited by Amsterdam J, and Rohan M. Philadelphia, W.B. Saunders, 1996.
2. Sachs GS: Bipolar mood disorder: practical strategies for acute and maintenance phase treatment. J Clin Psychopharm (suppl) 1996; 16:32s-47s.
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Industry-Supported Symposium 15 — **Monday, October 5, 12 noon-1:30 p.m.**

PERENNIAL ISSUES IN THE MANAGEMENT OF DEPRESSION

Supported by Wyeth-Ayerst Laboratories

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to demonstrate greater ability to diagnose comorbid anxiety and depressive disorders and select optimal pharmacotherapies for major depression.

SUMMARY:

Diagnosis and treatment in major depression are constantly evolving. This symposium focuses on two important issues—treatment of comorbid anxiety/depressive disorders and new advances in pharmacotherapy of depression. The first talk will be presented by Dr. R. Bruce Lydiard, who will first address how anxiety (including generalized anxiety disorder) and depression are related, and then optimal drug therapy for comorbid patients. Dr. Charles Nemeroff will present on recent studies on the basic differential pharmacology of newer antidepressants and clinical trials pointing to a range of responsivity in major depressed patients.

No. 15A
ANXIETY AND DEPRESSION: NEW TREATMENT OPTIONS

R. Bruce Lydiard, M.D., Ph.D., *Department of Psychiatry, Medical University of South Carolina, 171 Ashley Avenue, Charleston, SC 29425-0001*

SUMMARY:

The coexistence of anxiety and depression is a common clinical problem. There is accruing evidence that much of the risk for depression in women derives from

the presence of preexisting anxiety. Worse yet, even "subdiagnostic" anxiety may cause relative resistance to depression treatment, worsen disability, and increase subsequent morbidity. Scientific data regarding treatment of coexisting anxiety and depression are very limited. This presentation will review the early concept of "anxious depression," and the evolution of our current diagnostic classification system. The clinical relevance of the primary-secondary distinction for anxiety disorders and depression will be reviewed. Finally, treatment options for mixed anxiety-depression and comorbid anxiety disorders with major depression will be discussed. The benefits and relative disadvantages of the available treatments will be highlighted.

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4. Brown C, Schulberg HC, Shear MK: Phenomenology and severity of major depression and comorbid lifetime anxiety disorders in primary medical practice. Anxiety 1996; 2:210-218.
5. Schatzberg AF, Nemeroff CB (eds): Textbook of Psychopharmacology, 2nd Edition. Washington, American Psychiatric Press, 1998.

No. 15B
RECENT ADVANCES IN THE PHARMACOLOGY OF MAJOR DEPRESSION

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

SUMMARY:

With the introduction of the SSRIs ten years ago, the hope was that use of such selective antidepressants with a limited range of pharmacological actions as defined by neurotransmitter receptor and transporter affinities would result in improved efficacy and side-effect profile. Although there is little doubt that the SSRIs have, in fact, become the first line agents in the treatment of depression, there is a growing belief among clinicians and investigators alike that a sizeable percentage of patients with major depression exhibit an inadequate therapeutic response to SSRIs, either classified as nonresponders or partial responders, the latter with persistent symptomology of affective disorder. This has led to the development of a third generation of antidepressants beyond the first generation (TCAs and MOAIs) and the second generation (SSRIs). These comprise the dual reuptake inhibitors (venlafaxine), pure norepinephrine reuptake inhibitors (reboxetine), selective receptor modulators (nefazadone and mirtazepine), and other atypical antidepressants (bupropion), as well as CRF-1 receptor antagonists, tachykinin antagonists, etc. The efficacy of the newer antidepressants in the treatment of particular patient populations will be discussed, as well as their side-effect profiles.

REFERENCES:

1. Schatzberg AF, et al: McLean Hospital Depression Research Facility: early onset phobic disorders and adult onset major depression. Br J Psychiatry, in press.

Industry-Supported Symposium 16 — **Monday, October 5, 5:30 p.m.-8:30 p.m.**

ACCELERATING ANTIDEPRESSANT RESPONSES IN THE SEVERELY ILL

Supported by Forest Laboratories, Inc., and Parke-Davis

Steven P. Roose, M.D., *Professor of Clinical Psychiatry, New York State Psychiatric Institute, 722 West 168th Street, New York, NY 10032-2603*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to inform the clinician of treatment approaches to speed response.

SUMMARY:

Antidepressant treatments take time to work; for example, it is widely believed that patients exhibit maximum response only after four to six weeks on medication. Whether the delay in antidepressant response is inherent in the mechanism of antidepressant action or may be affected by clinical strategies to shorten response time remains an unanswered question. A number of variables affect the speed of response to medication, including the mode of administration, dosing strategy, and patient's age. With electroconvulsive therapy (ECT) as well, time to response is affected by the method of administration, e.g., high or low voltage and unilateral or bilateral lead placement. Speed of response is an especially critical question in the severely ill patient whose care requires the most resources, and who, until recovery, is at the greatest risk for mortality associated with depressive illness.

This symposium will address the issue of accelerating antidepressant response in the severely ill. Dr. Steven Roose will discuss the methodological issues in defining accelerated response, and will illustrate how the rate of dose escalation can affect speed of response to tricyclics. Dr. Bruce Pollock will present new data on the impact

of intravenous SSRI administration on speed of response. Dr. Craig Nelson will discuss the relationship between serotonin and down regulation of beta-adrenergic receptors and the translation of this into combination pharmacological treatment to accelerate response. Dr. Harold Sackeim will present data on the variables in ECT that affect the speed of response, including voltage and lead placement, and will discuss the use of transcranial magnetic stimulation as a possible augmentation strategy to accelerate antidepressant response.

No. 16A
DEFINING SPEED OF RESPONSE

Steven P. Roose, M.D., *Department of Clinical Psychopharmacology, New York State Psychiatric Institute, 722 West 168th Street, New York, NY 10032-2603*

SUMMARY:

Recently there has been considerable interest in assessing the onset of symptom reduction and speed of response with antidepressant treatment, prompted in part by pharmaceutical companies promoting new medications as "working faster than standard treatments." If a medication were to demonstrate early therapeutic effect, this would have important benefits, specifically: (1) it would help engage the patient in treatment and likely increase adherence, and (2) if early onset of symptom reduction does predict end point response, this knowledge could contribute to decreased patient dropout or forestall premature drug discontinuation by the physician.

However, the onset of symptom reduction may or may not be a harbinger of full response. It is important that a treatment reduces severity of depression significantly in the first week only if the patient goes on to have a full response when the treatment is continued. Not surprisingly, there is considerable debate over the criteria that define significant symptom reduction and speed of response, as well as the appropriate statistical methods to use when comparing treatments.

To illustrate the complexity of this issue, the relationship between dosing strategy, time to reach therapeutic plasma levels, and speed of response will be discussed for the tricyclic antidepressants. Whatever the delay in response inherent in antidepressant treatment, the unsubstantiated belief that rapid dose escalation increases side effects can contribute significantly to the choice of a treatment plan that needlessly delays antidepressant response.

No. 16B
USING COMBINATION THERAPY TO ACCELERATE RESPONSE

J. Craig Nelson, M.D., *Department of Psychiatry, Yale University, 20 York Street, New Haven, CT 06504*

SUMMARY:

Although a variety of antidepressant medications are now available, all are associated with a delay in antidepressant response. As a result, various strategies have evolved with the objective of accelerating response to treatment. Two of the earliest strategies reported involved the addition of either thyroid hormone or lithium to ongoing antidepressant therapy. Although these strategies have usually been employed in refractory patients, a few reports suggest that each agent, used from the initiation of treatment, may help to accelerate response. The combination of a serotonergic and a noradrenergic antidepressant has also been explored. In a preliminary investigation, we found the combination of desipramine and fluoxetine more rapidly effective than desipramine alone. The accelerated response did not appear to be the result of increased plasma levels of desipramine. A recent approach, which has received considerable attention, is pindolol augmentation. It is suggested that pindolol blocks the presynaptic $5HT_{1A}$ receptor and, by doing so, interferes with the feedback mechanism that reduces serotonin turnover when reuptake blockade occurs. Three placebo-controlled studies of pindolol augmentation have now been reported that address speed of response. These various combination strategies will be reviewed, and their clinical application described.

No. 16C
INTRAVENOUS ANTIDEPRESSANT THERAPY IN THE SEVERELY ILL

Bruce G. Pollock, M.D., Ph.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh, PA 15213-2593*

SUMMARY:

Parenteral drug administration avoids hepatic first-pass metabolism, leading to higher initial plasma levels of drug. Moreover, nonspecific factors, including absolute compliance and intensity of treatment, may be therapeutically beneficial. Intravenous clomipramine has been used in Europe for many years; our previous study using a double-blind, double-dummy method did not find evidence for shorter latency of response with parenteral clomipramine. Nonetheless, the use of large doses of parenteral tricyclic antidepressants is limited by their cardiotoxic actions. Citalopram is the most selective of the selective serotonin reuptake inhibitors (SSRIs) and the only SSRI available in a formulation for parenteral infusion. In European studies, citalopram has been shown to be safe and effective with a risk/benefit profile that is as favorable as the oral preparation. A double-blind comparison in 62 severely depressed patients found two weeks of slow-drip infusion with citalopram to be significantly more effective than the parenteral form of

the noradrenergic antidepressant, viloxazine. A tendency for quicker therapeutic action has also been found in a comparison of parenteral citalopram with the oral formulation. In addition, intravenous citalopram may be advantageous for severely ill patients who are unable to tolerate oral medication or physiologically incapable of intestinal absorption. The availability of a safe, parenteral form of a potent antidepressant would allow exploration of its utility for frail, medically compromised patients as well as those with depression or obsessive-compulsive treatment resistance.

No. 16D
ECT AND TRANSCRANIAL MAGNETIC STIMULATION IN DEPRESSION

Harold A. Sackeim, Ph.D., *Biological Psychiatry, New York State Psychiatric Institute, 722 West 168th Street, New York, NY 10032-2603*

SUMMARY:

This presentation will review key issues in the use of electroconvulsive therapy (ECT) and transcranial magnetic stimulation (TMS) in the severely depressed patient. Technical factors in ECT administration strongly influence efficacy and cognitive side effects. There is a distinct advantage for right unilateral over bilateral ECT with respect to cognitive side effects, independent of stimulus dosage. However, the efficacy of right unilateral ECT is highly sensitive to stimulus dosage relative to seizure threshold. Speed of ECT response is usually faster with ECT than pharmacologic alternatives, and is dependent on stimulus dosage for both right unilateral and bilateral ECT. Medication resistance has clinically useful predictive value with regard to ECT outcome. Patients with established medication resistance during the index depressive episode have a lower probability of ECT response and may require intensive treatment to achieve remission. TMS is a new technology that focally stimulates brain areas without seizure induction. Initial evidence suggests that repetitive TMS may have marked and rapid antidepressant effects. Developments in the use of TMS to treat severe depression will be discussed.

REFERENCES:

1. Derivian AT: Antidepressants: can we determine how quickly they work? Issues from the literature (1995), Psychopharm Bull. 1994; 31:23-28.
2. Bouchard JM (Data on file.).
3. Pollock BG, Perel JM, Nathan RS, Kupfer DJ: Acute antidepressant effect following pulse loading with intravenous and oral clomipramine. Arch Gen Psychiatry 46:29-35, 1989.
4. Nelson JC: Augmentation strategies for treatment of unipolar major depression, in, Mood Disorders: Systematic Medication Management. Edited by Rush AJ. Basel, Switzerland: S Karger AG, 1997.
5. Sackeim HA, Devanand DP, Nobler MS: Electroconvulsive therapy, in Psychopharmacology: The Fourth Generation of Progress. Edited by Bloom F, Kupfer D. New York, NY, Raven Press, 1995, pp 1123-1142.
6. Pascual-Leone A, Rubio B, Pallardo F, Catala MD: Rapid-rate transcranial magnetic stimulation of the left dorsolateral prefrontal cortex in drug-resistant depression. Lancet 1996; 348:233-237.

INNOVATIVE PROGRAMS: SESSION 1

OUTPATIENT CONTINUUM OF CARE

Innovative Program 1 **Friday, October 2**
10:00 a.m.-11:30 a.m.

PARTNERS IN HOUSING THE HOMELESS MENTALLY ILL

Marcella Anne Maguire, Ph.D., *Psychologist, Mobile Community Outreach Treatment Team, St. Elizabeths Hospital, 2700 Martin Luther King Avenue, S.E., Building 2E-13, Washington, DC 20032*; Ann M. Oliva, B.A., *Initiative Program Officer, The Community Partnership, Washington, DC, 801 Pennsylvania Avenue, S.E., Washington, DC 20003*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will have an applicable working model of cooperation necessary between public and private nonprofit agencies, if such agencies are to be able to successfully house the chronically, mentally ill homeless consumer.

SUMMARY:

Housing the persistently homeless and chronically mentally ill individual has been a challenge that the federal government through the Department of Housing and Urban Development has taken. The Outreach Demonstration Grant from HUD is a component of the award to the Community Partnership for the Prevention of Homelessness. The Community Partnership is the private nonprofit agency that coordinates homeless services in Washington, D.C. This grant targeted the most difficult to reach homeless clients with at least six months of living on the streets, unsheltered. A total of 150 clients were slotted to receive services; 107 clients were accepting of services. The vast majority of the 107 clients were either mentally ill or dually diagnosed. The program offered flexible funding to agencies involved in outreach to the chronically homeless. The agencies were able to finance whatever services they deemed clinically necessary to stabilize and permanently house the individual. The Program for Assertive Community Treatment (PACT) Team in Washington, D.C., was able to house many of its most persistently homeless individuals using this funding.

The presentation will focus on the collaboration between the public mental health agency, the agency's PACT Team, and the private, nonprofit agency charged with providing homeless services in a northeastern urban setting.

REFERENCES:

1. Dennis DL, Buckner JC, Lipton FR, et al: A decade of research and services for homeless mentally ill persons: where do we stand? American Psychologist 1991; 46:1129-1138.
2. Lehman AF, Dixon LB, Kernan E, DeForge BR: A randomized trial of assertive community treatment for homeless persons with severe mental illness. Archives of General Psychiatry, in press.

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

OUTPATIENT COMMITMENT: THE NEW YORK EXPERIENCE

Howard W. Telson, M.D., *Director, Outpatient Commitment Program, Department of Psychiatry, Bellevue Hospital, New York University, 215 East 24th Street, Apt. 321, New York, NY 10010-3804*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the clinical and legal theories underlying outpatient commitment, Bellevue's implementation of the New York State outpatient commitment pilot program, and the data of the first three years of the pilot.

SUMMARY:

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

In 1994 New York state passed legislation calling for a three-year pilot program to provide "involuntary outpatient treatment of mentally ill persons." The law also mandated an independent study to evaluate the program's success in preventing relapse and also participant satisfaction. In 1997 the pilot was statutorily extended for one year.

This presentation will describe Bellevue Hospital Center's implementation of the program since July 1995. It will also describe the outcome study being conducted by Policy Research Associates. It will review the first three years of clinical data and provide preliminary conclusions regarding outcome from the perspectives of

clinicians, patients, family members, and government officials.

REFERENCES:

1. Swanson JW, Swartz MS, George LK, Burns BJ, Hiday VA, Borum R, Wagner HR: Interpreting the effectiveness of involuntary outpatient commitment: a conceptual model. J Am Acad Psychiatry Law 1997; 25:5-16.
2. Torrey EF, Kaplan RJ: A national survey of the use of outpatient commitment. Psychiatric Services 1995; 46:778-784.

Innovative Program 3 **Friday, October 2**
10:00 a.m.-11:30 a.m.

A COUNTY NONPROFIT HOSPITAL PSYCHIATRIC CRISES SERVICE

Michael P. Resnick, M.D., *Medical Director, Portland/ Providence Crises Triage Center, 5228 North East Hoyt, Building B, Portland, OR 97213-2967*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session the participant should understand the processes and challenges by which a county nonprofit hospital partnership can develop a comprehensive crises intervention service.

SUMMARY:

This presentation describes the first year of development and implementation of a comprehensive psychiatric crises stabilization center. It is a joint effort of Multnomah Co. (Portland, Ore) and Providence Medical Center, a private, nonprofit hospital. Goals included providing high quality, accessible services to patients without regard to payment source, to provide a continuum of care to individuals in crises, to reduce involuntary hospitalizations, and to reduce "falling through the cracks." The program includes the following components: 24-hour crises line staffed by mental health professionals; 24-hour acute assessment service that includes psychiatrists on site, 23-hour observation capacity; 15-bed, on-site, enhanced respite capacity; 5-secure transport capabilities; provision of 30-day case management-linkage services; mobil crises response; 10-bed extended respite in attached housing.

The organizational and financial challenges of providing this array of services to a diverse population of patients in an urban center are discussed. The evolution to the present model and the challenges of integration in both a community mental health and managed care environment will be presented.

REFERENCES:

1. Lamb HR, Shaner R: When there are almost no state hospital beds left. Hospital and Community Psychiatry 1993; 44:973-6.
2. Dvoskin JA, Steadman HJ: Using intensive case management to reduce violence by mentally ill persons in the community. Hospital and Community Psychiatry 1994; 45:679-84.

INNOVATIVE PROGRAMS: SESSION 2

CREATIVE TREATMENT OPTIONS FOR THE HOMELESS

Innovative Program 4 **Friday, October 2**
1:30 p.m.-3:00 p.m.

OUTREACH TO HOMEBOUND AIDS PATIENTS WITH SUBSTANCE ABUSE

Lawrence B. Jacobsberg, M.D., Ph.D., *Psychiatric Consultant, AIDS Mental Health Team, Community Mental Health Services, Visiting Nurse Service, 2170 McDonald Avenue, Brooklyn, NY 12229*; Neil Pessin, Ph.D., *Clinical Director, Community Mental Health Services, Visiting Nurse Service, 1250 Broadway, 3rd Floor, New York, NY 10001*; David C. Lindy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to formulate innovative and effective interventions for homebound AIDS patients with substance use histories.

SUMMARY:

Patients with HIV/AIDS are often homebound as a result of their illness. Particularly challenging is the situation of injection drug users, many of whom continue, at least occasionally, to abuse substances and practice unsafe sexual activities. In ambulatory and institutional settings, abstinence and 12-step programs have traditionally been prescribed for such patients within a traditional medical model. The frequent failure of such approaches has led to an approach of harm reduction. Underlying this philosophy is the principle of minimizing harm, rather than striving for maximum individual benefit. This outlook sometimes requires clinicians to tolerate a level of treatment noncompliance and drug abuse in the service of a larger, societal good.

The Visiting Nurse Service of New York supports HIV-mental health consultation and treatment teams to provide consultation, liaison, and ongoing treatment to the medical home care services of such patients. Cases will be presented to illustrate a range of clinical situations, including scenarios for both traditional and harm-

reduction interventions. Adaptations needed for the home-care setting will be described. The audience will be encouraged to share reactions and enrich the discussion from their own clinical experiences. The presentation will thus broaden the treatment repertoires of all participants.

TARGET AUDIENCE:

Psychiatrists, psychiatric nurses, and clinical social workers.

REFERENCES:

1. Hurley PM, Ungavarski PJ: Mental health needs of adults with HIV/AIDS referred for home care. Psychosocial Rehab 1994; 17:117-126.
2. Jacobsberg L, Laitman L, Lindy D, Pessin N: Mental health services for home care clients, in Home Care Manual Making the Transition. Edited by Zang SM; Bailey NC. Lippincott, Philadelphia 1996, 373-386.

Innovative Program 5 **Friday, October 2**
1:30 p.m.-3:00 p.m.

HOMELESS DUALLY DIAGNOSED CLIENTS: A PUBLIC/PRIVATE COLLABORATION TO ESTABLISH A CONTINUUM OF CARE

Marilyn Seide, Ph.D., *Manager, Adult Services, Department of Mental Health, Riverside County, 4095 County Circle Drive, Box 7549, Riverside, CA 92503*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the clients who might benefit from such a program and learn the essential elements needed to provide the support, treatment, and aftercare services essential for its success.

SUMMARY:

A nonprofit agency operating several residences for substance abusers in Riverside County received a HUD grant in 1996 toward the creation of a residence for mentally ill substance abusers. The project was to have the following three parts: a team of outreach workers from the county department of mental health who would identify and assess homeless men and women for appropriateness for the project; referrals would then be screened by staff from the residential facility and, if they met the criteria, would be admitted to the program for a period of six to nine months; after successfully completing the program, they would move on to a transitional housing/vocational training program run by another nonprofit, community-based agency.

This presentation reports our experiences in conceptualizing and operating the program, modifying it, working out difficult collaborative disagreements, and identifying elements that should be added to enhance a continuum of care that would result in the ability of the formally homeless, dually diagnosed clients to live independently, constructively, and substance-free in the community with their psychiatric symptoms under control.

TARGET AUDIENCE:

Those working with homeless and dually diagnosed clients and those interested in establishing effective services for this population.

REFERENCES:

1. Center For Substance Abuse Treatment: Assessment & Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse, Dept. HHS1994.
2. Sciacia, K, Thompson CM: Program development & integrated treatment across systems for dual diagnosis: mental illness, drug addiction & alcoholism. Journal of Administration, Summer 1996; Vol. 23, No 3.

Innovative Program 6 **Friday, October 2**
1:30 p.m.-3:00 p.m.

CRISIS INTERVENTION AS OUTREACH TO THE HOMELESS

Neil A. Falk, M.D., *Assistant Professor of Psychiatry, Oregon Health Sciences University, 3181 S.W. Sam Jackson Park Road, Portland, OR 97201-3011*; Julie Larson, M.S.W., *Coordinator, Project Respond, Mental Health Services West, 310 N.W. Flanders, Portland, OR 97209*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate a knowledge of appropriate methods of crisis intervention with the homeless mentally ill, and how to utilize these contacts as a basis for a therapeutic relationship. The participant should also be able to recognize the risks and advantages of working within a crisis oriented care system while providing outreach services.

SUMMARY:

Project Respond, started in 1993 and recipient of the APA 1997 Gold Achievement Award, is a mental health team that performs psychiatric outreach, crisis intervention, and community education in downtown Portland, Oregon. The clientele consists mostly of severe and persistently mentally ill persons with extended periods of homelessness who reside in the open spaces and "skid row" areas of the city. The team receives many requests

for crisis intervention from multiple sources, ranging from case managers requesting client welfare checks to police officers requesting assistance in hostage negotiations. Throughout the years, team members have identified methods of intervention that are acceptable to both the client and the community. As many of the clients are re-referred by other sources, these interactions are best viewed as part of an ongoing relationship as opposed to single random events. Even though crises are difficult and often traumatic for clients, these contacts can be used to foster an ongoing relationship with them, leading to better therapeutic outcomes. The process can also work "in reverse," as outreach contacts often facilitate future crisis contacts due to the relationship already established with the client. Even difficult clients who are antagonistic toward team members at first contact can, over time, come to trust and rely on team members for support and assistance. Examples will be provided of both successful and unsuccessful crisis intervention techniques, from the standpoint of both acute and long-term management. Case studies will also be provided to demonstrate the longitudinal approach, which this work mandates.

TARGET AUDIENCE:

Physicians, nurses, and social workers.

REFERENCE:

1. Linking mentally ill persons with services through crisis intervention mobile outreach, & community education. Psychiatric Services 1997; 47:1450-1453.

INNOVATIVE PROGRAMS: SESSION 3

COMMUNITY SERVICES: NEW AND OLD

Innovative Program 7 **Saturday, October 3**
8:00 a.m.-9:30 a.m.

THE VILLAGE INTEGRATED SERVICES AGENCY

Mark Ragins, M.D., *Psychiatrist, Village Integrated Services Agency, 456 Elm Avenue, Long Beach, CA 90802-2426*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand how a small, self-contained, comprehensive, integrated mental health system can be designed and run; understand how to use a capitated budget to cost shift from institutional to rehabilitative services with an empowerment, quality-of-life outcome focus.

SUMMARY:

The Village Integrated Service Agency is a demonstration project initially funded by the California legislature to create better mental health services.

Services were designed around (1) collaborative case management teams, (2) capitated funding, and (3) psychosocial rehabilitation including clubhouse community, employment services, community integration, and many management services.

Accomplishments of the program include (1) integrating and sustaining care over years, (2) focusing on quality of life outcomes, (3) decentralizing financial responsibility and decision making, (4) budgeting that reflects values and goals, (5) collaborating with "treatment-resistant" members, (6) reducing dependence on hospitalization, and (7) integrating substance abuse treatment.

We have recently expanded, lowered costs with two capitation rates, and joined the county mental health system as a contractor.

REFERENCES:

1. Ragins M: Does anything work? The Journal of CAMI 1993; Vol. 4, No. 2.
2. Hargreaves, WA: A capitation model for providing mental health services in California, H & CP, March 1992; 43(3), 275-277.

Innovative Program 8 **Saturday, October 3**
8:00 a.m.-9:30 a.m.

TRANSITION FROM INDIVIDUAL TO GROUP MODEL IN A COMMUNITY MENTAL HEALTH CENTER

Amy S. Hoffman, M.D., *Director, Outpatient Psychiatry, Mt. Sinai-Elmhurst Hospital, 79-01 Broadway, Elmhurst, NY 11373*; Shelley S. Lennox, Ph.D., *Senior Psychologist, Department of Psychiatry, Mt. Sinai-Elmhurst Hospital, 79-01 Broadway, Elmhurst, NY 11373*; Gabriela Centurion, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate awareness of how mental health organizations can fulfill managed care clinical and cost demands by transition to group treatment.

SUMMARY:

Managed care, with its emphasis on cost containment and efficiency of service delivery, requires the psychiatric clinic to modify its provider system. The traditional individual model, the treatment prototype, is demonstrating cost, time, and clinical ineffectiveness relative to the group modality. Therefore, the latter is seen as a

viable way of providing care to the majority of mental health consumers.

This innovative program presents the experience of a community mental health center in transition from the individual to group model. The first topic is the philosophical change and staff support necessary for success of the new service delivery system. In addition, the actual group program in operation at this CMHC will be described. The second topic is that of strategies to promote continuity of care. For example, to minimize the loss of referrals from more intensive levels of care, intakes from inpatient and emergency room services affiliated with the CMHC are conducted in those sites. Finally, discussion will focus on the attempt to identify variables associated with the referral source that predict treatment adherence.

After presentation of each topic, audience participation will be elicited. As all providers are confronting issues surrounding managed care, the session will afford the opportunity to share ideas about other innovative programs and methods of evaluation.

TARGET AUDIENCE:

Mental health care providers.

REFERENCES:

1. Tillitski CJ: A meta-analysis of estimated effect size for group vs. individual vs. control treatments. Int J Group Psychother 1990; 40:215-224.
2. MacKenzie KR: Effective Use of Group Therapy in Managed Care. Washington, DC, American Psychiatric Press, 1995.

Innovative Program 9 **Saturday, October 3**
8:00 a.m.-9:30 a.m.

FOCUSING A STATE SYSTEM: CLINICAL CARE IS JOB ONE

Dale P. Svendsen, M.D., *Medical Director, Ohio Department of Mental Health, 30 East Broad Street, 8th Floor, Columbus, OH 43215-3414*; Michael R. Schroeder, M.S.W., *Ohio Department of Mental Health, 30 East Broad Street, 8th Floor, Columbus, OH 43215-3414*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the elements in effecting systemic change in a large state system, and be able to apply those elements to other settings.

SUMMARY:

Focusing a state system on providing quality mental health care has been a five-year initiative of the Ohio Department of Mental Health. The Therapeutic Activities and Recovery Program (TARP) is the title of the quality initiative under the direction of the medical director. Despite a period of downsizing, the applied focus on clinical issues, with involvement of both central office and hospital staffs, resulted not only in the maintenance but improvement of clinical quality care. This systematic approach and its application throughout the state hospital system will be described.

TARP goals have been: (1) improve the skills and competencies of line staff; (2) increase family involvement in treatment; (3) develop substance abuse/mental illness (SAMI) programming; (4) integrate cultural issues in the assessment and treatment of patients; (5) improve communication and information sharing among clinical staff; and (6) promote recovery as a philosophy and in clinical practice.

The innovative program will describe how these goals have been achieved, the ongoing process that allows for creativity within the overall structure, and the monitoring and results of the program. This will be an interactive presentation with presenters discussing the program with participants throughout.

TARGET AUDIENCE:

Single and multi-hospital medical directors, line clinicians, system administrators, and quality improvement professionals.

REFERENCES:

1. Svendsen DP: TARP Newsletter, Ohio Department of Mental Health, Spring 1996.
2. Svndsen DP, Herndon S: TARP Newsletter, Ohio Department of Mental Health, Summer 1996.

INNOVATIVE PROGRAMS: SESSION 4

ENGAGING AND TREATING THE HOMELESS SERIOUSLY MENTALLY ILL

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

NWHOME PROJECT: WORKING WITH THE HOMELESS MENTALLY ILL

Kenneth A. Cohen, M.D., *Instructor of Clinical Psychiatry, Stone Institute of Psychiatry, Northwestern Memorial Hospital, 259 East Erie Street, Room 251, Chicago, IL 60611-2814*; Sarah R. Shelby, *Graduate Student in Clinical Psychology, Northwestern University Medical School, 303 East Chicago Avenue, Ward 9-217, Chicago, IL 60611*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the heterogeneity of a

homeless mentally ill population; and describe strategies for engagement and treatment of these individuals.

SUMMARY:

The NWHome Project is a HUD funded, supportive services program for homeless mentally ill individuals in Chicago. The program and its operation will be described. A summary of structured evaluations of over 200 consecutively admitted patients will be presented, with focus on the individuals at intake and at one-year follow-up. Presented data will demonstrate that individuals can be engaged successfully, reduce their symptomatology, and improve their psychological functioning and quality of life. Characteristics distinguishing those who remained in the project from those who did not remain in the project will be reviewed, with discussion centered upon implications and strategies for engaging and treating this vulnerable population.

The presenters propose that the homeless mentally ill can more meaningfully be considered as composed of identifiable subgroups each with special characteristics and needs, and that the understanding of this can lead to more individually tailored and effective engagement and treatment. The influence of gender differences upon the engagement and treatment course of homeless individuals with mental illness will be elucidated, and thereby add to the relatively few studies available about gender differences among homeless individuals with mental illness.

REFERENCES:

1. Cohen KA, Edstrom KE, Smith-Papke L: Identifying early dropouts from a rehabilitation program for psychiatric outpatients. Psychiatric Services 1995; 46:1076-1078.
2. Goering P, Wasylenski D, St Onge M, Paduchak D, Lancee W: Gender differences among clients of a case management program for the homeless. Hospital and Community Psychiatry 1992; 42:160-165.

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

RISK FACTORS FOR CHRONIC HOMELESSNESS IN A MENTALLY ILL POPULATION

Katherine E. Edstrom, Ph.D., *Instructor of Clinical Psychiatry, Northwestern University School of Medicine, 30 North Michigan Avenue, Suite 717, Chicago, IL 60602*; Sarah R. Shelby, *Graduate Student in Clinical Psychology, Northwestern University Medical School, 303 East Chicago Avenue, Ward 9-217, Chicago, IL 60611*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize risk factors for chronic homelessness among mentally ill individuals.

SUMMARY:

Early studies tended to view the homeless as a homogeneous group; however, more recent research has focused on subgroups and has demonstrated considerable heterogeneity in this population. The authors of this study single out one such subgroup: a sample of first-time mentally ill homeless individuals who participate in the NWHome Project. No research to date has examined a first-time mentally ill homeless group. The authors define first-time homelessness as having been homeless for less than one year, and chronic homelessness as having experienced more than one episode of homelessness and at least one episode of more than one year's duration. They predict that the first-time homeless differ from the chronically homeless in terms of their symptomatology, prior institutionalization, social connectedness, and criminal history. The authors also predict that in a sample of first-time mentally ill homeless individuals, those at particular risk for chronic homelessness can be identified by examining such variables as early childhood trauma, victimization, hospitalization history, and psychiatric status.

TARGET AUDIENCE:

Practitioners, trainees, program directors, family members, and consumers.

REFERENCES:

1. Calsyn RJ, Roades LA: Predictors of past and current homelessness. J Community Psychology 1994; 22:272-278.
2. Wenzel SL, Gelberg L, et al: Indicators of chronic homelessness among veterans. Hospital & Community Psychiatry 1993; 44:1172-1176.

Innovative Program 12 Saturday, October 3 10:00 a.m.-11:30 a.m.

MONEY MANAGEMENT IN THE SEVERELY MENTALLY ILL

Daniel Yohanna, M.D., *Assistant Professor of Psychiatry, Northwestern University, 303 East Superior, Chicago, IL 60611*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be familiar with the use of representative payees for the homeless mentally ill, its advantages and disadvantages, and how to evaluate the needs for payeeship.

SUMMARY:

Representative Payee (RP) programs are used throughout the country to help patients who have difficulty managing their money (usually entitlement funds) maintain their basic needs, obtain treatment, and learn skills needed for independent living. Although proclaimed to be a necessary service for people with severe mental illness, little is really known about the overall effects of payeeship.

This discussion will review the literature on the Representative Payee program and current knowledge about its effectiveness on financial stability, housing stability, hospitalizations, quality of life, victimization, health care costs, use of community services, substance use, and its effects on mental and psychical health. We will also present preliminary data on a two-year study of payeeship that looks at these factors in three sites in Chicago, through a comparison of patients who meet criteria for payeeship. We will discuss the use of newly developed instruments used to determine the need for payeeship in this population.

REFERENCES:

1. Piazza SE, Ford J, Cogswell SH, Pietila S: Case management and representative payeeship as problems for homeless severely, mentally disabled persons. Final Report to NIM, 1991.
2. Stoner MR: Money management services for the homeless mentally ill. Hospital and Community Psychiatry 1989; 40: 7:751-753.

INNOVATIVE PROGRAMS: SESSION 5

TREATMENT OPTIONS FOR CHILDREN AND PARENTS

Innovative Program 13 **Saturday, October 3**
1:30 p.m.-3:00 p.m.

OPTIONS FOR PARENTS WITH PSYCHIATRIC DISABILITIES

Joanne Nicholson, Ph.D., *Associate Professor of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue, North, Worcester, MA 01655*; Alexis D. Henry, Sc.D., *Assistant Professor of Research, Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue, North, Worcester, MA 01655*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to list the rehabilitation needs of parents with psychiatric disabilities, to identify common goals of parents, and to describe examples of participatory action strategies in program development.

SUMMARY:

The goal of this session is to describe an innovative model for the development of rehabilitation strategies in collaboration with parents with psychiatric disabilities. The Parenting Options Project is a three-year, NIDRR-funded effort by the University of Massachusetts Medical School (UMMS); Employment Options, Inc., (EO, Inc.), a clubhouse-model psychiatric rehabilitation program in Marlborough, MA; and the Massachusetts Department of Mental Health (MA/DMH) to address the unmet rehabilitation needs of parents with psychiatric disabilities. Participatory action research (PAR) strategies are being employed to develop an education and skills training curriculum, and a goal-setting and assessment tool for parents with psychiatric disabilities and their helping professionals.

Active consumer involvement is integral to the Parenting Options Project. Four research assistants, in transitional employment positions managed by the clubhouses, and trained and supervised at the UMMS Center for Research, create a pool of consumers with program development and evaluation skills for future projects.

We will describe the development of sample curriculum modules and the assessment tool, and their use by individuals and in parent support groups. We will describe mechanisms for maximizing stakeholder involvement, and highlight strengths and difficulties in employing the PAR approach in program development.

TARGET AUDIENCE:

Mental health clinicians, occupational therapists, and consumers.

REFERENCES:

1. Nicholson J, Geller JL, Fisher WH: "Sylvia Frumkin" has a baby: a case study for policymakers. Psychiatric Services 1996; 47:497-501.
2. Nicholson J, Blanch A: Rehabilitation for parenting roles in the seriously mentally ill. Psychosocial Rehabilitation Journal 1994; 18:109-119.

Innovative Program 14 **Saturday, October 3**
1:30 p.m.-3:00 p.m.

PREVENTING YOUTH VIOLENCE

Robert S. Marin, M.D., *Associate Professor, Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213*; Rashad Byrdsong, *Community Empowerment Association, 714 North Home-*

wood Avenue, Pittsburgh, PA 15208; Russell G. Schuh, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) describe principles for developing youth violence prevention collaboration between community owned organizations and medical center resources, and (2) identify approaches for dealing with conflicts over programmatic aims, institutional roadblocks, roles and authority among organizers, and lack of understanding of formative evaluation principles.

SUMMARY:

A crucial element in effective community-based mental health initiatives is effective collaboration between community organizations and traditional medical center resources. Youth violence affects all levels of society, but cultural and political issues often obviate such collaborations. The objective of this workshop is to describe the aims, principles, and strategies underlying the development of a funded community-university collaboration whose aim is to reduce youth (so-called gang related) violence in Pittsburgh, PA. The intervention involves collaboration between a community-owned grassroots organization, a medical center's trauma service, and a psychiatry department's division of community psychiatry. The intervention links youth hospitalized for gunshot wounds to the community organization's spectrum of psychological and social programs. Psychiatric professionals provide mental health consultation, as indicated, to traumatized victims and their families. Some of the topics addressed will include: mission and values of program, e.g., giving priority to the community mission over the academic mission; dealing with institutional obstacles, e.g., value conflicts, racism, and ethics of research; program development concepts, e.g., distinguishing formative and summative evaluation processes; and working relationships, e.g., defining roles, sharing authority, value conflicts.

TARGET AUDIENCE:

Clinicians, community workers, and administrators.

REFERENCES:

1. Lipsey MW: Practice and malpractice in evaluation research. Evaluation Practice November 1988; Vol. 9 No. 4, 5-25.
2. Lipsey MW, Cordray, DS, Berger DE: Evaluation of a juvenile diversion program: using multiple lines of evidence. Evaluation Review 1981; 5(3):283-306.

Innovative Program 15 **Saturday, October 3**
1:30 p.m.-3:00 p.m.

CHILD AND ADOLESCENT PSYCHIATRIC EMERGENCY SERVICES: HELP FOR CHILDREN AND ADOLESCENTS IN CRISIS

Debra M. Katz, M.D., *Medical Director, Child and Adolescent Services Division, Mental Health and Mental Retardation Authority of Harris County, 2850 Fannin Street, Suite 200, Houston, TX 77002-6098*; Rochelle Kibert, Ph.D., *Director of Crisis Services, Mental Health and Mental Retardation Authority of Harris County, 3630 West Dallas, Houston, TX 77019*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify psychiatric crisis, triage case appropriate services, stabilize patient and family, and refer for ongoing treatment as determined by emergency assessment.

SUMMARY:

Child and Adolescent Psychiatric Emergency Services (C.A.P.E.S) was instituted in September 1996 in response to the need for community-based emergency services. It has created a partnership between the delivery of quality care in the least restrictive environment and the demands of managed care. C.A.P.E.S. services children and their families where they reside in the community. The ability to work with both the patient and others involved in the crisis helps to stabilize the current situation and empower parents, school officials, police, and other persons within the community to deal with similar situations should they recur. While intensive on-site crisis stabilization does not override the need for acute care or crisis respite, it is a viable alternative for treatment.

It has greatly impacted the utilization of inpatient beds in Harris County and has therefore saved money, which may be shifted to other alternative treatments.

C.A.P.E.S. has evaluated over 400 children and adolescents. The program has been both an efficient and cost-effective way of identifying children and adolescents in need of mental health services who in the past have fallen through the cracks because of the system's inability to respond quickly. Often, the only treatment utilized by these individuals was costly hospitalization.

TARGET AUDIENCE:

Providers of mental health services to children and adolescents.

REFERENCES:

1. Reding GR, Rapnelson M: Crisis intervention: another effective alternative to psychiatric hospitalization. Comm Mental Health J 1995; 31:(2)179-187.

2. Ruffin JE, Spencer HR, Abel A, Gage J, Miles L: Crisis stabilization services for children and adolescents: a brokerage model to reduce admissions to state psychiatric facilities. Comm Mental Health J 1995; 29:(5)433-446.

INNOVATIVE PROGRAMS: SESSION 6

EMERGENCY SERVICES, CROSS-CULTURAL ISSUES, AND SELF-INJURY

Innovative Program 16 **Saturday, October 3**
3:30 p.m.-5:00 p.m.

DEVELOPING AREA-WIDE EMERGENCY PSYCHIATRIC SERVICES

Tammy M. Scott, Ph.D., *Assistant Professor, Department of Psychiatry, Tufts University School of Medicine, 750 Washington Street, Box 1007, Boston, MA 02111*; Oscar Morales, M.D., *Department of Psychiatry, New England Medical Center, 750 Washington Street, Box 1007, Boston, MA 02111*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the pros and cons of implementing an area-wide integrated psychiatric emergency service, and to have the basic knowledge of how such a program is developed.

SUMMARY:

In the current climate of managed health care, the ability to evaluate ill psychiatric patients in an efficient, community-based, cost-effective manner has become pivotal. In an effort to control cost and at the same time improve quality of care, the department of mental health in metro Boston and the managed care company responsible for Medicaid psychiatric services contracted with the department of psychiatry at Tufts/New England Medical Center to develop a city-wide emergency psychiatric service. The goals were (1) to improve access to care by instituting a central triage system accessed through a publicized 800 telephone number and a computerized electronic medical record that was available to clinicians at all Boston Emergency Services Team (BEST) sites; and (2) to control costs by encouraging the use of community-based teams staffed by master's level clinicians instead of hospital emergency departments. Thus, BEST was designed as a *virtual* emergency department for publically funded psychiatric patients.

During the discussion period we will share the challenges and successes we have had in implementing BEST. Participants will be encouraged to explore the pros and cons of setting up similar programs in other catchment areas, and to discuss the logistics of starting such a program.

TARGET AUDIENCE:

Mental health professionals, educators, and administrators interested in emergency psychiatric services.

REFERENCES:

1. Scott TM, Carroll DB, Wharff E, et al: The VASA: psychometrics and utility by community-based psychiatric emergency teams. Submitted to Psychiatric Services.
2. Asbrand D: Boston Emergency Services Team: BEST system is a medical miracle. Infoworld, September 18, 1995.

Innovative Program 17 **Saturday, October 3**
3:30 p.m.-5:00 p.m.

CLINICAL AND CULTURAL ISSUES OF ASIAN COMMUNITIES

Abdul Basit, Ph.D., *Assistant Professor of Clinical Psychiatry, University of Chicago Psychiatric Rehabilitation Center, 7230 Arbor Drive, Tinley Park, IL 60477*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize those clinical and cultural issues that are special impediments in psychosocial rehabilitation of Asian communities. The participants will learn what kinds of psychiatric problems are most prevalent in this community and what treatment strategies have been found effective by professionals.

SUMMARY:

To respond to the growing psychiatric problems among Asian Americans, many clinics and centers have been established during the past three decades. Though relatively small, we have a growing body of research data to suggest how therapeutic approaches can be tailored to the specific needs of Chinese, Filipino, and Korean Americans. But until recently, almost no information was available to determine what kinds of special problems Asian Americans from the Indian subcontinent [India and Pakistan] are confronted with, and whether racial and sociocultural variables have been major impediments in their rehabilitation. With the establishment of two mental health centers in Chicago designed to help and assist communities from the Indian subcontinent, hosts of important variables have emerged that are clinically different from other groups. Knowing how the sociocultural and religious differences make this community different from other Asian groups is important for mental health professionals. A proper understanding of these differences is crucial not only for clini-

cal and research studies but also for treatment strategies. The presentation will also focus on how Asian Americans respond to the Western-oriented therapy and psychosocial approach.

TARGET AUDIENCE:

Psychiatrists, psychologists, and other professionals working with the Asian community.

REFERENCES:

1. Laura Uba: Asian Americans: Personality Patterns, Identity, and Mental Health. New York, Guilford Press, 1994.
2. Segall MH, Dasen PR, et al: Human Behavior in Global Perspective: An Introduction to Cross-cultural Psychology. Boston, Allyn & Bacon, 1990.

Innovative Program 18 **Saturday, October 3**
3:30 p.m.-5:00 p.m.

UNDERSTANDING AND TREATMENT OF SELF-INJURY

Wendy Lader, Ph.D., *Clinical Director, S.A.F.E. Alternatives, MacNeal Hospital, 3249 S. Oak Park Avenue, Berwyn, IL 60402*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) recognize the presence of a self-injury disorder, (2) learn treatment strategies as well as do's and dont's of treatment with this population, and (3) understand the dynamics of pathological coping behaviors.

SUMMARY:

Repetitive self-injury may be a key psychiatric problem in the 21st century. Once viewed as a rare form of masochistic behavior, a survey in the primary work in this area (Bodies Under Siege, 1987) suggests that self-mutilation, a pathological form of self-regulation, may affect about two million Americans annually or 7.5 of every 1,000 persons. Few treatment approaches have successfully resolved the problem of self-mutilation or self-injury. Now, the S.A.F.E. Alternatives Program (Self Abuse Finally Ends), at the Rock Creek Center in Illinois has data that suggest a high level of success. The treatment incorporates insight and cognitive and medication therapies in a "no excuses," personal responsibility group, an individual approach achieving a major shift in patterns of self-injury. An initial retrospective study of 45 patients from a group of 48 successfully completing the program showed that severe self-injury dropped dramatically (74%) and mild self-injury declined substantially (67%). Moreover, coping style changed 232% and, among these respondents, there was an overall 92% satisfaction score. This presentation will include discussion of the diagnosis of this problem, the psychotherapeutic treatment of these cases, and the pharmacological interventions found to be helpful.

REFERENCES:

1. Favazza AR, Favazza B: Bodies Under Siege: Self-mutilation in Culture and Psychiatry Baltimore, MD: Johns Hopkins Press, 1987.
2. Miller D: Women Who Hurt Themselves, New York: Harper Collins Press, 1994.

INNOVATIVE PROGRAMS: SESSION 7

INNOVATIVE INTERAGENCY COLLABORATIONS

Innovative Program 19 **Sunday, October 4**
8:00 a.m.-9:30 a.m.

CASE MANAGEMENT FOR HIGH UTILIZERS IN LOS ANGELES COUNTY

Jeffrey A. Adams, R.N., *Program Coordinator, Edmund D. Edelman Westside Mental Health Center, 11080 West Olympic Boulevard, Los Angeles, CA 90064*; Lawrence A. Wicker, M.S.W., *District Chief, Edmund D. Edelman Westside Mental Health Center, 11080 Olympic Boulevard, Los Angeles, CA 90064*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand negotiating skills required in forging interagency collaborative treatment programs.

SUMMARY:

The Adult Targeted Case Management Services Program is an intensive case-management program designed to enhance community-based services and reduce costs for the highest utilizers of mental health services. The Los Angeles County Department of Mental Health requested submissions from each of the eight service areas. Several full-service mental health agencies as well as specialty providers within our geographic region came together to design and implement the program in our service area. Difficulties that were overcome centered around agencies accustomed to competing and guarding resources needing to share information and compromise in order for the program to meet the departmental requirements and receive funding.

TARGET AUDIENCE:

Mental health managers and clinicians.

REFERENCES:

1. Herinckx HA, et al: Assertive community treatment versus usual care in engaging and retaining clients with severe mental illness. Psychiatric Services 1997; 48:1297-1306.
2. Bachrach: The chronic patient: "breaking down the barriers:" commentary on a conference theme. Psychiatric Services 1997; 48:281-294.

Innovative Program 20 **Sunday, October 4 8:00 a.m.-9:30 a.m.**

PROVIDING SERVICES FOR TRANSITION AGE YOUTH

Christine J. Coho, M.S.W., *Psychiatric Social Worker, Edelman Westside Mental Health Center, 11080 West Olympic Boulevard, Los Angeles, CA 90064*; Robin C. Kay, Ph.D., *Program Manager, Edelman Mental Health Center, 11080 West Olympic Boulevard, Los Angeles, CA 90064*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify challenges in organizing and delivering services to this difficult patient population.

SUMMARY:

The Transition Age Youth (TAY) program is a new program of the Los Angeles County Department of Mental Health that provides services to youth who have previously been served in the children's system of care or are new to the adult system. Traditional approaches have resulted in a large number of mentally ill youth falling out of care at the age of emancipation, but alternative programs have been scarce. Program designers were challenged to recruit skilled clinicians who would be accepted by this population and versatile in engaging youth. In addition, TAY case managers needed to understand the developmental issues that contribute to the lack of success in engaging this troubled population, provide intensive case management, and work with family members and other agencies to establish more collaboration and linkage. An additional challenge was linking multiple systems of care such as schools, probation, and the Department of Children and Family Services to ensure the identification of the most vulnerable clients to maximize opportunities for educational and vocational interventions. Educational efforts at the agency level were needed to ensure referrals and linkage of clients. Within the Department of Mental Health, the children's and adult bureaus needed to shift from separate but equal to integration and collaboration.

TARGET AUDIENCE:

Mental health managers and clinicians.

REFERENCES:

1. Galaway B, Hudson J: Youth In Transition. Toronto, Thompson Educational Publishing, Inc., 1996.
2. Duva JG: Transitional Difficulties of Out of Home Youth. NY: William T. Grant Foundation, 1988.

Innovative Program 21 **Sunday, October 4 8:00 a.m.-9:30 a.m.**

INTERAGENCY DUAL DIAGNOSIS TREATMENT

Nancy L. Nowlin-Finch, M.D., *Program Psychiatrist, Edelman Westside Mental Health Center, 11080 West Olympic Boulevard, Los Angeles, CA 90064*; Charles A. Lennon, M.S.W., *Psychiatric Social Worker, Edelman Westside Mental Health Center, 11080 West Olympic Boulevard, Los Angeles, CA 90064*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize obstacles in creating interagency collaborative treatment programs.

SUMMARY:

The HUD-funded Santa Monica Dual Diagnosis Program provides outreach, housing, and access to health care for homeless individuals with substance abuse and mental or physical health problems. The program was planned in collaboration with Venice Family Clinic (physical health care), Ocean Park Community Center (homeless outreach, food, and shelter) and the Edmund D. Edelman Westside Mental Health Center (mental health and rehabilitation services). Difficulties that were overcome include the creation of an interagency, interdisciplinary treatment team with providers unaccustomed to a clinical perspective; the division and sharing of tasks among different agency providers; and resolving the financial and bureaucratic issues related to contracts between governmental and nonprofit agencies.

TARGET AUDIENCE:

Mental health managers and clinicians.

REFERENCES:

1. Randolph F, et al: Creating integrated service systems for homeless persons with mental illness: the access program. Psychiatric Services 1997; 48:369-373.
2. Nuttbrock LA, et al: Outcomes of homeless mentally ill chemical abusers in community residences and a

therapeutic community. Psychiatric Services 1998; 49:68-76.

INNOVATIVE PROGRAMS: SESSION 8

HOUSING FOR THE HOMELESS MENTALLY ILL

Innovative Program 22 **Sunday, October 4**
1:30 p.m.-3:00 p.m.

A COLLABORATIVE EFFORT FOR HOMELESS MENTALLY ILL WOMEN

Michelle May, M.S.W., *Program Director, Calvary Shelter, Inc., 928 5th Street, N.W., Washington, DC 20001*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to develop successful collaborative programs and strategies that can increase program efficacy and efficiency in serving homeless mentally ill women in an urban setting.

SUMMARY:

This seminar will discuss the history of the collaborative process among women's shelter providers in Washington, D.C. in developing housing programs that serve the multiple needs of homeless mentally ill women.

Women's shelter providers (WSP) is a long-standing coalition of nonprofit homeless programs that meet monthly to discuss the needs of homeless women in the areas of funding, program development and implementation, joint trainings, and system evaluations.

Often individual program development is done in conjunction with a formal or informal needs assessment of the WSP. Reccomendations can then be made to private agencies and local or federal funding agencies.

Since its inception, WSP has spawned a number of outside agencies that continue to service homeless women today, including an overnight shelter, a transitional shelter, a permanent housing program, and currently a low-demand safe-haven model permanent housing program for chronically mentally ill women.

TARGET AUDIENCE:

Mental health clinicians and administrators who serve homeless, mentally ill or dually diagnosed populations.

REFERENCES:

1. Bacharach LL: What we know about homelessness among mentally ill persons: an analytical review and commentary. Hospital and Community Psychiatry, 1992; 43:453-464.
2. Mechanic DA: Strategies for integrating public mental health services. Hospital and Community Psychiatry, 1991; 42(8):797-801.

Innovative Program 23 **Sunday, October 4**
1:30 p.m.-3:00 p.m.

BROTHER, CAN YOU SPARE SOME TIME? BRINGING IN THE UNSHELTERED HOMELESS

Kenneth Freeman, M.P.H., *Mental Health Specialist, EPRS Department, Community Mental Health Services, 1905 E Street, S.E., Building 25, Washington, DC 20003*; Sara F. Carroll, M.S.N., *Nurse Consultant, Department of Human Services, Government of the District of Columbia, 1905 E Street, S.E., Building 25, Washington, DC 20003*; Ronald J. Koshes, M.D.; Robert W. Keisling, M.D.; Lien A. Hung, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to learn a manner and method for approaching, assessing, and establishing long-term relationships with the unsheltered homeless mentally ill.

SUMMARY:

The unsheltered homeless mentally ill in Washington D.C. present a unique opportunity to develop and evaluate the methods of long-term intervention.

The Emergency Psychiatric Response Division-Homeless Outreach Program of the D.C. government has had the same team working with this population for six years. This workshop will demonstrate the methods used to engage unsheltered persons in relationships designed to get them off the streets and into housing. It will include an in-depth analysis of outcome data on a cohort of unsheltered homeless mentally ill that was studied from 1992-1997.

Participants will learn the techniques used with the most regressed and treatment-resistant clients, including rules of engagement, timing, dealing with alienation and family/social anger, reliability, reputation, case-management, and treatment on the street in adverse conditions.

Special attention will be paid to assessment of mental illness, physical illness, and hypothermia among unsheltered homeless at night during the winter months.

Participation will be elicited from the audience by the presenters, in the same manner as they do on the street with new clients.

TARGET AUDIENCE:

Persons working with the homeless mentally ill population.

REFERENCES:

1. Torrey EF: Out of the Shadows, John Wiley & Sons, N.Y. 1997.
2. Isaac RJ, Armat VC: Madness in the Streets, Free Press, N.Y.

Innovative Program 24 **Sunday, October 4**
1:30 p.m.-3:00 p.m.

PERMANENT HOUSING FOR THE DUALLY DIAGNOSED CONSUMER

Marinna A. Banks, M.S.W., *Social Worker, Mobile Community Outreach Treatment Team, St. Elizabeths' Hospital, 2700 Martin Luther King Avenue, S.E., Washington, DC 20032*; Ann M. Oliva, B.A., *Initiative Program Officer, The Community Partnership, Washington, DC, 801 Pennsylvania Avenue, S.E., Washington, DC 20003*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to apply the principles used in housing the homeless, dually diagnosed consumer and will have knowledge of the programmatic details of the Shelter Plus Care housing program, a partnership between the federal government and a public mental health authority.

SUMMARY:

Federally funded demonstration projects have found that with the appropriate combination of services and housing, a segment of the homeless dually diagnosed population can be permanently housed. This presentation will demonstrate the workings of a successful program to house the dually diagnosed homeless population. Shelter Plus Care is a Stewart McKinney Act program that is funded competitively through the Department of Housing and Urban Development (HUD). The program provides rental subsidies and requires the individuals to receive accessory services including mental health treatment and intensive case management.

A total of 141 individuals were designated as meeting program criteria of suffering from a major mental illness and a substance abuse problem. The program was administered by the Community Partnership for the Prevention of Homelessness. The Community Partnership is the private nonprofit agency that coordinates homeless services in Washington, D.C. The Program for Assertive Community Treatment Team in Washington, D.C. is a service agency designated to provide the treatment and services necessary to maintain individuals in housing. At this time, 157 individuals are enrolled in the program and have made the transition to housing. The presentation will highlight the programmatic details and clinical principles used in maintaining the homeless dually diagnosed consumer in permanent housing.

TARGET AUDIENCE:

Mental health clinicians and administrators who serve the homeless, mentally ill, or dually diagnosed populations.

REFERENCES:

1. Drake RE, Oscher FC, Wallach MA: Homelessness and dual diagnosis. American Psychologist. 1991; 46(11):1149-1158.
2. Bebot R.R., Drake R.E., Xie H, et al: Housing status among formerly homeless dually diagnosed adults. Psychiatric Services. 1997; 48(7):936-941.

INNOVATIVE PROGRAMS: SESSION 9

CRISIS TREATMENTS, SEXUAL DISORDERS, AND SEVERE MENTAL ILLNESS

Innovative Program 25 **Sunday, October 4**
3:30 p.m.-5:00 p.m.

FROM THE EMERGENCY ROOM TO THE OUTPATIENT DEPARTMENT: RAPID ACCESS IN AN URBAN MEDICAL CENTER

Guedy Arniella, M.S.W., *Coordinator, Intake Services, Mt. Sinai Hospital, One Gustave Levy Place, Box 1228, New York, NY 10029*; Jorge R. Petit, Jr., M.D., *Director, Psychiatry Emergency Service, Mt. Sinai Hospital, One Gustave Levy Place, Box 1228, New York, NY 10029*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize strategies implemented to facilitate transition of patients from the emergency room to the outpatient department setting.

SUMMARY:

This presentation will describe the Psychiatric Outpatient Rapid Access Service at a major academic, inner-city medical center with a focus on effective and timely service delivery providing continuity of care to patients seen in the psychiatric emergency room. A review of referrals from the psychiatric emergency room to the outpatient department revealed that a large percentage of these patients did not keep their follow-up appointments. In an effort to facilitate continuity of care and to enhance the likelihood of aftercare compliance, we began to provide a brief face-to-face contact by an outpatient department clinician to a cohort of emergency room

patients. Each patient was given an appointment to be seen in the outpatient department within 72 hours of their emergency room discharge. The patient is called the day before his or her scheduled appointment as both a therapeutic contact and a reminder. A self-report instrument, the Basis 32, is completed as an outcome measurement.

This pilot study has thus far shown a dramatic increase in aftercare compliance. It is, therefore, our contention that a personalized meeting with an outpatient department clinician while the patient is still in the emergency room, as well as rapid access to the outpatient department serve to bridge the critical transition from acute care to ongoing treatment. Furthermore, it may be hypothesized that quicker engagement can lead to swifter symptom resolution, decreasing the need for future emergency room visits in the noncompliant patient.

REFERENCES:

1. Kaplan KH: Development and function of a psychiatric liaison clinic. Psychosomatics 1981; 22:502-12.
2. Oldham JM, DeMasi ME: An integrated approach to emergency psychiatric care. San Francisco, CA, Jossey-Bass Inc., 1995.

Innovative Program 26 **Sunday, October 4**
3:30 p.m.-5:00 p.m.

PROVIDING TREATMENT AND PSYCHOSOCIAL REHABILITATIVE SERVICES TO ADULTS WITH SEVERE MENTAL ILLNESS AND SEXUALLY DEVIANT BEHAVIORS IN A COMMUNITY SETTING

Shahla Behjat, M.D., *Psychiatrist, STAR Program, CareLink, Inc., 1201 Stanbridge Street, Building 13, Norristown, PA 19401*; J.P. West, B.S.W., *Social Worker, STAR Program, CareLink, Inc., 1201 Stanbridge Street, Building 13, Norristown, PA 19401*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to distinguish between sexual acting-out behaviors that are institutionalized and deviant; to identify the critical components of a psychosocial specialized treatment program.

SUMMARY:

The STAR Program, which is part of CareLink Community Support Inc., is a treatment and rehabilitation residence that specializes in the treatment of schizophrenia for individuals who have a history of deviant sexual behaviors or who have been convicted of sexual offenses.

In the presentation, we will discuss how behaviors previously associated with long-term institutionalization could be the sexual offender's way of coping with his offending urges while being hospitalized. The notion that the individual acts out sexually because he does not know any better may actually be the offender's way of compensating for his offending behavior. We will also address how the system enables the mentally ill offender to continue offending, because the observer has not been trained to recognize the offending act.

We will then address the value system of the mentally ill offender, targeting his own cognitive distortions regarding sex and his victim's issues. We will then discuss the notion of informed consent, as well as the program's design and various evaluation techniques.

TARGET AUDIENCE:

Psychiatrists, social workers, and psychologists.

REFERENCES:

1. Wodarsky JS, Whitaker DL: Treatment of Sexual Offenders in Social Work and Mental Health Setting. New York, The Haworth Press, 1989.
2. Maletzky BM: Treating the Sexual Offender. Newburg Park, CA, 1991.

Innovative Program 27 **Sunday, October 4**
3:30 p.m.-5:00 p.m.

PSYCHOSOCIAL REHABILITATION OF THE MENTALLY ILL

Albert C. Gaw, M.D., *Associate Professor of Psychiatry, Boston University School of Medicine, and Department of Psychiatry, Bedford Veterans Affairs Hospital, 200 Springdale Road, Bedford, MA 01730*; Elaine Finneral, M.S.W.; MaryAnn Petrillo, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the basic concepts of and team work in psychosocial rehabilitation.

SUMMARY:

Psychosocial rehabilitation has gained prominence in the treatment of patients with severe and chronic mental illness. We conceptualize the process of psychosocial rehabilitation as a series of progressive, coordinated, and integrated steps in moving the patient from a severely regressed position in the hospital to become an independent, functioning individual in the community. Effective teamwork is required to achieve this. By focusing on the patient's needs and establishing alliances across disciplinary lines, professional "turf" struggles are avoided. Areas of overlapping interprofessional concerns, which potentially could be a source of struggle

for control and power, are converted into shared areas of accountability in the development and implementation of comprehensive treatment plans for patients.

Lessons learned from 20 years of psychosocial rehabilitation are summarized to enhance professional satisfaction in long-term work with the chronic mentally ill. Attention is drawn to providing the necessary ingredients for an integrated and comprehensive psychosocial rehabilitation program for the chronic mentally ill in the era of managed care.

REFERENCES:

1. Bachrach LL: Psychosocial rehabilitation and psychiatry: what are the boundaries? Canadian J of Psychiatry 1966; 41:28-35.
2. Meyerson AT, Solomon P: New Developments in Psychiatric Rehabilitation: New Directions for Mental Health Services. Edited by Meyerson AT Solomon P. San Francisco, Jossey-Bass.

INNOVATIVE PROGRAMS: SESSION 10

DELIVERY OF MENTAL HEALTH SERVICES IN NATURALLY OCCURRING RETIREMENT COMMUNITY SITES

Innovative Program 28 **Monday, October 5**
8:00 a.m.-9:30 a.m.

FUNDING AND ADMINISTRATIVE ISSUES IN NATURALLY OCCURRING RETIREMENT COMMUNITY SITES

Neil Pessin, Ph.D., *Clinical Director, Community Mental Health Services, Visiting Nurse Service, 1250 Broadway, 3rd Floor, New York, NY 10001*; Leila B. Laitman, M.D.; Linda Sacco, C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and describe the development of programs at naturally occurring retirement community (NORC) sites that have received funding from the state.

SUMMARY:

Approximately 68% of the geriatric population of the New York City borough of the Bronx (8,669 persons) live in a 1.3 square mile area called Co-op City. While mental health outreach services have always been available in this area, usage of such services has been low. In 1995, a NORC grant was obtained. The mission of the NORC was to enhance and knit together mental health, physical health, and social services; to identify at-risk individuals through outreach, education, and coordination with community gatekeepers; and to make use of providers in the Bronx currently serving this geriatic community. Mental health services lead the way for the first time in the development of this project. A continuum of patient care was established through facility-based and home-care services forming a seamless mental health delivery system. Mental health home care referrals tripled over the year before. Participants in the mental health project are the Visiting Nurse Service of New York (home care license), Jewish Board of Family and Children's Services (clinic license), and Jewish Association for Services for the Aged (concrete and mental health services). Patient flow and patient demographics at this NORC site will be compared and contrasted with other NORCs described in this session to demonstrate how the unique needs of this population have been addressed.

REFERENCES:

1. Hunt M, Ross L: Naturally occurring retirement communities: a multiattribute examination of desirability factors. Gerantologist. 1990; 30:667-674.
2. Nathanson M: A proposal for mental health delivery to naturally occurring retirement communities. Psychiatry on-line 1995; Internet address. http://publinet.It/polnorc.htm.

Innovative Program 29 **Monday, October 5**
8:00 a.m.-9:30 a.m.

MENTAL HEALTH SERVICES AT NATURALLY OCCURRING RETIREMENT COMMUNITY SITES

Mark R. Nathanson, M.D., *Associate Professor of Psychiatry, Geropsychiatry Fellowship, Columbia University for Geriatric/Gerontology Rehabilitation, 85 Fifth Avenue, New York, NY 10003*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should understand aging in place and naturally occurring retirement communities (NORCs) as these terms relate to mental health service delivery to elderly community residents.

SUMMARY:

This session will describe the experience of the author as a psychiatric consultant, program developer and evaluator, and as the director of the geriatric psychiatry fellowship at a New York City hospital. He will review the barriers to care for community seniors and discuss why traditional services are underutilized by the aging population. Aging in place will be described as a foundation for the need for supportive services in the commu-

nity. Two NORC sites will be reviewed: Penn South Houses in the Chelsea section of Manhattan and the Warbasse Houses in the Coney Island area of Brooklyn. The author provided direct patient care in their homes, organized and ran a weekly support group for more mobile individuals, and met and supervised all staff. The session describes the patterns of referrals, the diagnoses, treatment planning, and roadblocks along the way. The conclusion is that home-based services are effective and prevent institutionalization. Funding for such programs needs to be advocated at all government levels. Case finding of seniors in need of care is of urgent importance.

REFERENCES:

1. Nathanson M: A proposal for mental health delivery to naturally occurring retirement communities. Psych On-Line 1995, Internet.
2. Hunt V, Ross L: Naturally occurring retirement communities examination of factors. Gerontologist 1995; 30:667-674.

Innovative Program 30 **Monday, October 5**
8:00 a.m.-9:30 a.m.

THE NATURALLY OCCURRING RETIREMENT COMMUNITY AT CO-OP CITY

Leila B. Laitman, M.D., *Psychiatric Consultant, Community Mental Health Services, Visiting Nurse Service, 1601 Bronxdale Avenue, Bronx, NY 10462*; Neil Pessin, Ph.D.; Wanda Rodriguez, C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to begin to develop home-based mental health services in the acute crisis intervention mode and the case management dimension and understand the implementation of mental health services focusing on barriers to care and the need for a coordinated effort of disciplines and community agencies.

SUMMARY:

Naturally occurring retirement communities are defined as housing developments that are not planned or designed for older people but that attract a preponderance of residents over 60 years of age. These elderly residents need help to remain independent as they "age in place." While the concept of a NORC has existed for a long time in many areas of the country, NORC's seem to flourish in locations where funding sources have encouraged their development. In 1986, Penn South Houses, a 2,820 unit co-op located on the West Side of Manhattan, became home to the very first NORC supportive service program in the United States. It began when the co-op board voted to allocate funds for a part-time social worker. Soon after, additional sources of funding were obtained from a private foundation, so that more comprehensive services could be offered. Other NORC's developed in New York City when, under the 1994 Laws of New York State, the State Office for the Aging established demonstration supportive service programs to provide services to NORC residents. The demonstration projects must seek their own funding to maintain and expand services. This presentation will look at how NORC's are organized and financed to meet the needs of the geriatric populations living in them.

REFERENCES:

1. General Accounting Office: The elderly remain in need of mental health services GAO/HRD-82-112 1982; Washington, DC US General Accounting Office.
2. Hunt M, Gunter-Hunt G: Naturally occurring retirement communities. Journal of Housing for the Elderly 1985; 3:321.

INNOVATIVE PROGRAMS: SESSION 11

BUILDING ALLIANCES IN THE COMMUNITY

Joint Session with the California Psychiatric Association and the National Alliance for the Mentally Ill

Innovative Program 31 **Monday, October 5**
10:00 a.m.-11:30 a.m.

COMMUNICATING WITH DIVERSE CONSTITUENCIES: PUBLIC AWARENESS AND EDUCATION THROUGH COALITIONS AND ALLIANCES

Stella March, B.A., *National Alliance for the Mentally Ill, 317 Bronwood Avenue, Los Angeles, CA 90049*; Inez Kimi Mann, M.A., A.P.R., *President, Mann & Associates, 1719 Gillette Crescent, South Pasadena, CA 91030*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the dynamics of coalition building and explore the use of coalitions as an innovative means for communicating with diverse constituencies working towards common goals.

SUMMARY:

The Anti-Discrimination Task Force was created as an action item in the Southern California Psychiatric Society's first joint meeting with the Presidents Council of the Los Angeles County AMI. The issues were (1)

creating an alliance that would serve as a communications vehicle, (2) developing a more diverse constituency (than the original two sponsoring organizations) to support public awareness programs, including minority outreach, (3) creating/adopting goals and objectives supportable by the larger constituency, and (4) creating significant opportunities for joint programming to enhance coalition (and organizational) effectiveness and performance. This program concentrates on strategies and techniques to build that wider, more diverse constituency with limited staff and limited funding; explores navigating and mediating through different agendas to forge common goals; demonstrates how opportunistic action by organizations—separately and working together—can build positive and effective programs for public awareness and public education; and ends with practical advice about creatively nurturing alliances to expand organizational outreach for added impact.

REFERENCES:

1. Wandersman A, Valois R, Ochs L, et al: Toward a social ecology of community coalitions, Am J Health Promot. 1996; 10:299-307.
2. Borkman T: Self-help groups at the turning point: emerging egalitarian alliances with the formal health care system? Am J Community Psychol 1990; 18:321-332.

Innovative Program 32 **Monday, October 5**
10:00 a.m.-11:30 a.m.

LEADERSHIP ISSUES: HOW CARE IS PROVIDED TO THE MENTALLY ILL

Marc D. Graff, M.D., *Partner Physician, Department of Psychiatry, Southern California Permanente Medical Group, and Local Arrangements Consultant, APA Institute Scientific Program Committee, 18040 Sherman Way, Reseda, CA 91335*; Brian Jacobs, *Program Director, NAMI Family-to-Family Education and Support Program in California, 203 Argonne Avenue, B-104, Long Beach, CA 90803*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the dynamics of coalition building, to learn to forge a common agenda on issues with impact on mental health public policy development, and to explore the use of coalitions as an innovative means for communications with diverse constituencies working towards common goals.

SUMMARY:

Both organized psychiatry and advocacy/support groups such as the Alliance for the Mentally Ill have long recognized the importance of forging common ground on critical issues related to how care is provided to the mentally ill and on the need for effective, community-based action. This program focuses on the roles of the sponsoring organizations and critical leadership issues, including defining the scope of the alliance, developing the opportunities to build trust relationships, and working together to define issues and approaches supportable by organizations whose agendas were not necessarily in congruence at all times. Additional topics include the advantages of working together, an exploration of the limitations of alliance-based activities from the perspective of leaders from two different organizations, and recommendations about structuring joint programs for the greatest public impact.

REFERENCES:

1. Sommer R: Family advocacy and the mental health system: the recent rise of the Alliance for the Mentally Ill. Psych Q, 1990; 61:205-21.
2. Briggs HE, Koroloff NM: Enhancing family advocacy networks: an analysis of the roles of sponsoring organizations, Community Mental Health Journal, 1995; 31:317-33.

Innovative Program 33 **Monday, October 5**
10:00 a.m.-11:30 a.m.

FORGING COMMON GROUND: A NEW LOOK AT CALIFORNIA'S INVOLUNTARY COMMITMENT LAW

Elizabeth Galton, M.D., *Past President, Southern California Psychiatric Society, 2901 Wilshire Boulevard, Suite 449, Santa Monica, CA 90403-4907*; Carla Jacobs, *National Alliance for the Mentally Ill, 203 Argonne, Long Beach, CA 90803*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the dynamics of coalition building, to learn to forge a common agenda on issues with impact on mental health policy development.

SUMMARY:

The CPA-AMI LPS Task Force was born as an action item in the Southern California Psychiatric Society's first (now biennial) joint leadership meeting with the Presidents Council of the Los Angeles County AMI. The issue was dealing with the problems families and psychiatrists were facing in attempting to obtain treatment for people suffering from psychotic disorders who refused treatment. The task force felt that the laws written ostensibly to protect the civil rights of such people were, in fact, preventing them from receiving treatment. In California, involuntary treatment is codified in laws

known as the Lanterman-Petris-Short Act, evolving into 19 points of due process as aspects of civil rights protection were honed and refined over the years. This discussion will focus on both the issues and the process by which the task force was able to (1) define its charge, (2) examine the issues, (3) explore studies and relevant programs, (4) define terms to arrive at a consensus, (5) espouse a list of principles, and (6) plan for future action.

REFERENCES:

1. LaFond JQ: Law and the delivery of involuntary mental health services, Am J Orthopsychiatry 1994; 64:209-222.
2. Young JL, Mills MJ, Sack RL: Civil commitment by conservatorship: the workings of California's law, Bull Am Acad Psychiatry Law, 1987; 15:127-139.

INNOVATIVE PROGRAMS: SESSION 12

MANAGED CARE, CAPITATION, AND TELEMEDICINE

Innovative Program 34 **Monday, October 5**
1:30 p.m.-3:00 p.m.

COMPREHENSIVE PSYCHIATRY SERVICES VIA TELEMEDICINE

Sara F. Gibson, M.D., *Psychiatrist, Northern Arizona Regional Behavioral Health Authority, 611 North Leroux, Flagstaff, AZ 86001*; Teresa D. Bertsch, M.D., *Medical Director, Northern Arizona Regional Behavioral Health Authority, 611 North Leroux, Flagstaff, AZ 86001*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify telepsychiatry as a viable means of providing access to services in rural, underserved areas, to demonstrate an understanding of the risks and benefits of utilizing telemedicine for ongoing psychiatric care.

SUMMARY:

Rural access to psychiatry is often difficult to obtain. Northern Arizona Regional Behavioral Health Authority (NARBHA) is responsible for psychiatry services in a geographic area encompassing 62,000 square miles and 440,000 people. In the past 1 1/2 years, NARBHA has successfully brought up 13 telepsychiatry sites in northern Arizona. Since December 1996, when Apache County, (located 160 miles from Flagstaff, the largest community in the region) lost its access to a psychiatrist, all psychiatry services have been provided via videoconferencing. Psychiatric evaluations, medication monitoring, staffings, emergency care, and staff consultations are provided long distance, to patients of all ages, encompassing a broad range of diagnoses, including chronic mental illness, childhood disorders, and dementia. About 30-40 patients are seen weekly, and more than 1,000 psychiatric services have been delivered via video. In addition to describing the clinical, administrative, and training uses of the system, clinical protocols, patient and physician satisfaction, data on cost effectiveness, and the unique network design features of this telepsychiatry program will be discussed.

REFERENCES:

1. Jones BN: Telemedicine and geriatric psychiatry. Psychiatric Services. 1997; 6:783-785.
2. Zarte CA, et al: Applicability of telemedicine for assessing patients with schizophrenia: acceptance and reliability. Clin Psychiatry 1997; 58:22-24.

Innovative Program 35 **Monday, October 5**
1:30 p.m.-3:00 p.m.

CREATIVE ALTERNATIVES: A CAPITATED MENTAL HEALTH PROJECT

Gerard Gallucci, M.D., *Director of Community Psychiatry, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, D-2 East, Baltimore, MD 21224*; Thomas Marshall, L.C.S.W.G., *Creative Alternatives, 2400 Broening Avenue, Baltimore, MD 21224*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the complexity of issues related to starting a capitated mental health program for patients with severe and persistent mental illness.

SUMMARY:

Creative Alternatives is a capitated mental health demonstration project and is a component of the Johns Hopkins Bayview Community Psychiatry Program. The program serves individuals with severe and persistent mental illness and provides comprehensive mental health and case management services. It is supported by a capitated funding mechanism, which has increased flexibility for program design and patient services. Prior to enrollment in the program, patients were either long-term residents of the state hospital or heavy users of mental health services in the community. The project is currently in its fourth year. We have reviewed various issues related to the start-up of the project including patient events/outcomes, staffing patterns, and various financial and administrative issues. A number of important factors have emerged pertaining to the care of the vulnerable adult in the community. Those attending the session will be asked to participate in the discussion, which will focus on the unique advantages/disadvantages of a program of this type.

REFERENCES:

1. Scheffler R, Grogan C, Cuffel B, et al: A specialized mental health plan for persons with severe mental illness under managed competition, Hospital and Community Psychiatry 1993; 44:937-942.
2. Quinivan R, McWhinter D: Designing a comprehensive care program for high-cost clients in a managed care environment. Psychiatric Services 1996; 47:813-815.

Innovative Program 36 **Monday, October 5**
1:30 p.m.-3:00 p.m.

MENTAL HEALTH ACCESS POINT: MANAGED CARE IN THE PUBLIC SECTOR

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this sesssion, 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 also 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 in Cincinnati. Like most managed care systems, it has three functions: (1) assessment/evaluation, (2) authorization of services, and (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 brief 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 the usual variables of decreased hospitalizations and consumer satisfaction. Lastly, we will relate some clinical outcomes and case vignettes before and after MHAP, including those of children and patients with chronic mental illness.

REFERENCE:

1. Kaufman C, Ganju V: How to measure and improve public/private consumer satisfaction and meet payor performance requirements. Symposium7, High-Performance Public/Private Partnerships, Part 1. Mental Health in the Public Sector, Edited by Minkoff KA, 1997.

Lecture 1 **Friday, October 2**
8:00 a.m.-9:30 a.m.

LESSONS LEARNED FROM THE CALIFORNIA MANAGED CARE EXPERIENCE: PRACTICAL SURVIVAL STRATEGIES FOR ACADEMIC DEPARTMENTS OF PSYCHIATRY

Robert E. Hales, M.D., M.B.A., *Professor and Vice Chair, Department of Psychiatry, University of California at Davis School of Medicine, and Medical Director, Sacramento County Mental Health Services, 2150 Stockton Boulevard, Sacramento, CA 95817*

SUMMARY:

The managed care revolution has radically transformed the way medical and mental health care is delivered in the United States. Perhaps the most dramatic changes have occurred in California. In particular, Sacramento has one of the highest proportions of patients enrolled in managed care health plans (an estimated 94% of the non-Medicare population).

To survive this revolution, departments of psychiatry at academic medical centers have had to radically transform their clinical services from an emphasis on teaching and research to an equally important emphasis on the delivery of cost efficient clinical services that are competitive in a managed care environment. This presentation will summarize the steps that have been taken by the University of California, Davis, Department of Psychiatry, in order to survive and thrive in a highly competitive managed care environment. Data will be presented concerning two years' experience in delivering capitated mental health services to an expanding population of patients receiving care through private insurance and Medi-Cal. The use of telemedicine to deliver mental health services to distant rural sites will also be discussed, along with the educational opportunities that this new technology offers. From all these results, recommendations will be made concerning how academic departments may compete successfully in this environment and still fulfill their educational and research missions.

REFERENCE:

1. American Psychiatric Press Textbook of Administrative Psychiatry, New Concepts for Changing Behavioral Health System. Edited by Talbott JA, Browne J, Freeman M, Hales RE. Washington, DC, American Psychiatric Press 1998.

Lecture 2 **Friday, October 2**
10:00 a.m.-11:30 a.m.

"YA HADDA" BE THERE: OBSERVATIONS FROM THE PSYCHOLOGY OF PLACE ON COMMUNITY-BASED SERVICES

Mindy Thompson Fullilove, M.D., *Associate Professor of Clinical Psychiatry and Public Health, New York State Psychiatric Institute, 722 West 168th Street, New York, NY 10032-2603*

SUMMARY:

This presentation will explore how place-related psychological processes (identity, attachment, and orientation) shape the experience of community-based services for both providers and clients.

REFERENCE:

1. Fullilove MT: Psychiatric implications of displacement: contributions from the psychology of place. American Journal of Psychiatry 1996; 153:1516-1523.

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

THE EXPERT CONSENSUS PRACTICE GUIDELINE FOR SCHIZOPHRENIA

Allen J. Frances, M.D., *Professor of Psychiatry, Duke University Medical Center, Box 3950, Durham, NC 27710*

SUMMARY:

The participant will learn how expert consensus practice guidelines are developed; to choose medication for first episodes of schizophrenia, for recurrences, and for partial responders; to improve medication compliance and deal with substance abuse; facilitate continuity from inpatient to outpatient care; and to integrate psychopharmacological, psychosocial, and programmatic strategies in treatment.

REFERENCE:

1. Frances A, Kahn DA, Carpenter D, Ross R, Docherty J: The expert consensus practice guideline: A new method of establishing best practice. Journal of Practice Psychiatry and Behavioral Health September 1995; 295-306.

Lecture 4 **Friday, October 2**
3:30 p.m.-5:00 p.m.

PSYCHOPHARMACOTHERAPY IN THE CONTEXT OF CULTURAL AND ETHNIC DIVERSITY

Keh-Ming Lin, M.D., M.P.H., *Professor of Psychiatry, and Director, Research Center on the Psychobiology of Ethnicity, Harbor-UCLA Residential and Educational Institute, 1124 West Carson Street, B-4, Torrance, CA 90502-2006*

SUMMARY:

Do ethnic and cultural factors influence patients' psychotropic responses? Are such influences of clinical importance? What mechanisms may be responsible? To address these issues, relevant literature will be reviewed and discussed in the context of recent advances in divergent fields ranging from pharmacogenetics and pharmacoanthropology to medical anthropology. The presentation will highlight the following: (1) substantial biological and cultural diversities exist and are often clinically significant; (2) substantial ethnic differences in the dose range and side-effect profiles have been documented for psychotropics and non-psychotropics; (3) both genetic and environmental (e.g., dietary) mechanisms are responsible for cross-ethnic and inter-individual variations in drug responses; (4) such information should not be interpreted stereotypically. It is hoped that the continuing expansion of research in this area will contribute toward the development of psychiatric practices that are increasingly more bio-psycho-socio-culturally integrated.

REFERENCE:

1. Lin KM, Poland RE: Ethnicity, culture and psychopharmacology, Psychopharmacology: The Fourth Generation of Progress. Edited by Bloom FE, Kupfer DJ. chapter 162, New York, NY, 1995; pp. 1907–1917, Raven Press.

Lecture 5 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

SYNDROMAL AND FUNCTIONAL OUTCOME IN BIPOLAR DISORDER

Michael J. Gitlin, M.D., *Clinical Professor of Psychiatry, University of California at Los Angeles School of Medicine, 1100 Glendon Avenue, Suite 1538, Los Angeles, CA 90024-3519*

SUMMARY:

It is clear that without treatment, patients with bipolar disorder suffer frequent relapses and highly disrupted lives. Recent data suggest however, that despite the availability of a number of effective mood stabilizers, treated bipolar patients show poorer outcome than would be expected as measured by relapse rates. Not suprisingly, patients with a greater number of affective episodes have poorer psychosocial outcome. Simple episode counting, however, is a relatively crude measure of the destructive effect of a psychiatric disorder. Results from our study indicate that a cumulative measure of psychopathology may correlate more strongly with psychosocial outcome than does simple episode counting. Moreover, in addition to symptoms leading to worse psychosocial outcome, psychosocial variables lead to worse syndromes, implying a circular, not linear relationship between these two variables. Life events and personality variables are two other factors that should always be considered as contributing to functional outcome in bipolar disorder. This leads to the need for multimodal evaluation and treatment for optimal outcome in this population.

REFERENCE:

1. Gitlin M, Hammen C: Syndromal and psychosocial outcome in bipolar disorder: a complex and circular relationship: Hospital and Community Psychiatry 1991; 26:451-457.

Lecture 6 **Saturday, October 3**
1:30 p.m.-3:00 p.m.

DEPRESSION IN THE MEDICALLY ILL: IMPLICATION FOR OUTCOME

K. Ranga Rama Krishnan, M.D., *Professor of Psychiatry, Duke University Medical Center, Box 3018, Durham, NC 27710-0001*

SUMMARY:

Depression is quite common in medically ill patients. It is more common among inpatients than outpatients. The frequency of depression is particularly common among patients with certain medical illness, including endocrine disease, such as diabetes; hypothyroidism; coronary artery disease; cerebral vascular disease, etc. Recent studies are clearly beginning to document the impact of depression on the course and outcome of these medical illnesses. A study in Montreal has demonstrated that depression following a mild cardiac infarction can increase the mortality rate in the subsequent period following the MI. Similar studies have demonstrated that the presence of depression following stroke impairs recovery, increases disability, and also potentially increases mortality. The studies that we have conducted in coronary artery disease patients also clearly documents the impact of depression on activities of daily living and in functional outcome. Morbidity studies in

medically ill depression have been few and far between. Two ongoing studies are worth mentioning: (1) SADHART, a trial of Sertraline and the treatment of patients with post-myocardial depression, and (2) ENRICHD, a treatment study for cognitive-behavior therapy in depression. A pilot study of post-stroke depression has demonstrated that SSRIs can improve recovery in patients following a stroke. In summary, depression and its effects on morbidity and mortality in the context of medical illness need further study.

REFERENCE:

1. Frasire-Smith N, Lesperance F, Talajic M: Depression following myocardial infarction: impact on 6-month survival. J Am Med Assoc 1993; 270:1819-1825.

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

MENTAL HEALTH SERVICES FOR PHYSICIANS IN TRAINING

Robert O. Pasnau, M.D., *Professor of Psychiatry and Assistant Dean, University of California at Los Angeles School of Medicine, and Past President, American Psychiatric Association, 760 Westwood Plaza, Los Angeles, CA 90024-8300*

SUMMARY:

This lecture will cover the author's experiences from 1990-1998 as director of the UCLA Mental Health Services for Physicians-in-Training (MHSPT). The service was founded in 1981 by Dr. Daniel Borenstein to prevent impairment of medical students and residents through early intervention, and treatment at all stages of training. During the past 17 years over 1,000 physicians-in-training have been evaluated and referred to treatment for a variety of ills and complaints, ranging from simple adjustment problems to life-threatening mental and physical disorders. This presentation examines the data compiled from 543 medical students from all four medical school classes and 534 residents from every year of training who consulted the service during a 10-year period between July 1987 and June 1997. It covers the history of the program, the methods of providing services, the utilization rates, and diagnoses.

After the presentation, the members of the audience should be able to: describe the extent and scope of psychiatric disorders occurring in medical training; appreciate how psychiatric services can be effectively provided to address and resolve these disorders; and learn about the biopsychosocial problems that medical students and residents encounter during the stressful years of medical training.

REFERENCE:

1. Pasnau RO, Stoessel P: Mental health services for medical students. Med Education 1994; 28:33-39.

Lecture 8 **Sunday, October 4**
8:00 a.m.-9:30 a.m.

THE EVOLUTION OF COMMUNITY PSYCHIATRY: FROM RELATIONSHIPS TO CONTRACTS

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

SUMMARY:

Community psychiatry may be considered applied social psychiatry. To the extent that biological psychiatry incorporates the basic sciences to help in understanding and ameliorating aberrant thinking, mood, and behavior, community psychiatry draws upon the social sciences for a comprehensive approach to mental illness.

Recognizing the important contributions of culture, economic status, stigma, and social justice, community psychiatrists have often taken advocacy positions in order to modify socio-environmental contributors to dysfunction. These approaches are components of community psychiatry's public health function. Additional dimensions of community psychiatry have included population-based services and attention to cost of care factors. Ironically, many managed care practices derive from these aspects of community psychiatry. The differences lie in the values of the auspices that control professional practice: psychiatry as a governmental service versus psychiatry as a corporate product.

This lecture will trace the development of community psychiatry and explore the changes in the ethical context. Evolving issues in the training of community psychiatrists will also be discussed.

REFERENCE:

1. Cohen CI: Poverty and the course of schizophrenia: implications for research and policy. Hospital and Community Psychiatry 1993; 44:951-958.

Lecture 9 **Sunday, October 4**
8:00 a.m.-9:30 a.m.

PSYCHIATRIC LEADERSHIP IN HEALTH SYSTEMS REFORM

José M. Santiago, M.D., *Corporate Medical Officer, Carondelet Health Network, 5112 North Via Condesa, Tucson, AZ 85718-5714*

SUMMARY:

Leadership in today's American psychiatry is an imperative need. Mental health professionals, like the rest of their colleagues in health care, have seen a profound change in their culture environment. The turmoil has been particularly acute for physicians who have experienced a major challenge to their fundamental values. As a result, mental health professionals have attempted to react via a variety of initiatives ranging from resisting change to asking government to regulate the field. Most of these reactions do not bode well for professionals' self-esteem.

A leadership and a message is required that will focus on the fundamental values of the mental health field (What are we trying to do?). The professional role definitions (Who will do it?), and the value of services to the individuals and to the community (How do we know we did it?). In this context, the leaders' "story" must be articulated and disseminated. The team of professionals and the leader must make hard choices in the critical elements of the story. A model to assist leaders and "team" members will be proposed. Included in this model will be the identification and management of the critical variables needed for a social movement to have any chance of success.

REFERENCE:

1. Herzlinger R: Market driven health care: who wins, who loses in the transformation of America's largest service industry? Harvard Business School, Harvard Press 1995; 12:211-229.

Lecture 10 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

PSYCHIATRY AND THE TWO REVOLUTIONS OF MEDICINE

Herbert Pardes, M.D., *Professor and Chairman, Department of Psychiatry, Columbia University, Dean of the College of Physicians and Surgeons, and Past President, American Psychiatric Association, 630 West 168th Street, New York, NY 10032-3702*

SUMMARY:

Psychiatry has experienced a series of eras (state hospital, psychoanalytic, community mental health, neuroscience, etc.)—somewhat overlapping—each laying down a portion of the psychiatry going forward. As the 90s developed, managed care began to revolutionize all health care at the same time that the scientific revolution became more intense and promising.

As we face the 21st century, psychiatry is considerably reinforced not only by better science and better therapeutics, but also by a growing citizen advocacy movement that grew up in the 80s and has flourished in the 90s. This has encouraged destigmatization, so that mental health programs now have a reasonable possibility of achieving equity in reimbursement.

Still, the market effect on the health care system, much like predators on the African plains, picks out the most vulnerable. How psychiatry will fare between the challenges of managed care and the promise of science will be the focus of this presentation.

REFERENCE:

1. Pardes, H.: The future of the academic medical center in the era of managed care. Academic Medicine February 1997; Vol. 72, No. 2, 97-102.

Lecture 11 **Sunday, October 4**
1:30 p.m.-3:00 p.m.

ACTIVE TREATMENT OF PRESENILE DEMENTIA IN PERSONS WITH DOWN'S SYNDROME

APA's Frank J. Menolascino Award Lecture

Mark H. Fleisher, M.D., *Assistant Professor of Psychiatry, and Director, Dual Diagnosis Service for Mental Retardation and Developmental Disabilities, Creighton University School of Medicine and Nebraska College of Medicine, P.O. Box 98575, Omaha, NE 68198-5575*

SUMMARY:

This presentation will highlight innovative palliative treatment options for dementia associated with Down's syndrome. We have entered an era of active treatment for dementias once considered hopeless. Treatment options for signs of impaired cognition and mood as well as psychotic symptoms will be highlighted. Case presentations will allow attendees to follow patients from their first clinic visit through treatment and follow up. This will highlight the critical diagnostic signs, staging of dementia progress, treatment options, ethical considerations, and methods of measuring treatment outcome. Treatment choices will focus on mood and psychotic symptoms as well as on the cardinal signs of dementia. The discussion will include the complex elements associated with dementia and mental retardation and how they complicate an already difficult process. The presentation will also allow for a theoretical discussion concerning the nature and definition of dementia specifically associated with Down's syndrome. It is hoped that the quality of the presentation will benefit from the attendees active participation including their own clinical experiences.

REFERENCE:

1. Rogers SL, Farlow MR, Doody RS, et al: Donepezil study group. a 24-week double-blind, placebo-controlled trial of donepezil in patients with Alzheimer's disease. Neurology 1998; 50:136-45.

Lecture 12 **Sunday, October 4**
1:30 p.m.-3:00 p.m.

SEX, CHILDREN AND TV: WHAT DO WE KNOW?

Elissa P. Benedek, M.D., *Center for Forensic Psychiatry, and Past President, American Psychiatric Association, 3607 Chatham Way, Ann Arbor, MI 48105-2873*

SUMMARY:

Unfortunately, there is little or no literature reviewing the effects of viewing televised pornography on children. The ethics of our profession presents controlled experimentation in this area. Extrapolating from the effects of viewing violence on television leads one to be concerned. Based on our experience with the connection between television viewing and violence, we recommend that viewing pornographic material be prohibited. This issue is now before the courts.

REFERENCE:

1. van der Kolk B, McFarlane A, Weisaeth L: Traumatic stress: the effects of overwhelming experience on mind, body and society. The Guilford Press, New York, 1991; 8:301-340.

Lecture 13 **Sunday, October 4**
3:30 p.m.-5:00 p.m.

WOMEN PSYCHIATRISTS, PERSONAL AND PROFESSIONAL CHOICES: IMPLICATIONS FOR THE FUTURE

Silvia W. Olarte, M.D., *Clinical Professor of Psychiatry, New York Medical College, 37 East 83rd Street, Apt. 1, New York, NY 10028*

SUMMARY:

Working women of childbearing age continue to increase in numbers, but our child-rearing practices are still mainly based on a traditional division of labor along gender lines (Rankin, 1993; Jamieson, 1995). In order to research how professional peers mapped their personal and professional lives, I surveyed the Association of Women Psychiatrists' members residing in the United States. The questionnaire was divided into seven sections addressing demographic information, parent's education, parent's employment and child care arrangements during the growing years of the respondent, number of children in the life of the respondent, child-care arrangements for those children during the respondent's working hours, respondent's personal career, board certification, academic affiliation, time off during their career, relationship between career and personal life, their current professional circumstance, their level of satisfaction and stress about their professional circumstance, research activities, and publications, with a final place for comments.

Relevance of findings to current mental health policies and future professional opportunities for women psychiatrists will be discussed.

REFERENCES:

1. Jamieson KH: The binds that tie. In: Beyond the Double Bind: Women and Leadership. Oxford University Press, New York, 1995; pp. 3-21.
2. Rankin EA: Stress and rewards experienced by employed mothers. Health Care for Women International, 1993; 14:527-37.

Lecture 14 **Monday, October 5**
8:00 a.m.-9:30 a.m.

PRIMARY CARE IN PSYCHIATRY: THE FINAL FRONTIER

John S. McIntyre, M.D., *Chairperson, American Psychiatric Association Steering Committee on Practice Guidelines, Past President, American Psychiatric Association, and Chairperson, Department of Psychiatry and Behavioral Health, Unity Health Systems, 81 Lake Avenue, Third Floor, Administration, Rochester, NY 14608*

SUMMARY:

Many studies over the last decade have clearly shown that most patients who receive treatment for mental illness receive this treatment from primary care physicians. Although much of this care may be of good quality, a number of studies have demonstrated that mental illnesses are frequently underdiagnosed and undertreated by primary care physicians. Changes in the health care system may accentuate these problems. A number of models of collaborative and integrated care have been developed to address these issues. This presentation will explore these models and their potential impact on patient care.

In addition, psychiatry's potentially greatest contribution to medicine, namely operationalizing and reenforcing the biopsychosocial approach to understanding and treating illness, has been underemphasized. Within psychiatry as well as in the rest of medicine, a reductionistic biomedical model continues as the primary paradigm. This presentation will discuss these issues and potential solutions.

REFERENCES:

1. Nickels MW, McIntyre JS: A model for psychiatric services in primary care settings. Psychiatric Services 1996; 47:522-526.
2. Engel GL: The need for a new medical model: a challenge for biomedicine. Science 1997; 196:129-135.

Lecture 15 **Monday, October 5**
10:00 a.m.-11:30 a.m.

ANXIETY, DEPRESSION AND ALCOHOL DEPENDENCE: WHAT IS THE CHICKEN AND WHAT IS EGG?

Marc A. Schuckit, M.D., *Department of Psychiatry, University of California at San Diego School of Medicine, and Director, Alcohol Research Center, San Diego VA Medical Center, 3350 La Jolla Village Drive, San Diego, CA 92161-0002*

SUMMARY:

Intoxication with alcohol is capable of producing intense levels of depressive symptoms, and alcohol-related withdrawal syndromes produce prominent levels of anxiety. These substance-induced conditions are likely to remain at relatively intense levels for between two and four weeks following abstinence. Subsequently, levels of anxiety and depression diminish with continued abstinence, with some problems persisting for several months or more. The treatments and prognoses for substance-induced depressive and anxiety syndromes are quite different from the therapies appropriate for independent major depressive and anxiety disorders. This presentation reviews the importance of distinguishing between substance-induced and independent psychiatric syndromes among alcohol-dependent individuals, and presents a discussion of the time-line approach for making this distinction. An emphasis will be placed on data published over the prior year from the Collaborative Study on the Genetics of Alcoholism that demonstrate that these distinctions can be made in clinical and research settings, and that they carry important clinical information. The presentation will also review appropriate treatments for substance-induced and independent psychiatric disorders among alcohol-dependent patients.

REFERENCE:

1. Schuckit MA, Tipp JE, Bergman M, et al: Comparison of induced and independent major depressive disorders in 2,945 alcoholics. Am J Psychiatry 1997; 154:948-957.

Lecture 16 **Monday, October 5**
1:30 p.m.-3:00 p.m.

MENTAL HEALTH SERVICES IN THE NEW VA

Kenneth W. Kizer, M.D., *Undersecretary of Health Affairs, U.S. Department of Veterans Affairs, 810 Vermont Avenue, N.W., #800, Washington, DC 20420*

SUMMARY:

The veterans health care system is the largest fully integrated health care system in the U.S., and the largest single provider of services to persons with mental illness, addictive disorders, homelessness, or other behavioral medical problems. In 1995, the VA initiated a fundamental transformation of its historically inpatient and specialty-focused hospital system to become a patient-centered, comprehensive health care system that is grounded in primary and ambulatory care. The rapidity and magnitude of the changes that have occurred in the subsequent three years are unprecedented in American health care. This lecture will provide an overview of the VA's reengineering, focusing especially on the enhancement of mental health services, including the newly prominent role of primary care physicians in delivering mental health care, the essentiality of having parity of mental health and other health care services, the need for an integrated continuum of services, and the need to link education and research efforts to clinical care priorities.

REFERENCE:

1. Kizer KW, Fonseca ML, Long LM: The Veterans health care system: preparing for the twenty-first century. Hospital & Health Services Administration 1997; 42:283-298.

Lecture 17 **Monday, October 5**
1:30 p.m.-3:00 p.m.

THE QUIET ROOM

Lori J. Schiller, *Author, c/o Jean Traflet, Ogilvy Public Relations, 708 Third Avenue, New York, NY 10017*

SUMMARY:

Name: Lori Schiller

Age: 38

Quote: "I would not be here today enjoying life if it wasn't for Clozaril. I would either be in a state hospital or dead."

Background: When Lori was first diagnosed with schizophrenia her parents were told that Lori was a "hopeless schizophrenic that would never become well and they might as well put her away forever." Through nine years, Lori was hospitalized three times, experi-

enced 21 electric shock treatments (ECT), and was given every available antipsychotic medication in huge quantities. Lori experienced side effects from these medications such as tremors, drugged stupors, nausea, dry mouth that rotted her teeth, and a weight gain of 60 pounds from damage to her thyroid gland. Throughout her hospitalizations, Lori would punch holes in the walls and protective screens of her room to escape her demonic hallucinations. She was often placed within a confinement area called "the quiet room" where she would experience limited stimulation and be bound in ice-soaked sheets for hours at a time to calm her agitation. Lori would sometimes show signs of improvement, and she would be released from the hospital. But as the illness became too overwhelming, Lori would self medicate and eventually acquired a thousand-dollar-a-week cocaine habit.

Impact of Treatment: In 1989, Lori was given clozapine, which was still in its experimental stage. Within two weeks the sparkle returned to Lori's eyes and her sense of humor began to return. The voices that had tormented her for years began to diminish in both frequency and volume. Her thoughts seemed to become untangled and she started to talk about her future. A few months later, Lori was released from the hospital and went to a rehabilitation home. Lori has been out of the hospital for almost ten years. In that time she has co-authored a book, "*The Quiet Room,*" which details her illness, the impact it has had on her family, and her ability to reclaim her life. Lori is a peer counselor in Boca Raton, FL. and travels the world spreading hope to recipients, family members, and health care professionals with the message that they should never give up.

REFERENCE:

1. Schiller L, Bennett A: *The Quiet Room,* Warner Books, January 1996.

Lecture 18 **Monday, October 5**
3:30 p.m.-5:00 p.m.

ADVANCES IN CHILD PSYCHIATRIC TREATMENT: WHAT NEXT?

James T. Mc Cracken, M.D., *Director, Division of Child and Adolescent Psychiatry, University of California at Los Angeles, Neuropsychiatric Institute, 760 Westwood Plaza, Room 48-270, Los Angeles, CA 90024-8300*

The summary and reference were not provided for this lecture. Therefore, attendees may only claim 1.5 hours of Category 2 CME credit for attending this session.

Lecture 19 **Tuesday, October 6**
10:00 a.m.-11:30 a.m.

TREATING BIPOLAR DEPRESSION

Lori L. Altshuler, M.D., *Department of Psychiatry, VA Medical Center, 336 10th Street, Manhattan Beach, CA 90266-5408*

SUMMARY:

While extensive literature exists regarding the acute and prophylactic treatment of bipolar mania and unipolar major depression, treatment studies for acute bipolar depression are limited. The principal treatment for acute depression is the use of antidepressant medications. The efficacy of these medications has been well established in studies involving patients with unipolar depression. Similarly, data exist for unipolar depression that demonstrate the benefits of continuing treatment beyond the acute illness to prevent recurrence or relapse. In this lecture, the definition, common characteristics, and treatment strategies for bipolar depression will be reviewed. Special risks associated with the treatment of bipolar depression, such as the induction of cycle acceleration or mania through the use of antidepressant medications, will also be covered.

REFERENCE:

1. Altshuler LL, Post RM, Leverich GS, et al: Antidepressant-induced mania and cycle acceleration: a controversy revisited. Am J Psychiatry 1995, 152: 1130-1138.

Medical Update 1 **Friday, October 2**
3:30 p.m.-5:00 p.m.

UPDATE ON THE MANAGEMENT OF ASTHMA

Michael S. Kaplan, M.D., *Chief, Department of Allergy and Clinical Immunology, Kaiser Hollywood, Southern California Permanente Medical Group, 1515 North Vermont Avenue, Los Angeles, CA 90027*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand and treat asthma, in both adults and children, using the most current pharmacological interventions.

SUMMARY:

Asthma affects ten million Americans. It is a leading cause of hospitalizations and work and school absences. It is recognized that many individuals with asthma do not receive optimal treatment. To meet this need the NIH convened a panel of experts from primary care and specialty care to develop guidlines for the diagnosis and management of asthma. The Expert Panel 2 Report[1] was published and distributed in 1997 along with a user-friendly practical guide that contained reproducible patient handouts and physician worksheets to facilitate asthma care.

Asthma is a chronic inflammatory disease of the bronchi with multiple triggers and precipitants. Treatment is based on effectively controlling this inflammation by avoiding allergens that cause allergic inflammation, yearly influenza vaccine for at-risk asthmatics, appropriate pharmacotherapy for the level of severity, and recognizing and treating other conditions that either mimic or complicate asthma.

Severity is determined by the intensity and frequency of symptoms, frequency of ER use and hospitalization, and the amount of interference with daily activities such as work, school, sleep, and physical activity. Two broad categories of asthma medications are used: "Preventers" and "Relievers" or rescue meds. Preventer medications range from nonsteroid inhalers with some anti-inflammatory action such as Intal and Nedocromil through high-potency inhaled corticosteroids to regular use of oral coricosteroids for the most refractory patients. Prevention of persistent nocturnal asthma can be achieved with timed-release theophylline or long-acting, inhaled beta adrenergic agonist, salmeterol. The main reliever meds are the rapid-acting, inhaled beta agonists such as albuterol.

Patients who are educated in self management and who have a written action plan from their provider have better asthma outcomes.

REFERENCE:

1. Expert Panel 2 Report: *Guidelines for the Diagnosis and Treatment of Asthma.* NIH Publication No 97-4051 April 1997. May be accessed through the Internet: http://www.nhlbi.nih.gov/nhlbi/lung/asthma/prof/asthgdln.htm.

Medical Update 2 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

AIDS UPDATE

Samuel Wilson, M.D., *Private Practice, 7345 Medical Center Drive, #150, West Hills, CA 91307*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will gain an understanding of the current status of the HIV pandemic and a better insight into the medical situation facing patients who are suffering from HIV disease.

SUMMARY:

After a brief discussion of the current status of the AIDS pandemic, I will discuss the nature of the viral pathogen responsible for the infection and its interaction with the host. I will then demonstrate the relationship of these etiological principles to both clinical and diagnostic considerations. Both the acute retroviral syndrome and chronic HIV disease, along with new data on intrinsic resistance to HIV infection will be discussed. An overview of current treatments being used to treat infection will be provided, and the session will conclude with a survey on current treatments and treatments that are expected in the near future.

REFERENCES:

1. Panel of Clinical Practices of HIV Infection: Guidelines for the use of antiretroviral agents in HIV infected adults and adolescents. MMWR 1998; 47, RR5.
2. Fauci AS, Pantaleo G, Stanley S, et al: *Immunopathogenic mechanisms of HIV infection.* Ann Intern Med 1996; 124:654-663.
3. Ho DD, Neumann AU, Perelson AS, et al: Rapid turnover of plasma virions and CD4 lymphocytes in HIV-1 infection. Nature 1995; 373:123-126.

Medical Update 3 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

BREAST CANCER

Patricia Ganz, M.D., *Professor of Oncology, University of California at Los Angeles, 1100 Glendon Avenue, #711, Los Angeles, CA 90024*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the current diagnosis and treatment of breast cancer; describe the heterogeneity of breast cancer treatment and prognosis; and describe the long-term health outcomes and psychosocial impact of breast cancer and its treatments.

SUMMARY:

Breast cancer is the most common cancer in women, with an estimated five-year survival of 75%. For patients with very small tumors (less than a centimeter and noninvasive cancers), survival usually meets or surpasses that of age-matched controls, with an anticipated five-year disease-free survival rate in excess of 90%. Patients with a history of breast cancer are the most frequent cancer survivors in primary care practice, with a recent prevalence estimate of 1,332 per 100,000. Therefore, it is critical for health care professionals to become familiar with the impact of a breast cancer diagnosis and its treatment on patients' lives—beyond the acute phase of cancer treatment. This presentation will review the current strategies for breast cancer screening, diagnosis, and treatment, as well as common long-term health outcomes. Emphasis will be placed on the heterogeneity of the disease and its prognosis, treatment options, and psychosocial effects of the disease and treatment.

REFERENCES:

1. Harris JR, Lippman ME, Veronesi U, Willett W: Breast cancer. *New England Journal of Medicine* 1992; 327:319–28; 327:390–8.
2. Ganz, PA: Advocating for the woman with breast cancer. *CA-A Cancer Journal for Clinicians* 1993; 45:114–126.
3. Ganz, PA, Rowland JH, Desmond K, Meyerowitz BE, Wyatt GE: Life after breast cancer: understanding women's health-related quality of life and sexual functioning. *J Clinical Oncology* 1998; 16:501–514.

Medical Update 4 **Monday, October 5**
3:30 p.m.-5:00 p.m.

HORMONE REPLACEMENT THERAPY

Madeline I. Ortega, M.D., *Department of Obstetrics and Gynecology, Kaiser Permanente at Panorama City, 25636 Wilde Avenue, Stevenson Ranch, CA 91381.*

Educational Objectives, references and a summary were not provided for this session. Therefore, attendees may only claim 1.5 hours of Category 2 CME credit for attending this session.

Multimedia Session 1 **Withdrawn**

Multimedia Session 2 **Friday, October 2**
8:00 a.m.-9:30 a.m.

VIDEO WORKSHOP: AN HISTORICAL PORTRAIT

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to acquaint mental health professionals with the contributions of Milton H. Erickson, M.D., to the field of creative, yet brief, psychotherapy interventions.

SUMMARY:

This video is a fascinating portrait of the life and work of one of the world's foremost authorities on medical hypnosis and therapy, and contains rare archival footage of Erickson at work, allowing the viewer to see firsthand his extraordinary ability to heal both mind and body through his work within hypnosis.

REFERENCES:

1. Erickson MH: The identification of a secure reality. Family Process 1962;1:294–303.
2. Haley J.: Changing Families - A Family Therapy Reader, New York, Grune & Strattan, 1971.

Multimedia Session 3 **Friday, October 2**
10:00 a.m.-11:30 a.m.

COMPUTER WORKSHOP: UTILIZING THE INTERNET

1997–1999 APA/Bristol-Myers Squibb Fellows

Kenneth S. Chuang, M.D., *1997–1999 APA/Bristol-Myers Squibb Fellow, and Resident in Psychiatry, University of California at Los Angeles, Neuropsychiatric Institute, 821 Bay Street, #B-2, Santa Monica, CA 90405-1331;* Albert A. Hyman, M.D., *1997–1999 APA/Bristol-Myers Squibb Fellow, and Resident in Psychiatry, Harvard University Medical School, One Devonshire Place, Apt. 1414, Boston, MA 02109-3512*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) utilize internet search engines, databases, listserves, and newsgroups to retrieve psychiatric data; and (2) explain how internet resources are used to augment or provide primary psychiatric care.

SUMMARY:

The internet is an extraordinarily rich and increasingly accessible network that facilitates the rapid exchange of information between clinicians and patients. The rapid growth of internet resources has led to a proliferation of psychiatric sites, the sheer numbers of which may prove daunting to the novice user. Furthermore, the unregulated nature of the internet has allowed the dissemination of didactic materials of widely varying quality. This presentation will help the novice user to most effectively utilize the internet by identifying the most useful didactic resources and by introducing some of the more innovative therapeutic modalities being used. We will review the use of search engines, databases, listserves/newsgroups, BBS, chat groups, etc. Participants will also be introduced to several novel online services that are being developed to either augment or provide primary psychiatric care (such as televideo conferencing, remote psychotherapy and/or prescription services).

REFERENCES:

1. Glowniak JV, Bushway MK: Computer networks as a medical resource; accessing and using the Internet. JAMA 1994;271:1934–1939.
2. Huang MP, Alessi N: The internet and the future of psychiatry. Am J Psychiatry 1996;153:861–869.

Multimedia Session 4 **Friday, October 2**
10:00 a.m.-11:30 a.m.

VIDEO WORKSHOP: THE IMPACT OF MENTAL ILLNESS ON A COMMUNITY

Stephen M. Goldfinger, M.D., *Consultant, Institute Scientific Program Committee, and Vice Chairman, Department of Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, Brooklyn, NY 11203*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation; the participant should be able to understand this powerful documentary giving voice to people at the multiple levels of community where the impact of mental illness is so deeply experienced, and where the community restores its hope.

SUMMARY:

"In Their Shoes" is a 27-minute video documenting the prevalence and problems of persons with severe and persistent mental illness in the Greater Houston area. It presents an overview of the nature of severe mental illness as well as problems associated with homelessness and involvement in the criminal justice system. It cap-

tures the firstperson perspectives of persons with mental illness, their families, clinicians, and public officials. Although primarily produced for lay audiences, this video has didactic value for students and faculty. It has received awards from the Texas Alliance for the Mentally Ill and the Houston Psychological Association.

REFERENCES:

1. Edited by Walsh F, Anderson A. Chronic Disorders and the Family. Edited by Walsh Anderson A. New York, The Haworth Press, 1988.
2. Swados E: The Four of Us: The Story of a Family, New York, Farrar Straus & Giraux, 1991.

Multimedia Session 5 **Friday, October 2**
1:30 p.m.-3:00 p.m.

VIDEO WORKSHOP: DEPRESSION

Harriet Koskoff, *PBS Producer/San Francisco, 415 Noe Street, Suite 5, San Francisco, CA 94114-2064;* Keh-Ming Lin, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to increase understanding of the role of multi-cultural factors in the manifestations of depressive disorders, and to identify creative or personal characteristics that modify the course of depressive reaction.

SUMMARY:

Horizons narrow for those overshadowed by depression. Depression shapes a life of reduced expectation, compromised talents, and unfulfilled emotional relationships. It erodes self-esteem.

"Despair," is the first full-length American PBS special about depression to consider the pervasive mood disorder from multicultural viewpoints. In sensitive personal portraits and riveting interviews with experts from diverse racial and ethnic backgrounds, this spellbinding, hour-length documentary explores depressive illness from traditional and nontraditional perspectives. Live classical music and jazz, poetry, and art enrich "Despair" as it unmasks the stigma and denial that veil a misunderstood and potentially fatal illness.

Created in association with Connecticut Public Television, "Despair" has aired on 100 PBS stations nationwide. Producer Harriet Koskoff (whose multi-award-winning, patently offensive, "Porn UnderSiege" was screened at the 1996 APA Annual Meeting) will introduce the film. Keh-Ming Lin, M.D., director of the Center for Research into the Psychobiology of Ethnicity, is the discussant.

REFERENCES:

1. Storr A: Solitude: A Return to the Self, Ballantine Books, 1988.
2. Mezzich: Culture and Psychiatric Diagnosis: A DSM-IV Perspective. American Psychiatric Press, 1996.

Multimedia Session 6 **Friday, October 2**
3:30 p.m.-5:00 p.m.

VIDEO WORKSHOP: SCHIZOPHRENIA'S IMPACT ON THE FAMILY

Roman N. Anshin, M.D., *Chairman, Professional Education Committee, Department of Psychiatry, Cedars-Sinai Medical Center, 116 North Robertson Boulevard, Suite 601, Los Angeles, CA 90048-3109*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to increase awareness and understanding of the subjective effects of schizophrenia on the patient, parents, and siblings.

SUMMARY:

In these two tapes "Bonnie," an attractive and articulate young woman with schizophrenia, and members of her family, discuss her illness and its impact on all of them. She tells what it felt like to have schizophrnenia, and they all consider how this illness and recovery have strengthened the entire family. This series has been described as providing an unparalleled way for families and providers to "know" what mental illness is really like.

REFERENCES:

1. Hatfield AB: Family Education in Mental Illness. New York, The Guilford Press, 1990.
2. Torry EF: Surviving Schizophrenia: A Manual for Families, UC Consumers & Providers, 3rd edition. New York, Harper Perennial, 1995.

Multimedia Session 7 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

VIDEO WORKSHOP: CONSUMERS AND SURVIVORS OF PSYCHIATRIC SERVICES

Roderic Gorney, M.D., Ph.D., *Professor of Psychiatry, University of California at Los Angeles, and Director, The Ashley Montagu Institute, 635 Walther Way, Los Angeles, CA 90049-2314*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to identify and better understand the nature of patients subjective experiences of their ill-

nesses and should be able to facilitate patients' developing empowering strategies in their own recovery.

SUMMARY:

This workshop will feature the videotape "Nerve," which features four individuals living in Vienna and New York who define themselves as "consumers" or "survivors" of psychiatric services. The protagonists are involved in the international self-help movement, which is focused on individuals recovering from mental illnesses who undertake to organize their own self-help organizations, establishing new relationship contracts with both care providers and mental health institutions, and with other family members. In the film, these patients discuss their experiences in the mental health system in both Europe and the United States, as well as describing their emotional crises. They demonstrate that subjective perspectives are valuable and that empowering activities are crucial to recovery.

REFERENCES:

1. Chamberlin J, Rogers J: Planning a community-based mental health system: perspective of service recipients. American Psychologist 1990;45, 1241–44.
2. Fisher DB: Health care reform based on an empowerment model of recovery by people with psychiatric disabilities. Hospital and Community Psychiatry. 1994;45, 913–915.

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

COMPUTER WORKSHOP: VIRTUAL REALITY THERAPY

Ian E. Alger, M.D., *Multimedia Consultant, Institute Scientific Program Committee, and Clinical Professor of Psychiatry, New York Hospital-Cornell Medical Center, 500 East 77th Street, New York, NY 10162-0025;* Larry F. Hodges, Ph.D., *Associate Professor, College of Computing, and Associate Director for Industrial Relations, Georgia Institute of Technology, 801 Atlantic Avenue, Atlanta, GA 30332-0280;* Hunter Hoffman, Ph.D., *Human Interface Technology Laboratory, University of Washington, Seattle, WA 98195*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to show new advances in applications of Virtual Reality Therapy in post-traumatic stress syndrome and to show stress and pain reduction in burn patients mitigated by virtual reality immersion.

SUMMARY:

New advances in applications of virtual reality therapy in post-traumatic stress syndrome, and fear of flying syndrome will be discussed and demonstrated with video documentations by Larry Hodges, Ph.D. Stress and pain reduction in burn patients mitigated by virtual reality immersion will be demonstrated by Hunter Hoffman, Ph.D.

The Virtually Better Fear of Flying Therapy System Software provides the therapist and his patient with a complete flight scenario. Using a head-mounted display the patient is immersed in the passenger cabin of a commercial aircraft. The therapist, with a few simple keystrokes, controls the patient's virtual flight experience. In several centers this program is being investigated in research protocols, and a demonstration will be given during this presentation, through video documentations. The application of a similar program for treatment of post-traumatic stress in veterans who participated in the Vietnam conflict is now under research at a V.A. hospital, and these studies also will be demonstrated.

Dr. Hunter Hoffman presents a video demonstration of a case using virtual reality (VR) as an adjunct to opioids in pediatric pain management. There are few alternatives to opioid analgesics for treating burn pain, even though such pharmacologics often fail to make patients comfortable during wound debridements. As a step toward treating such intense pain, this study explored the efficacy of virtual reality (VR) as an adjunct to opioids in pediatric burn pain management. Two patients received VR to distract them from moderate-level background burn pain. The first was an 11-year-old male with third-degree flash burns on his right hand and leg. He reported forgetting his leg hurt while in VR, and pain ratings showed considerable pain reductions while in VR relative to baseline reports collected before and after VR. The second patient was a 16-year-old male with 27% total body surface area flash burns on his face, neck, arms, and hands. He showed a statistically significant decline in burn pain intensity and/or unpleasantness for two out of three of his VR treatments. Overall, the effectiveness of VR for distracting patients and reducing their resting pain in this pilot study suggests that it merits more attention as a potentially viable form of treatment for acute pain.

REFERENCES:

1. Rothbaum BO, Hodges LF, Kooper R, Opdyke D, Williford J, North MM: Effectiveness of virtual reality graded exposure in treatment of acrophobia. American Journal of Psychiatry, 1995;152, 626–628.
2. Hoffmnan 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).

Multimedia Session 9 **Saturday, October 3**
3:30 p.m.-5:00 p.m.

COMPUTER WORKSHOP: OUR PATIENTS AND THE INTERNET

Roger L. Gould, M.D., *Associate Clinical Professor of Psychiatry, University of California at Los Angeles, Neuropsychiatric Institute, and Chief Executive Officer, Interactive Health Systems, 1337 Ocean Avenue, #C, Santa Monica, CA 90401-1029*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to see how such a program can be a useful adjuct to psychotherapy and a powerful self-help tool for those who are not in treatment, and demonstrate that a computer program can carry out a "conversation" with a patient and arrive at the same cognitive end-point as a face-to-face session with a qualified therapist.

SUMMARY:

The subject matter of most therapeutic hours are the topics of tension in daily life, relationships, disappointment with others and self, ambitions not realized, and fears of both dependence and independence.

The implicit question that drives the patient's part of the conversation is, "What can he or she do better or different in order to more successfully conduct their lives?," which means to minimize tension and to increase their satisfaction and sense of forward motion. This leads to decisions about action and conflict about taking action or changing patterns of behavior.

In this session, Dr. Gould will demonstrate how the computer can be used in a step-by-step fashion to help people sort out what is bothering them, focus on the most important, and think through their action options.

REFERENCES:

1. Gould RL: Reengineering mental health, in Reengineering Health, Edited by The American College of Physician Executive, Tampa, Florida, in progress.
2. Gould RL: Development, problem solving, and generalized learning: The Therapeutic Learning Program (TLP), in Mental Health Computing: Computers and Medicine, Edited by Miller M, Hammond K, Hile M. Springer, 1995.

Multimedia Session 10 **Sunday, October 4**
8:00 a.m.-9:30 a.m.

VIDEO WORKSHOP: AN IN-DEPTH LOOK AT SHORT-TERM DYNAMIC PSYCHOTHERAPY

Manuel Trujillo, M.D., *Professor of Psychiatry, New York University Medical Center, 550 First Avenue, Suite 22-North, New York, NY 10016;* Waguih W. Ishak, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will acquire knowledge about the process of learning short-term dynamic psychotherapy including the difficulties encountered by trainees, and planned systematic ways to address them in supervision.

SUMMARY:

Short-term dynamic psychotherapy, a time-limited therapy, is gaining more attention as an effective and efficient treatment modality for a variety of psychiatric disorders. Training in this particular modality requires the trainee to have an adequate knowledge base of psychodynamic theory, and to acquire new therapeutic skills throughout the process. The highlights of these skills include assuming an active role, helping the patient to develop specific dynamic focus or foci and be more specific, and challenging defensive styles. The ultimate goal is to help the patient gain more access to painful feelings and insight into the way they react to both their outer and inner worlds. For trainees, learning these new skills can be initially difficult. The trainees have to change their stance from the traditional, active listener role to active participants who confront defenses, invoke and tolerate intense emotions, and help develop insights. The supervisor's role is to help the trainees develop rapidly a psychodynamic understanding of the patient's problems, to identify the patient's responses in the therapeutic inteaction including verbal and nonverbal communication, guiding the trainee in making the most appropriate interventions. The use of videotaped sessions for supervision has proven to be extremely helpful in assisting the trainees in overcoming their initial difficulties. In this workshop, the experiences of a trainee, a middle career therapist, and a senior supervisor will be reviewed in detail. The participants will have the opportunity to participate in an active discussion about the psychotherapy learning-teaching process.

REFERENCES:

1. Watters WW, Rubenstein, JS, Bellissimo A: The effects of short-term dynamic psychotherapy. Can J Psychiatry 25(2):111–7, 1980.
2. Trujillo M: Short-term dynamic psychotherapy in Psychoterapists Casebook, Theory and Techniques. Edited by Kutash L, Wolf I, San Francisco/London, Josey Bass Publishers, 1986.

Multimedia Session 11 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

VIDEO WORKSHOP: A LOOK AT HUMANE REPRODUCTION

Group for the Advancement of Psychiatry's Committee on Social Issues

Martha J. Kirkpatrick, M.D., *Clinical Professor of Psychiatry, University of California at Los Angeles, and*

Senior Faculty at Los Angeles Psychiatric Society and Institute, 988 Bluegrass Lane, Los Angeles, CA 90049-1433

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) better understand the current aspects of infertility and the assisted reproductive technologies, their psychosocial implications, and the role of mental health professionals in this field; and 2) To consider some of the ethical issues raised by these technologies such as gamete donation and surrogacy, postmenopausal conception and childbearing, use of antidepressant drugs in infertility patients, and the place of cloning in human reproduction.

SUMMARY:

Mental health professionals always have been interested in reproduction, its relation to human development and behavior, sex, parenting, and children. Technology has had an enormous impact on infertility and reproduction, making family formation more complex than ever. Medical scientists can intervene in a variety of ways to make pregnancy and parenthood possible, but should they? The Group for the Advancement of Psychiatry Social Issues Committee have been studying some of these questions, mainly through literature review and clinical vignettes. This workshop will address the psychological, social, and ethical aspects of some of these questions such as ova and sperm donation, surrogacy, postmenopausal conception and childbearing, cloning of human embryos, and use of antidepressant drugs in infertility patients. The workshop will be conducted via case presentations including videos, with active participation of the audience in the discussion. The goal of this workshop is to encourage the need for the involvement of mental health professionals in the care of these patients and in the formation of policy regarding such technologies.

REFERENCES:

1. Psychological issues in fertility, in the book *Infertility And Reproductive Medicine Clinics Of North America;* Ed: Dorothy Greenfeld; July 1993; W.P Saunders, Philadelphia, PA.
2. *The Ethics Of Reproductive Technology;* Ed. Kenneth D. Alpren, Oxford University Press, NY 1993.

Multimedia Session 12 **Sunday, October 4**
1:30 a.m.-3:00 p.m.

VIDEO WORKSHOP: COPING WITH SCHIZOPHRENIA

Marvin I. Herz, M.D., *Professor of Psychiatry, University of Rochester, 300 Crittenden Boulevard, Rochester, NY 14642-1018*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to obtain knowledge about training programs and coping skills when dealing with a schizophrenic patient.

SUMMARY:

This presentation will demonstrate a new educational training program for individuals with schizophrenia and their families designed to improve their coping skills. The program consists of a series of brief, videotaped case vignettes with actors graphically portraying persons with schizophrenia who experience stressful life events, and the gradual unfolding of the relapse process. A leader's manual accompanies each vignette.

Multimedia Session 13 **Sunday, October 4**
3:30 p.m.-5:00 p.m.

COMPUTER WORKSHOP: A NEW TYPE OF MEDICAL RECORD

Daniel A. Deutschman, M.D., F.A.P.A., *Medical Director of Behavioral Health, Southwest General Health Center, Cleveland, OH, and Associate Clinical Professor, Case Western University School of Medicine, 7255 Old Oak Boulevard, Suite 303, Middleburg Heights, OH 44130*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the basic organization of an electronic medical record; the power of such records in enhancing patient care and office efficiency; how such records can be constructed; and where to find resources to help design and build such systems.

SUMMARY:

This multimedia presentation, developed by a psychiatrist, will introduce practicing psychiatrists to an electronic medical record that enhances patient assessment, diagnosis, and treatment. The information system improves practice management and enhances medical records. It also aids in facilitating research.

The psychiatrist enters data into more than 100 fields during the interview. A data entry form guides and prompts the interviewer so the record is more complete. The form carries forward important elements of the history into each subsequent visit. Because clicking on look-up fields enters most of the data, little typing is necessary. The completed data entry form prints as a report of the interview. Prescriptions, medication trial reports, and billing data are available at a keystroke.

Developed in 1995, it has evolved continually. Currently over 3,000 patients have generated 11,000 records

from nine workstations in outpatient and inpatient settings.

The multimedia presentation will be interactive. The basic principles in building such systems and the resources readily available to obtain or develop them will be discussed.

Electronic medical records have the potential to enhance patient care significantly. When the psychiatrist programs the software, he is in a position to continually upgrade and strengthen the system. Quality and efficiency improve with each iteration.

TARGET AUDIENCE:

Practicing psychiatrists.

REFERENCES:

1. Modai I, Rabinowitz J: Why and how to establish a computerized system for psychiatric case records. Hosp Community Psychiatry 1993;44:1091–1095.
2. Hammer JS, et al: Operationalizing a bedside pen entry notebook clinical database system in consultation-liason psychiatry. General Hospital Psych 1995;17:165–172.

Multimedia Session 14 **Monday, October 5**
10:00 a.m.-11:30 a.m.

COMPUTER WORKSHOP: HOW TO USE THE COMPUTER TO OBTAIN PSYCHIATRIC INFORMATION

R. Bhawani Prasad, M.D., *Private Practice of Psychiatry, 9250 Columbia Avenue, Suite C-1, Munster, IN 46321-3538*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to use search-utilities to find psychiatric information on the Internet, on the Medline, and on their personal computers.

SUMMARY:

The rapid growth of computers and the internet has made it necessary for all of us to know about searching techniques so that we can find the files that contain the information we need. There are three levels where such information is stored: (1) our own computers where information is stored as files; (2) in a dedicated database like the Medline where information is stored as citations; and (3) on the internet, which has the largest amount of different kinds of information. Each of these three systems has its own way of storing and retrieving information though they all have common features. In this presentation, I will discuss how files are stored in a personal computer and the different file types that exist, and how stored files can be searched for on a personal computer using a program like Alta Vista Search Personal Extension 97 or QuickFinder. I will then show how to search a dedicated database. The Medline database stores information from medical journals where each article is stored as a collection of individual fields. I will show how a program like Grateful Med or PaperChase or Silver Platter can be used to retrieve information from the Medline. Finally, the internet has such a vast amount of information that specialized programs called search engines are necessary to retrieve information. Some common search engines are Alta Visa Engine and Yahoo. All these different searching tools require some knowledge of Boolean logic to narrow down the results of searches. Boolean logic employs what are called Boolean operators like AND, OR, NEAR. These help narrow down the results of searches to manageable proportions.

TARGET AUDIENCE:

All psychiatrists interested in using computers.

REFERENCES:

1. McKibbon KA, Walker-Dilks CJ: The quality and impact of MEDLINE searches performed by end user - Health Libr Rev, 12(3):191–200, Sept 1995.
2. Horton KM: Internet on-ramp. Searching the Internet. Biotechniques 20(3):406–8, 1996.
3. QuickFinder: Word Perfect Magazine, April 1994.

Multimedia Session 15 **Monday, October 5**
1:30 p.m.-3:00 p.m.

VIDEO WORKSHOP: LIVING WITH TOURETTE SYNDROME

Winner of the 1998 Psychiatric Services Video Award

H. James Lurie, M.D., *Clinical Professor of Psychiatry, University of Washington, 1417 East Aloha Street, Seattle, WA 98112-3931*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to increase the level of awareness of the general public on the difficult social consciousness for a person suffering from tourette's syndrome.

SUMMARY:

"Twitch and Shout" provides an intimate journey into the startling world of tourette syndrome, a genetic disorder that can cause a bizarre range of involuntary movements, obscene vocalizations, and compulsions. This emotionally absorbing, sometimes unsettling, and ultimately uplifting film is about people who must contend with a society that often sees them as crazy, or

bad, and a body/mind that won't do what it's told. Funny and poignant, illuminating and challenging, this film has received universal acclaim by professionals, students, and the reviewers.

REFERENCES:

1. American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, 4th ed. Washington, DC, American Psychiatric Association, 1994.
2. Eldridge R, Sweet R, Lake R, Ziegler M, Shapiro AK: Gilles de la Tourette's Syndrome: clinical, genetic, psychological, and biochemical aspects in 21 selected families. Neurology 1977;27:115–24.

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

COMPUTER WORKSHOP: LITIGATION-PROOFING

John A. Liebert, M.D., *Associate Clinical Professor of Psychiatry, University of Washington, 10020 Main Street, #A-134, Bellevue, WA 98004-6056*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the basic process of computer-assisted triage, its potential for operational and legal influence on all clinical specialities, particularly psychiatry, and a working model driven by health questionnaire and structured interview.

SUMMARY:

Convergence of violence, computers, and unlimited leveraging of case loads on medicine's frontline invites a new approach to clinical encounter with unknown or unrecognized patients.

Triage specialists of varied licensure, assisted by a health-questionnaire-driven computerized triage program, can rapidly and safely screen patients with either immediate med/surg emergencies or psychiatric syndromes threatening imminent harm to staff, others, and self. This triage approach focuses first on patient's presenting appearances and relatedness. It then screens progressively, instructing through directed selectives examination, from highest to lowest lethality of clinical presentation via colored zones that project clinician states of awareness. Such flexible, yet disciplined, computer-assisted triage significantly strengthens facilities' legal safety, effectiveness, and budgeting. Not only can scarce and valuable clinician time be economically prioritized but both clinical staff and patients can be better protected from assaults, contagiousness, litigation, and hazardous, costly anchoring in misdiagnoses. It also enables clinicians to change their minds and rapidly reassess decisions when new presentations occur in either the same or a new patient. This process is already used retrospectively by legal and managed care firms. It is harder to use on-time with presentations, because clinicians must be able to rapidly reassess without legal, physical, or economic threat.

TARGET AUDIENCE:

Medical administrators, hospital administrators, nurses, emergency personnel, and mental health professionals.

REFERENCES:

1. Pulier ML: Psychiatric diagnosis. Medical Software 1993;10:1–3.
2. Mackway-Jones K, Manchester Triage Group: Emergency Triage. London, BMJ Publishing Group 1997.

POSTER SESSION 1

Posters 1–34

PERSONALITY DISORDERS, PTSD, SUICIDE, PRIMARY CARE, CROSS-CULTURAL ISSUES AND GERIATRICS

Poster 1 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

A CULTURAL SENSITIVITY TRAINING WORKSHOP FOR PSYCHIATRY RESIDENTS

Sheila M. LoboPrabhu, M.D., *Consultation-Liaison Psychiatry Fellow, Department of Psychiatry, Baylor College of Medicine, 3729 Murworth, Houston, TX 77025;* Carolyn M. King, M.D., *Resident, Department of Psychiatry, University of Michigan, 8162 East Jefferson, Apt. #6-B, Detroit, MI 48214-2611;* Ronald C. Albucher, M.D.; Israel Liberzon, M.D.

SUMMARY:

Background: Efforts have been made in psychiatric residency education to develop a core curriculum for cultural sensitivity training. This study examines the effectiveness of a four-hour workshop at the University of Michigan, designed to teach psychiatry residents about ethnic and cultural issues in patient care.

Method: 24 residents from PGY-IV attended the program consisting of three 45-minute lectures by University of Michigan faculty members with expertise in cultural sensitivity training. The workshop ended with a one-hour role play. Two different questionnaires were designed to measure residents' understanding of specific issues involved in treating African-American and Latin-American patients, and general cultural issues in patient care. These were administered before and after training.

Results: The overall effect was increasing performance on the test (2-way ANOVA $F = 30.6$, $p < 0.001$). Improvement in scores was not significantly different in one questionnaire as compared with the other (Interaction effect $F = 2.20$, $p = 0.145$).

Conclusions: The results indicate that a four-hour workshop significantly improved residents' knowledge about cultural sensitivity. Further studies are necessary to determine more effective types of cultural sensitivity training for psychiatry residents.

TARGET AUDIENCE:

Psychiatrists and residents in psychiatry

REFERENCES:

1. Foulks EF: The concept of culture in psychiatric residency education. Am J Psychiatry, 1980; 137 (7):811-816.
2. Collins JL, Mathura CB, Risher DL: Training psychiatric staff to treat a multicultural patient population. Hosp Community Psychiatry, 1984; 35(4):372-376.

Poster 2 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

SOMATIC ISSUES IN HOMELESS PERSONS WITH SEVERE MENTAL ILLNESS

Ann L. Hackman, M.D., *Assistant Professor of Psychiatry, Mobile Assessment Unit, University of Maryland, 630 West Fayette Street, Baltimore, MD 21201;* Lisa B. Dixon, M.D., M.P.H., *Associate Professor of Psychiatry, Center for Mental Health Services Research, University of Maryland, 645 West Redwood Street, Baltimore, MD 21201;* Leticia Postrado, Ph.D.; Janine Delahanty

SUMMARY:

Objectives: Homeless persons with severe mental illness have been found to have poorer physical health status than other populations. This study describes the physical health status of a group of homeless persons with severe mental illness and the relationship of health status to clinical and demographic characteristics, use of health services, and other outcomes.

Methods: 150 homeless persons with SMI who were randomized to a program of assertive community treatment (PACT) or traditional mental health services were studied (67% men, 72% Caucasian). Baseline, two-, six-, and 12-month interviews were conducted using the Short Form 36 (SF 36) from the Medical Outcomes Survey (MOS). Monthly client interviews provided information on service use.

Results: A total of 95 (63%) persons reported their general health as fair or poor; 84 (56%) reported experiencing moderate to severe pain. Women reported significantly better health than men ($p < .05$) but worse physical functioning ($p < .02$). Persons with higher educational levels reported significantly worse health ($p < .05$). Greater physical pain was associated with more somatic ER visits ($p < .05$) and more outpatient substance abuse treatment ($p < .05$) but not use of inpatient and outpatient somatic services. Health functioning was not associated with use of psychiatric services.

Conclusions: The poor health and degree of pain reported by these homeless persons is noteworthy. The fact that ER use is increased but not somatic outpatient care suggests the need to assist these individuals in using services appropriately and cost effectively.

REFERENCES:

1. DeForge B, Lehman A, Kernan E, Dixon LB: Quality of life assessment in homeless persons with severe mental illness (unpublished).

2. Dixon LB, Krauss N, Kernan E, Lehman AF, DeForge B. Modifying the PACT model to serve homeless persons with severe mental illness. Psychiatric Services, 1995; 46, 684-688.

Poster 3 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

PSYCHOTIC FEATURES AND SYMPTOM SEVERITY IN PTSD

Mark B. Hamner, M.D., *Director, PCT Clinic, Department of Psychiatry, Ralph H. Johnson Veterans Affairs Medical Center, 109 Bee Street, Charleston, SC 29401-5703;* Helen G. Ulmer, R.N., M.S.N.; Christopher B. Frueh, Ph.D.

SUMMARY:

Objective: Psychotic symptoms are common in the comorbidity of PTSD, present in up to 40% of patients with combat-associated PTSD. In this study we hypothesized that psychotic symptom ratings would correlate with severity of PTSD.

Method: Twenty-two Vietnam combat veterans with PTSD and comorbid psychotic features (well-characterize from a multidisciplinary evaluation) underwent a Structured Clinical Interview for DSM-III-R with psychotic screen (SCID-P), Clinician Administered PTSD Scale (CAPS), Positive and Negative Syndrome Scale (PANSS), and the Hamilton Depression Rating Scale (HDRS).

Results: There was a significant positive correlation between the CAPS and PANSS global ratings ($r = 0.83$, $p < 0.01$). Subscales except for the CAPS-B subscale (re-experiencing) and the PANSS-positive symptom scale ($r = 0.47$, $p = 0.20$) showed significant intercorrelations. Severity of depressive symptoms (HDRS) also correlated significantly with both CAPS ($r = 0.83$, $p < 0.03$) and PANSS ($r = 0.82$, $p < 0.02$) global scores.

Conclusion: As expected, patients with more severe PTSD illness as measured by the CAPS also had more severe ratings on the PANSS and some, but not all psychosis subscales. There is an overlap between symptoms rated by these scales although the PTSD re-experiencing scale (which includes psychotic symptoms) diverged from the positive symptom scale of the PANSS. PTSD with psychotic features may represent a more severe subtype of the disorder.

REFERENCES:

1. Butler RW, Mueser KT, Sprock J, Braff DL: Positive symptoms of psychosis in post-traumatic stress disorder. Biol Psychiatry 1996; 39:839-844.
2. Hamner MB: Psychotic features and combat-associated PTSD. Depression and Anxiety 1997; 5:34-38.

Poster 4 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

RISPERIDONE TREATMENT OF PSYCHOTIC FEATURES

Mark B. Hammer, M.D., *Director, PCT Clinic, Department of Psychiatry, Ralph H. Johnson Veterans Affairs Medical Center, 109 Bee Street, Charleston, SC 29401-5703;* Helen G. Ulmer, R.N., M.S.N.; Michael G. Huber, M.D.

SUMMARY:

Objective: Recent studies suggest that psychotic symptoms occur in up to 40% of combat veterans with PTSD. Although antidepressants may help global PTSD symptoms, there has been little systematic evaluation of the role of atypical antipsychotic treatment specifically for psychotic symptoms in these patients.

Method: Thirteen Vietnam veterans meeting DSM-IV criteria for PTSD had comorbid psychotic features assessed using the Structured Clinical Interview for DSM-III-R with Psychotic Screen (SCID-P) and the Positive and Negative Syndrome Scale (PANSS). All patients were on a stable antidepressant dose for at least three months (thus were partially treated). They then underwent six weeks of open-label treatment with risperidone titrated clinically. Symptom ratings included the Clinician Administered PTSD Scale (CAPS) and the PANSS given at baseline and following one and six weeks of treatment. Extrapyramidal side effects ratings were also administered.

Results: Ten of the 13 patients improved clinically (77%). There was a significant reduction in PANSS ratings (78.5 ± 5.0 versus 66.5 ± 5.8, $t = 3.24$, $p < 0.01$). The greatest magnitude of improvement in psychosis ratings was in the positive symptom subscale of the PANSS (18.8 ± 1.6 versus 14.2 ± 1.4, $t = 4.12$, $p < 0.001$). CAPS ratings remained the same, possibly reflecting prior antidepressant treatment (81.6 ± 9.2 versus 75.2 ± 10.3, $t = 0.27$, $p < 0.40$). The average dose of risperidone was 2.3 mg (range of 1 mg to 6 mg per day). There were no extrapyramidal side effects except for possible akathisia in one patient.

Conclusions: Risperidone treatment was efficacious as an adjunct to antidepressant medication in this clinical series. Further study utilizing a randomized, placebo-controlled, double-blind design is indicated to better define the role of atypical antipsychotics in this PTSD population.

REFERENCES:

1. Butler RW, Mueser KT, Sprock J, Braff DL: Positive symptoms of psychosis in post-traumatic stress disorder. Biol Psychiatry 1996; 39:839-844.

2. Hamner MB, Fossey MD: Psychotic symptoms associated with post-traumatic stress disorder. Neuropsychopharmacology 1993; 9:S121-122.

Poster 5 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

A CROSS-CULTURAL STUDY ON PERSONALITY DISORDER

Yueqin Huang, M.D., M.P.H., *Associate Professor and Chairperson, Department of Preventive Medicine, Beijing Medical University, Apt. 46, No. 203, Zhong Guan Yuan, Beijing, P.R. China 100871;* Christopher Reist, M.D., *Assistant Professor and Vice Chairman, Department of Psychiatry, University of California, 5901 East Seventh Street, Long Beach, CA 90822;* Wentian Dong, M.D.; Siu W. Tang, M.D.

SUMMARY:

The reported prevalence of personality disorder (PD) in China seems exceptionally low when compared with the U.S. Different attitudes toward child rearing were suggested as having an important bearing on personality formation. In order to explore the relationship between parental rearing behavior and the incidence of PD, this study applied the Personality Diagnostic Questionnaire-revised (DSM-III-R Axis II personality disorders assessing instrument) and EMBU (Swedish questionnaire of "one's memories of upbringing") in 33 hospitalized patients with PD and 73 normal controls in southern California, and 60 PD patients and 47 normal controls in Beijing. The cross-cultural comparison of parental rearing behavior showed that Chinese PD patients perceived more parental behavior favoring the subject than American PD patients, while rejection, emotional warmth, and over-protection did not show significant differences. Intra-group comparison for the EMBU factors indicated that compared with their respective control groups, American PD patients received less emotional warmth and behavior favoring the subject, while Chinese PD patients received less emotional warmth and more rejection. For all subjects, PD patients showed lower parental and own educational levels than controls. This supports that negative childhood experiences of parental rearing affect PD in different cultures.

REFERENCES:

1. Tang SW, Huang Y: Diagnosing personality disorder in China. International Medical Journal. 1995; 2(4):291-297.
2. Huang Y, Someya T, Takahashi S, et al: A pilot evaluation of the EMBU Scale in Japan and the USA. Acta Psychiatrics Scandinavica. 1996; 94:445-448.

Poster 6 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

A BRIDGING STUDY OF METRIFONATE IN PATIENTS WITH PROBABLE ALZHEIMER'S DISEASE

Jerome F. Costa, M.D., M.P.H., *Research Psychiatrist, California Clinical Trials, 8500 Wilshire Boulevard, 7th Floor, Beverly Hills, CA 90211;* Pamela A. Cyrus, M.D., *Deputy Director of Central Nervous System Medical Research, Bayer Corporation, 400 Morgan Lane, West Haven, CT 06516;* Florian Bieber, M.D.; Neal R. Cutler, M.D.; Paul Tanpiengco, M.S.; Barbara Gulanski, M.D.; John J. Sramek, Pharm.D.

SUMMARY:

Objective: Metrifonate is the pro-drug of DDVP (2,2-dichlorovinyl dimethyl phosphate) a potent and long-acting acetylcholinesterase (AChE) inhibitor. This safety/tolerability study was designed to determine the maximum tolerated dose (MTD) of metrifonate in patients with AD.

Methods: In this open-label, inpatient/outpatient bridging study, two sequential cohorts of eight AD patients each received metrifonate once daily. The first cohort received loading doses by weight of 125–225 mg (2.5 mg/kg) for 14 days, followed by 200–360 mg (4.0 mg/kg) for three days, and, finally, a maintenance dose of 100–180 mg (2.0 mg/kg) for 14 days followed by a maintenance dose of 75–135 mg (1.5 mg/kg) for 35 days.

Results: Six patients in the first cohort were discontinued during the maintenance phase on days 25–27 due to moderate to severe asthenia, cramps, incoordination, abdominal pain, and/or decreased appetite, and the panel was discontinued. All adverse events resolved after discontinuation, most within two to five days. Adverse events in the second cohort were primarily mild and transient; only one patient was discontinued.

Conclusions: The MTD of metrifonate was a maintenance dose of 75–135 mg (1.5 mg/kg). Neither plasma metrifonate nor DDVP concentrations nor erythrocyte AChE inhibition levels were predictive of tolerability.

This study was sponsored by Bayer Corporation.

REFERENCES:

1. Cutler NR, Sramek JJ: The target population in Phase I clinical trials of cholinergic compounds in Alzheimer disease: the role of the "bridging study." Alzheimer Dis Assoc Disord 1995; 9:139-145.
2. Pettigrew LC, Bieber F, Lettieri, et al.: Study of the pharmacokinetics, pharmacodynamics and safety of metrifonate in Alzheimer's disease patients. J Clin Pharmacol (in press), 1998.

Poster 7 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

SMOKING IN SEVERE AND PERSISTENT MENTAL ILLNESS AND ASSOCIATED MEDICAL PROBLEMS

Varsha V. Kunnirickal, M.D., *Director of Consultation Psychiatry, Johns Hopkins Bayview Medical Center, 411 Greenbrier Drive, Silver Spring, MD 20910-4227;* Gerard Gallucci, M.D., M.H.S., *Director of Community Psychiatry, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, D-2 East, Baltimore, MD 21224*

SUMMARY:

It is well recognized that the prevalence of smoking among patients with schizophrenia is reported to be three times higher than the general population and exceeds the elevated rates of smoking among those with other psychiatric illness. (Masterson & Oshea 1984, Huges 1986).

Smokers with schizophrenia tend to have an earlier age of onset of psychiatric illness, more hospitalizations, and require higher doses of neuroleptics than nonsmokers with this illness. (Sandy & Kay 1991, Goff et. al 1992, Ziedonis 1994)

There have been newer studies outlining the genetic linkage between schizophrenia and smoking. Tobacco smoking alters medication blood levels and effectiveness, modifies psychiatric symptoms, and is a clue for other substance abuse.

We attempted to look at smoking in a population of severe and persistently mentally ill adults and its correlation with medical problems. Creative Alternatives is a capitated mental health program that provides intensive psychiatric and case management services to long-term state hospital residents as well as adults with severe and persistent mental illness who are "heavy utilizers" of services in the community.

We decided to study the prevalence of smoking in this population and the possible relationship with Axis III diagnoses.

We feel studying smoking habits and its medical complications (with its associated effect on the patient's life and increased cost in medical expense) in this vulnerable population warrants a specially designed smoking cessation program. This program would most likely be effective if it had a multidisciplinary approach with incentives, motivational enhancement therapy, and relapse prevention behavior therapy, combined with more traditional programs of nicotine replacement and group therapy.

REFERENCES:

1. Smoking, smoking withdrawal and schizophrenia: case reports and a review of the literature. Schizophrenia Research. 1996; 22(2):133-41.
2. Lohr JB, and Flynn K: Smoking and Schizophrenia, 1992.
3. Masterson E and Oshea B: Smoking and Malignancy in Schizophrenia. British Journal of Psychiatry. 1984; 145 429-432.

Poster 8 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

SOCIAL SUPPORT OF MOTHERS WITH MENTAL ILLNESS

John D. McLennan, M.D., *Community Psychiatry Fellow, University of North Carolina at Chapel Hill, and Former APA/Bristol-Myers Squibb Fellow, 501 Billingsley Road, Charlotte, NC 28211;* Nasim Shajihan, M.D.; Samina Habibi, M.D.; Rohan Ganguli, M.D.

SUMMARY:

Objective: To investigate social support patterns of mothers with chronic, mental illness. Though there are several studies of social support in child development and adult mental illness, there is a paucity of research specific to mothers with mental illness.

Methods: Mothers with severe and persistent mental illness (SPMI), recruited from a community mental health center, were interviewed with a semi-structured instrument.

Results: The mothers' parents and partners were the most frequently seen persons and the most frequently endorsed supports with regard to child rearing. Frequency of contact did not necessarily correspond with a rating of helpfulness. In particular, church and friends were seen frequently but were rarely endorsed as helpful with regard to child-related issues. Professionals were endorsed as frequently being helpful but infrequently seen. Over half of the children were reported to attend church, though less than one-third participated in any other specific social activity. One-fifth never participated in any community or extra curricular program.

Conclusions: Children of SPMI mothers may be at a higher risk for poor developmental outcomes due to insufficient social support and exposure to diverse social experiences. Further assessment of these factors may provide direction for preventive interventions.

TARGET AUDIENCE:

Mental health clinicians and high-risk workers.

REFERENCES:

1. Salzinger S: Social networks in child rearing and child development. Annals New York Academy of Sciences 1990; 602:171-188.
2. Hammer M: Social supports, social networks, and schizophrenia. Schizophrenia Bulletin 1981; 7:45-57.

Poster 9 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

RACIAL FACTORS IN BIPOLAR DISORDER

William B. Lawson, M.D., Ph.D., *Chief of Psychiatry, Roudebush VA Medical Center, 1481 West 10th Street, Indianapolis, IN 46202*

SUMMARY:

Racial differences in diagnosis, access to services, pharmacotherapy, and treatment outcomes have been reported for psychiatric disorders. Few recent studies have investigated racial comparisons in bipolar affective disorder. We examined Caucasian and African Americans in a multisite study supporting the NIMH genetics initiative. The Diagnostic Interview for Genetic Studies (DIGS), a structured interview for bipolar disorder, served as the assessment instrument. Only one of the four sites recruited African-American patients equivalent to the general population. Demographically, racial differences were consistent with the general population. African Americans were less likely to have a DIGS diagnosis of bipolar II or depression. They were more likely to have more frequent hospitalizations, to receive antipsychotic medication, and to report more severe hallucinations and delusions. Racial differences were not seen in lithium use, help-seeking behavior, or substance abuse use. Additional research needs to be done to determine the generalizability and etiology of these differences.

REFERENCES:

1. Strakowski SM, Shelton RC, Kolbrener ML: The effects of race and comorbidity on clinical diagnosis in patients and psychosis. J Clin Psychiatry. 1993; 54:96-102.
2. Strickland TL, Lin KM, Fu P, et. al: Comparison of lithium ratio between African-American and Caucasian bipolar patients. Biol Psychiatry. 1995; 37:325-330.

Poster 10 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

INSTITUTIONALIZED HOMELESS WOMEN IN BOMBAY

Charles Pinto, M.D., *Associate Professor of Psychiatry, Byl Nair Hospital, Dr Al Nair Road, Mumbai, India 40-0008;* Shobha S. Nair, M.D., *Resident in Psychiatry, Byl Nair Hospital, Dr Al Nair Road, Mumbai, India 40-0008*

SUMMARY:

It appears from American and British studies that between one quarter and one half of the homeless are suffering from severe and chronic mental disorders. With almost 40% of the population of Bombay dwelling in slums, a vast subgroup is virtually "roofless." There are charitable institutions for the destitute, which cater to the totally disaffiliated and sick.

Aims: To study the sociodemographic profile of homeless women; prevalence of psychiatric disorders; and reasons for homelessness

Materials & Methods: The 60 homeless women inmates of a charitable institution for destitutes (women picked up from streets).

Instruments: (1) Clinical interview (2) SCID-I (DSM-III-R) patient version.

The study was conducted over a period of one year. Information regarding sociodemographic profile, reasons for homelessness, history of substance use disorders, history of physical and sexual abuse, and involvement in criminal activities was obtained. Psychiatric morbidity was assessed using SCID-I; diagnosis of dementia and mental retardation was made using DSM-III-R criteria.

Results: There was a high prevalence of psychiatric disorders, with 45% meriting an Axis I diagnosis; 25% of the women were mentally retarded. Only 8.33% attributed the cause of homelessness directly to mental illness. History of physical and sexual abuse was obtained in 36.7% and 15% of the women respectively. A history of substance use disorders was low (6.66%) and no one reported involvement in criminal activities.

REFERENCES:

1. Cohen CI, Thompson KS: Homeless mentally ill or mentally ill homeless? Am J Psychiatry 1992; 149:816-823.
2. Bassuk EL, Rubin L, Lauriat A: Is homelessness a mental health problem? Am J Psychiatry 1984; 141:1546-1550.

Poster 11 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

TREATMENT UTILIZATION BY PATIENTS WITH PERSONALITY DISORDERS

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Ph.D.; Danika L. Altman, Ph.D.; Paul Erickson, M.D.; Andrew E. Skodol II, M.D.

SUMMARY:

Objective: The purpose of this study was to compare recent and lifetime treatment histories of four groups of patients with personality disorders (PDs)—schizotypal (STPD), borderline (BPD), avoidant (AVPD), and obsessive compulsive (OCPD)—and a group diagnosed with major depression and no personality disorder (MD).

Method: 523 participants in the NIMH-funded Collaborative Longitudinal Study of Personality Disorders were assessed at intake with the SCID and the Diagnostic Interview for Personality Disorders. Treatment utilization data were drawn from the Health Care Utilization section of the LIFE-Base.

Results: All types of psychotherapy (i.e., individual, group, family, and self-help) and residential treatment (i.e., hospitalization, day treatment, and halfway houses) were reported more often and in greater amounts by patients with BPD than by other PD groups, either lifetime or in the past six months. A history of individual psychotherapy was more frequently reported by patients in the BPD and OCPD groups than by patients with AVPD or MD. Residential treatment was more common for patients with BPD, STPD, or MD than for patients with AVPD or OCPD. Use of antidepressants, but not other psychotropic medications, was more frequently reported by patients with AVPD, OCPD, and MD.

Conclusions: Consistent with previous research, patients with BPD receive more diverse and intensive treatments in greater amounts than patients with other PDs. Comorbidity, social functioning, recent life events, and specific personality traits may help to explain the differences in treatment utilization among these groups.

TARGET AUDIENCE:

Mental health practitioners and personality disorder researchers.

REFERENCES:

1. Clarke M, Hafner RJ, Holme G: Borderline personality disorder: a challenge for mental health services. Australian & New Zealand Journal of Psychiatry, 1995; 29:409-414.
2. Skodol AE, Buckley P, Charles E: Is there a characteristic pattern to the treatment history of clinic outpatients with borderline personality? The Journal of Nervous and Mental Disease 1983; 171:405-410.

Poster 12 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

THE PRIMARY CARE ANXIETY PROJECT: PSYCHIATRIC AND GENERAL MEDICAL TREATMENT RECEIVED BY PATIENTS WITH ANXIETY DISORDERS

Regina T. Dolan, Ph.D., *Associate Director, Clinical Assessment Unit, Department of Psychiatry, Brown University, 700 Butler Drive, Box G-B4, Providence, RI 02906;* Martin B. Keller, M.D., *Chairman, Department of Psychiatry and Human Behavior, Brown University and Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906;* Larry Culpeper, M.D.; Thomas T. Gilbert, M.D.; Deborah J. Johnson; Trudy Manchester, M.D.; Ann Massion, M.D.; Meredith Warshaw, M.S.S.; John H. Wasson, M.D.

SUMMARY:

Objective: To report preliminary findings from subjects presenting for treatment in primary care settings who met criteria for one of the following DSM-IV anxiety disorders: panic disorder with or without agoraphobia (PD), agoraphobia without panic (AWOP), social phobia (SP), generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD), or mixed anxiety depression (MAD).

Method: Patients from six primary care clinics were screened for anxiety symptoms. Diagnostic status was determined using the SCID-IV. The medical history form and the anxiety and treatment form were used to gather medical and treatment data for 150 subjects.

Results: Findings will be presented regarding the following: rates of psychotropic, psychosocial, and general medical treatment received; number of hospitalizations; number and type of medical conditions; and treatment-provider preferences for mental and physical health problems. Data will also be presented regarding treatment sought and received for anxiety disorders.

TARGET AUDIENCE:

Primary care practitioners, mental health practitioners and psychiatry researchers.

REFERENCES:

1. Roger M, White K., Warshaw M., et. al: Prevalence of medical illnesses in patients with anxiety disorders. International Journal of Psychiatry in Medicine. 1994; 224:83-97.
2. Yonkers K., Ellison J., Shera D. et al: Pharmacotherapy observed in a large prospective longitudinal study on anxiety disorders. Psychopharmacology Bulletin, 1992; 28:131-137.

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

THE PRIMARY CARE ANXIETY PROJECT: INITIAL FINDINGS

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SUMMARY:

Objective: To report initial findings from the first large-scale, prospective study of subjects seeking treatment for general medical conditions in primary care settings and who are diagnosed with one of the following DSM-IV anxiety disorders: panic disorder with or without agoraphobia (PD), agoraphobia without panic (AWOP), social phobia (SP), generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD), or mixed anxiety depression (MAD).

Method: This report will be on the intake data of 250 subjects with an anxiety disorder recruited from six primary care clinics and the six-month follow-up data on 50 subjects.

Results: 64% of subjects met criteria for one index disorder, 29% had two, and 7% had three or four. Rates for the index disorders were: GAD-37%, PD-34%; SP-34%; PTSD-30%; AWOP-6%; MAD-4%. Depressive disorders (42%) and alcohol/substance use disorders (35%) were frequently comorbid. The mean GAF score was 59 (SD = 7), with 45% of subjects having moderate symptoms and 31% having mild symptoms. Data will be presented on disorder duration and psychosocial functioning.

Conclusions: Anxiety disorders are common in primary care settings. Severity of psychopathology is high, as are rates of comorbidity. These findings are similar to those for subjects with anxiety disorders who seek treatment in psychiatric settings, with the exception that agoraphobia rates are much lower in the primary care sample.

TARGET AUDIENCE:

Primary care practitioners, mental health practitioners and psychiatry researchers.

REFERENCES:

1. Keller M., Yonkers K., Warshaw M., et al: Remission and relapse in subjects with panic disorder and panic with agoraphobia: a prospective short-interval naturalistic follow-up. Journal of Nervous and Mental Disease. 1994; 182(5) 290-296.
2. Massion A., Warshaw M., Keller M: Quality of life and psychiatric morbidity in panic disorder and generalized anxiety disorder. American Journal of Psychiatry, 1993; 150:600-607.

Poster 14 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

EFFECTS OF RIVASTIGMINE ON PET IN PATIENTS WITH ALZHEIMER'S DISEASE

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SUMMARY:

Introduction: Alzheimer's disease (AD) produces deficiencies in several central neurotransmitters, especially acetylcholine. Functional brain imaging techniques, such as positron emission tomography (PET), typically show decreases of activity/perfusion in the parietal and temporal regions of the brain in AD patients. Centrally acting cholinergic enhancers have been reported to have memory and cognitive efficacy in AD. Rivastigmine is an acetylcholinesterase inhibitor of the carbamate type that is currently under study as a treatment for AD.

Objective: We studied the effects of rivastigmine in AD patients as measured by PET imaging of brain perfusion using O-15 water.

Method: Four patients with probable AD were PET scanned with O-15 water perfusion at baseline and following 26 weeks of treatment with open-label rivastigmine 3-12 mg/day. Baseline PET imaging revealed biparietal and bitemporal perfusion deficits in three of the patients, and disclosed bifrontal hypoperfusion in the fourth patient.

Results: All three patients with biparietal and bitemporal abnormalities showed improvement in the perfusion of parietal and temporal regions as measured by mean change from baseline to endpoint on PET perfusion imaging of the brain (qualitative measurement), whereas the patient with hypofrontality on PET imaging did not show any improvement.

Conclusion: Our data suggests that treatment with rivastigmine can reverse the baseline perfusion deficits in the brain of AD patients, particularly in those with biparietal and bitemporal abnormalities on PET imaging of the brain.

This study was partly funded by Novartis Pharmaceuticals Corporation.

REFERENCES:

1. Jagust WJ: Functional imaging in dementia: an overview. J Clin Psychiatry 1994; 55 [11 suppl]:5-11.
2. Doraiswamy PM: Current cholinergic therapy for symptoms of Alzheimer's disease. Primary Psychiatry 1996; 3:56-68.

Poster 15 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

PAROXETINE TREATMENT OF DEPRESSION IN THE ELDERLY

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SUMMARY:

The occurrence of depression in the elderly population is a significant public health issue. Although surveys have shown that elderly depression is highly prevalent within the community, double-blind, placebo-controlled studies have only recently emerged in the published literature regarding selective serotonin reuptake inhibitors (SSRIs) in treating depression in this population. This 12-week placebo-controlled trial compared the efficacy of paroxetine in 210 (paroxetine = 103, placebo = 107) moderately depressed elderly outpatients (≥60 years of age) who exhibited no signs of dementia. The study employed a flexible dosage scheme for paroxetine with a range of 10–40 mg given once daily. Efficacy was determined primarily by the HAMD total score (17-item) change from baseline, as well as the HAMD depressed mood item and Clinical Global Impressions (CGI), severity of illness changes from baseline.

Results: With respect to efficacy, paroxetine patients exhibited a greater mean (s.e.) HAMD change from baseline to last-observation-carried-forward endpoint (−12.3, s.e. = 0.70) than placebo patients (−9.5, s.e. = 0.71). This difference between treatment groups was statistically significant ($p = 0.003$). Further substantiating this result was the HAMD depressed mood item mean (s.e.) change from baseline of −1.4 (s.e. = 0.15) for paroxetine and −0.9 (s.e. = 0.15) for placebo which was highly significant, statistically ($p < 0.001$). The CGI, severity of illness distribution at list-observation-carried-forward study endpoint was statistically significant in favor of paroxetine as well ($p = 0.019$). Paroxetine safety data related to adverse experiences commonly associated with SSRIs were as follows: somnolence 15%; insomnia 14%; ejaculatory disturbance 13%; nausea 13%; asthenia 12%; nervousness 6%. The incidence of these events was similar to that occurring in premarketing paroxetine studies, with the exception of nausea which is substantially reduced from earlier studies (26%). In conclusion, these data are indicative of paroxetine's efficacy in treating elderly depression as well as demonstrating the absence of unexpected adverse experiences in this population.

REFERENCES:

1. Dunbar, GC et al: Paroxetine in the elderly: a comparative meta-analysis against standard antidepressant pharmacotherapy, Drugs and Aging, 1997; 10/3 (209-218).
2. Newhouse P: Use of serotonin selective re-uptake inhibitors in geriatric depression, J Clin Psychiatry, 1996; 57 (suppl 5).
3. Rothchild AJ: The diagnosis and treatment of late-life depression, J Clin Psychiatry, 1996; 57 (suppl).

Poster 16 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

EFFECTS OF RISPERIDONE ON AFFECTIVE SYMPTOMS IN PATIENTS WITH SCHIZOPHRENIA

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SUMMARY:

The effects of risperidone on affective symptoms were analyzed using combined data from six double-blind comparative trials of risperidone and haloperidol (one placebo-controlled) in patients with schizophrenia. Symptoms were assessed by mean shifts from baseline on the Positive and Negative Syndrome Scale (PANSS) excited factor score, grandiosity score, and anxiety/depressive cluster score.

Among all patients, the excited factor score decreased in both active treatment groups; the risperidone group showed a greater improvement than the placebo or haloperidol groups. In excited patients with grandiosity (≥4 excitement and ≥4 grandiosity baseline score) manic-like-symptom scores (excitement + grandiosity; excited factor + grandiosity) improved significantly more with risperidone than with haloperidol ($p \leq 0.05$). Dropouts due to lack of efficacy among this excited group of patients were less frequent with risperidone (8.5%) than haloperidol (18.4%) or placebo (80%). For patients who dropped out because of inefficacy, endpoint scores for

all measures were not significantly different among the three groups.

Among all patients and those with anxious/depressive symptoms (baseline score ≥ median), the anxious/depressive cluster scores decreased in both active treatment. The risperidone group had a significantly ($p \leq 0.01$) greater improvement in the anxious/depressive cluster score than patients receiving haloperidol or placebo. These results suggest that risperidone is more efficacious for effective symptoms than haloperidol in patients with schizophrenia.

TARGET AUDIENCE:

Psychiatrists, psychologists, nurse clinicians and social workers.

REFERENCES:

1. Peuskens J, the Risperidone Study Group: Risperidone in the treatment of chronic schizophrenic patients: a multinational, multicenter, double-blind, parallel group study versus haloperidol. Br J Psychiatry 1995; 166:712-26.
2. Marder SR, Meibach RC: Risperidone in the treatment of schizophrenia. Am J Psychiatry 1994; 151:825-35.

Poster 17 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

PSYCHOSIS AND BEHAVIORAL DISTURBANCES IN DEMENTIA: EFFECTS OF RISPERIDONE IN 969 PATIENTS

Martin B. Brecher, M.D., *Director, Medical Development, Janssen Pharmaceutica and Research Foundation, 1125 Trenton-Harbourton Road, Titusville, NJ 08560;* Peter P. DeDeyn, M.D.; Goedele DeSmedt

SUMMARY:

Combined data from two multicenter, randomized, double-blind, placebo-controlled trials of risperidone in patients with dementia were analyzed. Of the 969 patients included in these 12-week trials, 277 received placebo, 577 risperidone, and 115 haloperidol. In the first trial, patients received a fixed dose of risperidone (0.5, 1, or 2 mg/day) or placebo; in the second trial, patients received a flexible dose (0.5–4 mg/day) of risperidone or haloperidol (mean dose at endpoint, 1.1 and 1.2 mg/day, respectively) or placebo. In the present analysis, responses to placebo, <0.75, 0.75–<1.5, and > 1.5 mg/day of risperidone, and haloperidol were evaluated. The patients (65% women) were aged 58 to 105 years (median, 83 years); 72% had dementia of the Alzheimer's type, 18% vascular dementia, and 10% mixed dementia. The severity and frequency of symptoms were assessed by means of the Behavioral Pathology in Alzheimer's Disease Rating Scale (BEHAVE-AD) and the Cohen-Mansfield Agitation Inventory (CMAI). At 12 weeks and at endpoint, score reductions on the BEHAVE-AD paranoid/delusional scale were significantly greater ($p \leq 0.05$) in patients receiving ≥0.75 mg/day of risperidone than placebo. On both the BEHAVE-AD and the CMAI, score reductions on the aggressiveness scales were significantly greater ($p \leq 0.05$) in patients receiving ≥0.75 mg/day of risperidone than placebo; BEHAVE-AD total score reductions were also significantly greater ($p < 0.05$) in this group. Review of the combined safety data (adverse events, laboratory test results, mortality) from these two trials revealed no major hazard associated with risperidone in patients with dementia. It is concluded that risperidone is both efficacious and well tolerated in elderly patients with dementia.

TARGET AUDIENCE:

Psychiatrists, psychologists, nurse clinicians and social workers.

REFERENCES:

1. Jeste DV, Eastham JH, Lacro JP, et al: Management of late-life psycosis. J Clin Psychiatry 1996; 57(suppl 3):39-45.
2. Marder SR, Meibach RC: Risperidone in the treatment of schizophrenia. Am J Psychiatry. 1994; 151:825-835.

Poster 18 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

FOLLOW-UP STUDY OF RISPERIDONE IN THE TREATMENT OF PATIENTS WITH DEMENTIA: INTERIM RESULTS ON TARDIVE DYSKINESIA AND DYSKINESIA SEVERITY

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SUMMARY:

A multicenter, double-blind study was conducted in 625 institutionalized patients with dementia (73% Alzheimer's, 15% vascular, 12% mixed) to evaluate the efficacy and safety of risperidone. Patients were randomly assigned to receive placebo or 0.5 mg/day, 1 mg/day, or 2 mg/day of risperidone for 12 weeks. According to their scores on the Behavior Pathology in Alzheimer's Disease Rating Scale (BEHAVE-AD) and the Cohen-Mansfield Agitation Inventory, significantly greater im-

provements were seen in psychosis and in the severity and frequency of aggressive behaviors in patients receiving 1 or 2 mg/day of risperidone than placebo. The frequency of adverse events (including extrapyramidal symptoms) was similar in patients receiving 1 mg/day of risperidone and placebo. Two hundred sixteen of the patients are participating in a one year, open-label, follow-up study. To date, the 216 patients have been exposed to risperidone for a mean (±SD) of 184 ± 128 days (69% have been exposed >90 days). No cases of tardive dyskinesia have been reported, and the patients show improvements on five measures of dyskinesia: dyskinetic movements, hyperkinesia, buccolinguomasticatory factor, choreoathetoid movements, and clinical global impression of dyskinesia.

TARGET AUDIENCE:

Psychiatrists, psychologists, nurse clinicians and social workers.

REFERENCES:

1. Jeste DV, Caliguiuri MP, Paulsen JS, et al: Risk of tardive dyskinesia in older patients. Arch Gen Psychiatry 1995; 52:756-65.
2. Finkel SI, ed. Behavioral and psychological signs and symptoms of dementia: implications for research and treatment. Int Psychogeriatr 1996; 8(suppl 3):215-242.

Poster 19 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

THE TREATMENT OF CHRONIC MASTURBATION WITH FLUOXETINE

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SUMMARY:

Recently, the successful treatment of the paraphiliac sexual addictions, such as fetishism, frorteurism, and voyeurism, has focused on the use of selective serotonin reuptake inhibitors (SSRIs) as the therapy of choice. Less prevalent and much less studied is the treatment of nonparaphiliac sexual addictions (NPSA), such as chronic masturbation. We evaluated and treated one patient with reoccurrence of NPSA and depression following initiation of interferon therapy for hepatitis C infection. Four weeks after the patient began Monday, Wednesday, and Friday interferon injections, he was masturbating 60 hours a week. His total sexual output (TSO), defined as the total number of completed orgasms per week, was approximately 30. Treatment with up to 60 mg of fluoxetine and supportive psychotherapy was begun seven weeks after initiation of interferon therapy. At 14 weeks post-interferon initiation, the number of hours masturbating per week had decreased to six and the TSO decreased to five, approximating the patient's pre-interferon levels. This level of symptomology was maintained for the duration of his interferon treatment. This case suggests that NPSA's such as chronic masturbation are responsive to SSRIs and that psychiatric disorders induced by interferon are potentially treatable, ameliorating the need for abrupt discontinuation of a potentially life-saving therapy.

REFERENCES:

1. Black DW., Kehrberg LLD., Flumerfelt DL., Schlossen SS: Characteristics of 36 subjects reporting compulsive sexual behavior. Am. J. Psychiatry, 1997; 154:243-249.
2. Kafko MP, Prentky R: Fluoxetine treatment of nonparaphiliac sexual addictions and paraphilias in men. J Clin Psychiatry 1992; 53:351-358.

Poster 20 **Saturday, October 3**
10:00 a.m. - 11:30 a.m.

COMORBIDITIES OF HOMELESS CLIENTS ON A MEDICAL VAN

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SUMMARY:

Substance abuse dominated the medical history and treatment of 128 clients on a mobile medical clinic serving homeless people in New York City, staffed by physicians, paraprofessionals, and a social worker. Based on radioimmune hair assays, 75% had used cocaine during the prior month, with 18% having used opiates. Twenty-eight percent and 42% reported symptoms consistent with a DSM-III-R diagnosis of abuse/dependences for alcohol and other drugs, respectively. Twenty-three percent showed evidence of liver inflammation (GGTP > 50). Lifetime history of injection drug use (20%) was linked, as expected, to hepatitis C (r = .56) and hepatitis B core antibodies (r = .31). Alcohol dependence/abuse was associated with depressive symptoms as measured by a short version of the CES-D (r = .29) and psychotic ideation as measured by the Dohrenwend scale (r = .18). Substance abuse was also involved in acute physical

conditions (cocaine use with cuts/wounds, r = .26 and dental problems, r = .31; alcohol dependence and blackouts/seizures, r = .39). The high comorbidity between serious levels of chemical abuse and both psychiatric and physical health problems highlight the necessity of adapting street outreach methods to full multidisciplinary formats.

REFERENCES:

1. McQuistion H, D'Ercole A, Kopelson E: Urban street outreach: using clinical directives to steer the system. In, Psychiatric Outreach to the Mentally Ill, Cohen N. (ed.). New Directions in Mental Health Services 52:17-27.
2. Harris, W. et al: Physical health, mental health, and substance abuse problems of shelter users. Health and Social Work 1994; 19:37-45.

Poster 21 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

AD7C-NTP IS SPECIFICALLY ELEVATED IN ALZHEIMER'S DISEASE

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SUMMARY:

This study was carried out to confirm the specificity of AD7C-NTP as a biochemical marker for Alzheimer's disease (AD). AD7C-NTP is a 41 kD protein present in neurons that is selectively upregulated in AD brain and is associated with the pathology of the disease. *In situ* hybridization and immunostaining studies have localized AD7C-NTP gene expression in early-stage degenerating neurons. Over-expression of AD7C-NTP in transfected neuronal cells promotes neuritic sprouting and cell death. Using an enzyme-linked sandwich immunoassay (ELSIA), AD7C-NTP levels have been measured in cerebrospinal fluid (CSF) samples from cases of AD as well as age-matched controls and a variety of neurological disease controls, including cases of stroke, Pick's disease, amyotrophic lateral sclerosis, diffuse Lewy body disease, and certain psychiatric disorders of the elderly. The mean AD7C-NTP level in the possible/probable AD group (4.3 $\pm$ 3.2 ng/ml) was significantly higher ($P < 0.0001$) than the age-matched non-AD demented control group (1.1 $\pm$ 0.9 ng/ml). However, there was no significant difference between AD7C-NTP levels in the non-AD dementia control group and age-matched normal controls (1.1 $\pm$ 0.9 vs 1.2 $\pm$ 0.9). Levels of AD7C-NTP greater than 2.0 ng/ml were found in 83% of possible/probable AD, 89% of early AD, and in only 6% of the non-AD demented control group. The data clearly confirm specificity of AD7C-NTP as a biochemical marker for Alzheimer's disease.

TARGET AUDIENCE:

Physicians treating elderly patients.

REFERENCES:

1. de la Monte SM, Ghanbari K, Frey WH, et al: Characterization of the AD7C-NTP cDNA expression in Alzheimer's disease and measurement of a 41-kD protein in cerebrospinal fluid. J Clin Invest 1997; 100:3093-3104.
2. de la Monte SM, Carlson RL, Brown NV, et al: Profiles of neuronal thread protein expression in Alzheimer's disease. J Neuropathol Exp Neurol 1996; 55:1038-1050.

Poster 22 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

EVALUATION OF A DISEASE-STATE MANAGEMENT PROTOCOL FOR DEPRESSION IN A HOSPITAL-BASED MEDICAL OUTPATIENT CLINIC

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SUMMARY:

Objective: This prospective, crossover, pre/post study was designed to evaluate the impact on patient outcomes from implementing a disease-state management protocol for depression at the outpatient clinic of a teaching hospital.

Method: Patients were recruited before and after the implementation of the disease-state management protocol, which included four components; 1) screening for depression using the Zung Self-Rating Depression Scale, 2) training of primary care residents on treating depression in an outpatient setting, 3) criteria for psychiatric referral, and 4) outcomes assessment. Patient's computerized medical utilization records, a quality-of-life survey, and Zung depression scale results were used in the analysis.

Interim Result: A total of 376 primary care patients were recruited for the study. Of these, 130 patients (35%) exceeded the threshold for depression (Zung $\geq$ 60). Positive screening results were associated with higher prior health care utilization costs and higher rates of comorbid lung disease, hypothyroidism, headache, and history of

depression ($p < 0.05$). The disease-state management protocol resulted in a three- to six-fold increase in recognition of depression.

Conclusion: Implementation of a disease-state management protocol increased recognition and treatment of depression.

REFERENCES:

1. Cole S, Raju M: Making the diagnosis of depression in the primary care setting. Am J Med 1996; 101(suppl 6A):10S-17S.
2. Katon W, Von Korff M, Lin E et al: Collaborative management to achieve treatment guidelines: impact on depression in primary care. JAMA 1995; 273:1026-1031.

Poster 23 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

WEIGHT GAIN AND ATYPICAL ANTIPSYCHOTICS

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SUMMARY:

It is well established that atypical antipsychotics have superior efficacy in treating the positive and negative symptoms of schizophrenia as well as in preventing relapse and decreasing hospitalization. They cause fewer extrapyramidal symptoms and lessen the risk of developing tardive dyskinesia. The issue of weight gain, a potentially serious side effect, has not been clearly determined. Will atypical agents such as risperidone and olanzapine cause patients to gain greater amounts of weight than the traditional antipsychotics?

In a supportive residence for formerly homeless persons living with serious and persistent mental illness, we tracked the weight gain of patients stabilized on atypical medications for at least one year. We started to see a pattern of initial weight increases, followed by a plateau in weight, and eventually, for most, weight loss.

In July, 1997, the diet at the residence was re-evaluated and changed to a low-fat, low-caloric diet. We also increased patient education through support groups focusing on healthy eating habits and weight reduction. We found that patients who had been taking atypical medications and who followed the dietary changes for over one year showed an overall weight loss.

REFERENCES:

1. Bernstein JL: Induction of obesity by psychotropic drugs. Ann NY Acad Sci 1987; 499:203-215.
2. Bustillo JR, Buchanan RW, Irish D, Breier A: Differential effect of clozapine on weight: a controlled study, Am J Psychiatry 1996; 153:817-819.

Poster 24 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

LESS TRANQUILIZER USE WITH RIVASTIGMINE FOR ALZHEIMER'S

Keith R. Edwards, M.D., *Director, Neurological Research Center, 140 Hospital Drive, Suite 210, Bennington, VT 05201*

SUMMARY:

Background: Many patients with Alzheimer's disease (AD) are placed in nursing homes due to unmanageable behavior. These behaviors may be disruptive to caregivers and often require tranquilizers.

Objective: To analyze the efficacy of rivastigmine at 12 and 26 weeks in improving patient's behavior, cognition, and tranquilizer use.

Design and Methods: Forty-two nursing home patients with probable Alzheimer's disease were enrolled in an open-label study with rivastigmine. Twenty of these patients were receiving tranquilizers prior to rivastigmine use. MMS, NPII, and psychotropic medication use were analyzed at baseline and at 12 and 26 weeks.

Results: Of 20 patients on tranquilizers, 50% were able to be withdrawn from these medications within a period of 12 weeks and had not resumed use at 26 weeks. Dosage of rivastigmine ranged from 6 mg to 12 mg per day.

Discussion: In this group of patients, behavior improved to the extent that 50% had tranquilizer use terminated. This resulted in improved quality of life for the patient, improved functional status, and decreased caregiver burden. It is unknown at this time whether the improved behavior is due to cognitive improvement or if there is an independent cholinergic modification of behavior.

REFERENCES:

1. Kaufer DI, Cummings JL: Effect of tacrine on behavioral symptoms in Alzheimer's disease: an open-label study. J Geriatr Psychiatry Neurol 1996; 9:1-6.
2. Cummings JL, Kaufer KI: Neuropsychiatric aspects of Alzheimer's disease the cholineric hypothesis revisited. Neurology 1996; 47:876-883.

Poster 25 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

ATTENTIONAL IMPROVEMENT AND QUETIAPINE FUMARATE IN SCHIZOPHRENIA

Kenji W. Sax, Ph.D., *Assistant Professor of Psychiatry, University of Cincinnati, 231 Bethesda Avenue (ML 559), Cincinnati, OH 45267;* Stephen M. Strakowski, M.D., H. Lee Rosenberg, B.S.

SUMMARY:

Background: Although attentional improvement following treatment with antipsychotic medication has been observed in schizophrenia,[1] this has been little studied with the new atypical antipsychotic quetiapine. We therefore examined changes in attentional performance and symptom severity over two months of quetiapine treatment in patients with chronic schizophrenia.

Methods: Patients with schizophrenia (N = 10) were evaluated using the Continuous Performance Test (CPT), Brief Psychiatric Rating Scale (BPRS), and Clinical Global Impression (CGI) once prior to treatment, then twice after quetiapine administration (mean dose-330 mg) at one-month intervals. The CPT was used to assess attentional functioning since it has been shown to be sensitive to the effects of antipsychotic medication.[2] Normal volunteers (N = 12) matched for age, sex, race, and education also performed the CPT.

Results: Prior to treatment, patients performed significantly more poorly on the CPT than controls (Wilcoxon signed ranks: $z = 2.5$, $p < 0.01$). However, their performance significantly improved over time ($F = 13$, $df = 2,7$; $p < 0.005$), and by the final evaluation, was similar to controls. There were no significant associations between changes in CPT performance and symptom ratings over time.

Conclusions: Results indicate that quetiapine produces significant improvement in attentional performance over the first two months of treatment in patients with chronic schizophrenia.

REFERENCES:

1. Serper MR, Chou JCY: Novel neuroleptics improve attentional functioning in schizophrenic patients: ziprasidone and aripiprazole. CNS. Spectrums 1997; 2:56-59.
2. Nuechterlein KH: Vigilance in schizophrenia and related disorders. In S.R. Steinhauer, J.H. Gruzelier, and J. Zubin (eds). Handbook of Schizophrenia, Vol 5: Neuropsychology Psychophysiology and Information Processing (pp. 397-433). Amsterdam: Elsevier Science Publishers, pp. 397-433, 1991.

Poster 26 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

WELL BEING IN DEPRESSION AND PTSD

Seung K. Park, M.D., *Department of Psychiatry, VA Medical Center, 3495 Bailey Avenue, Buffalo, NY 14215-3021;* Kye Y. Kim, M.D., *Department of Psychiatry, VA Medical Center, 8412 Clarence Lane Court, East Amherst, NY 14051-2003;* Murray A. Morphy, M.D.; Giovanni A. Fava, M.D.

SUMMARY:

Objectives: The aim of this preliminary study is to explore levels of psychological well-being in depression and PTSD. Psychological well-being is defined by factors of autonomy, environmental mastery, purpose in life, interpersonal relationships, personal growth, and self-acceptance. Subsequent studies in three and six months may demonstrate the relationship between well-being scores and relapse rate.

Methodology: Patients admitted to the psychiatric unit of Buffalo VA Hospital who satisfy DSM-IV criteria for depressive disorders and PTSD are being studied for their psychological well-being. The study will include patients with diagnoses of depressive disorders (N = 30) and patients with diagnoses of PTSD (N = 30). Patients will be subdivided into two age groups; 18–59 and 60 and older. Control (N = 30). The following questionnaires are administered: (a) Ryff's Well-Being Scale (b) Kellner's Sx. Questionnaires (c) Stress Index (d) BPRS, and (e) Hamilton Depression Rating Scale.

Clinical Implications: This study may have clinical implications in identifying specific impairments of well-being in certain psychiatric disorders. If the higher level of well-being is related to a reduction of relapse in psychiatric illnesses, this knowledge may be applied to outpatient psychotherapy settings to reduce the rate of relapse, so that the need for admission to inpatient units may be decreased. Preliminary data indicate the need to develop "well-being therapy" as a valuable tool for the above stated goal.

REFERENCES:

1. Ryff CD, Singer B: Psychological well-being. Psychother Psychosom 1996; 65:14-23.
2. Fava GA: The concept of recovery in affective disorders. Psychother Psychosom 1996; 65:2-13.

Poster 27 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

VENLAFAXINE XR IS AN EFFICACIOUS SHORT- AND LONG-TERM TREATMENT FOR GENERALIZED ANXIETY DISORDER

A. Richard Entsuah, Ph.D., *Assistant Director, Clinical Biostatistics Department, Wyeth-Ayerst Laboratories,*

P.O. Box 42528, Philadelphia, PA 19101; John T. Haskins, Ph.D., *Senior Director, Clinical Research and Development, Wyeth-Ayerst Research, P.O. Box 42528, Philadelphia, PA 19101;* Richard L. Rudolph, M.D.; Eliseo Salinas, M.D.

SUMMARY:

This six-month study compared the safety and anxiolytic efficacy of once daily V-XR (75-225 mg/d) with placebo (pbo) in outpatients with generalized anxiety disorder (GAD). V-XR is a new formulation of the 5HT/NE reuptake inhibitor antidepressant, venlafaxine. Patients who met DSM-IV criteria for GAD but not major depressive disorder (MDD) could be enrolled into the study. Patients who had a current, or within six months of study day 1, diagnosis of MDD (using structured interview as a guide to complete diagnostic criteria), had a Raskin Depression Scale (RDS) score greater than the Covi Anxiety Scale (CAS), score, had a total RDS score greater than 9, or who had any single RDS item score greater than 3 were excluded.

Significant improvements were observed for the V-XR-treated patients from week one through six months on the HAM-A, the Clinical Global Impressions scale, the Hospital Anxiety and Depression Scale, and the CAS. This study is the first pbo-controlled demonstration of long-term efficacy for any drug class in treating outpatients meeting DSM-IV criteria for GAD who do not have comorbid MDD. These data suggest that V-XR is an effective, rapidly acting, safe agent for both short- and long-term treatment of anxiety, which may provide an important alternative to currently available anxiolytics.

TARGET AUDIENCE(S):

General practitioners, psychiatrists and clinical researchers.

REFERENCES:

1. Feighner J, Entsuah A, McPherson M: Efficacy of once-daily venlafaxine extended release (XR) for symptoms of anxiety in depressed outpatients. J of Affective Disorders 1998; 47:55-62.
2. Rudolph R, Entsuah R, Chitrar R: A meta-analysis of the effects of venlafaxine on anxiety associated with depression. J Clin Psychopharmacol 1998; vol 18/no 2.

Poster 28 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

DOUBLE-BLIND, PLACEBO/ COMPARATOR-CONTROLLED STUDY OF ONCE-DAILY VENLAFAXINE AND BUSPIRONE IN OUTPATIENTS WITH GENERALIZED ANXIETY DISORDER

John T. Haskins, Ph.D., *Senior Director, Clinical Research and Development, Wyeth-Ayerst Research, P.O. Box 42528, Philadelphia, PA 19101;* A. Richard Entsuah, Ph.D., *Assistant Director, Clinical Biostatistics Department, Wyeth-Ayerst Laboratories, P.O. Box 42528, Philadelphia, PA 19101;* Richard L. Rudolph, M.D.; Loren M. Aguiar, M.D.

SUMMARY:

This study compared the safety and anxiolytic efficacy of once daily V-XR (75, 150 mg/d) with placebo (Pbo) and Bsp (30 mg/d) in outpatients with generalized anxiety disorder (GAD). V-XR is a new formulation of the 5HT/NE reuptake inhibitor antidepressant, venlafaxine. Patients who met DSM-IV criteria for GAD but not for major depressive disorder (MDD) could be enrolled into the study. Patients who had a current, or within six months of study day 1, diagnosis of MDD (using structured interview as a guide to complete diagnostic criteria), had a Raskin Depression Scale (RDS) score greater than the Covi Anxiety Scale (CAS) score, had a total RDS score greater than 9 or who had any single RDS item score greater than 3 were excluded from the study.

Statistically significant improvement was observed for V-XR-treated patients on the HAM-A response rate, psychic anxiety factor, anxious mood, and tension items, the Clinical Global Impressions Scale, the Hospital Anxiety and Depression Scale, and the CAS. The safety profile was consistent with that of V-XR use in depressed patients. This study showed that venlafaxine XR is an efficacious treatment for outpatients with GAD who do not have comorbid MDD and suggested V-XR also has significant advantages versus Bsp.

TARGET AUDIENCE:

General practitioners, psychiatrists and clinical researchers

REFERENCES:

1. Brown TA, et al: The empirical basis of generalized anxiety disorder. Am J Psychiatry 1994; 151: 1272-1280.
2. Fankhauser MP, German ML: Understanding the use of behavioral rating scales in studies evaluating the efficacy of antianxiety and antidepressant drugs. Am J Hospital Pharmacy 1987; 44:2087-2100.

Poster 29 **Saturday, October 3 10:00 a.m.-11:30 a.m.**

DOUBLE-BLIND, PLACEBO-CONTROLLED STUDY OF ONCE-DAILY VENLAFAXINE XR IN OUTPATIENTS WITH GENERALIZED ANXIETY DISORDER

John T. Haskins, Ph.D., *Senior Director, Clinical Research and Development, Wyeth-Ayerst Research, P.O. Box 42528, Philadelphia, PA 19101;* Loren M. Aguilar, M.D., *Director, Clinical Research Development, Wyeth-Ayersterst Laboratories, P.O. Box 42528, Philadelphia, PA 19101;* Alan Pallay, M.S.; Richard L. Rudolph, M.D.

SUMMARY:

This study compared the safety and anxiolytic efficacy of once daily V-XR (75, 150 or 225 mg/d) with placebo in outpatients with generalized anxiety disorder (GAD). V-XR is a new formulation of the serotonin norepinephrine reuptake inhibitor antidepressant, venlafaxine. Patients who met DSM-IV criteria for GAD but not major depressive disorder (MDD) could be enrolled into the study. Patients who had a current, or within six months of study day 1, diagnosis of MDD (using structured interview as a guide to complete diagnostic criteria), had a Raskin Depression Scale (RDS) score greater than the Covi Anxiety Scale (CAS) score, had a total RDS score greater than 9, or who had any single RDS item score greater than 3 were excluded from the study.

Significant improvement was observed for V-XR-treated patients on the HAM-A, the Clinical Global Impressions Scale, the Hospital Anxiety and Depression Scale (HAD), and the CAS. This study is the first demonstration of the effectiveness of a psychotropic agent in treating outpatients meeting DSM-IV criteria for GAD who do not have comorbid MDD. Significantly, these data suggest that V-XR is an effective, safe, once-daily agent for the treatment of GAD, which may provide an important alternative to currently available anxiolytics.

TARGET AUDIENCE:

General practitioners, psychiatrists and clinical researchers

REFERENCES:

1. Brown TA, et al: The empirical basis of generalized anxiety disorder. Am J Psychiatry, 1994; 151: 1272-1280
2. Fankhauser MP, German ML: Understanding the use of behavioral rating scales in studies evaluating the efficacy of antianxiety and antidepressant drugs. Am J Hospital Pharmacy 1987; 44:2087-2100.

Poster 30 **Saturday, October 3 10:00 a.m.-11:30 a.m.**

FIREARMS AS A MEANS OF SUICIDE IN THE BRITISH ISLES AND THE UNITED STATES

John F. Connolly, M.D., *Chief Consultant, Department of Psychiatry , St. Mary's Hospital, Westport Road, Castlebar Co Mayo, Ireland;* Anne Cullen, M.B.; Josephine Scott

SUMMARY:

For the purpose of this study, official suicide mortality data for the jurisdictions of Ireland, Northern Ireland, Scotland, England and Wales, and the United States for the years 1978–1994 were obtained. Rates of suicide and undetermined deaths by firearms are calculated and compared for the different jurisdictions.

Changing rates of suicide by firearms as a percentage of total suicides for each of the jurisdictions and for the different sexes and age groups are examined. Factors influencing firearms as a choice of means of committing suicide are examined. In particular, the impact of gun control legislation and the availability of firearms on suicide rates is discussed. The availability of illegal weapons as a result of subversive and paramilitary activity in Ireland and Northern Ireland is a possible factor in the increasing number of suicides by this means in these countries. The findings are discussed in the light of the literature on the subject. The importance of gun control as part of suicide prevention programs is stressed.

REFERENCES:

1. Bille-Brahe U, Jesen G: Suicide in Denmark, 1922-1991: the choice of method. Acta Psychiatrica Scandinavica 1994; 90:91-96.
2. Rich CL, Young JG, Fowler RC, et al: Guns and suicide: possible effects of some specific legislation. Am J Psychiatry 1990; 147:342-346.

Poster 31 **Saturday, October 3 10:00 a.m.-11:30 a.m.**

HISTORY OF CHILDHOOD ABUSE AND PERSONALITY TRAITS IN NONPSYCHIATRIC ADULT POPULATION

Lindsay B. Paden, M.D., *Child and Adolescent Psychiatrist, Mental Health Department, Naval Medical Center, 34800 Bob Wilson Drive, San Diego, CA 92027-3607;* Stanley W. Raczek, M.D., *Department of Psychiatry, U.S. Naval Medical Center, PCS 827, Box 4837, FPO AE 09617;* Matthew Carroll, M.D.

SUMMARY:

Objectives: In several recent studies childhood abuse has been implicated as a significant etiologic factor in the development of personality disorders. However, a significant limitation of many of these studies is the fact that they focus mainly on the psychiatric patient population. In this study, the association among childhood physical, sexual, and emotional abuse and pathological traits in a normal adult population was evaluated.

Method: One hundred forty-nine nonpsychiatric adult subjects participated in the study. After informed consent was obtained, all subjects completed the Childhood Trauma Questionnaire (CTQ), and each subject was also given the Personality Inventory-OMNI developed by Loranger. The personality profile of subjects reporting a history of significant childhood trauma was compared with the personality profile of those without such history. Data were analyzed using multiple logistic regression test.

Results: The results strongly indicate a significant relationship between the history of multiple childhood abuse (combined physical, sexual, and emotional abuse) and pathological personality traits, particularly traits from cluster B personality disorders in nonpsychiatrically ill adults.

Conclusions: Findings indicate that childhood abuse may play a significant role in the development of character pathology in adulthood. Implication for the prevention of childhood abuse as well as development of Axis II psychopathology will be discussed.

TARGET AUDIENCE:

Clinical psychiatrists and psychologists.

REFERENCES:

1. Rutter M, Maughan B: Psychosocial adversities in childhood and adult psychopathology. J Personality Disorders 1997; 11:4-18.
2. Paris J: Childhood trauma as an etiological factor in the personality disorders. J Personality Disorders 1997; 11:34-49.

Poster 32 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

EVALUATION OF OLANZAPINE THERAPY IN SCHIZOPHRENIC AND SCHIZOAFFECTIVE PATIENTS WHO ARE RESISTANT TO RISPERIDONE

Shyam Karki, Ph.D., *Pharmacy Department, Monroe Community Hospital, 435 East Henrietta Road, Rochester, NY 14620;* Terrance Bellnier, M.P.A., *Pharmacy Department, Rochester Psychiatric Center, 1600 South Avenue, Rochester, NY 14620;* Herman Burliss, M.D.

SUMMARY:

Olanzapine, a recently approved drug, is reported to be effective in treating both positive and negative symptoms of schizophrenia. Recent reports indicate it to be more efficacious than risperidone in treating negative symptoms and to cause fewer extrapyramidal side effects. Here we report our experience with olanzapine in schizophrenic and schizoaffective patients resistant to risperidone.

Forty-two patients were started on olanzapine. Four were discharged and 15 were discontinued before six months of treatment. Psychiatrists treated patients according to their usual practice patterns and conducted all ratings; BPRS, AIMS, Simpson-Angus, and Barnes Akathisia at baseline, six weeks, and six months.

Patients had a mean ± (SD) age of 48 ± 14 years, length of stay of 11 ± 13 years, and were 73% men and 27% women. Mean daily dose was 17 ± 4 mg. There was a change in BPRS from 54 ± 14 at baseline to 51 ± 15 at six weeks and 41 ± 13 at six months. There was a decrease of less than 20% in BPRS ratings in 21% of patients at six weeks and 31% of patients at six months. There was no significant change in other scales and side effect check.

In our study, 17 (40%) of 42 risperidone-resistant patients had a positive response.

TARGET AUDIENCE:

General and geriatric psychiatrists.

REFERENCES:

1. Tollefson GD, Beasley CM Jr., 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; 154:457-465.
2. Sheitman BB, Lindgreen JC, Early J, Sved M: High-dose Olanzapine for treatment refractory schizophrenia. Am J Psychiatry 1997; 154:1626 (letter).

Poster 33 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

EVALUATION OF A THERAPEUTIC INTERCHANGE PROGRAM

Shyam Karki, Ph.D., *Pharmacy Department, Monroe Community Hospital, 435 East Henrietta Road, Rochester, NY 14620;* Terrance Bellnier, M.P.A., *Pharmacy Department, Rochester Psychiatric Center, 1600 South Avenue, Rochester, NY 14620;* Herman Burliss, M.D.

SUMMARY:

Valproic acid is used as a sole and adjunct therapy in convulsive disorders. It is also used as an adjunct

therapy in schizophrenia. It has significant adverse gastrointestinal effects and is not tolerated well. Divalproex sodium, a derivative product of valproic acid, has been reported to be much more tolerable. However, with the advent of generic valproic acid, divalproex has become very expensive and to decrease costs, many patients have been switched from divalproex to valproic acid. We report our experience with such a therapeutic interchange program.

All (61) schizophrenic or schizoaffective patients stabilized on divalproex were switched to valproic acid. Patients' charts were reviewed before and after the switch as to dosage, frequency, adverse drug effect, concomitant gastrointestinal medication, and compliance.

Patients had a mean ± (SD) age of 48.4 ± 15.4 years, length of stay of 7.5 ± 9.6 years, and were 72% men and 28% women. Mean daily doses decreased, and use of gastrointestinal medications increased, in seven patients. Valproic acid was discontinued in 14 patients at three months and in an additional seven patients at six months. Three patients were switched back to divalproex. Automatic switch from divalproex to valproic acid failed in 31 (51%) patients in our experience.

TARGET AUDIENCE:

General and geriatric psychiatrists.

REFERENCES:

1. Orchard JL, Stramat J, Wolfgang M, et al: Upper gastrointestinal tract bleeding in institutionalized mentally retarded adults. Arch Fam Med 1995; 4:30-3.
2. Wilder BJ, Krass BJ, Penry JK, et al: Gastrointestinal tolerance of divalproex sodium. Neurology 1983; 33:808-11.

Poster 34 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

OBSESSIVE COMPULSIVE SYMPTOMS IN CLOZAPINE-TREATED PATIENTS

Rohan Ganguli, M.D., *Professor of Psychiatry and Pathology, Department of Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213-2593;* Mishita Mehta, M.D.; Samina Habibi, M.D.

SUMMARY:

It has been speculated that 5-HT2 receptor blockade by clozapine leads to a hyposerotonergic state that may result in the manifestation of obsessive-compulsive (OC) symptoms in patients with schizophrenia. We compared the severity of OC symptoms in two groups of community dwelling patients with DSM-IV schizophrenia and examined the relationship of these symptoms to other aspects of psychopathology. A comprehensive assessment of symptoms (Yale-Brown Obsessive Compulsive Scale, subscales of the Brief Psychiatric Rating Scale for positive symptoms and anxiety, Manchester Scale for negative symptoms, Montgomery-Asberg Depression Rating Scale, Simpson-Angus Scale for extrapyramidal side effects, Barnes Akathisia Scale, and Global Assessment of Functioning Scale), was carried out in 50 patients attending a clozapine clinic and 48 patients receiving depot medications (haloperidol or fluphenazine). There were no statistically significant differences in the severity of any group of symptoms (including OC symptoms) between the two groups. OC symptoms were positively correlated with the positive symptom subscore in both groups. In the group treated with depot medications, OC symptoms were also positively correlated to anxiety and depressive symptoms, and *reported* akathisia. These data fail to support the reported increased prevalence of OC symptoms in clozapine-treated patients in comparison to patients on typical antipsychotic agents.

REFERENCES:

1. Baker RW, Chengappa KN, Baird JW, et al: Emergence of obsessive compulsive symptoms during treatment with clozapine. Journal of Clinical Psychiatry 1992; 53:439-42.
2. Ghaemi SN, Zarate CA Jr, Popli AP, et al: Is there a relationship between clozapine and obsessive-compulsive disorder?: a retrospective chart review. Comprehensive Psychiatry 1995; 36:267-70.

POSTER SESSION 2

Posters 35–65

ANTIDEPRESSANTS, NEWER MEDICATIONS AND CATEGORIZATION OF DISEASE

Poster 35 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

MEDICATION ALGORITHMS IN TEXAS: A STATUS REPORT

A. John Rush, M.D., *Betty Jo Hay Distinguished Chair in Mental Health, Rosewood Corporation Chair in Biomedical Science, and Professor, Department of Psychiatry, University of Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, MC-9086, Dallas, TX 75235-9086;* M. Lynn Crismon, Pharm.D.; Steven P. Shon, M.D.

SUMMARY:

The University of Texas Southwestern Medical Center and Texas Department of Mental Health and Mental Retardation collaborated for over four years to evaluate the clinical and economic effects of specific medication management programs (or algorithms) for schizophrenic (SCZ), bipolar (BPD), and major depressive disorders (MDD). The Texas Medication Algorithm Project (TMAP) will (1) develop (by consensus and scientific evidence) high quality, psychopharmacological management guidelines for each mental disorder, (2) determine the feasibility of implementing such programs, and (3) estimate the cost and clinical benefits of such care. In Phase 1, algorithms and a patient/family educational package were developed for SCZ, BPD, and MDD. Phase 2, an open feasibility trial, evaluated the outcomes of these packages in 220 patients with one of these disorders. In brief, patients had a substantial reduction in symptomatology, and clinically significant improvement in function. Physician, clinical staff, and patient satisfaction were high. Self-reports were inadequate to gauge symptom severity, except in outpatients with nonpsychotic MDD. Phase 3 is ongoing. This three-year trial involves over 1,000 patients in a matched-clinic comparison of treatment as usual with algorithm-driven treatment, patient education, and an incremental increase in clinical staffing. The impact on symptoms, function, and costs will be evaluated.

TARGET AUDIENCE:

Practitioners, administrators, psychopharmacologists and patients/families.

REFERENCES:

1. Rush AJ, Crismon ML, Toprac MG, et al: Consensus guidelines in the treatment of major depressive disorder. Journal of Clinical Psychiatry, in press.
2. Crismon ML, Trivedi MH, Pigott TA, et al: The Texas Medication Algorithm Project. Report of the Texas Consensus Conference Panel on medication treatment of major depressive disorder, submitted for publication.

Poster 36 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

SERTRALINE TREATMENT OF PANIC DISORDER: CLINICAL CORRELATES OF TREATMENT RESPONSE

Mark H. Pollack, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, Boston, MA 02114;* Mark H. Rapaport, M.D.; Robert Wolkow, M.D.

SUMMARY:

Objective: The acute anti-panic efficacy of sertraline has been demonstrated in several placebo-controlled treatment studies. We analyzed the combined results from two flexible dose studies to obtain data on the differential response to sertraline among clinical subgroups of panic patients.

Methods: Two placebo-controlled 10-week treatment studies of patients diagnosed with panic disorder, with or without agoraphobia, were combined (n = 351) since the protocols were identical. Regression and analysis of variance models were run to assess the effect of key baseline clinical variables on outcome.

Results: Sertraline was found to be effective across the spectrum of clinical variables studies. Patients were defined with high versus low severity by the CGI severity score at baseline (5-6 or 3-4); in both groups, sertraline was statistically superior to placebo, with the high severity group showing a more robust differentiation. In addition, treatment effect was the same for patients whether they had the presence or absence of agoraphobia at baseline (p = 0.52). The results of the CGI subscales, which measured treatment effect on a variety of clinical measures, including panic attacks, anticipatory anxiety, phobic avoidance, and social and occupational functioning, were also all statistically significant at the p.005 level, and will be presented.

Conclusions: These findings suggest that sertraline treatment was beneficial for panic disorder as measured by either panic attack or phobic avoidance symptomatology. Furthermore, the beneficial effect did not depend upon the presence or absence of agoraphobia or the initial severity of symptoms. This research was supported by Pfizer Inc.

REFERENCES:

1. Pohl RH, Clary C, Wolkow R: Sertraline treatment of panic disorder: combined results from two placebo-controlled trials. Poster presented at APA meeting, San Diego, CA 1997.
2. Pollack MH, Wolkow R, Clary C: Multi-dimensional outcome and quality of life in panic disorder: the effects of sertraline treatment. Poster presented at APA meeting, San Diego, CA 1997.

Poster 37 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

QUALITY-OF-LIFE DIFFERENCES IN SERTRALINE AND PLACEBO RESPONSIVE PANIC DISORDER PATIENTS

Mark H. Rapaport, M.D., *Department of Psychiatry, University of California at San Diego, 8950 Villa Jolla*

Drive #2243, La Jolla, CA 92037-2315; Robert Wolkow, M.D.; Cathryn M. Clary, M.D.

SUMMARY:

High placebo responses, which may mask true drug effect, are common in psychopharmacology treatment trials in panic disorder, yet attempts to characterize placebo response have yielded mixed results. An analysis of two identical multicenter 10-week panic disorder treatment studies was performed examining functional improvement as measured by the change from baseline to endpoint in quality-of-life assessed by the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q). Quality-of-life assessments significantly enhanced the separation between sertraline and placebo effects in panic disorder treatment responders. The cohort consisted of 167 sertraline-treated patients flexibly dosed in the range of 50 to 200 mg/day and 175 placebo-treated patients. Patients were first categorized as panic disorder responders based upon seven different criteria at endpoint. Sertraline and placebo-treated responders were then compared by the mean change from baseline in Q-LES-Q total score at endpoint. It was notable that for all seven responder criteria, sertraline-treated responders demonstrated a significantly greater improvement in quality of life compared with placebo responders ($p \leq 0.01$). This result suggests that placebo response as ordinarily defined by the change in number of panic attacks and/or clinical global impression does not necessarily reflect functional improvement and that differentiation between pharmacological and placebo treatment may require consideration of quality-of-life measures.

This research was supported by Pfizer Inc.

REFERENCES:

1. Shear MK, Leon AC, Pollack MH, Rosenbaum JF, Keller MB: Pattern of placebo response in panic disorder, Psychopharmacol Bulletin 1995; 31:273-278.
2. Endicott J, Nee J, Harrison W, Blumenthal R: Quality of life enjoyment and satisfaction questionnaire: a new measure. Psychopharmacol Bulletin 1993; 29:321-326.

Poster 38 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

PANIC DISORDER AND RESPONSE TO SERTRALINE: THE EFFECT OF PREVIOUS TREATMENT WITH BENZODIAZEPINES

Mark H. Rapaport, M.D., *Department of Psychiatry, University of California at San Diego, 8950 Villa Jolla Drive #2243, La Jolla, CA 92037-2315;* Mark H. Pollack, M.D.; Robert Wolkow, M.D.

SUMMARY:

Objective: Despite abuse, dependence, and withdrawal liability, benzodiazepines (BZ) continue to be widely prescribed treatments for panic disorder. Prior treatment with benzodiazepines has been suggested to be inversely correlated with response to serotonergic anxiolytics. We analyzed the combined results from four placebo-controlled sertraline treatment studies to assess whether prior exposure to benzodiazepines predicted a reduced response to sertraline, or a higher attrition rate, in patients with moderate-to-severe panic disorder.

Methods: Four placebo-controlled 10-12 week treatment studies of patients diagnosed with panic disorder, with or without agoraphobia, were combined (n = 664). Patients were not allowed to take concomitant BZs during the studies. Analyses were conducted to assess whether prior treatment with benzodiazepines (whether taken for panic disorder, anxiety, or overall) was associated with differences in response to sertraline on a variety of panic disorder outcome parameters, or was associated with early attrition.

Results: 62% of patients at baseline had previously taken BZs. Prior BZ use did not affect sertraline efficacy on reduction of panic attacks (p - 0.43) (and there was no differential attrition rate (BZ treated, 14%; BZ-naive, 19%) in the first three weeks of treatment. However, BZ-naive patients had significantly higher placebo response rates than patients with previous BZ treatment.

Conclusions: These findings suggest that prior BZ exposure does not predict a poorer response or a higher early attrition rate to sertraline treatment of patients with panic disorder. This research was supported by Pfizer Inc.

REFERENCES:

1. Schweizer E, Rickels K, Lucki I: Resistance to the anti-anxiety effect of buspirone in patients with a history of benzodiazepine use (letter). N Engl J Med March 13, 1996; 314(11)719-720.
2. Sheehan DV: Diagnosis and psychiatry: examination of the psychiatric patient. In *Comprehensive Textbook of Psychiatry,* Kaplan HI, Sadock BJ, eds. Williams & Wilkins, Baltimore, MD, 1989.

Poster 39 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

RESISTANCE TO INTERFERENCE AND POSITIVE SYMPTOMATOLOGY IN SCHIZOPHRENIA

Gildas Brebion, Ph.D., *Post-Doctoral Research Scientist, Institute of Psychiatry, 103 Denmark Hill, London, England SE5 8AZ;* Mark J. Smith, M.D., *Psychiatrist, National Institute of Mental Health, 1414 17th Street,*

N.W., Washington, DC 20036-6415; Xavier F. Amador, Ph.D.; Jack M. Gorman, M.D.

SUMMARY:

Resistance to disruption by visual distractors seems to be a robust finding in patients with schizophrenia, especially those with positive symptoms. This seems to contradict the view that positive symptoms are linked to poor inhibition of distracting stimuli. We assessed the interference effect in the Stroop color and word test, and its correlation with positive symptomatology in 40 patients with schizophrenia. Two hypotheses were pitted against each other: (1) A positive correlation would be observed between interference and positive symptoms, suggesting that positive symptoms were linked to a deficit in inhibition of non-relevant stimuli; (2) A negative correlation would be observed, suggesting that positive symptoms were linked to resistance to disruption by non-relevant stimuli. Results showed that a negative correlation was observed between the amount of interference and the score of hallucinations, confirming the second hypothesis: more hallucinations were associated with more resistance to the effect of distractors. This is in agreement with studies showing that resistance to negative priming was linked to positive symptomatology in schizotypes or schizophrenic patients. It is proposed that both resistance to negative priming and to interference in patients with positive symptomatology stem from incomplete processing of the distractor information.

REFERENCES:

1. Beech A, McManus D, Baylis G, Tipper S, Agar K: Individual differences in cognitive processes: towards an explanation of schizophrenic symptomatology. British Journal of Psychology 1991; 82:417-426.
2. Jones S, Hemsley D, Gray, JA: Contextual effects on choice reaction time and accuracy in acute and chronic schizophrenics. Impairment in selective attention or in the influence of prior learning? British Journal of Psychiatry 1991; 159:415-421.

Poster 40 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

MEMORY IN SCHIZOPHRENIA: CORRELATION WITH CLINICAL SYMPTOMATOLOGY

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SUMMARY:

This study investigated clinical correlates of memory impairment in schizophrenic patients. In particular, we hypothesized that depressive symptoms would be linked to memory efficiency, as found in other clinical populations. As regards positive and negative symptomatology, we tested Frith's pathophysiological model predicting links between negative symptoms and failure to respond, as well as between positive symptoms and production of erroneous responses. Several memory tasks were administered to a sample of 31 patients. Superficial encoding of information was assessed by the ability to recall the items sequentially; deep encoding was assessed by the ability to organize the items according to their semantic properties. Two types of memory measures were individualized: measures reflecting memory efficiency and measures reflecting production of erroneous memory responses (intrusions, perseverations, false alarms). Consistent correlations appeared between severity of depressive symptoms and measures reflecting deep, but not superficial encoding; none, however, were correlated with negative symptoms. Two of the three types of erroneous memory responses were positively linked to positive symptoms. Efficiency of memory processes relying on deep encoding seemed linked to depressive symptoms. In addition, the two distinct types of impairment predicted by Frith's model were found. The expected link of one with positive symptoms was verified, but not the other with negative symptoms.

REFERENCES:

1. Burt DB, Zembar MJ, Niederehe G: Depression and memory impairment: a meta-analysis of the association, its pattern and specificity. Psychological Bulletin 1995; 117:285-305.
2. Frith CD: The cognitive neuropsychology of schizophrenia. Lawrence Erlbaum Associates: Hove, U.K, 1992.

Poster 41 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

ST. JOHN'S WORT: META-ANALYSIS WITH UPDATED CRITERIA

Hannah L. Kim, M.D., *Resident, Department of Psychiatry, University of Hawaii, 4132 Napali Place, Honolulu, HI 96816;* Jon M. Streltzer, M.D., Debbie Goebert, M.S.

SUMMARY:

Objective: A previous meta-analysis of 23 clinical trials concluded that St. John's wort (*Hypericum perforatum*) was an effective antidepressant. However, that study used a broad definition of depressive disorders.

The goal of this study was to update the previous meta-analysis using more selective inclusion criteria.

Method: Trials using single hypericum preparations in randomized, double-blind, controlled studies with outpatients meeting depression criteria defined by ICD 10, DSM III-R, or DSM-IV were analyzed. Hamilton Depression (HAMD) scores were monitored in two manners: the rate of change at different times of study and the number of "treatment responders." The side-effect rates and dropout rates were also examined.

Results: Acceptable studies included two that compared hypericum with placebo and four that compared hypericum with tricyclic antidepressants (TCAs) allowing for an examination of a total of six trials. Hypericum was found to be 1.5 times more likely to result in an antidepressant response than placebo and was equivalent to TCAs. The meta-analysis also showed that there was a higher dropout rate in the TCA group and that the TCAs were nearly twice as likely to cause side effects, including those more severe than hypericum.

Conclusions: The results suggest that hypericum may be a useful antidepressant with good efficacy, minimal side effects, and a potential treatment option for those that prefer alternative therapies. The quality of the studies analyzed, even with our stringent inclusion criteria, indicate that further study is necessary before definitive conclusions can be reached.

TARGET AUDIENCE:

Psychiatrists and general practitioners.

REFERENCES:

1. Linde K, Ramirez, Mulrow CD, Pauls A, Weidenhammer W, Melchart D: St. John's wort for depression—an overview and meta-analysis of randomized clinical trials. BMJ 1996; 313:353-358.
2. Wheatley D: LI 160, an extract of St. John's wort, versus amitriptyline in mildly to moderately depressed outpatients—a controlled 6-week clinical trial. Pharmacopsychiat 1997; 30:S77-S80.

Poster 42 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

ONE-YEAR COSTS OF ALTERNATIVE SECOND-LINE THERAPIES FOR DEPRESSION

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SUMMARY:

Objective: We compared patterns of medical resource use and costs among patients receiving Venlafaxine (SNRI), an SSRI, a TCA, or other second-line therapies for depression.

Methods: Using claims data from a managed care organization, we identified patients diagnosed with depression who received second-line antidepressant therapy between 1993 and 1997. Second-line therapy was defined as a switch between antidepressant classes. Patients with psychiatric comorbidities were excluded. We compared mean one-year medical expenditures using pairwise bivariate and multivariate statistical analysis.

Results: There were no significant differences in total one-year medical expenditures between patients receiving SNRI (n = 208), SSRI (n = 232), TCA (n = 191), or other (n = 250) second-line antidepressant therapies ($6,945, $7,237, $7,925, and $7,371, respectively; p = 0.88). Although medication expenditures were significantly higher among SNRI and SSRI patients compared with TCA patients, facility and professional service expenditures were significantly lower. Multivariate findings were consistent with bivariate comparisons. Notably, the prescribing physician was more likely to be a psychiatrist among SNRI patients compared with SSRI or TCA patients (46% versus 27% and 25%, respectively).

Conclusions: One-year medical expenditures are similar among patients receiving SNRJ, SSRI, TCA, and other second-line therapies for depression. Further research should explore patterns of switching between antidepressants among these patients.

Research supported by Wyeth-Ayerst Laboratories, Philadelphia, PA.

TARGET AUDIENCE:

Clinicians and mental health services researchers.

REFERENCES:

1. Burke MJ, Silkey B, Preskorn SH: Pharmacoeconomic considerations when evaluating treatment options for major depressive disorder. J Clin Psychiatry 1994; 55:42-52.
2. Sclar DA, Robison LM, Skaer TL, et al: Antidepressant pharmacotheraphy: economic outcomes in a health maintenance organization. Clin Therapeutics 1994; 16(4):715-730.

Poster 43 **Saturday, October 3 4:00 p.m.-5:30 p.m.**

COMPARISON OF THE EFFICACY AND SAFETY, INCLUDING SEXUAL FUNCTIONING, OF BUPROPION SUSTAINED RELEASE AND SERTRALINE IN DEPRESSED OUTPATIENTS

Richard J. Kavoussi, M.D., *Department of Psychiatry, Allegheny University, 3200 Henry Avenue, Philadelphia, PA 19129-1137;* Robert T. Segraves, M.D.; Sharyn Batey, Pharm.D.

SUMMARY:

Objective: This study was conducted to compare the efficacy and safety, including sexual functioning, of bupropion SR and sertraline in depressed outpatients.

Methods: Outpatients with moderate to severe depression who were in a stable relationship and had normal sexual functioning were randomized to receive bupropion SR (100-300 mg/day) or sertraline (50-200 mg/day) for 16 weeks. Efficacy was assessed by using the HAMD, HAMA, CGI-S, and CGI-I scales. Safety was assessed by monitoring vital signs, weight, and adverse experiences. Sexual functioning was assessed by investigators using structured interviews.

Results: One hundred and twenty-two patients were randomized to bupropion SR; 126 to sertraline. Efficacy measures were comparable between the two treatment groups. A statistically significantly greater percentage of sertraline-treated patients experienced sexual dysfunction, including orgasm dysfunction, which began as early as day 7 of the study. The adverse events nausea, diarrhea, somnolence, and sweating were experienced more frequently by sertraline-treated patients. Vital signs and weight assessments were comparable between the two groups.

Conclusion: Bupropion SR and sertraline are similarly effective for the treatment of depression. Although both compounds were relatively well tolerated, sexual dysfunction and several side effects were observed more commonly in sertraline-treated patients. This study was funded by Glaxo Wellcome, Inc.

Poster 44 **Saturday, October 3 4:00 p.m.-5:30 p.m.**

INHIBITION OF PLATELET 5HT UPTAKE BY SERTRALINE

Mujeeb U. Shad, M.D., *Senior Psychopharmacology Fellow, Psychiatric Research Institute, University of Kansas at Wichita, 1100 N. St. Francis, Suite 200, Wichita, KS 67214;* Sheldon H. Preskorn, M.D.; Anne Harvey, Ph.D.

SUMMARY:

Objective: To determine the *in-vivo* relationship between plasma levels of sertraline (SRT) and its effect on the serotonin (SE) uptake pump using platelets as a surrogate marker for central SE neuron.

Method: 24 healthy male volunteers were divided into four equal groups. Five subjects from each group received fixed doses of 50, 100, 150, or 200 mg a day of SRT for two weeks and the sixth received placebo. Radiolabeled SE was used to quantitate platelet SE uptake at screening and eight hours after SRT administration on days 1, 7, and 14 (Ghose method). Active uptake was calculated as the difference between total at 37°C and passive uptake at 4°C. The affinity constant (Km) and maximum transport rate (Vmax) were calculated by expressing the data using a Lineweaver-Burk plot.

Results: Platelet uptake of SE was inhibited by 76% to 87% at steady state in subjects dosed with 50, 100, 150, or 200 mg/day of SRT.

Discussion: Steady state dosing with 50 mg/day of SRT resulted in near maximal SE uptake inhibition. These results are consistent with SE uptake inhibition being the mechanism mediating the antidepressant efficacy of SRT and are consistent with the flat dose-antidepressant response relationship found in double-blind, fixed-dose antidepressant trials with this medication.

REFERENCES:

1. Lingjaerde O: Platelet uptake and storage of serotonin, in serotonin in health and disease: Edited by Essman WB. New York, Spectrum Publications, Inc., 1977; pp 139-199.
2. Ghose K: Biochemical assessment of antidepressive drugs. Br J Clin Pharmacol 1980; 10:539-550.

Poster 45 **Saturday, October 3 4:00 p.m.-5:30 p.m.**

FLUOXETINE: PHARMACOKINETICS AND CYP2C19 INHIBITION

Mujeeb U. Shad, M.D., *Senior Psychopharmacology Fellow, Psychiatric Research Institute, University of Kansas at Wichita, 1100 North St. Francis, Suite 200, Wichita, KS 67214;* Sheldon H. Preskorn, M.D.; Anne Harvey, Ph.D.

SUMMARY:

Objective: To determine age and dose-dependent pharmacokinetics of fluoxetine (Flx) and norfluoxetine (NFlx) and to observe age and dose-related effects of Flx and NFlx on the metabolism of S-mephenytoin (MP), a CYP2C19 substrate.

Method: This was a 104-day, multiple-dose study in healthy male subjects. Flx, 20 mg/day, was administered

on days 1-43 and 40 mg/day on days 44-86. Washout period lasted from days 87-104. Trough levels of Flx/NFlx drawn weekly during dosing and on days 87, 89, 92, 95, 99, and 104. Urinary S/R MP ratios obtained after a single dose of MP on days 0, 43, and 86.

Results:

	Young (n = 14, age 18-40)		Old (n = 16, age 65-82)	
Parameters	20mg/d	40mg/d	20mg/d	40mg/d
Fix levels (Cmin).	71.2 ± 35.1	218 ± 64.4	67.4 ± 29.3	21.6 ± 74.6
NFlx levels (Cmin)[a]	137 ± 36.3	260 ± 70.6	107 ± 22	205 ± 58.9
Flx half-life	NA	3.9 ± 1.5	NA	5.0 ± 2.6
NFlx half-life[b]	NA	15.0 ± 6.5	NA	20.3 ± 9.6
Urinary MP S/R	0.68 ± 0.21	0.77 ± 0.23	0.72 ± 0.18	0.82 ± 0.11

Cmin = minimum concentration (predose through levels), [a]$p < .05$ (elderly vs. young), [b]$p < .10$

Discussion: A two-fold increase in Flx dose caused a 3.2-fold increase in Flx levels ($p < .05$) and a 75% increase in Flx/NFlx ratio. There was a trend for older versus younger subjects to have a longer half-life (20 versus 15 days; $p = .09$). Fluoxetine significantly inhibited CYP2C19 ($p < 01$) as indicated by increase in S/R MP ratios. At 40 mg/d, Flx converted 13 out of 28 CYP2C19 extensive metabolizers (S/R MP ratio < 0.60) to poor metabolizers.

REFERENCES:

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2. Kobayashi K, Yamumoto T, Chiba K, Tani M, Ishizaki T, Kuroiwa Y: The effects of selective serotonin reuptake inhibitors and their metabolites on S-mephenytoin 4′-hydroxylase activity in human liver microsomes. Br J Clin Pharmacol 1995; 40:481-485.

Poster 46 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

NEFAZODONE HC1 TREATMENT OF PATIENTS WITH POOR RESPONSE TO SSRIS

Michael E. Thase, M.D., *Professor, Department of Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213;* John M. Zajecka, M.D., *Assistant Professor of Psychiatry and Medical Director, Ambulatory Psychiatric Service, Rush Presbyterian-St. Luke's Medical Center, 1725 West Harrison Street, Suite 955, Chicago, IL 60612;* Susan G. Kornstein, M.D.; Frances E. Borian, R.N.; Darlene N. Jody, M.D.

SUMMARY:

Introduction: Nefazodone HCl is an antidepressant with potent 5HT 2 receptor antagonism combined with reuptake inhibition of 5-HT and NE. Clinical studies have demonstrated nefazodone and the selective serotonin reuptake inhibitors (SSRIs) to have similar antidepressant response rates. However, little is known about the outcome of patients who are switched from an SSRI to nefazodone because of poor response or intolerance. We analyzed data from a large, prospective, open-label study of nefazodone in the treatment of depressed patients to determine if patients who discontinued prior SSRI treatment due to "poor response" responded to nefazodone. We explored differences in response rates to nefazodone between the SSRI "poor responders" (SSRI-PR) and patients who were antidepressant naive (A-N). In addition we analyzed the data to determine if those patients who discontinued prior SSRI treatment due to intolerance (SSRI-I) were able to respond and tolerate nefazodone.

Methods: This 12-week, open-label study was conducted at 150 sites in the United States. Depressed patients 18 to 75 years old were enrolled. After a washout period of two weeks for paroxetine or sertraline and four weeks for fluoxetine, nefazodone was given BID, flexibly dosed within the therapeutic dose range (300-600 mg/day) according to subject response and tolerability. The CGI-Improvement scale was the primary efficacy assessment. Response was defined as "much" or "very much" improved. Adverse event information was recorded at each visit. Tolerability was assessed based on presence and severity of adverse events and discontinuation rates due to adverse events.

Results: Of 1,151 patients enrolled, 404 were considered A-N, 627 had received previous SSRI treatment, and 119 had received other medication treatment for depression. Among the evaluable patients who were previous SSRI users, 33% (184/565) were SSRI-PR and 42% (239/565) were SSRI-I. Response rates for observed cases (OC) at Week 12 and Endpoint (LOCF) were as follows: A-N = 87% (OC) and 69% (LOCF); SSR-PR = 66% (OC) and 48% (LOCF); SSRI-I = 79% (OC) and 54% (LOCF).

REFERENCES:

1. Thase ME, Blomgren SL, Birkett MA, et al: Flouxetine treatment of patients with major depressive disorder who failed initial treatment with sertraline. J Clin Psychiatry 1997; 58:16-21.
2. Thase ME, and Rush AJ: When at first you don't succeed: sequential strategies for antidepressant nonresponders. J Clin Psychiatry 1997; 58:(Supp 13) 23-29.

Poster 47 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

COURSE AND COST OF TREATMENT WITH SSRIS

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SUMMARY:

Introduction: Several retrospective comparative studies of SSRI treatment costs have been published recently. The time period for these studies was when sertraline and paroxetine were newly approved agents, making their use more likely in treatment-refractory patients.

Objective: A 1995 and 1996 claims database was used to compare SSRI treatment course and costs in depressed patients to minimize the likelihood of disease severity and physician practice biases.

Method: Records of 2,362 patients diagnosed with depression who began treatment with an SSRI in 1995 were identified from a national medical claims database. Treatment course and associated medical costs were examined.

Results: Nine hundred eleven (911) sertraline, 498 paroxetine, and 953 fluoxetine patients met inclusion criteria. The groups were similar and representative with respect to gender and age distribution. Mean doses for sertraline, paroxetine, and fluoxetine were 71.4 mg, 24.4 mg, and 24.7 mg, for which the mean number of titrations were 1.7, 1.6, and 1.8, respectively ($p = 0.06$). Adjusting for treatment duration, mean total prescription costs were $460 for sertraline, $431 for paroxetine, and $546 for fluoxetine ($p < 0.01$). During the 12-month follow-up period, average total cost for depression-related physician visits was $662 for sertraline, $707 for paroxetine, and $661 for fluoxetine. Mean costs for all depression-related hospitalizations were $3,928 for sertraline, $3,385 for paroxetine, and $5,734 for fluoxetine.

Conclusion: During this study period when the three SSRIs were established agents, similar treatment course and cost characteristics were observed. Pharmaceutical costs were greatest for fluoxetine. Supported by a grant from Pfizer Inc.

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Poster 48 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

DOUBLE-BLIND COMPARISON OF CITALOPRAM AND FLUOXETINE: TREATMENT OF DEPRESSION WITH AND WITHOUT BENZODIAZEPINES

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SUMMARY:

Objective: To compare citalopram and fluoxetine, with and without concomitant benzodiazepines, in the treatment of depression.

Method: The present study was a double-blind, multicenter, fixed-dose, parallel-group, eight-week comparison of citalopram and fluoxetine in primary care patients with DSM-III-R unipolar major depression. Citalopram and fluoxetine were both administered at a dose of 20 mg/d.

Results: There was a statistically significant ($p < .05$) higher response rate in the citalopram group after two weeks of treatment on both the Hamilton Depression Rating Scale and Montgomery Asberg Depression Rating Scale (MADRS), suggesting a more rapid onset of action for citalopram. Additionally, more than half the patients in both groups received concomitant benzodiazepines. Analysis of the patients who did not receive benzodiazepines revealed significantly greater improvement on the MADRS scale at weeks 2, 4, 6, and 8 for citalopram-treated patients as compared with fluoxetine-treated patients.

Conclusion: These findings are suggestive of an advantage for citalopram versus fluoxetine in patients not receiving concomitant benzodiazepines, sedatives, hypnotics, or antianxiety medications, possibly due to anxiogenic effects of fluoxetine and/or anxiolytic effects of citalopram. These results also support the conclusion that the concomitant use of benzodiazepines in comparative clinical trials of antidepressants may mask significant between-drug differences in antidepressant efficacy.

Poster 49 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

ADVERSE EVENTS PROFILE OF CITALOPRAM IN THE ELDERLY

Heikki Hakkarainen, M.D., *Medical Director, Forest Laboratories, 909 Third Avenue, New York, NY 10022;* Per Tanghoj, M.D., *Medical Director, H. Lundbeck A/S, Copenhagan, Ottiliavej 9, DK-2500 Copenhagen, Denmark*

SUMMARY:

Objective: Citalopram, one of the most selective of the selective serotonin reuptake inhibitors available, has been in use for the treatment of depression since 1989 and has been administered to >25,000 subjects in clinical trials. A multi-study analysis was performed in 1,346 citalopram-treated patients and 545 placebo-treated patients who participated in placebo-controlled studies.

Results: The most common (>10% incidence) adverse events (AEs) occurring significantly ($p < .05$) more frequently in the citalopram group were nausea, dry mouth, somnolence, and increased sweating. Among the subset of 179 citalopram-treated patients and 86 placebo-treated patients ≥60 years old, all of these AEs occurred at similar or lower rates; only increased sweating was reported significantly more frequently in the citalopram group. Tremor and asthenia were the only AEs that occurred frequently in elderly citalopram-treated patients but not in citalopram-treated patients overall. The incidence of premature discontinuation due to AEs was 19% among elderly citalopram-treated patients and 16% among all citalopram-treated patients; this difference was not statistically significant.

Conclusion: These results demonstrate that citalopram is well tolerated by both young and elderly adults, with a similar incidence and pattern of AEs, and suggest that citalopram is safe for use in the treatment of geriatric depression.

Poster 50 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

DOUBLE-BLIND COMPARISON OF THE ADVERSE EVENT PROFILE OF THE TRICYCLIC ANTIDEPRESSANTS AND THE SSRI CITALOPRAM

Heikki Hakkarainen, M.D., *Medical Director, Forest Laboratories, 909 Third Avenue, New York, NY 10022;* Per Tanghoj M.D., *Medical Director, H. Lundbeck A/S, Copenhagan, Ottiliavej 9, DK-2500 Copenhagen, Denmark*

SUMMARY:

Objective: To compare the adverse effect profile of tricyclic antidepressants (TCAs) and citalopram.

Method: The safety profile of citalopram has been directly compared with that of the TCAs in double-blind trials including more than 1,200 patients. Comparative TCAs evaluated included imipramine, clomipramine, and amitriptyline. The incidence of adverse events was compared statistically in the pooled citalopram and TCA groups.

Results: For adverse events reported by at least 10% of patients in either group, dry mouth, somnolence, dizziness, constipation, and tremor occurred significantly more frequently in patients receiving TCAs. Only headache and nausea had a significantly higher incidence in the citalopram group. Blood pressure changes indicative of orthostatic hypotension were observed during TCA administration, but not in patients receiving citalopram.

Conclusion: Citalopram, the most selective of the selective serotonin reuptake inhibitors, produces no significant inhibition of catecholamine reuptake and has shown no significant affinity for any neurotransmitter receptor studied. The TCAs, by contrast, have been found to produce a blockade of both presynaptic norepinephrine reuptake and postsynaptic muscarinic receptors, pharmacologic actions associated with cardiovascular adverse events, and anticholinergic side effects. The results of this study confirm that treatment of depression with TCAs is associated with a greater incidence of adverse events and greater potential safety risks than treatment with the selective serotonin reuptake inhibitor citalopram.

REFERENCE:

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Poster 51 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

GENDER DIFFERENCES IN THE RESPONSE TO CITALOPRAM TREATMENT OF DEPRESSION

Mary Mackle, Ph.D., *Medical Department, Forest Laboratories, 909 Third Avenue, New York, NY 10022;* Marcelo Gutierrez, Ph.D., *Medical Department, Forest Laboratories, 909 Third Avenue, New York, NY 10022*

SUMMARY:

Objective: This study examined potential gender differences in response to the selective serotonin reuptake inhibitor citalopram in the treatment of depression.

Method: Safety and efficacy data from a total of 844 women and 502 men who received citalopram in eight double-blind, placebo-controlled trials were compared with control data from the 317 female and 228 male patients who were treated with placebo in these studies.

Results: Analysis of patients with a baseline and at least one follow-up Hamilton Depression Rating Scale score revealed significantly greater improvement in patients treated with citalopram vs those treated with placebo ($P = .002$), with no significant treatment-by-gender interaction ($P = .592$), suggesting that drug-placebo differences were similar in men and women. Women treated

with either citalopram or placebo showed a larger response to treatment than their male counterparts (P = .040). The most frequent (>10% incidence) adverse events (AEs) during citalopram treatment were the same in men and women and they occurred with a similar incidence. Female placebo patients reported more AEs than male placebo patients. Gender-specific AEs, including evidence of sexual dysfunction, were reported infrequently by citalopram patients: ejaculation disorder (primarily increased latency), decreased libido, and impotence by 6%, 4%, and 3% of male patients, respectively, and decreased libido and anorgasmia by 1% of female patients.

Conclusion: Citalopram's safety and efficacy profile is similar in men and women; however, its effects may be superimposed on a larger placebo effect in women.

REFERENCES:

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Poster 52 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

CITALOPRAM TREATMENT OF MELANCHOLIA

Mary Mackle, Ph.D., *Medical Department, Forest Laboratories, 909 Third Avenue, New York, NY 10022*

SUMMARY:

Objective: The mood disturbance of depressed patients with melancholia has been generally characterized as especially severe and endogenous, with a probable biological origin. It has been suggested that selective serotonin reuptake inhibitors (SSRIs) may not be the treatment of choice for melancholic patients, either because they are putatively less potent than more nonspecific alternative therapies or because side effects associated with some SSRIs—including psychomotor agitation, insomnia, anorexia, and weight loss—are also typical diagnostic features of melancholia. The present study provides an evaluation of the safety and efficacy of the selective serotonin reuptake inhibitor citalopram, the most selective of the currently available SSRIs, in the treatment of depressed patients with melancholia.

Method: In this multi-center, parallel-group study, 153 patients met DSM-III diagnostic criteria for melancholia and were randomized to double-blind treatment with citalopram (20-80 mg/day) or placebo.

Results: Citalopram produced significantly greater improvement (p<.05) than placebo on the Hamilton Depression Rating Scale (HAM-D), Clinical Global Impressions, and Zung Self-Rating Depression scales, the HAM-D depressed mood item, and the HAM-D melancholia subscale. A significant treatment effect was apparent during the first week of double-blind treatment.

Conclusion: The results of this study support the conclusion that the SSRI citalopram is a safe and effective treatment for melancholic depression.

REFERENCES:

1. Rush AJ, Weissenberger JE: Melancholic symptom features and DSM-IV. Am J Psychiatry 1994; 151:489-498.
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Poster 53 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

PSYCHIATRIC RESOURCE USE UNDER USUAL CARE CONDITIONS: WHAT IS THE COST OF RISPERIDONE'S BENEFITS?

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SUMMARY:

There is concern that introduction of newer, more expensive antipsychotics will substantially increase the resources needed for schizophrenia patients. Observational studies and modeling projections from efficacy trials suggest this may not be the case.

We report resource use from a naturalistic, multicenter, effectiveness trial to address this issue. We randomized 684 schizophrenia patients at relapse to initial treatment with risperidone (RIS) or conventional antipsychotic therapy (CON). During one year of follow-up, treatment was per customary community practice with minimal protocol interference. All psychiatric medication and acute and routine services were verified by primary source documentation. Costs were estimated based on documented utilization.

Despite extensive nondrug periods (mean > 100 days), polypharmacy, and treatment mixing (41% and 74% of CON and RIS patients, respectively, received one or more days of crossover therapy), RIS patients had fewer hospitalizations, longer time to first hospitalization, and fewer days of acute care (albeit not significantly). In addition, among patients remaining in treatment arms, RIS patients had statistically lower acute care service costs. Data on drug treatment patterns suggest that opportunities exist for improving community treatment strategies to realize reductions in resource use.

TARGET AUDIENCE:

Psychiatrists, psychologists, nurse clinicians and social workers.

REFERENCES:

1. Albright PS, Livingstone S, Keegan D, et al: Reduction of healthcare resource utilisation and costs following the use of risperidone for patients with schizophrenia previously treated with standard antipsychotic therapy: a retrospective analysis using the Saskatchewan Health linkable databases. Clin Drug Invest 1996; 11:289-99.
2. Viale G, Mechling L, Maislin G, et al: Impact of risperidone on the use of mental health care resources. Psychiatr Serv 1997; 48:1153-9.

Poster 54 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

CITALOPRAM VERSUS IMIPRAMINE IN THE TREATMENT OF INPATIENT DEPRESSION: RESULTS FROM A DOUBLE-BLIND, PLACEBO-CONTROLLED TRIAL

Charles L. Bowden, M.D., *Member APA Board of Trustees, and Professor of Psychiatry and Pharmacology, University of Texas Health Science Center at San Antonio, 7703 Floyd Curl Drive, San Antonio, TX 78284-7792;* Paul J. Tiseo, Ph.D., *Medical Department, Forest Laboratories, 909 Third Avenue, New York, NY 10022*

SUMMARY:

Objective: Citalopram is a selective serotonin reuptake inhibitor used widely since 1989 for the treatment of depression. This study compared citalopram and imipramine with placebo in the treatment of inpatient depression.

Method: This double-blind, placebo-controlled, parallel-group, six-week, comparative pilot study (N = 46) examined the efficacy of citalopram (20-80 mg/day), imipramine (50-300 mg/day), and placebo in hospitalized patients diagnosed with major depression or bipolar disorder. Efficacy was evaluated on the basis of change from baseline in the 24-item Hamilton Depression Rating Scale (HAM-D), the Zung Self-Rating Depression Scale, and the Clinical Global Impressions (CGI) scale. The mean HAM-D score at baseline was approximately 35, and most patients met diagnostic criteria for melancholia.

Results: Based on an intent-to-treat analysis of the change from baseline to endpoint, citalopram, but not imipramine or placebo, produced significant improvement on all scales.

Rating Scale	Citalopram	Imipramine	Placebo
HAM-D	−14.0[4]	−8.1[4]	−4.6
Zung	−13.1[4]	−3.6	+0.9
CGI Severity	−1.3[4]	−0.9[4]	−0.2

[4]Significantly different from baseline ($P < 0.05$).

Citalopram patients also rated themselves significantly less symptomatic at endpoint than imipramine or placebo patients.

Conclusion: The results provide evidence for citalopram's effectiveness in treating inpatient depression.

REFERENCES:

1. DuFour H, Bouchachart M, Thermoz P, et al: Citalopram-a highly selective 5-HT uptake inhibitor - in the treatment of depressed patients. Int Clin Psychopharmacol 1987; 2:225-237.
2. Gravem A, Amthor KF, Astrup C, et al: A double-blind comparison of citalopram and amitriptyline in depressed patients. Acta Psychiats Scand 1987; 75:478-486.

Poster 55 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

REGIONAL BRAIN SYMMETRY AND SUBTYPING SCHIZOPHRENIA

Steven J. Kingsbury, M.D., Ph.D.; *Department of Psychiatry, VA Hospital, 4500 South Lancaster Road, 116-A, Dallas, TX 75216;* Thamilarasi R. Nair, M.D.; David L. Garver, M.D.; James D. Christensen

SUMMARY:

Objective: To assess regional brain symmetry in schizophrenia patients compared with controls.

Method: 3D-MR images from 23 patients and 23 controls to determine right-left asymmetry. The 3D segmented brain was divided into six regions, at the midline, at the VCA (vertical line along anterior commisure) and at the VCP (vertical line along the posterior commisure) following alignment of the brain along the anterior-posterior commissure, and volume was calculated for each regions.

Results: Serial 3D-MRIs demonstrated that the schizophrenia cohort could be clustered into two groups. One group showed *stability* of ventricle and brain volumes during the course of illness (stable ventricle-brain psychosis), stability that was comparable to controls. A second group showed *instability* of ventricle-brain volumes, with ventricular change more than four times that of controls.

Asymmetery of Brain: As compared with controls, schizophrenia patients evidenced significant asymmetry (R>L) of the total brain ($p < 0.031$), especially in cerebrum posterior to the VCA plane in the cluster of schizophrenics with *stable* brain and ventricle volume [presumably neurodevelopmental psychosis] ($p = 0.003$). However, the asymmetry was reversed (L>R) in the cerebellar region.

Conclusion: Significant brain asymmetry posterior to the VCA plane in schizophrenia is a likely consequence of neurodevelopmental anomalies. No significant differences in symmetries were found in unstable ventricule-brain group.

REFERENCES:

1. Crow, et al: Developmental arrest of cerebral asymmetry in the early onset schizophrenia. Psychiatry Research 1989; 29:247-253.
2. Nair, et al: Progression of cerebroventricular enlargement and the subtyping of schizophrenia. Psychiatry Research 1997; 74:141-150.

Poster 56 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

REBOXETINE IS AS EFFECTIVE AND BETTER TOLERATED THAN IMIPRAMINE IN ELDERLY PATIENTS WITH DEPRESSION

Juan Massana, M.D., *Department of Pharmacology, Hospital Clinic, Rosellon 140, Barcelona, Spain 68036*

SUMMARY:

Objectives: Antidepressant therapy is often not well tolerated and may be contraindicated in the elderly. This affects choice of therapy, compliance and outcome.[1,2] This study compared the efficacy and tolerability of reboxetine, the first selective noradrenaline reuptake inhibitor (NARI), with imipramine in an elderly depressed population.

Method: 347 elderly patients (> 65 years) with a diagnosis of major depression or dysthymia were randomized to receive reboxetine (4-6 mg/day) or imipramine (75-100 mg/day in divided doses), for eight weeks. Efficacy was principally assessed using the HAM-D rating scale.

Results: Reductions in the mean total HAM-D score in both groups were comparable as was the cumulative risk of developing an adverse event, although hypotension and related symptoms were more frequent with imipramine (16%) than reboxetine (7%); odds ratio 0.43 (95% CI 0.21-0.85). Similarly, the frequencies of cardiovascular events (21 versus 13%), moderate to severe (73 versus 65%), serious (14 versus 2 events) and drug-related (9.2 versus 3.3%) adverse events and discontinuation of treatment (16 versus 11%) caused by adverse events were nonsignificantly greater in the imipramine group than the reboxetine group.

Conclusions: Reboxetine is as effective and better tolerated than imipramine in the elderly. Discontinuations and cardiovascular events are less frequent and adverse events were less serious in patients treated with reboxetine.

This study was supported by Pharmacia & Upjohn, Inc.

TARGET AUDIENCE:

Clinical psychiatrists, psychiatric nurses, researchers, pharmacologists and neuroscientists.

REFERENCES:

1. Feighner JP: Compliance and quality of response are major contributors to cost-effective antidepressant therapy. Human Psychopharmacology 1994; 9:S21-S23.
2. Katona C: Rationalizing antidepressants for elderly people. International Clinical Psychopharmacology 1995; 10:37-40.

Poster 57 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

IN SEVERE DEPRESSION, REBOXETINE IS AS EFFECTIVE AS IMIPRAMINE AND MORE EFFECTIVE THAN FLUOXETINE

Juan Massana, M.D., *Department of Pharmacology, Hospital Clinic, Rosellon 140, Barcelona, Spain 68036*

SUMMARY:

Objectives: Severely depressed patients often respond poorly to treatment.[1] TCAs are the mainstay of therapy and SSRIs (or at least fluoxetine) are considered less effective.[2] This analysis assesses the comparative efficacy and tolerability of reboxetine, imipramine, and fluoxetine in severely depressed patients.

Method: Among 1144 patients with major depression recruited to four randomized, double-blind, outpatient studies (two placebo controlled) 633 patients with severe depression received reboxetine 8-10 mg/day, fluoxetine 20-40 mg/day, imipramine 150-200 mg/day, or placebo

for six to eight weeks. Efficacy (change in HAM-D score) and tolerability results were pooled for analysis.

Results: Reboxetine was as effective as comparator agents and more effective than placebo in the overall population. In severely depressed patients, the between-treatment difference in HAM-D total score showed reboxetine to be as effective as imipramine (1.1 points; 95% CI-1.1 to 3.3), and more effective than fluoxetine (2.6 points; 95% CI 0.5 to 4.6) and placebo (4.7 points; 95% CI 2.5 to 6.8). Reboxetine tolerability was superior to that of imipramine and comparable to fluoxetine.

Conclusions: In severely depressed patients, reboxetine is as effective as a TCA and better tolerated. Furthermore, reboxetine is more effective than the SSRI fluoxetine in this population.

This study was supported by Pharmacia & Upjohn, Inc.

TARGET AUDIENCE:

Psychiatrists, general practitioners, psychiatric nurses and pharmacists.

REFERENCES:

1. Kocsis J, Croughan JL, Katz MM, et al: Response to treatment with antidepressants of patients with severe or moderate depression and of patients with psychotic depression. Am J Psychiatry 1990; 147:621-624.
2. Anderson IM, Tomenson BM: The efficacy of selective serotonin reuptake inhibitors in depression: a meta-analysis of studies against tricyclic antidepressants. J Psychopharmacol 1994; 8(4):238-249.

Poster 58 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

OVERALL EFFICACY AND TOLERABILITY OF REBOXETINE IN COMPARATIVE CLINICAL TRIALS OF 2,613 PATIENTS WITH DEPRESSIVE ILLNESS

Marcio V. Versiani, M.D., *Institute of Psychiatry, Federal University, R Visconde de Piraja 407 S 805, Ipanemem, Rio de Janeiro, Brazil 22410-003*

SUMMARY:

Objectives: Tricyclic antidepressants (TCAs) and selective serotonin reuptake inhibitors (SSRIs) are the principal treatments for depressive illness,[1] however, not all patients respond to or continue therapy. Here we report pooled results of comparative clinical trials of reboxetine, the first selective noradrenaline reuptake inhibitor.[2]

Method: Data from seven short-term (four to eight weeks) and one long-term (up to one year) double-blind trials comparing reboxetine with imipramine, desipramine, fluoxetine or placebo, in 2613 patients with major depression or dysthymia, were pooled. Efficacy was assessed using the HAM-D scale.

Results: In the short term, 8-10 mg/day reboxetine was more effective than placebo (three of four studies) and as effective as fluoxetine (2-40 mg/day), imipramine (50-200 mg/day), or desipramine (200 mg/day). In the long term, reboxetine was also more effective than placebo in preventing relapse and recurrence of depression. In the 1503 reboxetine-treated patients, the most common adverse events were dry mouth (22%), constipation (15%), sweating (12%) and insomnia (11%). Reboxetine was well tolerated; better tolerated than comparator TCAs and at least as well tolerated as fluoxetine.

Conclusions: Reboxetine is effective in short- and long-term treatment of depressive illness. Its clinical profile is comparable with TCAs and an SSRI; however, reboxetine is better tolerated than TCAs.

This study was supported by Pharmacia & Upjohn, Inc.

TARGET AUDIENCE:

Psychiatrists, general practitioners, psychiatric nurses and pharmacists.

REFERENCES:

1. Anderson IM, Tomenson BM: The efficacy of selective serotonin reuptake inhibitors in depression: a meta-analysis of studies against tricyclic antidepressants. J Psychopharmacol 1994; 8:238-249.
2. Dostert P, Benedetti MS, Poggest I: Review of the pharmacokinetics and metabolism of reboxetine, a selective noradrenaline reuptake inhibitor. Eur Neuropsychopharmacol 1997; 7(suppl 1):S23-S35.

Poster 59 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

THE SELECTIVE NORADRENALINE REUPTAKE INHIBITOR REBOXETINE HAS AN EARLY ONSET OF ACTION

Marcio V. Versiani, M.D., *Institute of Psychiatry, Federal University, R Visconde de Piraja 407 S 805, Ipanemem, Rio de Janeiro, Brazil 22410-003*

SUMMARY:

Objectives: A delay in the time to onset of antidepressant effect can adversely influence patient compliance and increase the burden on health care providers.[1] This report examines the time to relief of a range of depressive symptoms in patients given reboxetine, the first selective noradrenaline reuptake inhibitor.[2]

Method: In this double-blind, parallel-group study, 52 patients with major depressive disorder were randomized to receive reboxetine, titrated to 10 mg/day from day three, or placebo, for 42 days. Efficacy was principally assessed by reduction in total HAM-D score.

Results: Reboxetine produced significantly greater overall improvement in mean total HAM-D score compared with placebo (23.1 versus 4.5, $p < 0.001$). This difference was first evident on day 10 ($p = 0.006$). Superior improvements in individual HAM-D domains over placebo were first seen for depressed mood ($p = 0.004$) on day 10, insomnia ($p = 0.006$) and interest in work and daily activities ($p = 0.003$) on day 14, and somatic symptoms ($p < 0.001$) and anxiety ($p < 0.001$) on day 21.

Conclusions: Reboxetine is an effective antidepressant with an early onset of action, evident within two weeks of starting therapy. HAM-D assessment shows that mood is elevated first, followed by aspects of social functioning such as motivation and interest in daily activities.

This study was supported by Pharmacia & Upjohn, Inc.

TARGET AUDIENCE:

Psychiatrists, general practitioners, psychiatric nurses and pharmacists.

REFERENCES:

1. Derivan AT: Antidepressants: can we determine how quickly they work? Issues from the literature. Psychopharmacology Bulletin 1995; 31:23-28.
2. Dostert P, Benedenti MS, Poggesi I: Review of the pharmacokinetics and metabolism of reboxetine, a selective noradrenaline reuptake inhibitor. European Neuropsychopharmacology 1997; 7(suppl 1):S23-S35.

Poster 60 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

PHARMACOKINETICS OF REBOXETINE IN ELDERLY VOLUNTEERS AND DEPRESSED PATIENTS

Jospeh C. Fleishaker, Ph.D., *Central Nervous System Research, Pharmacia & Upjohn Company, Inc., 30 Henrietta Street, Kalamazoo, MI 49001*

SUMMARY:

Objectives: Depression in the elderly is generally well treated. Poor tolerability, possibly resulting from age-related changes in antidepressant pharmacokinetics, may lead to noncompliance.[1] Here the pooled results of several pharmacokinetic studies of reboxetine are reported.

Method: Single doses of reboxetine (4 mg) were given to cohorts of nine to 12 healthy volunteers aged 50-63 (middle-aged): 68-67 (elderly); and 66-98 (very elderly). Twelve depressed patients aged 75-87 also received reboxetine up to a maximum of 8 mg/day over four weeks. Reboxetine plasma pharmacokinetics were determined from periodic blood samples and compared with previously determined pharmacokinetics in the general population.[2]

Results: In the middle-aged and elderly, the pharmacokinetics of reboxetine do not differ from those of the general population. However, in very elderly volunteers, plasma AUC is increased (from 2974 ng.h/ml in the middle-aged to 8345 ng.h/ml) and renal clearance decreased (1.6 versus 0.5 ml/min). In elderly patients, systemic exposure after reboxetine 8 mg/day (steady-state), although not directly comparable with that following single-dose administration, was relatively higher (AUC 6841 ng.h/ml). However, reboxetine 4 mg/day was well tolerated, with no increase in the frequency or severity of adverse events.

Conclusion: Reboxetine 4 mg/day is a suitable starting dose for patients aged 65 years or older with depression.

This study was supported by Pharmacia & Upjohn, Inc.

TARGET AUDIENCE:

Psychiatrists, general practitioners, psychiatric nurses and pharmacists.

REFERENCES:

1. Feighner JP: Compliance and quality of response are major contributors to cost-effective antidepressant therapy. Human Psychopharmacology 1994; 9:S21-S23.
2. Dostert P, Benederri MS, Poggesi I: Review of the pharmacokinetics and metabolism of reboxetine, a selective noradrenaline reuptake inhibitor. European Neuropsychopharmacology 1997; 7(suppl 1):S23-S35.

Poster 61 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

ANTIDEPRESSANT DURATION OF THERAPY IN A MANAGED CARE ORGANIZATION

Karen Way, Ph.D., *Researcher, Outcomes Research, PCS Health Systems, 9501 E. Shea Boulevard, MC-034, Scottsdale, AZ 85260;* Elizabeth Brintnall, Ph.D.; David Whitehouse, M.D., M.B.A.; Christopher H. Young, Ph.D.; Karl J. Gregor, Pharm.D., M.S.; Tom E. Hughes, Ph.D.

SUMMARY:

Background: This study analyzes duration of therapy, titration, and switching patterns among 7,737 depressed patients initiating antidepressant therapy. Study patients received benefits through a national managed care organization (MCO) and its behavioral health subsidiary. This study was part of a national quality improvement initiative designed to understand and improve utilization of antidepressants and the quality of care provided to patients.

Methods: A retrospective analysis was conducted using prescription, diagnosis, and eligibility databases of the national MCO. The study population included adults continuously eligible for medical and pharmacy benefits, diagnosed with depression, who received one or more prescriptions for one of eight antidepressants between April 1, 1995 and August 31, 1995. Duration of therapy, titration, and switching patterns were evaluated in the nine months following therapy initiation.

Results: Fluoxetine patients experienced more continuous days of therapy and were less likely to switch than patients initiated on all other study drugs. The initial study drug and titration patterns on that drug were the strongest predictors of duration of therapy.

Conclusions: A majority of patients with depression did not receive an adequate regimen of antidepressant therapy, regardless of provider or medication type. The implications of these findings and potential contributing factors are discussed.

TARGET AUDIENCE:

Psychiatrists and/or clinicians treating depression.

REFERENCES:

1. Nemeroff CB: Evolutionary trends in the pharmacotherapeutic management of depression. Journal of Clinical Psychiatry 1994; 55(12, suppl):3-15.
2. Katon W, Robinson P, Von Korff M, et al: A multifaceted intervention to improve treatment of depression in primary care. Archives of General Psychiatry 1996; 23:924-32.

Poster 62 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

COMPUTERIZED CLINICAL QUALITY MONITORING

Daniel J. Luchins, M.D., *Associate Professor of Psychiatry, University of Chicago Medical School, 5841 South Maryland Avenue, Chicago, IL 60637-2602;* David B. Klass, M.D., *Medical Director, Computerized Medical Monitoring, Illinois Department of Human Services, 575 West Madison Street, Apt. 2804, Chicago, IL 60661-2543;* Patricia Hanrahan, Ph.D.; Mohsin Qayyum, M.D.; Randy D. Malan, R.P.H.; Valerie Raskin-Davis, M.D.

SUMMARY:

Introduction: The purpose of this study was to validate a computerized pharmacy/laboratory monitoring system as a quality improvement tool for state mental health hospitals.

Methods: The Illinois Department of Human Services has available a computerized record of all prescriptions and laboratory tests ordered at 19 state-operated hospitals. Computerized algorithms were developed that incorporated available practice guidelines regarding laboratory monitoring of medications and appropriate responses to abnormal laboratory tests. To validate this procedure, we reviewed patient charts at one facility to identify clinically significant problems and used computerized data from several hospitals to confirm these clinically derived impressions.

Results: Chart review: Most of the clinically significant cases identified by the computerized system involved abnormal serum levels of medication (95%). The majority (63%) were low valproate levels. Computerized review: Length of stay from the initial detection of a low valproate level until discharge was examined according to physician responses. Among patients whose physicians responded appropriately, the average length of stay was considerably shorter (57 days, SD = 65) than those that did not (96 days, SD = 77, T-test = 5.08, Df = 328, $p < .001$).

Discussion: This study supports the clinical validity of the computerized pharmacy/laboratory monitoring system. Because the great majority of clinically significant cases involved abnormal levels of medication, our computer system has been simplified to monitor only such indices. Our specific finding for valproate has led us to develop a focused educational program. We are also working to make our monitoring system available in real time.

REFERENCES:

1. Harris CS, Conner CB: Building a computer-supported quality improvement system in one year: the experience of a large state psychiatric hospital. Joint Commission Journal on Quality Improvement 1994; 20:330-42.
2. Rago B, Gilbert DA: QI as resolution to a major lawsuit. Joint Commission Journal on Quality Improvement 1996; 22:48-57.

Poster 63 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

THE BURDEN OF CARE IN RELATIVES OF PANIC DISORDER PATIENTS

Johann Windhaber, M.D., *Resident, Department of Psychiatry, University of Vienna, Waehringer Guertel 18-20, Vienna, Austria A-1090*

SUMMARY:

Objective: Panic disorder (PD) is a disabling psychiatric condition leading to poorer marital status, increased financial dependency, and decreased time on hobbies (Markowitz et al, 1989). The purpose of our study is to describe the burden of care in relatives of patients suffering from PD.

Methodology: The closest relatives of 40 consecutive DSM-III-R PD patients were interviewed with a specially designed questionnaire.

Results: The average duration of PD of the total patient sample was 28.7 months, 28 (70%) received a DSM-III-R diagnosis of PD with agoraphobia; 92.5% of the relatives who participated were partners or spouses. Female relatives reported more psychological problems since onset of PD in their relative. Male relatives felt more strongly that their working activities were impaired by the disorder of their spouses. Agoraphobia was the only clinical variable predicting burden in the relatives ($\beta = +0.43$, $p < 0.01$).

Conclusion: Similar to studies of other anxiety disorder patients (Chakrabarti et al, 1993) our study shows that PD strongly affects the quality of life of PD patients' relatives. It suggests that interpersonal relations might play a role in therapeutic interventions and should be further investigated.

REFERENCES:

1. Chakrabarti S, Kulhara P, Verma SK: The patterns of burden in families of neurotic patients. Soc Psych Psychiatr Epidemiol 1993; 28:172-177.
2. Markowitz JS, Weissman MM, Quellette R, Lish JD, Klerman GL: Quality of life in panic disorder. Arch Gen Psychiatry 1989; 46:984-992.

Poster 64 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

CITALOPRAM VERSUS SERTRALINE VERSUS PLACEBO: PRELIMINARY EFFICACY RESULTS

Stephen M. Stahl, M.D., Ph.D., *Director, Neuroscience Research Center, and Adjunct Professor, Department of Psychiatry, University of California at San Diego, 8899 University Center Lane #130, San Diego, CA 92122-1009;* Charles Flicker, Ph.D., *Senior Medical Director, Forest Laboratories, 909 Third Avenue, New York, NY 10022*

SUMMARY:

Objective: The present study-compared the antidepressant efficacy of the selective serotonin reuptake inhibitors citalopram and sertraline.

Method: After a one-week, single-blind, placebo lead-in, approximately 300 patients meeting DSM-IV criteria for major depressive disorder were randomized to 24 weeks of double-blind treatment with citalopram (20-60 mg/day), sertraline (50-150 mg/day), or placebo. Outcome measures included the 21-item Hamilton Depression Rating Scale (HAM-D), the Montgomery Asberg Depression Rating Scale (MADRS), and the Clinical Global Impressions (CGI) scale. The change from baseline to the last observation carried forward at each visit was compared between treatment groups by analysis of variance.

Results: Efficacy results from the initial eight weeks of treatment were available for all patients. On the HAM-D, citalopram patients exhibited significantly greater improvement ($P < .05$) than placebo patients from week 3 to week 8 of double-blind treatment; no significant sertraline-placebo differences were observed. However, the therapeutic response in the citalopram group was significantly greater than in the sertraline group at week 2 of double-blind treatment. The MADRS revealed significantly greater improvement in the citalopram group than in both the placebo group and the sertraline group at weeks 2, 4, 6, and 8 of double-blind treatment; no significant sertraline-placebo differences were observed. Similar results were obtained on the CGI Severity and Improvement scales.

Conclusion: Results from the acute treatment phase of this double-blind, placebo-controlled study provide clear evidence of the antidepressant effectiveness of citalopram and suggestive evidence of its superiority to sertraline.

REFERENCES:

1. Ekselius L, von Knorring L, Eberhard G: A double-blind multi-center trial comparing sertraline and citalopram in patients with major depression treated in general practice. Int Clin Psychopharmacol 1997; 12:323-331.
2. Noble S, Benfield P: Citalopram: a review of its pharmacology, clinical efficacy and tolerability in the treatment of depression. CNS Drugs 1997; 8:410-431.

Poster 65 **Saturday, October 3**
4:00 p.m.-5:30 p.m.

META-ANALYSIS OF PLACEBO-CONTROLLED TRIALS OF CITALOPRAM IN THE TREATMENT OF DEPRESSION

Charles Flicker, Ph.D., *Senior Medical Director, Forest Laboratories, 909 Third Avenue, New York, NY 10022;* Jia Yeoung Tsay, Ph.D., *Medical Department, Forest Laboratories, 909 Third Avenue, New York, NY 10022*

SUMMARY:

Objective: To conduct a pooled analysis of the results from placebo-controlled clinical trials in Europe and the United States evaluating the safety and efficacy of the selective serotonin reuptake inhibitor citalopram in the treatment of depression.

Method: Pooled data were analyzed from approximately 1,000 citalopram-treated patients, 17 to 91 years of age, with a diagnosis of depression, who participated in one of five double-blind, parallel-group, placebo-controlled trials of up to six weeks in duration. Efficacy assessments included the Hamilton Depression Rating Scale (HAM-D), Montgomery Asberg Depression Rating Scale (MADRS), and Clinical Global Impressions (CGI). The primary statistical approach was an endpoint analysis of the change from baseline to the last visit in all patients with an on-drug efficacy evaluation.

Results: Citalopram-treated patients exhibited significantly greater improvement ($P < .05$) than placebo-treated patients on the HAM-D, MADRS, and CGI. Analysis of HAM-D subscales or individual items measuring symptoms of depressed mood, anxiety, psychomotor retardation, and melancholia all revealed significantly greater improvement in citalopram-treated patients versus placebo-treated patients. Significant differences versus placebo were apparent as early as the first week of double-blind treatment. Subgroup analyses of male and female patients, young adult and elderly patients, patients with moderate or severe depression, and patients with high or low anxiety all demonstrated a consistent therapeutic response to citalopram regardless of baseline patient characteristics.

Conclusion: This meta-analysis provides strong evidence for the antidepressant efficacy of citalopram across a broad range of depression symptoms and depression subpopulations.

POSTER SESSION 3

Posters 66–95

TREATMENT, ASSESSMENT, SERVICES AND QUALITY OF LIFE

Poster 66 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

PSYCHIATRIC CONSULTATION AT AN ACCIDENT AND EMERGENCY DEPARTMENT

Wai-Song Yeung, M.D., *Department of Psychiatry, Pamela Youde Hospital, Hong Kong City, Hong Kong*

SUMMARY:

Consultation/liaison psychiatry is at the rudimentary stage in Hong Kong. Recently, we began psychiatric consultation for the newly established general hospital. Because it was difficult to start a new psychiatric department in the old general hospital, they received psychiatric consultation service from a nearby psychiatric hospital or psychiatric clinic. This survey demonstrated the necessity of on-site psychiatric consultation at an accident and emergency department in Hong Kong.

From February 1996 to May 1996, 223 patients were referred for psychiatric consultation to the accident and emergency department of Pamela Youde Nethersole Eastern Hospital. On-site urgent psychiatric assessments were done on 195 (87.8%) patients. The most common reason of referral was aggressive behavior (27.9%), followed by depressive symptoms (25.7%). Schizophrenia (37%) was the most common diagnosis, followed by mood disorders (20.6%). Concerning the outcome, 48% of the patients were admitted to the psychiatric ward, of which 12% were under compulsory order.

REFERENCES:

1. Ang AWK, et al: Psychiatric referrals from an accident and emergency department in Singapore. J Accid Emerg Med 1995; 12:119-122.
2. Tse SK, et al: A study on psychiatric referral and consultation from an accident and emergency department. Hospital Convention by Hospital Authority in Hong Kong 1997.

Poster 67 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

DAY TREATMENT HELPS REDUCE HOSPITALIZATIONS

Jeffrey B. Freedman, M.D., *Department of Psychiatry, St. Vincents Hospital, 203 West 12th Street, New York, NY 10011*

SUMMARY:

Objective: The goals of the Continuing Day Treatment Program (CDTP) are to prevent relapse and provide rehabilitation for the chronically mentally ill. One measurable way to test the effectiveness of the CDTP is to examine if participation in this program helps decrease the frequency of inpatient admissions.

Method: Study subjects were patients who have been in the CDTP for at least one year, excluding those transferred from other day programs. Of the 115 patients enrolled in the CDTP as of August 1, 1996, 41 qualified for the study.

Results: Thirty-one patients (76%) had at least one inpatient psychiatric admission one year prior to their admission to the CDTP. Nine patients (22%) of that same population had at least one inpatient psychiatric admission in the one year following their admission to the CDTP. Thus, patients were significantly more likely to avoid hospitalizations in their first year in the CDTP ($X^2 = 21.53$, df = 1, $p < .001$).

Conclusions: CDTPs help decrease hospitalizations. To prove that CDTPs are more effective than conventional outpatient treatments in reducing admissions, a prospective study with a comparison group is necessary.

REFERENCES:

1. Hoge MA, Davidson L, Hill WL, et al: The promise of partial hospitalization: a reassessment. Hospital and Community Psychiatry 1992; 43:345-354.
2. Lehman AF, Carpenter WT, Goldman HH, et al: Treatment outcomes in schizophrenia: implications for practice, policy, and research. Schizophrenia Bulletin 1995; 21:669-675.

Poster 68 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

DYNAMIC METAPHORIC DRAWING: THERAPEUTIC METHOD

Viktor YE. Kagan, M.D., *Department of Psychiatry, Maimonides Academy, P.O. Box 53, St. Petersburg, Russia 192238*

SUMMARY:

DMD is an original psychotherapeutic method based on creative imagination and metaphorizing, which provides a free and safe space for patient's inner therapeutic work. The reduced necessity of verbalization opens additional opportunities for patients with alexithymia and therapeutic resistance, and especially for children. DMD has been used with more than 400 patients—adults and children. The DMD technique includes three structural stages: (1) input drawing is the representation of the actual problem as a metaphoric tree; (2) proper therapeutic intervention and/or patient's imaginative work with this tree and drawings during the intervening stages; and (3) final output drawing. DMD may be used in a long-term or in a brief therapy. In some cases the author never saw clients in person but communicated only by letters and drawings by mail and e-mail; it was especially convenient for psychotherapy with patients of a different culture. The report is illustrated by patient's drawings.

REFERENCES:

1. Kagan V: Psychology and psychotherapy: humanization and integration. Psychology With Human Face: Humanistic Perspective in Post-Soviet Psychology. Edited by Leontyev D, Schur V Smysl Ltd., Moscow, 1997; pp 111-123.
2. Kagan V: What is Psychotherapy? Complect Ltd., St-Petersburg 1998; pp 487.

Poster 69 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

SIX-YEAR OUTCOME FOR COGNITIVE BEHAVIORAL TREATMENT OF RESIDUAL SYMPTOMS IN MAJOR DEPRESSION

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SUMMARY:

Objective: The author's goal was to determine whether cognitive-behavioral treatment of residual symptoms of depression might have a significant effect on relapse rate.

Method: In an earlier study, 40 patients with primary major depressive disorder who had been successfully treated with antidepressant drugs were randomly assigned to either cognitive-behavioral treatment (CBT) of residual symptoms or standard clinical management (CM). Both types of treatment resulted in a significantly lower relapse rate at a four-year follow-up. In this study, a six-year follow-up assessment was performed.

Results: Ten (50%) of the patients in the CBT group and 15 (75%) in the CM group relapsed. The difference did not attain statistical significance. Of the 25 patients who relapsed, 16 did it more than once during the observation period. Patients in the CBT group had a significantly lower number of depressive relapses than those in the CM group. In the vast majority of cases, patients responded to the same antidepressant drug of the index episode; in two cases (4%) resistance occurred.

Conclusion: Cognitive-behavioral treatment of residual symptoms improves the long-term outcome of de-

pression. Intermittent use of medication for relapses with attention to prodromal symptoms was found to be feasible, even though resistance may ensue.

REFERENCES:

1. Fava GA, Grandi S, Zielezny M, Canestrari R., Morphy MA: Cognitive behavioral treatment of residual symptoms in primary major depressive disorder. Am J Psychiatry 1994; 151:129-1299.
2. Fava GA, Grandi S, Zielezny M, Rafanelli C, Canestrari R: Four-year outcome for cognitive-behavioral treatment of residual symptoms in major depression. Am J Psychiatry 1996; 153:945-927.

Poster 70 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

DEVELOPMENT OF INTENSIVE PSYCHIATRIC COMMUNITY CARE STEP-DOWN

Michael E. Dieperink, M.D., Ph.D., *Department of Psychiatry, University of Illinois College of Medicine, and Department of Psychiatry, Minneapolis VA Medical Center, One Veterans Drive, Minneapolis, MN 55417;* Gregg Joly, M.S.W.

SUMMARY:

Intensive Psychiatric Community Care (IPCC) and other ACT model programs have been successful at decreasing inpatient utilization by the chronically mentally ill. IPCC programs, as originally designed, enroll patients on a permanent basis with no mechanism for eventual discharge. This is based on data that discharged patients revert to patterns of high use of inpatient services. Inevitably programs become saturated. We report on a decision tree developed to identify patients within the IPCC caseload who may remain stable with a lower intensity of intervention. This decision tree identifies three groups of patients. **Group 1** consists of patients who continue to require traditional IPCC intensity, included are patients enrolled less than one year. **Group 2** identifies patients requiring ongoing but less intensive case management. **Group 3** consists of patients who are candidates for rehabilitation and potential discharge from the program. In our caseload of 49 patients, 30 belong to **Group 1,** 14 to **Group 2,** and five to **Group 3.** The advantages of identifying a subset of our patients who require less intensity of intervention include that patients can be added without additional staff, intensity of services are defined by patient need, and a transitional step is provided, which may lead to satisfactory discharge of some patients. Outcome data will be gathered to strengthen our model.

REFERENCES:

1. McRae J, Higgins M, Lycan C, and Sherman W: What happens to patients after five years of intensive case management stops? Hospital and Community Psychiatry 1990; 41:175-179.
2. Mueser K, Bond G, Drake R, and Resnick S: Models of community care for severe mental illness: a review of research on case management. Schizophrenia Bulletin 1998; 24(1):37-74.

Poster 71 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

USE OF OUTPATIENT COMMITMENT AT AN ACADEMIC MEDICAL CENTER FOR PERSONS WITH SERIOUS MENTAL ILLNESS: SUBJECT SELECTION AND SERVICE UTILIZATION

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SUMMARY:

Objective: To measure the effect of outpatient commitment on service use at an academic medical center.

Methods: Medical records and service utilization of 39 study subjects committed to outpatient treatment were retrospectively reviewed and compared with medical records of 39 matched control subjects. Measures of expected treatment noncompliance included reported history of substance abuse, medication noncompliance, and medication failure. Service use variables were outpatient visits, emergency room visits, and psychiatric inpatient hospitalizations.

Results: Persons with outpatient commitment were more likely to have a history of substance abuse, medication noncompliance, and medication non-responsiveness over the five-year study period relative to controls ($p < 0.05$). Compared with the 12-month period prior to commitment, subjects had a reduced number of hospital admissions, lengths of stay, and total number of hospital days per year ($p < 0.01$), but an increased number of outpatient visits per year ($p < 0.01$) while on outpatient commitment.

Conclusions: Outpatient commitment in this patient subgroup is successful in reducing the "revolving door syndrome" as evidenced by an increased number of outpatient visits and decreased inpatient service use during the period of commitment.

REFERENCES:

1. Geller JL: Clinical guidelines for the use of involuntary outpatient treatment. Hospital and Community Psychiatry 1990; 41(7):749-755.

2. Swanson JW, Swartz MS, George LK, Burns BJ, Hiday VA, Borum R, Wagner HR: Interpreting the effectiveness of involuntary outpatient commitment: a conceptual model. Journal of the American Academy of Psychiatry and the Law 1997; 25(1):5-16.

Poster 72 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

A COMPARISON OF PATIENT SATISFACTION WITH TELEPSYCHIATRIC CARE VERSUS IN-PERSON PSYCHIATRIC CARE IN THE PRIMARY CARE CLINICS OF AN ACADEMIC HEALTH SYSTEM

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SUMMARY:

Telemedicine is a strategy to improve accessibility of mental health care for patients in primary care settings. In the University of California, Davis Health System, a study was designed to assess patient preference for, and satisfaction with, telepsychiatric (TP) care in comparison with in-person (IP) psychiatric care. The hypothesis of the study was that patients would choose TP care less often and that satisfaction would be reduced for TP care because the technology would adversely affect communication and the development of the doctor-patient relationship. To test this hypothesis, patients completed a survey to compare TP versus IP care in terms of their: (1) ability to speak freely; (2) experience with the provider; and (3) preference for using the same service for subsequent visits. A total of 118 patients in one primary care clinic were offered a 60-minute evaluation (24) or a 20-minute follow-up appointment (94) with TP or IP care, with all service parameters identical for the two options. Patients chose TP care for 29% (7/24) of initial evaluations and 35% (33/94) of follow-up appointments. No significant difference was found in compliance rates for initial evaluations or follow-up appointments between the TP and IP groups. On a five-point Likert scale (1 = strongly disagree and 5 = strongly agree), no significant difference by t-test analysis was found between the two groups in terms of their ability to speak freely (TP 4.7 versus IP 4.8), their experience with the psychiatrist (TP 4.6 versus IP 4.6), or preference for identical care on subsequent visits (TP 4.9 versus IP 4.7). Randomized trials are indicated for further evaluation of patient satisfaction.

REFERENCES:

1. Blackmon LA, Kaak HO, Ranseen J: Consumer satisfaction with telemedicine child psychiatry consultation in rural Kentucky. Psychiatric Services 1997; 48:1464-1466.
2. Brick JE, Bashchur RL, Brick JF, D'Alessandri RM: Public knowledge, perception, and expressed choice of telemedicine in West Virginia. Telemedicine Journal 1997; 3:159-172.

Poster 73 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

PATIENT SATISFACTION WITH MENTAL HEALTH VERSUS NON-MENTAL HEALTH TELEMEDICAL CARE

Robert E. Hales, M.D., M.B.A., *Professor and Vice Chair of Psychiatry, University of California at Davis School of Medicine, and Medical Director, Sacramento County Mental Health Services, 4430 V Street, Sacramento, CA 95817;* Donald M. Hilty, M.D., *Assistant Professor of Psychiatry, University of California at Davis School of Medicine, 4430 V Street, Sacramento, CA 95817;* Edward J. Callahan, Ph.D.; Thomas S. Nesbitt, M.D.

SUMMARY:

Telemedicine is a strategy to improve accessibility to specialty care for patients in primary care settings. In the University of California, Davis Health System, a study was designed to assess patient satisfaction with mental health (MH) and non-mental health (NMH) applications of telemedicine. The hypothesis of the study was that patients would be less satisfied with mental health care via telemedicine than other specialty care, because the technology would adversely affect communication and the development of the doctor-patient relationship. To test this hypothesis, patients completed a survey to rate the following parameters: (1) ability to speak freely; (2) experience with the provider, and (3) preference for using the telemedicine for future care. A total of 89 patients from several primary care clinics participated in the study: 31 received mental health services and 58 received cardiology, orthopedic, or otolaryngology services. On a five-point Likert scale (1 = strongly disagree and 5 = strongly agree), no significant difference by t-test analysis was found between the two groups in terms of their ability to speak freely (MH 4.6 vs. NMH 4.7), the experience with the specialty physician (MH 4.6 vs. NMH 4.8), or willingness to use telemedicine for future care (MH 4.6 vs. NMH 4.7). In

addition, 14 patients receiving mental health care by telemedicine were asked to compare it with usual care. Interestingly, 57% rated telemedicine care as better than usual care. Randomized trials are indicated for further evaluation of patient satisfaction for all specialty applications of telemedicine.

REFERENCES:

1. Bashshur RL: Critical issues in telemedicine. Telemedicine Journal 1997; 2:113-126.
2. Blackmon LA, Kaak HO, Ranseen J: Consumer satisfaction with telemedicine child psychiatry consultation in rural Kentucky. Psychiatric Services 1997; 48:1464-1466.

Poster 74 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

PREVALENCE OF THE MENTALLY ILL CHOOSING TO WORK

Victoria Miller, M.A., *Director, Project Renewal, 448 West 48th Street, New York, NY 10036;* Lisa Kartiganer, C.S.W., *Clinical Director, Project Renewal, 448 West 48th Street, New York, NY 10036*

SUMMARY:

It is currently believed that mental health consumers will choose to work when given the opportunity. Individuals living in a supportive residence were offered increasing vocational options over a four-year period. The residence houses formerly homeless, severely mentally ill men and women ranging in age from 27 to 75. Substance abuse disorder is seen in over 70% of this group.

The residence changes its program focus from one of engagement and support to that of rehabilitation, skills development, and empowerment. The original mission was to provide a safe and secure environment for residents who had experienced many years of homelessness and avoidance of traditional treatment modalities. The focus was maintaining stability and housing. It became apparent that some residents responded much more positively to activities that offered measurable productivity and compensation. Consequently, the program design was expanded to include pre-vocational positions in-house, as well as other sites within the agency. We examined the quantity of work done by residents during the year prior to the program change—1/93-12/93 and a year following—1/97-12/97.

REFERENCES:

1. Anthony WA, Rogers SE, Cohen M, et al: Relationships between psychiatric symptomology, work skills, and future vocational performance. Psychiatric Services 1995; 46:353-358.
2. Massel HK, Liberman RP, Mintz J, et al: Evaluation of the capacity to work with the mentally ill. Psychiatry 1990; 53:31-43.

Poster 75 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

WARD BEHAVIOR SCALE FOR NEGATIVE SYMPTOMS

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SUMMARY:

Objective: We report on the development, reliability, and validity of the Ward Behavior Rating Scale for Negative Symptoms (WBRS-NS), a 29-item nurses' rating scale for assessing negative symptoms in an inpatient setting.

Method: The WBRS-NS and PANSS were completed at baseline and after treatment on 63 adult psychiatric inpatients (23 schizophrenic; 14 schizoaffective; 19 major depression; and 7 bipolar, manic).

Results: Test-retest reliability was assessed on 12 patients rated twice on two separate occasions. The Pearson Correlation Coefficient for WBRS-NS total scores was $r = 0.87$ ($p < .001$). Inter-rater reliability among four nurses across 10 patients was $r = 0.95$ ($p < .001$). Principal components analysis revealed three factors accounting for 76% of the variance. Concurrent validity was assessed by comparing WBRS-NS subscale scores with scores on the PANSS. All three WBRS-NS subscales correlated significantly with the PANSS negative symptoms subscale both before and after treatment. None of the three WBRS-NS subscales correlated significantly with the PANSS positive symptoms subscale.

Conclusions: Preliminary results suggest that the WBRS-NS appears to be a comprehensive nurses' rating scale for negative symptoms, with good reliability and validity. Further analyses are needed to assess differences on the WBRS-NS between diagnostic groups.

TARGET AUDIENCE:

Psychiatrists, psychologists, and nurses.

REFERENCES:

1. Burdock EI, Hardesty AS, Hakerem G, Zubin J: A ward behavior rating scale for mental hospital patients. J Clin Psychol 1960; 16, 246-247.

2. Kay SR, Fiszbein A, Opler LA: The Positive and Negative Syndrome Scale (PANSS) for schizophrenia. Schizophr Bull 1987; 13, 261-276.

Poster 76 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

A NEW APPROACH TO INTENSIVE COMMUNITY TREATMENT

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SUMMARY:

Aim: The Intensive Community Treatment Programme was set up as a pilot project in August 1997 in the Down Lisburn Trust. It was felt that a more intensive community service for selected patients could provide a better quality of care and facilitate a reduction in the length of inpatient stay. A core team of six skilled mental health nurses under the direct supervision of consultant psychiatrists was established with input from other multidisciplinary team members.

Methodology: An independent evaluation, focused on areas such as clinical outcomes, patient and caretaker satisfaction, and resource usage, is being carried out by means of questionnaires, HONOS, and comparison of cost of service with hospital costs.

Results: Preliminary results demonstrate a high degree of acceptability to the multidisciplinary team and a high level (>80%) of patient/caretaker satisfaction. Greater than 80% of general practitioners found the program acceptable. A detailed analysis of the quality issues will be presented. The reduction in bed occupancy suggests that the program will be self-funding.

Conclusions: Psychiatric care and treatment in Northern Ireland still depends heavily on acute beds. In recent years the delivery of high-quality care to patients with mental illness has become increasingly difficult within the existing configuration of service provision. The intensive community treatment program was set up as an alternate method of service provision and our results demonstrate the feasibility of high-quality service in a community setting.

REFERENCES:

1. White, Ness, Craig, McNamea: Making community based comprehensive mental health services work. Psychiatric Bulletin 1996; 20:93-96.
2. Gournay & Brooking: Community psychiatric nurses in primary health care. British Journal of Psychiatry 1994; 165:231-238.

Poster 77 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

"HOUSING FIRST": SUCCESS IN AN URBAN ASSERTIVE COMMUNITY TREATMENT SAMPLE

Marcella Anne Maguire, Ph.D., *Psychologist, Mobile Community Outreach Treatment Team, St. Elizabeths Hospital, 2700 Martin Luther King Jr., Avenue, Building 2E-13, Washington, DC 20032;* David M. Band, M.D., *Clinical Director, Mobile Community Outreach Treatment Team, St. Elizabeths Hospital, 2700 Martin Luther King Jr., Avenue, Washington, DC 20032*

SUMMARY:

Introduction: Individuals with mental illnesses and those with a dual diagnosis of mental illness and substance use continue to reside in suboptimal housing in community settings. Debate exists in the clinical literature as to whether housing or psychiatric stability should be the initial goal of treating a homeless mental health consumer. The data presented reflect the outcome of a "housing first" perspective.

Methods: An Assertive Community Treatment (ACT) program evaluated its focus on clients' housing needs prior to other treatment concerns. Housing was assessed four times over an 18-month period and was categorized into four groups: homeless, institution, supervised community placement, and independent housing (total N = 58).

Results: Consumers were a mean age of 40.93, 67% were male, and 80% were African American. Sixty-five percent had schizophrenia spectrum disorders and 71% had a dual diagnosis of mental illness and substance abuse. A significant portion of consumers increased housing stability from time of admission to 18 months after entering the ACT program; m = 2.17 (SD = 1.17) to m = 3.35 (SD = 1.04). The population of homeless individuals decreased from 39% on admission to 7% at 18 months.

The ACT team "housing first" treatment model has helped its severe and persistent mentally ill consumers achieve more "liveable" housing in the community.

TARGET AUDIENCE:

Clinicans, administrators and policy makers who serve a homeless mentally ill population.

REFERENCES:

1. Bebot RR, Drake RE, Xie H, McHugo GJ, Harris M:. Housing status among formerly homeless dually diagnosed adults. Psychiatric Services 1997; 48: (7),936-941.
2. Muesser KT, Bond GR, Drake RE, Resnick S: Models of community care for severe mental illness: a review

of research on case management. Schizophrenia Bulletin, in press.

Poster 78 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

QUALITY OF LIFE IN SCHIZOPHRENIA: IMPACT OF SYMPTOMS

David P. Walling, Ph.D., *Vice President, Clinical Services, Psychiatric Management Resources, 501 Washington Boulevard, 5th Floor, San Diego, CA 92103;* Charles J. Klein, Ph.D., *Vice President, Clinical Quality Assurance, Psychiatric Management Resources, 501 Washington Boulevard, 5th Floor, San Diego, CA 92103;* Jack Stephens, M.A.; Susan D. Erskine, M.S.; Rick Bruce; Richard Jiminez, M.D.

SUMMARY:

Quality of life has increasingly become an important topic in both the care and research of individuals with schizophrenia. Numerous factors contribute to this focus, including the development of novel medications, family involvement, and the increased presence of individuals with schizophrenia in the community. This paper examines the relationship between quality of life and symptomatology in individuals with schizophrenia.

Research Question: What is the relationship, if any, between symptomatology and subjective quality of life?

Method: Individuals with schizophrenia (N = 196) were assessed upon admission to a psychiatric partial hospitalization program or an intensive outpatient service. Individuals were assessed using the Positive and Negative Syndrome Scale (PANSS) and the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q).

Results: The results of this study showed a significant inverse relationship between positive symptomatology and three of five Q-LES-Q subscales. Negative symptomatology correlated with one subscale, while general symptomatology was negatively correlated with all Q-LES-Q subscales. Total PANSS scores were negatively correlated with all Q-LES-Q subscales except physical health.

Discussion: This study suggests that increasing symptomatology, specifically those factors measured on the positive and general subscales of the PANSS, decreases an individual's perceived quality of life. In contrast with previous studies, positive symptomatology was more closely correlated with subjective quality of life than negative symptomatology.

REFERENCES:

1. Sainfort F, Becker M, Diamond R: Judgments of quality of life of individuals with severe mental disorders: patient self-report versus provider perspectives. Am J Psychiatry 1996; 153: 497-502.
2. Endicott J, Nee J, Harrison W, Blumenthal R: Quality of life enjoyment and satisfaction questionnaire: a new measure. Psychopharmacology Bulletin 1993; 29: 321-326.

Poster 79 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

VALIDATION OF THE Q-LES-Q: EVIDENCE OF A FOUR FACTOR MODEL

David P. Walling, Ph.D., *Vice President, Clinical Services, Psychiatric Management Resources, 501 Washington Boulevard, 5th Floor, San Diego, CA 92103;* Charles J. Klein, Ph.D., *Vice President, Clinical Quality Assurance, Psychiatric Management Resources, 501 Washington Boulevard, 5th Floor, San Diego, CA 92103;* Jack Stephens, M.A.; Alan Tepper, M.B.A.; Rick Bruce; Richard Jiminez, M.D.

SUMMARY:

Measurement of quality of life is an important issue in the development of efficacious pharmacologic interventions and in the delivery of psychosocial treatment. Numerous quality-of-life measures have been developed with varying levels of attention being paid to the psychometric properties of these tools. The present study examines the use of the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q) in a sample of individuals diagnosed with schizophrenia.

Research Question: What is the validity of a subjective scale of quality of life (Q-LES-Q) for use in a population of individuals with schizophrenia?

Methods: Subjects (N = 156) were assessed using the Q-LES-Q upon admission to either a partial hospitalization program or an intensive outpatient program.

Results: Factor analysis was employed to examine the construct validity of the instrument subscales. Results supported the construct validity for the four proposed subscales of the Q-LES-Q as each subscale was clearly an identifiable factor.

Discussion: These results replicate previous findings supportive of the Q-LES-Q in the broader population of seriously mentally ill individuals. The present study narrowed the selection criteria to individuals with schizophrenia, thus suggesting that the Q-LES-Q may be a valid tool for both research and treatment.

REFERENCES:

1. Gill T, Feinstein A: A critical appraisal of the quality of life measurements. JAMA, 272; 619-626.
2. Endicott J, Nee J, Harrison W, Blumenthal R: Quality of Life Enjoyment and Satisfaction Questionnaire:

a new measure. Psychopharmacology Bulletin, 29; 321-326.

Poster 80 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

STAFF'S PERCEPTION OF POTENTIAL ABSENT WITHOUT LEAVE PATIENTS

Regina L. Uliana, Ph.D., *Psychologist, Department of Quality Assurance, Metropolitan State Hospital, 11400 Norwalk Boulevard, Norwalk, CA 90650;* Robert Crane, M.S.W., *Program Director, Metropolitan State Hospital, 11400 Norwalk Boulevard, Norwalk, CA 90650;* David M. Malkin, M.S.W.

SUMMARY:

This poster presentation describes the results of a pilot study on staff's perceptions of potential AWOL patients. Thirty structured interviews were conducted on selected staff deemed most responsible for AWOL's on the unit, namely the physician, the shift leads, and select program/ unit management.

The interviews were to provide a descriptive profile of patients from staff perceptions and experiences of potential AWOL patients, a description of the difficulties staff face in preventing AWOL's and security risks from staff's perceptions, information as to the steps taken by staff to prevent AWOL's, and a description of what ideally would be involved in helping staff's perceptions of AWOL's.

Overall results revealed staff perceptions could be identified into four types:

15% were found to be Holistic type, who first consider the patient's personal factors and attitudes, whether or not overt signs of cues were exhibited; 45% were identified as Historians, who relied primarily on the patients history; 35% were identified as Behaviorist, who measured AWOL potential by observable overt behavioral signs; and the last group were identified as Generalist, who considered all patients as AWOL potential and focused on controlling and securing the environment to minimize risk. Implications on training and staff education are discussed.

REFERENCE:

1. The 1997 Behavioral Outcomes & Guidelines Sourcebook.

Poster 81 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

PATIENT POST-DISCHARGE SURVEY

David M. Malkin, M.S.W., *Director of Quality Assurance, Metropolitan State Hospital, 11400 Norwalk Boulevard, Norwalk, CA 90650;* Regina L. Uliana, Ph.D., *Psychologist, Department of Quality Assurance, Metropolitan State Hospital, 11400 Norwalk Boulevard, Norwalk, CA 90650;* Michael K. Nunley, R.N.

SUMMARY:

This poster presentation describes the results to date of an ongoing survey to gather selected follow-up data on patients who have been discharged from the hospital. The goal was to obtain baseline data on how the patients were doing and in what areas they did better than others. A total of 141 Patient Discharge Surveys were completed through telephone interviews with a staff member at the patient's placement facility who was familiar with the patient's level of functioning. The survey was a simple yes/no, dichotomous format. Staff were asked to assess patients in selected areas, which included appropriateness of the referral, patient's current functioning, patient's participation in treatment and types of treatment programs, and the patient's ability to function independently. Overall the results showed a greater percentage of the patients assessed were appropriate for discharge, were in programs that met their needs, were prescribed and compliant with medications, and were maintaining relative stability. However, less than half were attending day treatment or substance abuse programs. About half continued to have symptomatology and 16% of the total had symptoms that interfered with their ability to function. The use of these data for treatment planning and as outcome measures are discussed.

REFERENCE:

1. The 1997 Behavioral Outcomes & Guidelines Sourcebook.

Poster 82 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

RAPID ASSESSMENT INSTRUMENT FOR INPATIENT PROGRESS

Sarath Gunatilake, M.D., *Medical Director, Metropolitan Hospital, 11400 Norwalk Boulevard, Norwalk, CA 90650;* Bruce Hilsberg, Ph.D., *Clinical Psychologist, Metropolitan Hospital, 11400 Norwalk Boulevard, Norwalk, CA 90650;* Steve Brown, Ph.D.; David M. Malkin, M.S.W.; Michael K. Nunley, R.N.

SUMMARY:

This poster presentation describes the development and pilot testing of a rapid assessment instrument for assessing and graphing the progress of inpatients in a state-supported mental hospital. Patient progress is assessed on a five-point scale in five different areas. Activities of daily living, medication compliance; psychiatric condition, social skills, and management of abusive be-

havior. The instrument is designed to be used as a part of the patient's team conference. Scores are recorded so that a graphic record of progress or regression is immediately available.

Data will be reported concerning the psychometric properties of the instrument. Case examples will be used to demonstrate the utility of the instrument for treatment planning and outcome measurement.

REFERENCE:

1. The 1997 Behavioral Outcomes & Guidelines Sourcebook.

Poster 83 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

SUPPORT FOR GENETIC TESTING AND THERAPY IN PSYCHIATRY

Karen K. Milner, M.D., *Co-Director, Community Mental Health, University of Michigan Medical Center, 1500 East Medical Center Drive, Ann Arbor, MI 48109;* Tina Han; Elizabeth M. Petty, M.D.

SUMMARY:

Advances in DNA technology have resulted in identification of human disease genes and genes predisposing to human attributes. Both scientists and the lay public are actively debating how this technology should be applied. We surveyed faculty/residents of the University of Michigan department of psychiatry, members of the Alliance for the Mentally Ill (AMI), and university students to assess their support for prenatal testing and genetic therapy/enhancement for psychiatric diseases, neurological disorders, and human attributes. Sixteen "disease" phenotypes or human conditions were selected; 227 of the 1120 surveyed responded. Over 70% supported prenatal genetic testing for well-defined, serious psychiatric or neurological phenotypes (i.e., schizophrenia, autism, Huntington's disease, etc.,); prenatal genetic testing for human attributes was less desirable. AMI members were twice as likely than faculty to support testing for human attributes (i.e., homosexuality, low "normal" IQ). The faculty was more inclined to support testing for the "disease" phenotypes when genetic therapy was available, while AMI members felt that they would have been better able to deal with various developmental issues if they had known about the presence of the "disease" or attribute. Further discussion of these trends will be presented.

REFERENCES:

1. Milner KK, Collins EE, Connors GR, Petty EM: Attitudes of young adults to prenatal screening and genetic correction for human attributes and psychiatric conditions. Am J. Med Genet 1998; 76:111-119.
2. Sherman SL, DeFries JC, Gottesman II, et al: Behavioral Genetics '97 ASHG Statement: recent developments in behavioral genetics: past accomplishments and future directions. Am J Hum Genet 1997; 60:1265-1275.

Poster 84 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

THE EFFECTS OF ATYPICAL ANTIPSYCHOTIC DRUGS ON COGNITIVE FUNCTION IN SCHIZOPHRENIA

Susan R. McGurk, Ph.D., *Department of Psychiatry, Vanderbilt University Psychiatric Hospital, 1601 23rd Avenue South, #306, Nashville, TN 37212;* Herbert Y. Meltzer, M.D.

SUMMARY:

Cognitive dysfunction is a core deficit in schizophrenia that is resistant to typical antipsychotic medications. We studied the effects of treatment with risperidone and olanzapine on cognition. Schizophrenia patients (22 males, seven females) were evaluated at baseline (on typical agents) and again after treatment with risperidone (mean dose = 5.7 mg). Risperidone significantly improved performance on the Auditory Consonant Trigrams ($p < 0.05$), a measure of verbal working memory, with a trend for improvement on the Wisconsin Card Sort Categories (number of categories attained increased from 3 to 3.74; ($p < 0.90$). These findings are consistent with other reports (Green et al., 1997). In a study of 16 patients (12 males, four females) assessed at baseline (while on typical agents) and again after six weeks of treatment with olanzapine (mean dose = 12 mg), olanzapine significantly improved performance on measures of verbal fluency ($p < 0.01$), executive functioning (Stroop Test) ($p < 0.01$), reaction time ($p < 0.05$), and verbal memory ($p < 0.01$). However, unlike risperidone, performance on measures of spatial and verbal working memory was unresponsive to olanzapine. Performance on cognitive tests was unrelated to effects of these drugs on BPRS-rated psychopathology. A double-blind comparison of the effects of risperidone and olanzapine is ongoing in our clinic.

TARGET AUDIENCE:

Psychiatrists, psycholoists, nurse clinicians, and social workers.

REFERENCES:

1. Green MF, Marshall Jr, BD, Wirshing WC, et al: Does risperidone improve verbal working memory in treatment-resistant schizophrenia? *Am J Psychiatry* 1997; 154:799-804.

2. Goldberg TE, Greenberg RD, Griffin SJ, et al: The effect of clozapine on cognition and psychiatric symptoms in patients with schizophrenia. *Br J Psychiatry* 1993; 162:43-48.

Poster 85 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

CORRELATES OF MULTIPLE HOSPITALIZATIONS AMONG PATIENTS WITH SCHIZOPHRENIA

Leticia Postrado, Ph.D., *Data Manager, Department of Psychiatry, University of Maryland, 685 West Baltimore, MSTF Building 300, Baltimore, MD 21201;* Janine Delahanty, *Data Analyst, Department of Psychiatry, University of Maryland, 685 West Baltimore, MSTF Building 300, Baltimore, MD 20210;* Anthony F. Lehman, M.D., M.P.H.

SUMMARY:

Objectives: The aims of this study are to examine the frequency of hospitalization experienced by persons with schizophrenia over a one-year period, and to assess the association of multiple hospital admissions with demographic, clinical, and quality-of-life measures.

Methods: This is a sub-study of the Schizophrenia PORT Project, which utilized a stratified random sampling technique to survey persons with schizophrenia. A total of 719 individuals in two states who passed the criteria for selecting participants and consented to participate in the study, were interviewed.

Results: Almost half (48.8%) of the respondents were not hospitalized during a one-year period. A total of 144 (21.2%) respondents had one hospital admission, 14.2% had two, 8.4% had three, and 7.4% had four or more. The mean number of hospital admissions for the total sample was 1.3 (SD = 2.4). Bivariate analyses revealed that more frequent hospitalization was associated with older age ($p < .001$), not being employed ($p < .05$), drug abusing problem ($p < .001$), depression ($p < .05$), personality disorder comorbidity ($p < .05$), more severe symptomatology ($p < .001$), having been arrested for a crime ($p < .001$), lower satisfaction with social relations ($p < .05$), less satisfaction with finances ($p < .001$), and less satisfaction with health ($p < .01$). Multiple regression showed that having been arrested was the strongest correlate of number of hospitalizations in the previous year ($p < .001$), followed by unemployment ($p < .001$) and older age ($p < .01$). Greater satisfaction with finances ($p < .05$), and more frequent contact with family ($p < .05$) were associated with decreased hospitalizations. Surprisingly, none of the clinical variables was associated with frequency of hospital admission.

Conclusions: Having problems with the law, unemployment, and older age were important determinants of frequency of hospital admission. More research should be conducted to explain the factors that lead to multiple hospitalization among persons with schizophrenia.

REFERENCES:

1. Saravay SM, et al: Four-year follow-up of the influence of psychological comorbidity on medical rehospitalization. Am J Psychiatry 1996; 32:397-403.
2. Rossler W, et al: Case management for schizophrenic patients at risk for rehospitalization: a case control study. Archives of Psychiatry and Clinical Neuroscience 1995; 44:371-375.

Poster 86 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

OUTCOMES STUDY OF A RESIDENTIAL REHABILITATION CENTER

Jacquelyn G. Wilson, Pharm.D., *Assistant Professor of Psychiatry, Wayne State University, 9-B VHC, 4201 St. Antoine, Detroit, MI 48202;* Cynthia Arfken, Ph.D., *Department of Psychiatry, Wayne State University, 9-B VHC, 4201 St. Antoine, Detroit, MI 48202;* Husseini K. Manj, M.D.

SUMMARY:

The outcome of patients after leaving a new residential center that combines behavioral therapy and rehabilitation with aggressive pharmacotherapy are presented. Outcome measures were role functions, health care resource utilization, symptom severity (BPRS), depressive symptoms (BDI), abnormal involuntary movement (AIMS), and perceived health status (SF-36) for the entire cohort (n = 77) and by discharge status. The mean follow-up time was 2.5 ± 1.1 years (participation rate = 86%). The patients were predominately white males diagnosed with schizophrenia or schizoaffective disorder. The mean admission BPRS score was 40.5 ± 8.4. The patients at follow-up were mostly living in the community (77%), employed (31%), and in contact with physicians (91%). A minority had been hospitalized (31%) or had visited the emergency department (25%). The mean decline in BPRS scores was highly significant (13.3 ± 11.3; $p = .003$). High BDI scores were reported by 14%. Scores on emotional problems, energy, and well-being were significantly lower than for other aspects of perceived health status. Clozapine was used by 81% of the cohort, with 94% continuing on clozapine for at least six months (from registry data). The maintenance rates differed by discharge status ($p = .039$). The results suggested good outcomes and low current severity of

symptoms. More definitive conclusions would require a randomized effectiveness trial.

This study was supported by the Rose Hill Center.

REFERENCES:

1. Smith Jr GK, Mandorscheid RW, Flynn LM, Steinwachs DM: Principles or assessment of patients outcomes in mental health care. Psychiatric Services 1997; 48:1033-1036.
2. Guyatt GH, Naylor CD, Juniper E, et al: Evidence-based medicine working group: users' guides to the medical literature. 1996; 7:112-115.

Poster 87 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

ASSESSMENT OF VIOLENCE IN PSYCHIATRIC INPATIENTS

Chau-Shoun Lee, M.D., *Department of Psychiatry, Cheng-Kung University Hospital, 138 Shen-Li Road, NCKUH, Tainan, Taiwan 70428;* Jung-Chen Chang, M.S.N., *Department of Nursing, University of Washington, 3801 Brooklyn Avenue, N.E., M302A, Seattle, WA 98105*

SUMMARY:

Objective: This study aimed to evaluate the reliability and validity of a probabilistic approach to assessment of the potential for violence.

Method: Residents and nurses independently rated the probability that each of all newly admitted psychiatric patients would engage in aggression during their hospitalization on an university-based, locked, inpatient unit. Aggressive behaviors were measured with three subscales of the Overt Aggression Scale (verbal aggression, against objects, and against others).

Results: There was a moderate level of agreement between residents' and nurses' assessment of risk of violence (Kappa = 0.52, based on three levels of estimates—low, moderate, and high risk). Ratings of assaultive behavior showed an increase in the proportion of assaultive patients as the level of estimated risk of violence increased. Although the rate of aggression against others was overpredicted, there was a close correspondence between clinical estimates of patients' chance of becoming violent and later displayed some type of inpatient aggression.

Conclusions: These findings provide support for the utility of the probabilistic approach to assessment of the potential for violence in comparison with the previous studies.

TARGET AUDIENCE:

Psychiatric staff interested in violence.

REFERENCES:

1. McNiel DE, Binder RL: Clinical assessment of the risk of violence among psychiatric inpatients. Am J Psychiatry 1991; 148:1317-21.
2. Kho K, Sensky T, Mortimer A, Corcos C: Prospective study into factors associated with aggressive incidents in psychiatric acute admission wards. Br J Psychiatry 1998; 172:38-43.

Poster 88 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

IDENTIFYING NEED FOR PSYCHIATRIC SERVICES AMONG THE HOMELESS

Daniel W. Bradford, B.S., B.A., *Stanley Foundation Pre-Doctoral Research Fellow, Department of Psychiatry, University of North Carolina, P.O. Box 931, Chapel Hill, NC 27514;* Michael Golding, M.D., *Adjunct Assistant Professor of Psychiatry, University of North Carolina at Chapel Hill, CB-7160, Chapel Hill, NC 27599;* Stanley W. Carson, Pharm.D.; John J. Haggerty, Jr., M.D.

SUMMARY:

Although individuals with psychiatric and substance-related disabilities constitute a significant portion of the homeless population, there are few screening techniques for this population that have been well tested for both validity and specificity as well as convenience. We developed a one-page, 24-item, self-administered questionnaire to identify individuals with significant psychiatric or substance abuse disorders in a North Carolina homeless shelter. We administered the questionnaire to 13 (out of a planned 50) randomly selected shelter guests. While blinded to questionnaire results, we re-evaluated shelter guests with a SCID diagnostic interview. We developed *a priori* SCID-based criteria to define "need to see a psychiatrist," need for a "substance abuse counselor" (without a psychiatrist), and "no need for mental health treatment." The questionnaire accurately identified all five individuals who met the SCID criteria for "need to see a psychiatrist" (sensitivity 100%) and incorrectly categorized two who met SCID criteria only for "need to see a substance abuse counselor" (75% specificity). All 13 of the participants had substance use problems, and the questionnaire identified 12 of them for a sensitivity and specificity of 92% and 100%, respectively. This instrument, which can easily be administered by nonclinical staff, may prove useful for routine psychiatric triage in homeless shelters.

TARGET AUDIENCE:
Community psychiatrists.

REFERENCES:

1. McLellan AT, Cacciola J, Kushner H, et al: The 5th edition of the addiction severity index, cautions, additions and normative data. Journal Subst Abuse Treat 1992; 9:461-480.
2. Shanks NJ, et al: Use of the delusions-symptom-states inventory to detect psychiatric symptoms in a sample of homeless men. British Journal of General Practice 1995; 45:201-203.

Poster 89 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

LEVEL OF CARE UTILIZATION SYSTEM: RELIABILITY AND VALIDITY

Wesley E. Sowers, M.D., *Chief Clinical Officer, The Center for Addiction Services, St. Francis Medical Center, and Former APA/Bristol-Myers Squibb Fellow, 400 45th Street, Pittsburgh, PA 15201;* Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute and Clinic, and Former APA/Bristol-Myers Squibb Fellow, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

The American Association of Community Psychiatrists recently developed the Level of Care Utilization System for psychiatric and addiction services (LOCUS). This is an instrument designed to guide decisions regarding the level of intensity of treatment and support services relative to an assessment of service needs of consumers. LOCUS uses a quantifiable dimensional assessment format to arrive at placement recommendations in one of six defined levels of service intensity or "levels of care." To determine the degree to which clinicians could consistently make level of care recommendations using LOCUS and the rationality of the recommendations they make, some simple reliability and validity studies were developed. This poster will present the results of these studies in the context of the research design and data analysis.

REFERENCES:

1. Sowers W: Level of care determinations in psychiatry. Harvard Rev Psychiatry 1998; 5:286-90.
2. Sowers W: LOCUS: An aid for service need placement determinations. Clinical Psychiatry Quarterly 1997; 20:9.

Poster 90 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

CASE MANAGEMENT FOR THE CHRONICALLY RECIDIVISTIC PSYCHIATRIC POPULATION

Jean G. Shelor, C.S., *Associate Chief, Mental Health Services, Veterans Affairs Medical Center, 1970 Roanoke Boulevard, Salem, VA 24153*

SUMMARY:

A case management program for the chronically recidivistic psychiatric population has been established at a Mid-Atlantic Veterans Affairs medical center (VAMC). The intent is to establish administrative and clinical policies, procedures, and responsibilities for the case management of chronically recidivistic patients followed by the mental hygiene outpatient clinic. This program targets individuals who have three or more psychiatric admissions to acute inpatient psychiatric units in one fiscal year. The outcome of this program is a 50% reduction in bed-days of care for each patient.

The definition of case management for the purposes of this program includes: review of appointments, motivation, and encouragement to attend all scheduled appointments, reestablishing individuals in clinics if they fail to present for scheduled appointments, oversight, home visits, and counseling regarding medication compliance, living conditions, abstinence from controlled, illegal and addictive substances, advocacy for services needed, consultation with other disciplines as needed in provision for care, etc. Individuals are assigned to three levels of case management intervention: A: medication changes, crisis in the home or with family, and financial management; B: toxic screens, financial management, counseling, medication monitoring and management, symptom management, and substance abuse interventions; and C: need for case management to avoid hospitalization no more than one per month. Patients are reassessed every six months for appropriateness for this program.

REFERENCES:

1. Guiliano KK, Poirier CE: Nursing case management: critical pathways of desirable outcomes. Nursing Management 1991; 22:52-55.
2. Knollmueller RN: Case management: what's in a name? Nursing Management 1989; 20:38-42.
3. Zander K: Case management in acute care: making the connections. TCM/JAN 1991; 39-43.

Poster 91 Sunday, October 4 10:00 a.m.-11:30 a.m.

A SUCCESSFUL ALTERNATIVE TO BOTH HOSPITALIZATION AND PARTIAL HOSPITALIZATION

Sylvia J. Dennison, M.D., *Chief, Addiction Section, Department of Psychiatry, University of Illinois, 912 South Wood Street, Room 521, MC-913, Chicago, IL 60612;* Dennis Morrison, Ph.D., *Center for Behavioral Health, 812 South Rogers Street, Bloomington, IN 47401;* Mark E. Hickman, Ph.D.

SUMMARY:

The authors present a novel alternative to hospitalization for those with chronic mental illnesses (CMIs) with or without co-occurring substance use disorders. The impetus for development of the program was recognition of the following: 1) the area had no 24-hour contact available outside of an ER-based crisis service 2) a large percentage of patient admissions occurred outside of office hours and on weekends, and 3) the ER served a social function for some CMIs. A 24-hour drop in/sleep over clinic was developed, which includes 24-hour nursing service, psychiatric technicians, on-site social skills and abstinence counseling, recreational activities, and food. In the first six months of program operation, compared with the six months prior to operation: 1) nursing services were the most heavily utilized service, far above expected use, 2) inpatient admissions among the identified population decreased by 36%, but 3) the rate of ER visits showed an increase as a result of ER visits by two patients only. Re-examination of the rate of ER usage is offered with and without these data points, and explanations for this usage are offered. A detailed description of the program, its components, and recommendations for future hospital alternatives are discussed.

TARGET AUDIENCE:

Physicians, nurses and social workers.

REFERENCES:

1. Dickey BN, Sharon-Lise T, Norton E, et al: Managing the care of schizophrenia: lessons from a 4-year Massachusetts Medicaid study. Archives of General Psychiatry 1996; 53:945-952.
2. Lehman AF, Goldman HH, Steinwalchs DM: Treatment outcomes in schizophrenia: implications for practice, policy, and research Schizophrenia Bulletin 1995; 21:669-657.

Poster 92 Sunday, October 4 10:00 a.m.-11:30 a.m.

ELECTRONIC MEDICAL RECORDS REPLACE PEN AND PENCIL

Daniel A. Deutschman, M.D., F.A.P.A., *Medical Director of Behavioral Health, Southwestern General Health Center, Cleveland, OH, and Associate Clinical Professor, Case Western University School of Medicine, 7255 Old Oak Boulevard, Suite 303, Middleburg Heights, OH 44130*

SUMMARY:

An electronic medical record (EMR) replaced written records in a busy psychiatry and addiction inpatient/outpatient practice in February 1995. Since then 15,000 records have been logged through nine workstations. Data are entered during the interviews in real time by clicking on look-up tables. Minimal typing is required. With expedited data entry, the clinician is free to see more patients or spend time on patient education and counseling. The EMR prompts and reminds the clinician thus making the record more complete. Preprogrammed treatment response reports analyze symptom response to pharmacologic and psychosocial treatment. Clinical reports, prescriptions, billing summaries, etc., print and are faxed at a keystroke to communicate with other members of the treatment team and to reduce secretarial time. A psychiatrist in the practice programmed the EMR. It is undergoing continuous improvement. Increased clinical and secretarial productivity has more than offset the expense of the software and hardware. In a typical practice, the hardware and software expense of $2,000 to $3,000 would be recouped by increased productivity in two to three months. Psychiatrists can learn to program EMR to suit the needs of their practices. EMR's increase clinical quality and improve productivity.

TARGET AUDIENCE:

Practicing psychiatrists.

REFERENCES:

1. Hammer JS, Strain JJ, Friedberg A, Fulop G: Operationalizing bedside pen entry notebook clinical database systems in consultation-liaison psychiatry. General Hospital Psychiatry 1995; 17:165-172.
2. Andrew WF, Dick RS: Applied information technology: a clinical perspective feature focus: the computer-based patient record (part 2). Computers in Nursing 1995; 13:118-122.

Poster 93 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

SERVICE UTILIZATION BEFORE AND AFTER CASE MANAGEMENT

Jennifer Pasternak, M.D., *Associate Director of Behavioral Health, Department of Psychiatry, Northwest Medical Center, 174 East Bissell Avenue, Oil City, PA 16301;* Archana Dube, M.S.; Rohan Ganguli, M.D.

SUMMARY:

Many strategies have been developed to enable the severely mentally ill to receive treatment in the community and avoid hospitalization. Assertive community treatment (ACT), a multidisciplinary team approach, has been shown in controlled trials to decrease rates of hospitalization and to be cost-effective. However, intensive case management (ICM) programs are more common than ACT, even though their efficacy is not well established. We conducted a retrospective analysis of all clinical services utilized by patients in one community mental health center 18 months before and 18 months after they were assigned ICMs for the first time, using a balanced pre-post design.

For the 75 patients who received an ICM in 1994 (the index year), there was a decrease in emergency room visits and an increase in outpatient visits in the "post" period as compared with the "pre" period. However, there was also a two-fold increase in community-hospital inpatient days, with no change in state hospital inpatient days, in the post-ICM period. In this instance, ICM services may have been used by patients to resolve crises but did not reduce rates of hospitalization and, thus, were not cost-effective. Other benefits to patients may have occurred, but were not measured in this study.

REFERENCES:

1. Holloway F, Carson J: Intensive case management for the severely mentally ill. British Journal of Psychiatry 1998; 172:19-22.
2. Mueser KT, Bond GR, Drake RE, Resnick SG: Models of community care for severe mental illness—a review of research on case management. Schizophrenia Bulletin 1998; 24:37-74.

Poster 94 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

EFFECT OF PSYCHIATRIC REHABILITATION ON THE USE OF ACUTE CARE SERVICES

Rohan Ganguli, M.D., *Professor of Psychiatry and Pathology, Department of Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213-2593;* Marsha Wilson, M.S.W.; Gemma Lundberg, Ph.D.

SUMMARY:

There are few data on the cost-effectiveness of psychiatric rehabilitation. Furthermore, the results derived from controlled clinical trials are equivocal at best, leading to skepticism and reluctance from many medical insurers to reimburse these services. We studied the effects of psychiatric rehabilitation (Adult Rehabilitation Services (ARS program) in a routine clinical setting on the use of acute care services (inpatient hospitalization and emergency room visits) in patients with chronic psychiatric illnesses. Fifty-six (of 70) patients who were referred to the ARS program in a six-month period consented to participate in this study. Patients were divided into two groups, those who attended at least two scheduled rehabilitation sessions and those who did not, and the use of acute care services by these patients in the 12 months before and after enrollment in the ARS program was compared.

Significant reductions were observed in the number of inpatient hospitalizations (46 before ARS versus 16 after), emergency room visits (70 before ARS versus 13 after) and the number of hospital days (1,034 days before ARS versus 242 days after), only in the group that participated in the ARS program. The cost savings in this group were substantial and easily offset the cost for running the ARS program.

TARGET AUDIENCE:

Psychiatrists, and social workers.

REFERENCES:

1. Wallace CJ: Psychiatric rehabilitation. Psychopharmacology Bulletin 1993; 29:537-548.
2. Hogarty GE, Anderson CM, Reiss DJ, et al: Family psychosocial education, social skills training, and maintenance chemotherapy in the aftercare treatment of schizophrenia. Archives of General Psychiatry 1986; 43:633-642.

Poster 95 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

IMPROVEMENTS IN INFORMATION PROCESSING PERFORMANCE WITH NOVEL ANTIPSYCHOTIC TREATMENT

Philip D. Harvey, Ph.D., *Associate Professor of Psychiatry, Mt. Sinai School of Medicine, 100th Street and Madison Avenue, New York, NY 10029*

SUMMARY:

One of the major cognitive impairments in schizophrenia is a deficient ability to acquire skills with practice. Combined with general limitations in cognitive capacity, these impairments lead to a situation where patients are extremely impaired in their ability to benefit from rehabilitation programs aimed at improving functional outcome. In this study, patients with chronic schizophrenia in a program designed to enhance information processing skills with practice were assigned to treatment with either conventional antipsychotic medication or risperidone. Patients performed the continuous performance test (CPT) on a daily basis for five weeks, with dual-task sessions on a weekly basis. After 10,000 practice trials, patients treated with risperidone (n = 6) were uniformly performing in the normal range on the CPT and manifesting automatic information processing as evidenced by equivalent performance while performing simultaneous and single tasks. Patients treated with conventional antipsychotics (n = 6) had evidence of development of automatic information processing, but did not improve in performance on the test (mean endpoint d' = 011) These data suggest that an attention-enhancing effect, possibly associated with the blockade of the 5-HT2a receptor, is seen with risperidone treatment. This finding replicates several other studies that found enhancement of attentional functioning during treatment with risperidone and similar compounds.

TARGET AUDIENCE:

Psychiatrists, psychologists, nurse clinicians, and social workers.

REFERENCES:

1. Green MF, Marshall, Jr, BD, Wirshing, WC, et al: Does risperidone improve verbal working memory in treatment-resistant schizophrenia? Am J Psychiatry 1997; 154:799-804.
2. Harvey PD, Lombardi J, Kincaid MM, et al: Cognitive functioning in chronically hospitalized schizophrenic patients: age-related changes and age disorientation as a predictor of impairment. Schizophr Res 1995; 17:15-24.

POSTER SESSION 4

Posters 96–120

SUBSTANCE ABUSE, HIV, PATIENT EDUCATION, GENETICS, AND CHILD PSYCHIATRY

Poster 96 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

HIV-RISK ASSESSMENT AMONG 100 SUBSTANCE ABUSERS

Eve J. Wiseman, M.D., *Chief, Special Treatment Section, Department of Psychiatry, Little Rock Veterans Affairs Medical Center, 4415 North Lookout Street, Little Rock, AR 72205-2024;* Patricia S. O'Sullivan, Ed.D.

SUMMARY:

Purpose: To test the hypothesis that substance abusers may underestimate their risk of human immunodeficiency virus (HIV) infection.

Methodology: We prospectively compared the self-reported HIV risk estimates from 100 substance-abusing outpatients with interview-generated, composite measures of their HIV risk. We also compared risk recognition for HIV infection with knowledge of HIV and with serological testing for HIV.

Results: Patients were categorized as underreporting (34 patients), accurately reporting (41 patients) or overreporting (25 patients) their risk for HIV infection. Underreporting occurred despite good knowledge, as determined by a sample mean of 9.60 ± 0.68 correct out of ten true-false statements. Fewer underreporting patients were serologically tested for HIV (20 out of 34 patients) than patients in the other risk categories (42 out of 66 patients).

Importance: The current study appears to be the first to assess accuracy of HIV risk recognition in substance abusers. Our methodology enabled us to categorize patients as underreporting, accurately reporting (self-report similar to objective measure), or overreporting their risk for HIV infection. Clinicians may need to identify substance abusers who underreport their risk for HIV infection and work to increase accurate recognition of risk as part of comprehensive HIV risk-reduction interventions.

REFERENCES:

1. Rosenberger J, Wineburgh M: Working with denial: a critical aspect in AIDS risk intervention. Social Work Health Care 1992; 17:11-26.
2. Ickovics JR, Morrill AC, Beren SE, et al: Limited effects of HIV counseling and testing for women: a

prospective study of behavioral and psychological consequences. JAMA 1994; 272:443-448.

Poster 97 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

THE EFFECT OF A CONTRACT IN THE TREATMENT OF ADDICTIONS

Chandresh Shah, M.D., *Chief, Substance Abuse Programs, VA Outpatient Clinic, and University of Southern California, 351 East Temple Street, Los Angeles, CA 90012;* Marites Del Rosario, M.D., *Department of Psychiatry, University of Southern California, 1937 Hospital Place, Los Angeles, CA 90033;* Lena Simitian, Pharm.D.

SUMMARY:

Cocaine use by heroin addicts is a growing problem. Treatment with methadone reduces heroin use but not necessarily cocaine use. Thus, continued cocaine use by methadone receiving heroin addicts undermines the efficacy of methadone treatment. Therefore, we studied the role of contractual treatment (CT) in such a population. There were 69 patients admitted to methadone treatment; 21 of them were also using cocaine. Of these, 16 patients (age 51.13±9.84 years) were placed on CT. Their requests to adjust their daily methadone dose up to 80 mg were accepted. Their performance was studied at a monthly interval (T1, T2, T3, T4) for four months by monitoring their urine toxicology results. The frequency of cocaine use at T1 was 37.79±32.73% by 13 patients; at T2, 33.57±33.04% by 11 patients; at T3, 20.24±25.74% by 11 patients; and at T4, 17.18±26.12% by eight patients. The statistical analysis was done using ANOVA. The reduction in cocaine use was highly correlated to time on CT ($r = -.945$). The frequency of cocaine use at T4 was significantly ($p = <.005$) lower than that at T1 on CT. These data show that CT has a significant role in the treatment of cocaine use among methadone receiving heroin addicts. Long-term studies are required to ensure that these benefits are maintained over time.

TARGET AUDIENCE:

Addiction therapists, counselors, nurses, and psychiatrists.

REFERENCES:

1. Gondelli WS, Fairbanks JA, Dennis ML, Rachal JV: Cocaine use by clients in methadone programs: significance, scope, and behavioral interventions. Jr of Substance Abuse Treatment 1991; 8:203-212.
2. McCarthy JJ, Borders OT: Limit setting on drug abuse in methadone maintenance patients. Am Jr Psychiatry 1985; 142:1419-1423.

Poster 98 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

PATIENTS' USE OF THE INTERNET IN A PSYCHIATRIC CLINIC

Maher A. Karam-Hage, M.D., *Resident, Department of Psychiatry, University of Michigan, 3338 Turnberry Lane, Ann Arbor, MI 48108-2082;* Michelle B. Riba, M.D.; Milton P. Huang, M.D.

SUMMARY:

Context: The use of the Internet has exploded in the last several years. Our patients are experiencing this tremendous access to medical information. As physicians, we may not be fully prepared to recognize or adapt to how our patients receive such information. We lack knowledge as to how many of our patients are using on-line resources and for what purpose.

Objective: To determine the extent to which patients are using on-line resources. To evaluate patients' acceptance of online information.

Participants: Consecutive sample of 247 patients consisting predominantly of young, college educated, Caucasian females and of moderately high income.

Results: 81.5% had a computer or access to one; 58.9% reported an hour of use or less per day; 58.3% used the Internet to inquire about health information, whereas only 33.2% looked up information on their diagnosis or medications; 48.7% wanted their clinician's advice on specific Internet sites.

Conclusions: In this preliminary study, Internet availability and utilization was high. Obtaining information about patients' use of the Internet would seem to be important in order to provide advice to patients, as many are interested. More surveys in diverse populations are needed to generalize our findings.

TARGET AUDIENCE:

Psychiatrists, general practicioners and clinicians.

REFERENCES:

1. Wang KK, Wong Kee Song LM: The physician and the Internet. Mayo Clin Proc 1997; 72(1):66-71.
2. Huang MP, Alessi NE: The Internet and the future psychiatry. Am J Psychiatry 1996; 153(7):861-869.

Poster 99 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

DIAGNOSIS TREATMENT PROGRAM

John W. Tsuang, M.D., *Director and Staff Psychiatrist, Dual Diagnosis Treatment Program, West Los Angeles VA Medical Center, Building 205-C, 11301 Wilshire Boulevard, Los Angeles, CA 90073;* Thad Eckman,

Ph.D., *Program Manager and Psychologist, Dual Diagnosis Treatment Program, West Los Angeles VA Medical Center, Building 205-C, 11301 Wilshire Boulevard, Los Angeles, CA 90073*

SUMMARY:

Drug abuse among psychiatric patients is common. It creates serious problems for patients, families and clinicians, often leading to more severe psychiatric symptoms with poorer psychosocial functioning and treatment outcome, higher rates of relapse and rehospitalization, less treatment compliance, and more admissions to emergency rooms. In 1990, the West Los Angeles Veterans Affairs Medical Center launched a comprehensive dual diagnosis treatment program (DDTP) specifically designed for these "dual diagnosis" patients. The program is staffed by an interdisciplinary team of mental health clinicians who combine psychoeducation and behavioral training in social and independent living skills, and substance abuse management skills with psychopharmacological treatments, special incentive programs, intensive assertive case management, representative payee services, and weekly urine testing in acute inpatient treatment and long-term outpatient rehabilitation of both disorders in a single setting. The program components work by teaching patients the specific information and skills needed to improve social functioning and prevent relapses of psychosis and substance abuse while adhering to the program's central philosophy of harm reduction and relapse prevention.

REFERENCES:

1. Tsuang JW, Ho AP, Eckman TA, Shaner A: Dual diagnosis treatment for patients with schizophrenia who are substance dependent. Psychiatric Services 1997; 48:7, 887-889.
2. Shaner A, Eckman TA, Roberts LJ, Wilkins J, Tucker D, Tsuang J, Mintz J: Disability income, cocaine use and repeated hospitalization among schizophrenic cocaine abusers: a government sponsored revolving door? New England Journal of Medicine 1995; 333:12, 777-783.

Poster 100 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

DESTIGMATIZING MENTAL ILLNESS: A COMMUNITY CAMPAIGN

Leslie M. Snider, M.D., M.P.H., *Associate Director of Public Psychiatry, Department of Psychiatry and Neurology, Tulane University Medical Center, 1440 Tulane Avenue - TB53, New Orleans, LA 70112-2699;* Kathleen J. Welch, M.P.H., *Epidemiologist, HIV Outpatient Unit, Department of Infectious Diseases, Louisiana State University, 136 South Roman Street, New Orleans, LA 70112;* Mary C. Piker; Linda F. Yasnyi, B.S.

SUMMARY:

The purpose of this poster presentation is to inform communities in the development and organization of a campaign to decrease the stigma of mental illness and focus community awareness on mental health issues. "The Psychiatrist Is In...City Park" was a unique event held in New Orleans as the finale to Mental Illness Awareness Week activities and was the recipient of the 1998 APA Public Affairs Network Award. The event was a collaboration between the Tulane University Department of Psychiatry and Neurology, Tulane School of Public Health and Tropical Medicine, and the Friends Alliance for the Mentally Ill. Held in scenic City Park, the event provided information about major mental illnesses, popular myths surrounding mental illness, and a variety of treatments available at 16 local mental health agencies. The uniqueness of this event was its integration of information with the local arts in New Orleans; extensive publicity; use of limited funding and mobilization of community volunteers; and sponsoring of networking between consumers, families, and agencies. Local arts included musical performances by famous jazz musicians, larger-than-life paper mache Mardi Gras birds, silent art auction of works by local artisans, and a "Lucy Booth" for brief "consultation" with a psychiatrist.

REFERENCES:

1. Regier DA, et al: The de facto U.S. mental and addictive disorders service system, Archives of General Psychiatry February 1993.
2. Rohland B, et al: Perceived shortages of community support services, Administration and Policy in Mental Health January 1998; vol. 25, no. 3.

Poster 101 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

ALCOHOL OR DRUG USE IN HIV-INFECTED PATIENTS

Kathleen J. Welch, M.P.H., *Epidemiologist, HIV Outpatient Unit, Department of Infectious Diseases, Louisiana State University, 136 South Roman Street, New Orleans, LA 70112;* Anne Morse, B.S., *Study Coordinator, Louisiana Office of Public Health, 136 South Roman Street, New Orleans, LA 70112;* Patricia Kissinger, Ph.D.

SUMMARY:

In order to determine the factors associated with alcohol and/or drug (AOD) use in HIV-infected persons at a public HIV-outpatient clinic, a convenience sample of 300 patients completed an anonymous survey on AOD use. The sample's demographic profile compares with

data from the CDC Adult Spectrum of Disease database in New Orleans, which collects data on the clinic's population (n = 2,108). The majority of the patients in this sample were male, black, and unemployed. Psychosocial factors included homeless (12%), previous AOD treatment (12%), criminal history (8%), hospitalized for a mental illness (13%), and friends use drugs (44%). AOD use was reported by 22% and the drugs most frequently used in the past month included alcohol (59%), marijuana (31%), and crack/cocaine (9%), with 62% reporting polysubstance abuse. The following factors were significantly associated with AOD use.

Previous AOD treatment, criminal history, hospitalized for a mental illness, and friends use drugs. The vast majority of the AOD users (73%) also reported an interest in learning about humor as a treatment approach. As a result of this study, a humor intervention is being designed and implemented.

TARGET AUDIENCE:

Health care providers of HIV-infected patients.

REFERENCES:

1. Selwyn P, Batki S: Treatment for HIV-infected alcohol and other drug abusers. Rockville, MD, DHHS Publication No. (SMA) 95-3038, 1995.
2. O'Connor PG, Samat JH: The substance using human immunodeficiency virus patient: approaches to outpatient management. American Journal of Medicine 1996; 101:435-444.

Poster 102 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

ULTRA-RAPID OPIATE DETOXIFICATION: TREATMENT AND OUTCOMES

Bennett L. Oppenheim, Ph.D., *Clinical Director, Citamericas, 1580 Lemoine Avenue, Suite 8, Fort Lee, NJ 07024;* Clifford Gevirtz, M.D., M.H.A., *Chief of Anesthesiology, Metropolitan Hospital, 627 West Street, Harrison, NY 10528;* Anthony Albanese, M.D.; Jean Marie Field, Ph.D.

SUMMARY:

Objectives: (1) To evaluate the safety and efficacy of Ultra Rapid Opiate Detoxification ($UROD_{(SM)}$); and (2) to evaluate six-month outcome data of patients choosing this method.

Design: Two center parallel group clinical trial.

Setting: Two academic medical centers.

Participants: 93 men and 27 women, aged 18 to 55 years, with opiate dependency self-selected to undergo detoxification.

Interventions: $UROD_{(SM)}$ and aftercare costs were the responsibility of the patients and/or their significant others.

Main Outcomes Measure: (1) Completion of $UROD_{(SM)}$ as determined by a nonreactive response to a naloxone challenge test under anesthesia and nonreactive response to naltrexone administration before discharge. (2) Patient outcome as determined at six-month follow-up of $UROD_{(SM)}$ patients' relapse-free status as documented by drug urinalysis, self-report, significant other reports, and/or therapist reports.

Results: 100% successful detoxification with $UROD_{(SM)}$ with low morbidity and no mortality. Relapse data were available for 111/123 procedures performed (90%), with 61/111 patients (55%) with reported relapse-free status at the six-month follow-up interval.

Conclusions: For individuals who are addicted to opiates, the Ultra Rapid Opiate Detoxification method appears to be a viable treatment option.

REFERENCES:

1. Blackwell J: The saboteurs of Britain's opiate policy: over prescribing physicians or American-style "junkies?" Int. J. Addict 1988. May (23).
2. Stimmel B. The socioeconomics of heroin dependency. NEJM 1972; 287:1275-1280.

Poster 103 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

PATIENT SATISFACTION AT TIME OF DISCHARGE

David M. Malkin, M.S.W., *Director of Quality Assurance, Metropolitan State Hospital, 11400 Norwalk Boulevard, Norwalk, CA 90650;* Michael K. Nunley, R.N., *Nursing Quality Assurance, Metropolitan State Hospital, 11400 Norwalk Boulevard, Norwalk, CA 90650*

SUMMARY:

This poster presentation describes the results obtained from the administration of a patient satisfaction survey to a sample of 410 inpatients at a state-supported mental hospital. Patients rated the "concern and attention" given by different members of their treatment team. They compared how they felt at the time of the survey with how they felt when entering the hospital. They rated their opinions concerning such factors as privacy, meals, visiting hours, and numerous other factors. In addition, patients were also asked about their perceptions concerning the degree to which they participated in a variety of aspects of their treatment. The format of the survey was such that patients with minimal verbal skills could complete the questions.

All members of the treatment team were perceived as providing high levels of concern and attention; nursing

and the clergy received the highest ratings. A total of 85% of the respondents said they felt better after being hospitalized. There was generally high acceptance of unit privacy, food/meals, unit cleanliness, visiting hours and unit groups. The patient respondents showed nigh agreement that they received very good care and that they participated in their treatment.

REFERENCES:

1. The 1997 Behavioral Outcomes & Guidelines Sourcebook.
2. Outcomes Assessment in Clinical Practice.

Poster 104 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

PATIENTS' OPINIONS ABOUT PSYCHOLOGY SERVICES

Steve Brown, Ph.D., *Chief of Psychology Services, Metropolitan Hospital, 11400 Norwalk Boulevard, Norwalk, CA 90650;* Jerome F. Costa, M.D., M.P.H., *Research Psychiatrist, California Clinical Trials, 8500 Wilshire Boulevard, 7th Floor, Beverly Hills, CA 90211;* Arlabeth Hahn, Ph.D.

SUMMARY:

This poster presentation describes the results of a patient satisfaction scale used with a sample of 133 inpatients, who had a mean length of stay of 496 days, at a state psychiatric hospital. Patients rated the helpfulness of psychology services in the areas of "overall helpfulness," "getting along better with others," "stress management," "improved self-esteem," "learn more about yourself," "anger management," "learn about substance abuse," "problem solving," "understand feelings," and "feel better." The instrument had a coefficient alpha reliability of .95.

Overall psychology services were rated as "somewhat" to "very" helpful. Patients who received group therapy perceived psychology services as being significantly more beneficial in the areas of "helping them get along better with others", "stress management," and "feel better" than did those patients not receiving group therapy. Patients receiving individual therapy perceived psychology services as significantly more helpful in the areas of "improving self-esteem," "learning more about themselves," and "understanding their feelings." Length of stay, was significantly positively correlated with helping patients "get along with others" and "learn more about themselves" and significantly negatively correlated with "stress management." The use of these results as outcome measures and for program planning are also discussed.

REFERENCES:

1. The 1997 Behavioral Outcomes & Guidelines Sourcebook.
2. Outcomes Assessment in Clinical Practice.

Poster 105 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

CBCL AND CAFAS: OUTCOMES FOR CHILDREN IN FOSTER CARE

Bonnie T. Zima, M.D., M.P.H., *Director of Training, Division of Child and Adolescent Psychiatry, University of California at Los Angeles, Neuropsychiatric Institute, 300 Medical Plaza, Room 1414, Los Angeles, CA 90095;* Regina Bussing, M.D., *Associate Professor of Psychiatry, University of Florida, Box 100177, Gainesville, FL 32610-0234;* Aaron Kaufman, M.A., Thomas R. Belin, Ph.D.; Mel Widawski, M.D.; Madeleine Zwart, B.A.

SUMMARY:

Objective: To describe how findings from the CBCL and CAFAS, recently mandated clinical outcomes measures for all children receiving state funded mental health services is related to psychiatric diagnosis and clinician ratings of global impairment.

Method: Using a stratified sample of children aged 6-12 living in foster care from three country service areas, foster parents and children were interviewed twice in their home. The first interview was a structured survey that included the CBCL, and the second interview was a mental health evaluation conducted by an experienced country clinician.

Results: Prevalence estimates of child problems varied from 7% to 67% depending on assessment method and impairment criteria. Agreement between screening measures and clinician assessment was fair to poor. More than 20% of the children who did not screen positive for a behavior problem or for at least moderate impairment met medical necessity criteria. Latino children were more likely to be under-identified by screening measures than non-Latino children.

Conclusion: Policy decisions based on these clinical outcome measures should be made cautiously because level of need for mental health services, especially among Latino children, may be underestimated.

TARGET AUDIENCE:

Child mental health professionals and program administrators.

REFERENCES:

1. Rosenfeld AA, Pilowsky DJ, Fine P, et al: Poster care: an update. J Am Acad Child Adolesc Psychiatry 1997; 36:448-457.

2. Reddy LA, Pfeiffer SI: Effectiveness of treatment foster care with children and adolescents: a review of outcome studies. J Am Acad Child Adolesc Psychiatry 1997; 36:581-588.

Poster 106 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

SUBSTANCE ABUSE COMORBIDITY AMONG FORENSIC INPATIENTS: TRIPLE HAZARDS AND CHALLENGES

Simon S. Chiu, M.D., Ph.D., *Forensics Services, London Psychiatric Hospital, 850 Highbury Avenue, London, ON, Canada N6A 4H1*

SUMMARY:

Despite the known association between violence and criminality and substance abuse, there has been a paucity of data addressing the issue of substance abuse comorbidity among patients admitted to a psychiatric hospital for triage/crisis stabilization, competency to stand trial, and NGRI (not guilty by reason of insanity) assessment.

A pilot study was undertaken at a psychiatric hospital in Toledo, Ohio to characterize the clinical-demographic profile along with the substance abuse severity and pattern among forensic inpatients over a 12-month period. Data were collected through retrospective chart review, coupled with direct semistructured patient interview and treatment-team meetings. The results indicated that of the sample of 40 patients, 80% have a lifetime diagnosis of substance abuse/dependence. Alcohol was the preferred substance of choice, followed by marijuana and cocaine. Most of the patients had multiple violent felony charges (aggravated assault, attempted murder, property damage) which were preceded by evidence of dual psychiatric and substance use relapses precipitated by treatment noncompliance. The rank order of frequency of psychiatric diagnoses was schizophrenia, followed by schizoaffective disorder and bipolar disorder. All the patients were in the pre-engagement phase of recovery from addiction.

The results highlight the significance of dual disorders among the forensic targeted population and issues relating to addiction as both the aggravating and the mitigating factor in condition sentencing; culpability of dual disorders in NGRI defense, and the strategies for monitoring court-ordered relapse and treatment. Relapse and recidivism of offenses, client-focused empowerment and recovery, and community safety are identified as primary driving forces catalyzing the development of innovative mechanisms to facilitate closer collaboration and integration of criminal justice, mental health, and addiction treatment services.

REFERENCES:

1. Kermani EJ, Castaneda R: Psychoactive substance use in forensic psychiatry. Am J of Drug and Alcohol Abuse 1996; 22:1-27.
2. Modestin J. Ammann R: Mental disorder and criminality: male schizophrenia. Schizophrenia Bulletin 1996; 22:69-82.

Poster 107 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

SUBSTANCE USE AND ABUSE IN CHILDREN AND ADOLESCENTS

Madhavan Thuppal, M.D., *Fellow in Child Psychiatry, State University of New York at Stonybrook, 44-91-A Piedmont Drive, Port Jefferson Station, NY 11776;* Gerardo M. Montero, M.D.; Jeffrey Sverd, M.D.

SUMMARY:

Substance use disorders (SUD) in children and adolescents start with alcohol and tobacco at about ten to 12 years of age and progress to cannabis, cocaine, stimulants, hallucinogens, and prescription drugs. Only a subset of SUD in children and adolescents meet criteria for abuse and dependence. Majority of literature on SUD in adolescents is focused in inpatient or incarcerated youths. Findings from outpatient settings are limited. Patterns of substance use and abuse, psychiatric morbidity and comorbidity, and family characteristics of 86 children and adolescents attending an intensive day treatment program were studied. Patterns of substance use were recorded on a format made for the purpose at the time of intake. Psychiatric diagnosis was made independently by two psychiatrists. Those with SUD and without SUD were compared on a number of variables: psychiatric diagnosis, family pathology, cognitive function, legal problems, and psychiatric hospitalization. Alcohol and cannabis were used by 39.5% of children. Cocaine, LSD, and Special K were the other frequently used substances. Data showed that 82.4% of subjects with SUD used two or more substances. Attention deficit hyperactivity disorder, bipolar disorder, dysthymic disorder, and oppositional defiant disorder were the most common diagnoses. Seventeen met criteria for abuse of substances.

TARGET AUDIENCE:

Psychiatrists, social workers, and psychologists.

REFERENCES:

1. Weinberg NZ, Rahdest E, Colliver JD, Giantz MD: Adolescent substance abuse: a review of the past 10 years. J Am Child Adolescent Psychiatry 1998; 37:252-26.

2. Wilens TE, Biederman J, Abgantes AM, & Spencer TJ: Clinical characteristics of psychiatrically referred adolescents outpatients with substance use disorder. J Am Acad Child Adolescence Psychiatry 1997; 36:941-947.

Poster 108 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

MEASUREMENT OF DUAL DIAGNOSIS TREATMENT OUTCOMES

Andrew P. Ho, M.D., *Assistant Clinical Professor, Department of Psychiatry, Harbor-University of California at Los Angeles Medical School, 1000 West Carson Street, Box 497, Torrance, CA 90509;* John W. Tsuang, M.D.; Andrew L. Shaner, M.D.

SUMMARY:

Purpose: Patients who are severely mentally ill and with comorbid psychoactive substance use disorders are poorly retained in outpatient treatment and require frequent hospitalizations. Specialized programs with integrated psychiatric, relapse prevention, and case management services are being developed to provide more effective treatment to these patients. Cost-effective methods of evaluating these programs are needed to assess their clinical usefulness, provide guidance for continuous quality improvement, and justify their existence.

Methodology: We developed and implemented a minimum set of outcome measures at the Dual Diagnosis Treatment Program of the Veterans Administration Medical Center, West Lost Angeles. We used initial treatment engagement, 30-day treatment retention, and 90-day treatment retention as measures of the program's ability to have an impact on compliance with outpatient treatment. We used the percent of patients hospitalized, episodes, and days of hospitalization in the six months before and after entering treatment as measures of the program's impact on hospital utilization. We used twice a week urine toxicology screening to ascertain sobriety status.

Summary: We defined and implemented a minimum set of outcome measures for dually diagnosed patients. Issues of cost-effective data collection, management, and analysis in the clinical setting and without research funding will be discussed.

TARGET AUDIENCE:

Administrators, psychiatrists, and members of allied groups.

REFERENCES:

1. Miner CR, Rosenthal RN, Hellerstein DJ, Muenz LR: Prediction of compliance with outpatient referral in patients with schizophrenia and psychoactive substance use disorders. Arch Gen Psychiatry 1997; 54:706-712.
2. Tsuang JW, Ho AP, Eckman TA, Shaner A: Rehab rounds: dual diagnosis treatment for patients with schizophrenia who are substance dependent. Psychiatric Services 1997; 48:887-889.

Poster 109 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

PATIENT-CONTROLLED ELECTRONIC MEDICAL RECORDS

Andrew P. Ho, M.D., *Assistant Clinical Professor; Department of Psychiatry, Harbor-University of California at Los Angeles Medical School, 1000 West Carson Street, Box 497, Torrance, CA 90509*

SUMMARY:

Purpose: Although electronic medical records promise to improve the quality and cost-effectiveness of patient care, confidentiality concerns continue to limit the adaptation of these systems. Public acceptance of these systems, especially for mental health applications, demands greater control of access to record contents than can be achieved through current designs. A limitation of current electronic medical records systems is that they do not allow patients to control the access and distribution of their own records.

Methodology: A computerized mental health medical record database that permits patients to control the access to their own record is designed and tested. Multiple access levels and explicit access lists are used to control access to individual patient records. Clinicians who are not explicitly listed on the access list are allowed to access records only during emergency contacts. Logs of all clinicians who accessed each patient's record are provided to individual patients at regular intervals. Patients are encouraged to keep their access control lists up-to-date. Comparisons and contrasts with traditional paper and electronic medical record systems are discussed.

Summary: The provision of patient-controlled access to medical records is feasible using current technology. This innovation addresses a major obstacle to the implementation of electronic mental health medical record systems.

TARGET AUDIENCE:

Administrators, psychiatrists, and members of allied groups.

REFERENCES:

1. Segal G: Clinical informatics: the computerized medical record. Journal of Practical Psychiatry and Behavioral Health 1997; 3:378-381.
2. Kazmer J, Oliver K: The creation of the virtual electronic medical record (VEMR). Health Information & Management Systems Society Annual Conference, March 5, 1996, Atlanta, Georgia.

Poster 110 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

MOTHER'S EMOTIONAL RESPONSE TO THE HOMICIDAL DEATH OF THEIR ADOLESCENT CHILDREN

Robert Bennett, M.S.W., *Chief of Social Services, Metropolitan State Hospital, Adjunct Professor of Social Work, California State University of Long Beach, and Project Director, Loved Ones of Homicide and Victim Center, 1434 Point View Street, Los Angeles, CA 90035*

SUMMARY:

This poster describes six mothers' emotional responses to the murder of their teenage children. The mothers live in south central Los Angeles, the highest crime and most underserved area of California. The study is conducted three months after the murder. It is a phenomenological qualitative study using grounded theory methods. The findings describe the psychodynamic processes of the mothers' experiences organized in four phases. The mothers past and present stigmatization and victimization is part of the emerging recovery process.

TARGET AUDIENCE:

Psychiatrists, psychologists, social workers, nurses, and rehabilitation therapists.

REFERENCES:

1. Lindemann, E: Symptomology and management of acute grief. American Journal of Psychiatry 1944; 101:141-148.
2. Akhtar, S: Broken structures - seven personality disorders and their treatment. Jason Aronson, Inc. Northvale, New Jersey 1992.
3. Corwin, Miles: The killing season. Simon & Schuster, New York City, New York 1997.

Poster 111 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

THE PRESENTATION AND TREATMENT OF ADHD IN ASIANS

Sheryl H. Kataoka, M.D., *Fellow in Child Psychiatry, University of California at Los Angeles, Neuropsychiatric Institute, 300 Medical Plaza, P.O. Box 956967, Los Angeles, CA 90024-1759;* Pablo A. Davanzo, M.D., *Clinical Instructor, Department of Child Psychiatry, University of California at Los Angeles, Neuropsychiatric Institute, 760 Westwood Plaza, Los Angeles, CA 90024;* Catherine Erlich, M.D.; David Takeuchi, Ph.D.

SUMMARY:

Objective: This chart review was designed to examine the assessment and treatment of Asian-American children presenting to a community clinic with attention-deficit hyperactivity disorder (ADHD).

Method: The charts of 18 Asian-American children who presented to a Los Angeles County mental health clinic between 1995 to 1997 were reviewed. Subjects were 5-17 years old and were found to meet DSM-IV criteria for ADHD. Data collected included sociodemographic information, cultural information (immigration status and language of patient and parent), Child Behavior Check-List (CBCL) scores, and data on the type of psychosocial intervention received. Of those who did receive medication, information regarding the type of medication, dosage, side effects, and compliance was recorded.

Results: The CBCL scores indicated that these children had multiple presenting symptoms. The majority of cases received supportive therapy as their only psychosocial intervention. Few patients were compliant with medication treatment. Side effects were more common in the compliant group than the noncompliant group.

Conclusions: Although recent studies with university-based clinic populations have recommended multimodal treatment for ADHD, our results suggest that these Asian-American children did not receive this.

TARGET AUDIENCE:

Community mental health professionals, and child psychiatrists.

REFERENCES:

1. Leung PWL, Luk SL, Ho TP, et al: The diagnosis and prevalence of hyperactivity in Chinese schoolboys. Brit J Psychiatry 1996; 168:486-496.
2. Li X, Su L, Townes BD, Varley CK: Diagnosis of attention deficit disorder with hyperactivity in Chinese boys. J Am Acad Child Adolesc Psychiatry 1989; 28:497-500.

Poster 112 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

PREVENTION AGAINST USE OF DRUGS IN HOLIDAY CAMPS

Jorge A. Jaber, M.D., *Jorge Jaber Clinic, General Venancio Flores 305-SL601, Rio de Janeiro, Brazil 2244*

1090; Angela V. Hoffman, *Jorge Jaber Clinic, General Venancio Flores 305-SL602, Rio de Janeiro, Brazil 2244 1090*

SUMMARY:

The Jorge Jaber Clinic has been working jointly with the Community Council of Barra da Tijuca, a project of integrated action on social issues within a mental health approach in this population. This project was developed from a fusion of common interests in the scope of social action and from the performance in the health area of this community. It was given more attention for the question regarding the prevention against the use of drugs in such aspects as: primary (informative), secondary (treatment), and tertiary (resocialization). We believe this to be an emerging and growing problem with a great lack of attention and care, having in view the alarming and adverse consequences that we face in the accomplishment of our work.

The aim of this project is to possibly become a preventive action in the community through receiving population demands, mainly in two fields of performance:

Prevention Projects (Primary) in:

Schools

Clubs

Joint-Ownerships

Our aim is to inform the population about the aspects drug questions within a biopsychosocial approach.

Social Clinic Project

Free attendance to the public on daily shifts, where evaluation interviews, orientation and assessment by professionals from the Jorge Jaber Clinic are conducted.

The clinical performance is made by professionals from several health areas. These include psychiatrists, psychologists, pediatrists, phonoaudiologists and counselors on chemical dependence, turning possible, therefore, a multidisciplinary approach of the questions raised, as also the political/social performance organized and performed by the Community Council of Barra da Tijuca in partnership with the Jorge Jaber Clinic of Psychotherapy.

Poster 113 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

ASSOCIATION OF FRIENDS AND RELATIVES OF CHEMICAL DEPENDENTS

Jorge A. Jaber, M.D., *Jorge Jaber Clinic, General Venancio Flores 305-SL601, Rio de Janeiro, Brazil 2244 1090;* Angela V. Hoffman, Jorge Jaber Clinic, General Venancio Flores 305-SL602, *Rio de Janeiro, Brazil 2244 1090*

SUMMARY:

The Jorge Jaber Clinic has formed, because of the incentive and orientation of their therapists, the Association of Friends of the Jorge Jaber Clinic. Family groups of chemical dependents, our patients, were established with the goal of: 1) promoting family meetings (co-dependents), aiming emotional support to the same; and 2) promoting knowledge interchange regarding the difficulties as a mutual-help group, making it easier for them to meet their responsibilities in the therapeutic moment.

Our reason for encouraging the formation of this group was: trying to break the enormous resistance of the co-dependent to recognizing that he/she also needs help with treatment; aiming a greater adherence of the co-dependents to the treatment of his familiar chemical dependent.

The Association of Friends of the Jorge Jaber Clinic had four distinct moments in its formation: 1) difficulties in structuring and development, 2) conquests, discoveries, and growing of all the professional team from this experience, 3) concrete gains of the chemical dependent patient in his family relationship, and 4) success in the interaction between the clinic, association of friends, and the chemical dependent.

Poster 114 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

RESEARCH OF VIOLENCE IN JOINT OWNERSHIPS OF BARA DA TIJUCA

Jorge A. Jaber, M.D., *Jorge Jaber Clinic, General Venancio Flores 305-SL601, Rio de Janeiro, Brazil 2244 1090;* Angela V. Hoffman, Jorge Jaber Clinic, General Venancio Flores 305-SL602, *Rio de Janeiro, Brazil 2244 1090*

SUMMARY:

This research was an initiative of the Community Council of Barra da Tijuca, in which their participants together with the members of the Jorge Jaber Team, tried to point out the violent spots recognized and denounced by the residents of this community. There was evidence of the existence of a distorted behavior system from part of some of their joint ownership inhabitants, most of them youngsters, becoming delinquents and gang formers, turning the problem into an urgent necessity at a level of a problematic community issue.

Poster 115 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

CAMPAIGN OF PREVENTION AGAINST USE OF DRUGS IN BARRA DA TIJUCA

Jorge A. Jaber, M.D., Jorge Jaber Clinic, General Venancio Flores 305-SL601, Rio de Janeiro, Brazil 2244 1090;

Angela V. Hoffman, *Jorge Jaber Clinic, General Venancio Flores 305-SL602, Rio de Janeiro, Brazil 2244 1090*

SUMMARY:

The campaign was an initiative of the community itself and had the objective to reach those youngsters who haven't started taking use of drugs. This pioneer work was effected in Barra da Tijuca, district-city of Rio de Janeiro, with a population of 250,000. The origin of this event is the "Red Cross Campaign" that takes place every year in the United States. "Drugs, the Worst Poison" the name given to this movement, received technical advice from the professionals of the Jorge Jaber team, people who for more than ten years have dealt with this problem, thus in the prevention as in the treatment of chemical dependence.

A number of 107 joint-ownerships of Barra da Tijuca participated in this event, also schools, clubs, churches, gymnastic academies, associated with the Community Council of Barra da Tijuca, which coordinated this task. The main theme was "The Practice of Sport." There took place sports competitions, gathering thousands of youngsters. Besides sport, there were several lectures about the use of drugs and theatre plays prepared and acted by students of schools from the community. The campaign was a complete success, from the organizational aspect and from the involvement and knowledge of those that had the opportunity to participate in this event.

Poster 116 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

QUALITY-OF-LIFE COMPARING BUPRENORPHINE AND METHADONE IN SUBSTANCE ABUSERS

Gabriele Fischer, M.D., *Assistant Professor of Psychiatry, University of Vienna, Waehringer Guertel 18-20, Vienna, Austria A-1090;* Johann Windhaber, M.D., *Resident, Department of Psychiatry, University of Vienna, Waehringer Guertel 18-20, Vienna, Austria A-1090;* Harald Eder; Reinhold Jagsch, M.A.

SUMMARY:

Aims: The need to measure consumer's quality of life (QoL) is a new concept in psychiatry in general and particularly in substance abuse. This study addressed the question whether QoL is different in substance abusers who were randomized to buprenorphine (BUP) or methadone (MET) and whether QoL changed over the time of the study (six months).

Methods: In a randomized study comparing the efficacy of BUP or MET maintainance therapy in opiate-dependent patients, we used the German version of the Lancashire Quality of Life Profile (LQOLP), called the Berliner Lebensqualitätsprofil (BeLP) for the measurement of QoL. Pre- and post-treatment the BUP and the MET group were compared.

Results: The patients in the BUP group were more satisfied in their living conditions than the MET group after six months. Additionally, their partnership had improved more over the period of the study. Overall, the results of this study are limited by the high drop-out rate (BUP 55%, MET 25%).

Conclusion: These preliminary results show that the BUP group has achieved a higher QoL in some life domains compared with the MET group; the result is limited by the fact that in the BUP group more patients dropped out.

REFERENCES:

1. Eklund C, Melin L, Hiltunen A, Borg S: Detoxification from methadone maintenance treatment in Sweden: long-term outcome and effects on quality of life and life situation. Int J Addictions 1994; 29:627-45.
2. Holcomb WR, Parker JC, Leong GB: Outcome of inpatients treated on a VA psychiatric unit and a substance abuse treatment unit. Psychiatric Services 1997; 48:699-704.

Poster 117 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

BUPRENORPHINE MAINTENANCE IN PREGNANT OPIATE ADDICTS

Gabriele Fischer, M.D., *Assistant Professor of Psychiatry, University of Vienna, Waehringer Guertel 18-20, Vienna, Austria A-1090;* Harald Eder, *Department of Psychiatry, University of Vienna, Waehringer Guertel 18-20, Vienna, Austria A-1090;* Bettina Rossler, M.D.; Andreas Haberler, M.D.

SUMMARY:

It is well-known that maternal opiate use during pregnancy is associated with a long list of problems in the pregnant-woman as well as in the fetus, neonate, and young infant. Relevant pharmacological treatment for infants has not yet been established. Methadone maintenance therapy improves the situation for mother and child but cannot prevent the neonatal abstinence syndrome (NAS). Eleven opiate-dependent, pregnant addicts (mean age 24 years), with a mean duration of opioid dependence of 55.09 months, were enrolled in an open, standardized, treatment study with maintenance therapy of sublingual buprenorphine. Induction period to a daily dose of 8 mg sublingual buprenorphine (SD±2,8; range 4-10) was performed on an inpatient basis during the mean duration of pregnancy of 27 weeks (SD ± 5,4; range 17-36). Prior to buprenorphine, all subjects

were stabilized either on methadone (n = 8; mean daily dosage of 40.4 mg) or on slow-release morphine (n = 3; mean daily dosage of 400 mg). Buprenorphine was well tolerated during pregnancy. Eleven healthy neonates were born during week 39 of pregnancy (SD±1,8; range 36-42), the mean birth weight being 2,984 grams (SD±381,32; range 2,290-3,700) and with a weak occurrence of an opioid-related NAS (five did not show any NAS, six a weak occurrence). We propose that the partial agonistic profile of buprenorphine, in contrast to the full opiate agonistic properties of methadone, morphine, and heroin, accounts for the absence, respectively weak NAS following buprenorphine therapy.

REFERENCES:

1. Jasinski DR, Pevnick JS, Griffith JD: Human pharmacology and abuse potential of buprenorphine. Arch Gen Psychiatry 1978; 35:501-516.
2. Finnegan LP, Ehrlich SM: Maternal drug abuse during pregnancy: evaluation and pharmacotherapy for neonatal abstinence. Mod Methods Pharmacol Test Eval Drugs Abuse 1990; 6:255-263.

Poster 118 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

USE OF RISPERIDONE IN ADOLESCENTS: A RETROSPECTIVE CHART REVIEW

Joshua W. Calhoun, M.D., *Chief, Division of Child Psychiatry, St. John's Mercy Medical Center, 615 South New Ballas Road, St. Louis, MO 63141-8221;* Gretchen A. Barry, R.Ph., M.S.; Karen A. Guskin, Ph.D.

SUMMARY:

This retrospective study evaluated the use, safety, and efficacy of risperidone in adolescents hospitalized on an acute psychiatric unit of a community general teaching hospital. The charts of all 191 patients treated with risperidone during a 35-month period were reviewed. Specific target symptoms were identified for each patient, and adverse drug reactions were recorded.

The mean age of the patients was 14.6 years. Risperidone was used to treat psychotic symptoms (hallucinations, paranoid thinking, delusions, loose associations) in 131 patients (69%) and aggressive, violent, and agitated behaviors in 110 (58%). The average effective dose of risperidone was 1.8 mg/day. There were significant differences ($p < 0.005$) between males (2.1 mg/day) and females (1.5 mg/day) in the average maintenance dose. Side effects were reported by 23% of the patients, including sedation (16%) and extrapyramidal symptoms (4%). Of the 191 patients receiving risperidone, 86% were discharged from the hospital on maintenance doses of risperidone and other concurrent psychotropic agents. The reasons for risperidone discontinuation included side effects in 4% and lack of efficacy in 10%.

Risperidone was an effective and well-tolerated antipsychotic agent for the treatment of psychotic symptoms and aggressive and violent behaviors in adolescents hospitalized on an acute inpatient unit.

REFERENCES:

1. Armenteros JL, Whitaker H, Welikson M, et al: Risperidone in adolescents with schizophrenia: an open pilot study. J Am Acad Child Adolesc Psychiatry 1997; 36:694-700.
2. Finding RL, Groevich SJ, Lopez I, et al: Antipsychotic medications in children and adolescents. J Clin Psychiatry 1996; 57(suppl 9):19-23.

Poster 119 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

CHILDHOOD ANOREXIA NERVOSA AND THE POSSIBILITY OF ANTIBIOTIC TREATMENT

Hajime Sasaki, M.D., *International Trainee, Menninger Clinic, 5800 Southwest Sixth Avenue, Topeka, KS 66601;* Mae S. Sokol, M.D., *Department of Eating Disorders, Menninger Clinic, 5800 Southwest Sixth Avenue, Topeka, KS 66601-0829;* Guido Stein; Steven Burger

SUMMARY:

Objective: Some cases of anorexia nervosa (AN) in youngsters may be triggered by infection. This presentation describes this possible subtype of AN and its treatment.

Method: Four youngsters with AN who had the infection-triggered subtype characteristics were treated with an open antibiotic trial. Clinical information, weight, throat cultures, streptococcal serological tests (anti-DNase B and ASO titers), D8/17, and scores on the Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS), National Institute of Mental Health OCD scale (NIMH OCD scale), and the Yale-Brown-Cornell Eating Disorder Scale (YBC-EDS), are presented for each patient.

Results: Each patient responded with decrease in AN symptoms, weight increase, and decrease in CY-BOCS, NIMH OCD scale, and YBC-EDS scores. As the patients improved clinically, their anti-DNase B and ASO titers decreased. The patients' non-T lymphocytes with the D8/17 marker ranged from 28% to 38%. D8/17 is a B cell alloantigen associated, in several studies, with susceptibility to rheumatic fever, obsessive-compulsive disorder, and ties. Individuals are considered positive for the D8/17 marker when 12% or more of their non-T lymphocytes have the D8/17 marker.

Conclusions: Antibiotic treatment may be effective for an infection-triggered subtype of AN. Future research is necessary before this treatment becomes part of clinical practice.

TARGET AUDIENCE:

Researchers, and clinicians.

REFERENCES:

1. Sokol MS, Gray NS: Case study: an infection-triggered, autoimmune subtype of anorexia nervosa. J Am Acad Child Adolesc Psychiatry 1997; 36: 1128-33.
2. Swedo SE, Leonard HL, Mittleman BB, et al: Identification of children with pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections by a marker associated with rheumatic fever. Am J Psychiatry 1997; 154:110-2.

Poster 120 **Sunday, October 4**
4:00 p.m.-5:30 p.m.

ACCESS TO FOLLOW-UP CARE BY DUAL DIAGNOSIS PATIENTS

Lawrence Appleby, Ph.D., J.D., *The Psychiatric Institute, Department of Psychiatry, University of Illinois at Chicago, 1601 West Taylor, Chicago, IL 60603;* Daniel J. Luchins, M.D., *Associate Professor of Psychiatry, University of Chicago Medical School, 5841 South Maryland Avenue, Chicago, IL 60637-2604;* Vida B. Dyson, Ph.D.; Sally Freels, Ph.D.

SUMMARY:

Objective: The major purpose of this study was to examine the relationship between substance use treatment and aftercare contact among public psychiatric patients.

Method: Two groups, consisting of 93 participants and 99 nonparticipants in substance use treatment, were selected from 273 dual diagnosis patients admitted to a state facility in a six-month period. Selected outcomes included referral rates, aftercare contact, and recidivism. Data were collected from hospital and statewide computer files, central patient files, and aftercare clinics.

Results: Enrollment in a substance use treatment program was not related to any outcome measure. Regression analyses revealed that patients with psychotic diagnoses were more likely to be referred and keep clinic appointments. Personal linkage to the clinic also was significantly related to aftercare engagement. Nonpsychotic, male, and younger patients readmit earlier and more frequently. Individuals who make two or more clinic visits stay in the community longer.

Conclusions: Costly inpatient substance abuse treatment is inefficient; focus should be on integrated models dominated by outpatient care. Less severely ill dually diagnosed patients may have to be addressed with non-mental health models to facilitate engagement in treatment. Psychiatric bias needs to be addressed in order to facilitate greater access to services for mentally ill with co-occurring substance use disorders.

REFERENCES:

1. Herman SE, BootsMiller B, Jordan L, Mowbray CT, Brown WG, Deiz N, Bandla H, Solomon M, Green P: Immediate outcomes of substance use treatment within a state psychiatric hospital. J Ment Health Adm 1997; 24: 126-138.
2. Miner CR, Rosenthal RN, Hellerstein DJ, Muenz LR: Prediction of compliance with outpatient referral in patients with schizophrenia and psychoactive substance use disorders. Arch Gen Psych 1997; 54, 706-712.

POSTER SESSION 5

Posters 121–155

ANTIPSYCHOTICS AND SCHIZOPHRENIA

Poster 121 **Monday, October 5**
10:00 a.m.-11:30 a.m.

OLANZAPINE VERSUS FLUPHENAZINE; TREATMENT OF ACUTE SCHIZOPHRENIC SYMPTOMATOLOGY INCLUDING ANXIETY

Pierre V. Tran, Ph.D., *Research Physician, Eli Lilly and Company, Lilly Corporate Center, DC 2128, Indianapolis, IN 46268;* Gary D. Tollefson, M.D., Ph.D.; Ann Marie Crawford, Ph.D.

SUMMARY:

Unlike typical neuroleptics, olanzapine increases responding during the conflict component of a modified Geller Seiffer test, suggesting anxiolytic activities. To test this hypothesis clinically, a study was conducted comparing efficacy, including anxiolytic activity, between olanzapine (Olz) and fluphenazine (Flu). Sixty schizophrenic patients were randomized to Olz (5-20 mg) or Flu (6-21 mg). The study lasted 22 weeks with an acute treatment period of six weeks. Six-week results are reported. After six weeks, the Olz group showed superior improvement in mean change in HAM-A total (Olz −9.8 vs. Flu −5.8; p = .048) and HAM-A somatic (Olz −3.6 vs. −1.6; P = .04). There was a difference in favor of Olz in mean change of CGI-S scores (Olz −1.9 vs. Flu −1.2; p = .039). The Olz group achieved a numerically superior decrease in mean BPRS total,

PANSS total, PANSS positive, and PANSS negative. Assessment using the Simpson Angus Scale and the Hillside Akathisia Scale showed that the Olz group experienced significantly less EPS. Concomitant use of benzodiazepines and anticholinergics was also significantly lower in the olanzapine group. Olanzapine produced significantly superior global improvement in symptoms, including anxiety, compared with fluphenazine. The data extend preclinical observations of effectiveness of olanzapine in the conflict model of anxiety.

REFERENCES:

1. Moore NA, Tye NC, Axton MS, Risius FC: The behavioral pharmacology of olanzapine, a novel "atypical" antipsychotic agent. The Journal of Pharmacology and Experimental Therapeutics 1992; 262(2):545-551.
2. Tollefson GD, Beasley CB. Tran P, Street JS, Krueger JA, Tamura RN, Graffeo KA, Thieme ME. Olanzapine versus haloperidol in the treatment of schizophrenia and schizoaffective and schizophreniform disorders: results of an international collaborative trial. American Journal of Psychiatry 1997; 154 (4):457-465.

Poster 122 **Monday, October 5**
10:00 a.m.-11:30 a.m.

LITHIUM AND EKG FINDINGS

Marion E. Wolf, M.D., *Clinical Professor of Psychiatry, VA Medical Center, 3001 Green Bay Road, North Chicago, IL 60064;* Aron D. Mosnaim, Ph.D., *Professor of Pharmacology, Chicago Medical School, 3333 Green Bay Road, North Chicago, IL 60064*

SUMMARY:

Our recent findings in a bipolar patient on maintenance lithium therapy who developed hypercalcemia and severe bradyarrhythmia, prompted us to conduct a retrospective study of bipolar subjects with lithium-induced hypercalcemia (Group I, n = 12). We compared the electrocardiographic findings in these patients with those found among a control group of age- and sex-matched normocalcemic bipolar subjects treated with lithium for a comparable number of years (Group II, n = 40). We found that 58% of the patients in Group I had bradycardia and/or conduction defects as opposed to 22.5% of the patients in Group II (chi square 5.6; p = 0.018). Both lithium and calcium play an important role in the genesis of arrhythmia, as they interfere with the electrophysiological properties of cardiac cells involving currents of various ions. Our findings suggest that hypercalcemia potentiates lithium-induced bradyarrhythmia, and/or that lithium potentiates calcium-induced arrhythmias. These preliminary data emphasize the need for regular laboratory and electrocardiographic monitoring of patients on maintenance lithium therapy.

REFERENCES:

1. Wolf ME, Moffat, M, Mosnaim, J and Dempsey, S: Lithium, hypercalcemia and hyperparathyroidism. American Journal of Therapeutics 1997; 4:323-326.
2. Kingsbury RJ, and Salzman C: Lithium's role in hyperparathyroidism and hypercalcemia. Hospital and Community Psychiatry 1993; 44:1047-1048.

Poster 123 **Monday, October 5**
10:00 a.m.-11:30 a.m.

PRESCRIBING CHARACTERISTICS OF MAOIS IN MICHIGAN

Richard Balon, M.D., *Professor, Department of Psychiatry and Behavioral Sciences, University Psychiatric Center, Wayne State University, 2751 East Jefferson Street, Suite 200, Detroit, MI 48207;* Cynthia Arfken, Ph.D.; Rizwan M. Mufti, M.D.

SUMMARY:

Use of monoamine oxidase inhibitors has declined in past decades. However, MAOIs are an effective treatment of various disorders. To highlight trends in prescribing MAOIs in Michigan, we sent a one-page questionnaire to 1,129 members of the Michigan Psychiatric Society in three mailings during the summer of 1997. We received 717 responses (65%), 573 from currently practicing psychiatrists. Twelve percent of practicing psychiatrists never prescribed MAOIs, 27% prescribed more than three years ago, 17% prescribed one to three years ago, 14% prescribed three to twelve months ago, and 30% prescribed zero to three months ago. Of those who prescribed MAOIs and answered this question, 61% prescribed them rarely, 37% occasionally, and 3% frequently. The most frequent reasons for not prescribing MAOIs were: side effects and interactions (45%), preference of other therapies (30%), and dietary restrictions (17%). Ninety-two percent believed that MAOIs were useful for atypical depression, 63.7% for major depression, 53.8% for melancholic depression, 27.2% for dysthymia, 55.5% for panic disorder, 44.2% for social phobia, 12.2% for OCD, and 18.7% for PTSD. This study clearly documented the commonly held belief that practicing psychiatrists believe MAOIs are efficacious but use them infrequently, primarily due to concerns about side effects/interactions.

REFERENCES:

1. Krishnan KRR: Monoamine Oxidase Inhibitors, in: The APA Textbook of Psychopharmacology, Edited by Scharzberg AF, Nemeroff CB APPI, Inc., Washington DC, 1995, pp 183-193.

2. Bernstein JG: Handbook of Drug Therapy in Psychiatry. Third Edition. Mosby, St. Louis, Missouri, 1995.

Poster 124 **Monday, October 5**
10:00 a.m.-11:30 a.m.

A TALE OF THREE CITIES: COMPARISON OF PSYCHOTROPIC DRUG SALES AND UTILIZATION

Ronald Brenner, M.D., *Chairman and Director of Neurobehavioral Research, Department of Psychiatry, St. John's Episcopal Hospital, 327 Beach 19th Street, Far Rockaway, NY 11691-4423;* Michael S. Lesser, M.D., *Medical Director, The City Department of Mental Health, Mental Retardation and Alcoholism Services, 93 Worth Street, Room 414, New York, NY 10013-3412;* Huang Xingyue, M.S.; Julie Zito, M.D.

SUMMARY:

Background: The significant expansion in the use of psychotropic agents, especially of the newer, more costly products is widely known but has not been systematically studied. This study compared the sales and utilization patterns of psychotropic drugs in Boston (BOS), Los Angeles (LA), and New York (NYC).

Method: Analyses describe the similarities and differences in a cross-sectional survey (IMS America) of sales and utilization data for 1995. Drug potency was adjusted with the World Health Organization's defined daily dose (DDD) for five psychotropic classes as well as a relative potency scale for antipsychotics.

Results: (1) Psychotropic drug sales per capita were $15.16 (BOS), $9.08 (LA), and $17.24 (NYC). (2) More than 50% of the psychotropic sales were represented by antidepressants, regardless of the city. (3) Among drugs having generic alternatives, the greatest brand preference occurred for anxiolytics where the brand versus generic sales ratios were 3.4 (BOS), 4.3 (LA), and 7.4 (NYC). (4) Brand drugs had higher cost/DDD than their generic counterparts suggesting that it is differences in drug costs and not utilization that are responsible for the economic disparities. (5) Selective serotonin reuptake inhibitors not only were best selling (89%, 86%, and 84%, respectively) antidepressants but also had the highest cost/DDD ($15 and over). (6) The five top-selling drugs contributed 59% or more in psychotropic sales.

Conclusions: LA had nearly 50% lower sales per capita than BOS and NYC, which may be explained by managed care market penetration. New psychotropic drugs are appropriate targets for therapeutic efficiency studies.

TARGET AUDIENCE:

Psychiatrists, pharmacists, and other mental health professionals.

REFERENCES:

1. IMS America sales data (database) for calendar year 1995.
2. Country and City Data Book: A Statistical Abstract Supplement. U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census. 12th ed. 1994.

Poster 125 **Monday, October 5**
10:00 a.m.-11:30 a.m.

USAGE PATTERNS OF ATYPICAL NEUROLEPTICS

John Voris, Pharm. D., *Associate Professor, Department of Clinical Pharmacy, University of South Carolina, 1312 Country Squire Drive, Columbia, SC 29212*

SUMMARY:

Objective: To identify average doses (including age and diagnosis) and to assess the degree of dose escalation of risperidone and olanzapine.

Methods: Data were collected on over 12,000 outpatient risperidone and olanzapine prescriptions from six Veterans Affairs hospitals, by quarter, for one year. Additionally, data from all patients (n = 178) at one hospital were evaluated for diagnosis, age, and dose.

Results: There were 8,913 prescriptions for risperidone and 3,823 for olanzapine. The average dose per day for both groups did not vary more than 4% throughout the year: risperidone increased from 3.47 mg to 3.62 mg and olanzapine decreased to 10.01 mg from 10.48 mg. Average daily cost increased 5% for each drug (risperidone $3.59 to $3.79; olanzapine $5.29 to $5.56). The single hospital data showed the peak use of risperidone in the seventh decade, while maximum dose (4.71 mg) was in the 40s. Olanzapine's peak use was in the 40s, while maximum doses were in the 20s (11.25 mg). Dose for specific diagnosis showed average doses in the psychotic patient was 4.91 mg for risperidone and 7.89 mg for olanzapine. The demented patient used doses of 1.83 mg of risperidone and 6.78 mg of olanzapine.

Conclusion: The dosing and cost of each drug was fairly stable over a year. Risperidone is being used more in the older patient and olanzapine in the younger patient. Each shows decreasing doses after the fourth decade of life.

REFERENCES:

1. Glazer WM, Johnston BM: Pharmacoeconomic evaluation of antipsychotic therapy for schizophrenia. J Clin Psychiatry 1997; 58 Suppl 10:50-4.
2. Hargraves WA, Shumway M: Pharmacoeconomics of antipsychotic drug therapy. J Clin Psychiatry 1996; 57 Suppl 9:66-76.

Poster 126 **Monday, October 5**
10:00 a.m.-11:30 a.m.

MANAGED CARE AND PSYCHIATRIC TREATMENT PATTERNS

Joyce C. West, M.P.P., *Senior Research Associate, Office of Research, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005;* Deborah A. Zarin, M.D., *Deputy Medical Director, and Director, Office of Quality Improvement and Psychiatric Services, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005;* Harold Alan Pincus, M.D.

SUMMARY:

Objective: This study reports recent, nationally representative data on the nature and scope of psychiatric managed care arrangements; assesses variations in the treated patient case mix across different health plans and managed care organizations (MCOs); and describes variations in the type, intensity, and continuity of psychiatric treatments provided in different health plans and MCOs.

Methods: This observational study used data from the 1997 APA Practice Research Network (PRN) Study of Psychiatric Patients and Treatments, which was conducted in spring 1997. 78.5% of PRN members (417/531) participated, yielding detailed diagnostic, clinical, and treatment information on 1,245 patients. Multivariate logistic and ordinary least squares multiple linear regression were used to generate risk-adjusted estimates of treatment pattern variations.

Results: Treated patients in managed health plans were generally more severe than those in non-managed plans. Statistically significant variations in treatment patterns (e.g., visit length, treatment type, intensity, and duration) were also observed after adjusting for patient sociodemographic and clinical factors. Managed care patients had the fewest number of visits in the past 30 days (2.0 visits), while patients in non-managed private plans had 3.3 visits. Patients in managed behavioral health care plans were also more likely to receive medications alone without psychotherapy (60.0%) than patients in private non-managed care plans (34.4%).

Conclusions: The significant variations in patterns of care observed may have important implications for the quality of care provided under different types of health plan and MCO arrangements. Rigorous risk-adjusted analyses are needed to control for patient clinical factors, which are also associated with treatment pattern variations. The APA PRN is funded by the MacArthur Foundation and the federal CMHS.

REFERENCES:

1. Zarin DA, Pincus HA, West JC, & McIntyre JS: Practice-based research in psychiatry. Am J Psychiatry 1997; 154:1199-1208.
2. Pincus HA, Zarin DA, West JC: Peering into the "black box": measuring outcomes of managed care. Archives of General Psychiatry 1996; 53:870-877.

Poster 127 **Monday, October 5**
10:00 a.m.-11:30 a.m.

ANTIPSYCHOTIC USE IN PATIENTS WITH SCHIZOPHRENIA

Philip S. Wang, M.D., D.P.H., *Instructor in Medicine, Brigham Young Women's Hospital, and Department of Pharmaco-Epidemiology, Harvard Medical School, 221 Longwood Avenue, Suite 341, Boston, MA 02115;* Deborah A. Zarin, M.D., *Deputy Medical Director, and Director, Office of Quality Improvement and Psychiatric Services, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005;* Harold Alan Pincus, M.D.

SUMMARY:

Background: Little is known about recent patterns of use of antipsychotic medications (APMs) among patients with schizophrenia or the reasons for use of particular APM regimens.

Methods: Information on 150 patients with schizophrenia was collected from 1997 Practice Research Network (PRN) Patient-Level Core data. The frequency of use of particular APMs was identified. Characteristics of patients, prescribers, treatment settings, and health care systems that predicted the use of particular APM regimens were identified.

Results: Ninety-five percent of the patients with schizophrenia were on at least one APM at the time of the survey, 15% were on two, and 2% were on three or more. Seven percent of patients were on clozapine, 24% were on risperidone, and 23% were on olanzapine, reflecting an extremely rapid rise in the use of these newer agents. In addition, almost half of the patients had ever been on risperidone and nearly all had ever been on a conventional APM. The independent effects of several patient, psychiatrist, treatment setting, and health system factors on the probability of using newer APM agents were identified in multivariable models.

Conclusions: Data from the APA's PRN provide a powerful tool for both characterizing significant changes in the pharmacological treatment of schizophrenia that have occurred recently, and identifying important patient, prescriber, and health care system factors related to the use of particular regimens.

REFERENCES:

1. Zarin DA, Pincus HA, West JC, Mcintyre JS: Practice-based research in psychiatry. American Journal of Psychiatry 1997; 154:1199-1208.

2. American Psychiatric Association: Practice guideline for the treatment of patients with schizophrenia. Am J Psychiatry 1997; 154(April suppl):1-63.

Poster 128 **Monday, October 5**
10:00 a.m.-11:30 a.m.

HEART TRANSPLANTATION: MEANING AND DESIRED DONOR TRAITS

Kristi S. Williams, M.D., *Department of Psychiatry, Medical College of Ohio, 3120 Glendale Avenue, Toledo, OH 43537-9671;* Joy D. Skeel, M. Div., *Department of Psychiatry, Medical College of Ohio, 3120 Glendale Avenue, Toledo, OH 43614*

SUMMARY:

Heart transplantation is assumed to be a traumatic event. This project explores heart transplant candidates' attitudes to the pending loss of their hearts, and inquires about desired traits in their potential heart donors. Twenty patients—13 (65%) males and even—(35%) females, mean age 52.2 years—accepted by the institution's cardiac transplant committee were given a semi-structured interview. When given two chances to describe the meaning of the heart the two most common responses were: seat of emotions, 18; and physical life-sustainer, 15. The significance of the loss of the heart was (one response allowed): second chance, eight; fearful experience, four; disappointment in their heart, three; and grief, two. Important donor traits (two responses allowed) were: morality/goodness, 11; health, five; belief in God, three; and intelligence, three. Literature review shows minimal research in this area. This project, therefore, can help health professionals understand that the heart is more than a mechanical pump; it carries strong emotional meaning. This research has psychological and ethical implications with respect to emotional aspects of heart transplantation, including desired donor traits and questions about revealing donor characteristics that do not match subjects' ideals.

REFERENCES:

1. Bunzel B, Wollenek G, Grundböck A: Living with a donor heart: feelings and attitudes of patients toward the donor and the donor organ. J Heart Lung Transplant 1992; 11:1151-1155.
2. Bunzel B, Grundböck A, Wollenek G: Does changing the heart mean changing personality? A retrospective inquiry on 47 heart transplant patients. Qual Life Research 1992; 1:251-256.

Poster 129 **Monday, October 5**
10:00 a.m.-11:30 a.m.

WHAT IS THE DIFFERENTIAL RISK OF TARDIVE DYSKINESIA WITH NOVEL ANTIPSYCHOTIC OLANZAPINE?

Bruce J. Kinon, M.D., *Research Physician, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285;* Mary A. Dellva, M.S.; Charles M. Beasley, M.D.

SUMMARY:

Purpose: The incidence of tardive dyskinesia (TD) was evaluated in 1,714 patients with schizophrenia, schizophreniform disorder, or schizoaffective disorder treated with olanzapine or haloperidol for a period of up to 2.6 years in three randomized, double-blind, multicenter studies. It was hypothesized that olanzapine would be associated with a lower incidence of TD than haloperidol.

Methods: Baseline TD was assessed by the Abnormal Involuntary Movement Scale (AIMS) and the Schooler-Kane Research Diagnostic Criteria for TD (RD-TD) as modified by Glazer and Morgenstern. Kaplan-Meier survival analysis was used to estimate the risk of TD for each treatment group at various time points during double-blind therapy. Incidence rates of TD as well as rate ratios were also estimated during follow-up.

Results: The estimated risk remained higher with haloperidol than with olanzapine throughout the follow-up period ($p < .001$). Considering both acute (≤6 week) and delayed onset cases, the estimated rate ratio for haloperidol compared with olanzapine was 3.69 (95% CI = 2.10, 6.50). Based on data following the initial six weeks of observation, the estimated one-year risk of TD was 0.52% with olanzapine and 7.45% with haloperidol. The estimated risk with haloperidol was higher than with olanzapine throughout the follow-up period subsequent to the initial six weeks ($p = .002$). The estimated rate ratio was 11.86 (95% CI = 2.30, 61.14).

Conclusion: Results of multiple assessments of the incidence of TD indicated a substantially lower risk of TD with olanzapine than with haloperidol.

TARGET AUDIENCE:

Mental health care clinicians.

REFERENCES:

1. Kane JM, Woemer M, Weinhold P, Wegner J, Kinon B, Borenstein M: Incidence of tardive dyskinesia: five-year data from a prospective study. Psychopharmacology Bulletin 1984; 20:39-40.
2. Saltz BL, Woemer MG, Kane JM, Lieberman JA, Alvir JM, Bergmann KJ, Blank K, Koblenzer J, Kahaner K: Prospective study of tardive dyskinesia incidence in the elderly. JAMA 1991; 256:2402-2406.

Poster 130 **Monday, October 5**
10:00 a.m.-11:30 a.m.

GENDER-SPECIFIC PROLACTIN RESPONSE TO OLANZAPINE VERSUS RIEPERIDONE IN THE TREATMENT OF SCHIZOPHRENIA

Bruce J. Kinon, M.D., *Research Physician, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285;* Bruce Basson, M.S.; Gary D. Tollefson, M.D., Ph.D.

SUMMARY:

Objective: The influence of gender upon prolactin (PRL) response to either olanzapine (OLZ) or risperidone (RIS) was investigated during a six-month clinical trial (HGBG).

Method: Within a double-blind, controlled, comparative clinical trial of OLZ (N = 172; 10-20 mg/d) and RIS (N = 167; 4-12 mg/d) in predominantly schizophrenic patients, serum PRL was assessed at baseline (following drug-washout), after completion of up to eight weeks acute treatment, and after up to 28 weeks extended treatment.

Results: After acute as well as extended treatment, mean PRL for RIS-treated males and females was significantly higher than that of corresponding OLZ-treated males and females. Mean PRL after acute or extended treatment for OLZ-treated patients did not differ significantly from baseline in either gender. RIS-treated females had a significantly greater increase in mean change from baseline PRL than RIS-treated males not tested at specific timepoints but overall. Mean change from baseline did not differ significantly between OLZ-treated males and females. There was no significant relationship between mean PRL and dose.

Conclusions: Treatment with RIS is associated with a marked increase in mean PRL in both males and females (females > males). Both sexes demonstrate persistently elevated mean PRL during up to six months of treatment. OLZ is not associated with a significant increase in mean PRL in either males or females receiving extended treatment. The proportion of patients with elevated PRL at endpoint was numerically greater in RIS- versus OLZ-treated patients.

TARGET AUDIENCE:

Mental health care clinicians.

REFERENCE:

1. Tran PV, Hamilton S, Kuntz A, Potvin J, Anderson S, Beasley C, Tollefson GD: Double-blind comparison of olanzapine versus risperidone in the treatment of schizophrenia and other psychotic disorders. Journal of Clinical Psychopharmacology 1997; 17:407-418.

Poster 131 **Monday, October 5**
10:00 a.m.-11:30 a.m.

GENDER-SPECIFIC PROLACTIN RESPONSE TO OLANZAPINE VERSUS HALOPERIDOL IN THE TREATMENT OF SCHIZOPHRENIA

Bruce J. Kinon, M.D., *Research Physician, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285;* Bruce Basson, M.S.; Gary D. Tollefson, M.D., Ph.D.

SUMMARY:

Objective: The influence of gender upon prolactin (PRL) response to either olanzapine (OLZ) or haloperidol (HAL) was investigated for up to one year during a clinical trial (HGAJ).

Method: Within a double-blind, controlled, comparative clinical trial of OLZ (N = 1336; 5-20 mg/d) and HAL (N = 660; 5-20 mg/d) in predominantly schizophrenic patients, serum PRL was assessed at baseline, after up to six weeks acute treatment, and after up to 52 weeks extended treatment. A sub-population of HAL-treated patients (''HAL-OLZ'' patients) were switched to open-label OLZ treatment after acute treatment and followed to 52 weeks.

Results: Mean PRL for males and females treated acutely with HAL was significantly higher than that of OLZ-treated males and females. After extended treatment, mean PRL for HAL-treated males and females remained significantly elevated compared with OLZ-treated and with HAL-OLZ patients now on OLZ. HAL-treated females compared with males had a significantly greater increase in mean change from baseline PRL. Mean change from baseline PRL did not differ significantly between OLZ-treated males and females. The proportion of patients with elevated PRL at endpoint was greater in HAL- versus OLZ-treated patients.

Conclusions: Treatment with HAL is associated with a persistently marked increase in mean PRL in both males and females (females > males). HAL-associated increases in mean PRL are fully reversed (i.e., no significant increase over pre-HAL baseline) when patients are subsequently switched to OLZ treatment.

TARGET AUDIENCE:

Mental health care clinicians.

REFERENCES:

1. Tollefson GD, Beasley CM, Tran PV, Street JS, Krueger JA, Tamura RN, Graffeo KA, Thieme ME:

Olanzapine versus haloperidol in the treatment of schizophrenia, schizoaffective and schizophreniform disorders: results of an international collaborative trial. American Journal of Psychiatry 1997; 154:457-465.
2. Keks NA: Minimizing the non-extrapyramidal side effects of antipsychotics. Acta Psychiatr Scand 1996; 94:18-24.

Poster 132 **Monday, October 5**
10:00 a.m.-11:30 a.m.

THE NEGATIVE SYMPTOM COMPLEX: A FORENSIC VIEW

Andries M. Korebrits, M.D., *Consultant Psychiatrist, Department of Forensic Psychiatry, Dr. F.S. Meijers Institute, Sansstraat 168-170, Utrecht, The Netherlands 3528 EP*

SUMMARY:

Negative symptoms are of major concern in the treatment of schizophrenia. Especially in the treatment of psychotic, mentally disturbed offenders, these symptoms pose a serious problem to the physician. The poor outcome and prognosis of these symptoms in general is one of the greatest challenges in modern psychiatric treatment.

This study attempts to acquire insight in incidence and prevalence of negative symptoms in the psychotic, mentally disturbed offender, establishing risk factors (sensory deprivation, loss of perspective) and evaluating efficacy of treatment (typical versus atypical antipsychotic agents). A cohort of all psychotic, mentally disturbed offenders in the Netherlands is being studied and followed throughout the diagnostic and clinical treatment phases.

Preliminary results show a high incidence of negative symptoms and a greater efficacy of the new atypical antipsychotics although long-term effects are not yet known.

Early intervention and decreasing sensory deprivation seem to influence the treatment in the direction of a better outcome in general.

REFERENCES:

1. Crow TJ: The two syndrome concept: origin and current status Schizophr Bull 1985; 11:471-486.
2. Tollefson GD, Sanger TM: A path analytic approach to a double-blind, placebo- and haloperidol-controlled clinical trial with olanzapine. Am J Psychiatry April 1997; 154:4.

Poster 133 **Monday, October 5**
10:00 a.m.-11:30 a.m.

JUDICIALLY-FORCED PSYCHOTROPIC MEDICATIONS IN ILLINOIS

Jagannathan Srinivasaraghavan, M.D., *Professor of Clinical Psychiatry, Southern Illinois University, Choate Mental Health Center, Anna, IL 62906;* Atul R. Mahableshwarkar, M.D.; Michael C. Rockwell, M.D.; Shanta Nair, M.D.; Martin Cohen, M.D.; James B. Brunner, M.D.

SUMMARY:

Background: Illinois Department of Mental Health and Developmental Disabilities Code Section 2:107.1 deals with judicially ordered psychotropic medications to non-consenting recipients in non-emergency situations. During calendar years 1993 to 1995 there were 466 cases filed in Cook County, the most populous county in Illinois with 45% of the population of the state. Of these cases, 313 cases (67%) originated from three state-operated mental health facilities.

Objective: Aim of the study is to compare demographic findings such as age, sex, race, diagnosis, duration for disposition, and outcome from these three hospitals during calendar years 1993 to 1995.

Method: All relevant data were collected from 27 medical records (100%) from Madden, 36 medication records (100%) from Tinley Park, and non-randomly selected 122 of 250 medical records (49%) from Chicago Read.

Results: Mean age of patients was mid to upper forties. About 60% of patients were women. Schizophrenia and schizoaffective disorder accounted for two-thirds of cases. About 75% of patients were either single or divorced. Whites accounted for 43% and blacks 38% of cases. At Read it took a mean of 15 days from filing of petition to disposition; at Tinley Park and Madden the process took 2.5 to three times longer. Number of cases filed per 1,000 patients treated in Read, Madden, and Tinley Park was 35.54, 5.03, and 3.71, respectively. Read had the least denial at 0.4% and Tinley Park had the most at 11%.

Conclusions: There is wide variation in utilization and outcome in judicial overturning the patient's right to refuse medications in the three state-operated mental health facilities in Cook County. Patient demographic factors alone do not account for the differences.

REFERENCES:

1. Srinivasaraghavan J, Mahableshwarkar A: Illinois Experience with Court-Ordered Psychotropic Medication. 47th APA Institute on Psychiatric Services, Syllabus (Poster 80) 1995; p96.
2. Srinivasaraghavan J, Mahableshwarkar A: Forced Psychotropic Medication: Five Years Illinois USA

Data. Xth World Congress of Psychiatry, Abstracts 1996, Vol. 2:397.

Poster 134 **Monday, October 5 10:00 a.m.-11:30 a.m.**

INTENT-TO-TREAT ANALYSIS

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SUMMARY:

Objective: To evaluate the cost-effectiveness of olanzapine (OLZ) in comparison with haloperidol (HAL) from an intent-to-treat perspective in a randomized, double-blind trial of 812 schizophrenic patients from the United States.

Method: One-year outcomes were compared using survival analysis. We used mixed effects linear models to impute missing values and two-sample bootstrap analysis to estimate a confidence interval for the incremental cost-effectiveness ratio.

Results: OLZ was significantly more effective than HAL, measured as number of BPRS-based, symptom-free days experienced by patients (Wilcoxon $X^2 = 4.0$, $df = 1$, $p = .046$). OLZ therapy was significantly less costly than HAL therapy, measured as total medical expenditures incurred by patients (Wilcoxon $X^2 = 16.8$, $df = 1, p = .0001$). The difference in average annual costs per patient (OLZ – HAL) was $10,301. The difference in average number of symptom-free days (OLZ – HAL) was 18.3. The incremental cost-effectiveness ratio was $563 per symptom-free day. Resampling this result 25,000 times, the observed percentage of negative bootstrap estimates (indicating that OLZ therapy was more effective at lesser cost) was 96.4%.

Conclusions: OLZ displayed significant cost and effectiveness advantages for treatment of schizophrenia in comparison with HAL over one year from an intent-to-treat perspective.

TARGET AUDIENCE:

Physicians, health services researchers, pharmacists, and other providers.

REFERENCES:

1. Glazer WM, Johnstone BM: Pharmacoeconomic evaluation of antipsychotic therapy for schizophrenia. J Clin Psychiatry 1997; 58(suppl. 10):50-54.
2. Lehman AF: Evaluating outcomes of treatments for persons with psychotic disorders. J Clin Psychiatry 1996; 57(suppl. 11):61-67.

Poster 135 **Monday, October 5 10:00 a.m.-11:30 a.m.**

WEIGHT GAIN ASSOCIATED WITH CONVENTIONAL AND NEWER ANTIPSYCHOTICS: A META-ANALYSIS

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SUMMARY:

Objective: To estimate and compare the effects of both conventional and newer antipsychotics on body weight.

Method: A comprehensive literature search identified 78 studies that included data on weight change in patients treated with a specific antipsychotic. For each agent a meta-analysis and random effects regression estimated the change in weight at ten weeks of treatment.

Results: Except for molindone, antipsychotic treatment was associated with a weight gain. Placebo was associated with a weight reduction (mean 1.68 kg). Among conventional agents, thioridazine was associated with the greatest weight increase (3.25 kg). Among newer antipsychotics, mean increases were as follows: clozapine 4.46 kg, olanzapine 4.15 kg, sertindole 2.92 kg, risperidone 2.10 kg, and ziprasidone 0.87 kg ($p <$ 0.05 versus each of the former). Insufficient data were available to evaluate quetiapine.

Conclusion: Both conventional and newer antipsychotics are associated with weight gain. Among newer agents, clozapine appears to have greatest potential to induce weight gain and ziprasidone has the least. These differences among newer agents may be relevant for health risks related to obesity and for drug selection.

REFERENCES:

1. Bernstein JG: Induction of obesity by psychotropic drugs. Ann N Y Acad Sci 1987; 499:203-215.
2. Shadish WR, Haddock CK: Combining estimates of effect size, in: The handbook of research synthesis. Edited by H Cooper & LV Hedges, New York: Russell Sage 1994; 261-281.

Poster 136 **Monday, October 5 10:00 a.m.-11:30 a.m.**

THE EFFICACY OF ZIPRASIDONE IN THE TREATMENT OF AN ACUTE EXACERBATION OF SCHIZOPHRENIA OR SCHIZOAFFECTIVE DISORDER

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cinnati, P.O. Box 610559, 231 Bethesda Avenue, Cincinnati, OH 45267; David G. Daniel, M.D., *Clinical Studies, Limited, 6066 Leesburg Pike, 6th Floor, Falls Church, VA 22041;* Edmund P. Harrigan, M.D.; Karen R. Reeves, M.D.

SUMMARY:

Objective: To investigate the efficacy of the novel antipsychotic, ziprasidone, in the treatment of patients with an acute exacerbation of schizophrenia or schizoaffective disorder.

Method: Ziprasidone 40-160 mg/day was evaluated in four- and six-week randomized, double-blind, placebo-controlled, clinical trials.

Results: Ziprasidone 80-160 mg/day was clinically and statistically significantly more effective than placebo in improving positive symptoms. Similarly, ziprasidone 80 and 160 mg/day were clinically and statistically significantly more effective than placebo in improving negative symptoms. Significant improvements were observed with ziprasidone as early as one week after commencement of treatment. In patients with baseline MADRS score ≥14 or BPRS depression cluster score ≥18, improvements with ziprasidone 160 mg/day at six weeks and 120 mg/day at four weeks, respectively, were clinically and statistically significantly greater than with placebo. Discontinuation due to adverse events was rare. The most frequently reported adverse events associated with ziprasidone were generally mild somnolence and nausea. Notable was the very low incidence of movement disorders (including akathisia) and weight gain.

Conclusions: These results indicate that ziprasidone is effective in the treatment of positive, negative, and associated depressive symptoms of schizophrenia and schizoaffective disorder, without the attendant side-effect burden associated with neuroleptics and some of the newer antipsychotics.

REFERENCES:

1. Tandon R, Harrigan E, Zom S: Ziprasidone: a novel antipsychotic with unique pharmacology and therapeutic potential. Serotonin Res 1997; 4(3):159-177.
2. Seeger TF, Seymour PA, Schmidt AW, Zom SH et al: Ziprasidone (CP-88 059): a new antipsychotic with combined dopamine and serotonin receptor antagonist activity. Pharmacol Exp Ther 1995; 275:101-113.

Poster 137 **Monday, October 5**
10:00 a.m.-11:30 a.m.

VALIDATION OF THE BEHAVIORAL ACTIVITY RATING SCALE: A NOVEL MEASURE OF ACTIVITY IN AGITATED PATIENTS

Rachel H. Swift, M.D., *Central Research Division, Pfizer Inc, Eastern Point Road, Groton, CT 06340;* Edmund P. Harrigan, M.D., *Central Research Division, Pfizer Inc, Eastern Point Road, Groton, CT 06340;* Joseph Cappelleri, Ph.D.; David Kramer, Ph.D.

SUMMARY:

Objective: To validate the seven-point Behavioural Activity Rating Scale (BARS) used in the evaluation of the lipid-acting, intramuscular (IM) formulation of the novel antipsychotic, ziprasidone, which reduces the behavioral symptoms in patients with psychosis and acute agitation but is not profoundly sedating.

Methods: Data from a Phase III clinical trial were used.

Results: The correlation coefficients between the baseline BARS and the PANSS agitation grouping (hostility, excitement, anxiety, and tension) (0.33) and CGI-Severity (CGI-S) scores (0.40) were statistically significant (convergent validity), whereas the coefficient between the BARS and PANSS negative subscale scores (0.16) was not (divergent validity). The effect size was larger for the BARS (0.83) than for the PANSS agitation grouping (0.52) and the CGI-S (0.60) (responsiveness to treatment differences). A significant difference in BARS scores at baseline was found between two distinct populations ($P < 0.05$) (discriminant validity). Perfect inter-rater reliability and intra-rater reliability were achieved.

Conclusion: Evaluation of the BARS has shown it to be a psychometrically valid and reliable scale to objectively measure the level of activity in acutely agitated patients with psychotic disorders treated with rapid-acting IM ziprasidone.

REFERENCES:

1. Brook S, Swift RH, Harrigan EP, Tensfeldt T: The tolerability and efficacy of intramuscular ziprasidone. Eur Neuropsychopharmacol 1997; 7(Suppl 2):S215.
2. Bliwise DL, Lee KA: Development of an agitated behavior rating scale for discrete temporal observations. J Nursing Measurement 1993; 1(2):115-124.

Poster 138 **Monday, October 5**
10:00 a.m.-11:30 a.m.

A COMPARISON OF INTRAMUSCULAR ZIPRASIDONE WITH INTRAMUSCULAR HALOPERIDOL

Rachel H. Swift, M.D., *Central Research Division, Pfizer Inc., Eastern Point Road, Groton, CT 06340;* Edmund P. Harrigan, M.D., *Central Research Division, Pfizer Inc., Eastern Point Road, Groton, CT 06340;* Daniel P. Van Kammen, M.D.

SUMMARY:

Objective: To compare the tolerability of fixed-dose, IM ziprasidone with flexible-dose, IM haloperidol.

Method: In this randomized, open-label study, patients with psychotic disorder received either IM ziprasidone 20 mg/day (n = 69), 40 mg/day (n = 71), or 80 mg/day (n = 66), given qid, or IM haloperidol 10-40 mg/day (n = 100), given bid-qid (mostly bid), for three days. After IM treatment, patients received four days of oral treatment with randomized therapy (ziprasidone 40-200 mg/day, initial haloperidol dose = last IM dose).

Results: Notable was the lower incidence of EPS, dystonia, and akathisia associated with IM ziprasidone compared with IM haloperidol. Benztropine use was ≥2-fold greater with haloperidol than with any ziprasidone dose both during the IM period and at any time during the study. Tachycardia and postural hypotension were very infrequently associated with IM ziprasidone. In all three ziprasidone groups, the reduction in mean scores on the Behavioral Activity Rating Scale (BARS)™, a novel measure of agitated behavior, was more rapid than that observed with haloperidol. In all groups there was a moderate reduction in mean BPRS total score in the IM treatment period, which was maintained during the oral treatment period.

Conclusions: Based on these findings, ziprasidone shows promise as a novel IM treatment for acutely agitated patients and may have tolerability advantages over conventional rapid-acting IM antipsychotics.

REFERENCES:

1. Brook S, Swift RH, Harrigan EP, Tensfeldt T: The tolerability and efficacy of intramuscular ziprasidone. Eur Neuropsychopharmacol 1997; 7(Suppl 2):S215.
2. Tandon R, Harrigan E, Zorn S: Ziprasidone: a novel antipsychotic with unique pharmacology and therapeutic potential. J Serotonin Res 1997; 4(3):159-177.

Poster 139 **Monday, October 5**
10:00 a.m.-11:30 a.m.

INTRAMUSCULAR ZIPRASIDONE 10 MG AND 20 MG IN PATIENTS WITH PSYCHOSIS AND ACUTE AGITATION

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SUMMARY:

Objective: To evaluate the efficacy and tolerability of rapid-acting IM ziprasidone in the treatment of hospitalized patients with psychosis and acute agitation.

Methods: Two 24-h, randomized, double-blind, fixed-dose clinical trials of the rapid-acting IM formulation of the novel antipsychotic, ziprasidone, were conducted. Patients received an initial IM ziprasidone dose and, if needed, up to three subsequent doses of either 2 mg (n = 54) or 10 mg (n = 63) (up to q2 h) in one study and 2 mg (n = 38) or 20 mg (n = 41) (q4 h) in the other. Efficacy was assessed using the CGI, PANSS, and the Behavioural Activity Rating Scale (BARS)™, a novel measure of agitated behavior.

Results: Efficacy assessments demonstrated that both 10 mg and 20 mg were rapidly and significantly effective in reducing the symptoms of acute agitation compared with the 2 mg groups. A comparison of treatment effects confirmed a dose-response relationship for the 10 mg and 20 mg doses. All doses were very well tolerated. Assessments of movement disorders improved slightly between baseline and the last observation in all treatment groups. No acute dystonia was reported.

Conclusions: IM ziprasidone 10 mg and 20 mg are rapidly effective in ameliorating the symptoms of agitation associated with psychosis, without causing extreme sedation or movement disorders.

REFERENCES:

1. Brook S, Swift RH, Harrigan EP, Tensfeldt T: The tolerability and efficacy of intramuscular ziprasidone. Eur Neuropsychopharmacol 1997; 7(Suppl 2):S215.
2. Tandon R, Harrigan E, Zorn S: Ziprasidone: a novel antipsychotic with unique pharmacology and therapeutic potential. J Serotonin Res 1997; 4(3):159-177.

Poster 140 **Monday, October 5**
10:00 a.m.-11:30 a.m.

A COMPARISON OF RAPID-ACTING, INTRAMUSCULAR ZIPRASIDONE 2 MG AND 20 MG IN PATIENTS WITH PSYCHOSIS AND ACUTE AGITATION

Karen R. Reeves, M.D., *Central Research Unit, Pfizer Inc. Eastern Point Road, Groton, CT 06340;* Rachel H. Swift, M.D., *Central Research Division, Pfizer Inc, Eastern Point Road, Groton, CT 06340;* Edmund P. Harrigan, M.D.

SUMMARY:

Objective: To compare the efficacy and tolerability of fixed-dose, IM ziprasidone 2 mg (n = 38) and 20 mg (n = 41) in hospitalized patients with psychosis and acute agitation over a 24-hour period.

Method: In this randomized, double-blind study, after the initial IM dose, up to three subsequent doses could be administered a minimum of four hours apart. Assessments included the seven-point Behavioural Activity

Rating Scale (BARS)™, a novel measure of agitated behavior, the PANSS, and the CGI.

Results: The following were significantly different in favor of the 20 mg group compared with the 2 mg group: mean AUC for BARS at 2 hours and at 4 hours after the first injection; the improvement in CGI-Severity and PANSS agitation items at four hours; the CGI-Improvement score at 4 hours; and the percentage of patients classified as responders (≥2 point reduction in the BARS at 90 min). Mean Simpson-Angus, Barnes Akathisia, and AIMS scores improved slightly from baseline at the last observation in both groups. No dystonia was reported.

Conclusions: The results of this study indicate that patients with psychosis and acute agitation treated with IM ziprasidone 20 mg experienced a rapid and substantial reduction in agitation for at least 4 hours after administration and that this dose was very well tolerated, particularly with regard to movement disorders.

REFERENCES:

1. Brook S, Swift RH, Harrigan EP, Tensfeldt T: The tolerability and efficacy of intramuscular ziprasidone. Eur Neuropsychopharmacol 1997; 7(Suppl 2):S215.
2. Tandon R, Harrigan E, Zorn S: Ziprasidone: a novel antipsychotic with unique pharmacology and therapeutic potential. J Serotonin Res 1997; 4(3):159-177.

Poster 141 **Monday, October 5**
10:00 a.m.-11:30 a.m.

THE EFFICACY AND TOLERABILITY OF INTRAMUSCULAR ZIPRASIDONE VERSUS INTRAMUSCULAR HALOPERIDOL IN PATIENTS WITH ACUTE, NON-ORGANIC PSYCHOSIS

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SUMMARY:

Objective: To compare the efficacy and tolerability of the rapid-acting IM formulation of ziprasidone (n = 90) with IM haloperidol (n = 42) in the treatment of inpatients with acute, non-organic psychosis.

Method: In this seven-day, randomized, open-label study, patients received up to three days of IM treatment followed by oral therapy until the end of the study. Doses were as follows: ziprasidone 10 mg IM, followed by 5-20 mg IM 4-6 hourly (max 80 mg/day), then by oral ziprasidone 80-200 mg/day; or haloperidol 2.5 mg IM, followed by 2.5-10 mg IM 4-6 hourly (max 40 mg/day), then by oral haloperidol 10-80 mg/day.

Results: Mean BPRS improved with IM ziprasidone (−6.2) and haloperidol (−3.2). The mean IM dose at the last injection was 11.7 mg for ziprasidone and 4.6 mg for haloperidol. The incidence of movement disorders and anticholinergic use was notably lower with IM ziprasidone compared with IM haloperidol. Simpson-Angus and Barnes Akathisia scores improved with IM ziprasidone but deteriorated with haloperidol.

Conclusions: These results indicate that rapid-acting, IM ziprasidone was effective in reducing the symptoms of acute, non-organic psychosis. Moreover, ziprasidone was better tolerated than haloperidol, particularly in assessments of movement disorders.

REFERENCES:

1. Brook S, Swift R, Harrigan EP, Tensfeldt T: The tolerability and efficacy of intramuscular ziprasidone. Eur Neuropsychopharmacol 1997; 7(Suppl 2):S215.
2. Tandon R, Harrigan E, Zorn S: Ziprasidone: a novel antipsychotic with unique pharmacology and therapeutic potential. J Serotonin Res 1997; 4(3):159-177.

Poster 142 **Monday, October 5**
10:00 a.m.-11:30 a.m.

ZIPRASIDONE IN THE LONG-TERM TREATMENT OF NEGATIVE SYMPTOMS AND PREVENTION OF EXACERBATION OF SCHIZOPHRENIA

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SUMMARY:

Objective: To evaluate ziprasidone in the prevention of acute exacerbation and in long-term treatment of negative symptoms of schizophrenia in chronically ill, stable patients who had been treated with neuroleptics.

Method: This prospective, randomized, double-blind study in patients living under medical supervision compared ziprasidone 40 mg/day (n = 76), 80 mg/day (n = 72) and 160 mg/day (n = 71) with placebo (n = 75) over one year.

Results: The probability of experiencing an acute exacerbation at one year was significantly lower in the ziprasidone 40, 80, and 160 mg/day groups compared with placebo (P = 0.003, P = 0.001 and P = 0.001, respectively). Ziprasidone was associated with a clinically and statistically significant improvement in nega-

tive symptoms over the course of the study compared with placebo ($P < 0.05$). There was a small, early improvement with placebo with no change occurring after six weeks. In patients treated with ziprasidone, negative symptoms improved throughout the study. There was also a significant improvement in positive symptoms, PANSS depression factor, and GAF with ziprasidone compared with placebo. The tolerability of ziprasidone was excellent. Mean changes in movement disorder assessment scale scores with ziprasidone were indistinguishable from placebo. Ziprasidone was not associated with weight gain.

Conclusion: This study demonstrated that ziprasidone provides long-term improvement in negative symptoms, is effective in preventing acute exacerbation of schizophrenia, is very well tolerated, and improves global functioning.

REFERENCES:

1. Tandon R, Harrigan E, Zorn S: Ziprasidone: a novel antipsychotic with unique pharmacology and therapeutic potential. J Serotonin Res 1997; 4(3):159-177.
2. Reeves K, Harrigan EP: The efficacy and safety of two fixed doses of ziprasidone in schizophrenia. Eur Psychiatry 1996; 11(4):422S.

Poster 143 **Monday, October 5**
10:00 a.m.-11:30 a.m.

RISPERIDONE USE IN A COMMUNITY DAY-TREATMENT PROGRAM

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SUMMARY:

The efficacy and safety of once-daily risperidone were assessed in a retrospective study of 27 patients with a variety of psychiatric disorders who were attending a community day-treatment program. Their diagnoses included schizophrenia (14), bipolar disorder (5), schizoaffective disorder (4), major depression with psychosis (3), and post-traumatic stress disorder (1). The 27 patients were 15 women and 12 men; mean age 48 years, range 23-71 years; and mean duration of illness 18.4 years, range 4-47 years. They have received once-daily risperidone for a mean of 18.5 months (range 8-36 months). Most required doses of 1 to 6 mg/day of risperidone; however, a few patients, including severely chronic schizophrenics who were heavy smokers or alcohol abusers, received up to 16 mg/day without any significant side effects. According to the patients' perception, improvement was profound in 2, moderate in 16, mild in 8, and 1 reported no improvement. It is concluded that once-daily risperidone was effective, safe, and well tolerated over an extended period in a community setting.

TARGET AUDIENCE:

Psychiatrists, psychologists, nurse clinicians, and social workers.

REFERENCES:

1. Marder SR, Meibach RC: Risperidone in the treatment of schizophrenia. Am J Psychiatry 1994; 151:825-35.
2. Borison RL: Recent advances in the pharmacotherapy of schizophrenia. Harvard Rev Psychiatry 1997; 4:255-71.

Poster 144 **Withdrawn**

Poster 145 **Monday, October 5**
10:00 a.m.-11:30 a.m.

THE IMPACT OF RISPERIDONE ON SECLUSION AND RESTRAINTS AT A STATE PSYCHIATRIC HOSPITAL

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SUMMARY:

The impact of risperidone on seclusion and restraints was studied at a state hospital among patients who received risperidone for at least one month and who had experienced either of these interventions one or more times during the year before risperidone was initiated. Forty-six patients (23 men and 23 women; 31 Caucasian, 15 African American; schizophrenia or schizoaffective diagnoses mainly, few bipolar) were included; 28 patients experienced seclusion only, 11 restraints only, and seven both. The mean dose of risperidone was 5.8 mg/day. During the year after risperidone was initiated, the average number of seclusion incidents decreased by more than 50% (from 4.0 to 1.8, $p < 0.02$), as did the number of hours spent in seclusion (11.6 to 5.6, $p < 0.001$) and the number of restraint incidents decreased more than three-fold (from seven to two, $p < 0.01$). The numbers of hours spent in restraint also decreased, but the difference was not statistically significant. Hospital privileges doubled after risperidone was started ($p < 0.01$). There were no statistically significant changes in the use of p.r.n. medications after risperidone treatment.

The results indicate that risperidone may prove particularly useful for difficult-to-treat patients and may significantly improve their morale and quality of life.

TARGET AUDIENCE:

Psychiatrists, psychologist, nurse clinicians, and social workers.

REFERENCES:

1. Buckley PF, Ibrahim ZY, Singer B, et al: Aggression and schizophrenia: efficacy of risperidone. J Am Acad Psychiatry Law 1997; 25:173-81.
2. Czobor P, Volavka J, Meibach RC: Effects of risperidone on hostility in schizophrenia. J Clin Psychopharmacol 1995; 15:243-49.

Poster 146 **Monday, October 5**
10:00 a.m.-11:30 a.m.

OUTCOMES AFTER SCHIZOPHRENIA RELAPSE: FINDINGS FROM A PROSPECTIVE 684 PATIENT COHORT

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SUMMARY:

Patients suffering relapse, defined by clinical and service-need parameters, were prospectively enrolled at 21 sites and followed for one year while receiving "natural" community care. Interviews at four, eight, and 12 months recorded clinical status and quality of life, while treatment patterns were obtained through verified primary records of all types of psychiatric service use, prescribing, and dispensing.

Roughly 85% of patients completed the follow-up period. The largest diagnostic subgroups were paranoid type schizophrenia and schizoaffective disorder. Over 70% of patients had "government pay" insurance (e.g., Medicaid), 17% were V.A., and 11% were uninsured or private pay. The cohort showed ongoing improvements in both symptoms and quality of life during the year after relapse, despite the fact that over 50% required acute psychiatric rehospitalization. Rehospitalization rates and other patterns of service use were significantly and independently influenced by insurance category. Using standard national cost multipliers, total estimated psychiatric care costs exceeded $22,000 per patient. Drug therapy patterns were fragmented with characteristics such as frequent switching (range 0-10 switches), simultaneous antipsychotic use, and a high proportion of nonmedication days (mean 34% of days). The results of this study inform patients and providers about real-world outcomes and identify many opportunities for improving quality of care.

TARGET AUDIENCE:

Psychiatrists, psychologists, nurse clinicians, and social workers.

REFERENCES:

1. Kay SR, Fiszbein A, Opler LA: The positive and negative syndrome scale (PANSS) for schizophrenia. Schizophr Bull 1987; 13:261-276.
2. Ware JE, Sherbourne CD: The MOS 36-item short-form health survey (SF-36): framework and item selection. Med Care 1992; 30:473-83.

Poster 147 **Monday, October 5**
10:00 a.m.-11:30 a.m.

USE OF HEALTHCARE RESOURCE BY PATIENTS WITH RISPERIDONE AND OTHER ANTIPSYCHOTIC AGENTS

Luella M, Engelhart, M.A., *Manager, Outcomes Research, Janssen Pharmaceutica and Research Foundation, 1125 Trenton-Harbourton Road, Titusville, NJ 08560;* Frank D. Gianfrancesco, Ph.D., *President, HECON Associates, Inc., 15717 Crebs Broad Way, #202-B, Rockville, MD 20855;* Ramy A. Mahmoud, M.D., M.P.H.; Ruey-hua Wang, M.S.; Michael Durkin, M.S.

SUMMARY:

Data for a large U.S. managed care plan were analyzed to determine the health care costs incurred by that plan in association with risperidone relative to other antipsychotic agents, risperidone is a novel antipsychotic believed to be superior to conventional neuroleptics in reducing the symptoms of schizophrenia and other psychoses while producing fewer side effects. Although risperidone's drug acquisition cost is higher than generic antipsychotics, there is a growing body of evidence that these higher costs are more than offset by savings from reduced use of other health care resources. This comparative cost analysis, covering the years 1993-1996, focused on the 219 risperidone users within the plan with schizophrenic disorders, affective psychoses or other psychoses who had at least 60 days supply of the agent.

Two different approaches were used to measure risperidone's marginal effects on health resource use. Multivariate regression models were estimated to compare health care levels of the risperidone sample to those of a control group (906 individuals) using other antipsychotic agents. Models controlled for type and severity of psychosis, treatment period length, age, sex, coverage type and secular price and utilization trends. Compari-

sons were also made within the risperidone sample where health care levels during treatment with risperidone were contrasted to levels during treatment with other agents. Health care levels were trend adjusted to account for different calendar periods.

While antipsychotic drug costs were $1,152 higher per treated member per year under risperidone, other mental health care costs were $2,160 or $2,544 lower depending on analytic method.

REFERENCES:

1. Albright PS, Livingstone S, Keegan DL, et al: Reduction of healthcare resource utilization and costs following the use of risperidone for patients with schizophrenia previously treated with standard antipsychotic therapy. Clinical Pharmacoeconomics 1996; 11:289-298.
2. Viale G, Mechling L, Maislin G, et al: Impact of risperidone on the use of mental health care resources. Psychiatric Services 1997; 48:1153-1159.

Poster 148 **Monday, October 5**
10:00 a.m.-11:30 a.m.

HIGHER COST OF OLANZAPINE COMPARED TO RISPERIDONE IN ACUTE PSYCHOTIC RELAPSE

Henry A. Nasrallah, M.D., *Professor of Psychiatry and Neurology, University of Mississippi Medical Center, 1500 East Woodrow Wilson Drive, Jackson, MS 39216;* Yui-Chung Chan; Nicholas A. Votolato

SUMMARY:

Introduction: The superior safety and broader efficacy of the atypical antipsychotics have made them the first-line choice for managing psychotic relapses. Although costlier than conventional neuroleptics, atypical antipsychotics reduce the overall costs of disease management in chronic schizophrenia. But how do the first-line atypical antipsychotics (risperidone and olanzapine) compare in terms of pharmacy costs during acute inpatient management of relapsed schizophrenia? Here, we report data on this issue.

Methods: A thorough retrospective review of the first 49 patients receiving olanzapine in a university inpatient facility was compared with all patients in the proceeding year (64 patients) receiving risperidone. Patient charts were carefully reviewed for diagnosis, clinical improvement, side effects, concurrent medications, length of stay, dose, and the total cost to the institution of the agents in each group. Only patients with a definite diagnosis of schizophrenia or schizoaffective disorder were included in the analysis.

Results: The risperidone-treated patients had a mean final dose of 5.98 mg versus 14.02 mg for the olanzapine-treated group. The mean length of hospital stay was 17.30 days for risperidone patients versus 17.47 days for the olanzapine patients. Sixty-seven percent of the risperidone patients improved versus 70% of olanzapine patients. As for the drug costs during the inpatient period, the risperidone group costs was $71.80 per patient but much higher ($238.90 per patient) in the olanzapine-treated group.

Conclusion: Although there was similar improvement in both groups of patients in this study, the costs of antipsychotic medication were significantly higher in the olanzapine group. Additional controlled studies are needed to clarify this pharmacoeconomic difference. Implications will be discussed.

TARGET AUDIENCE:

Psychiatrists, psychologists, nurse clinicians, and social workers.

REFERENCES:

1. Davies L, Drummond M: Economics and schizophrenia: the real costs. British Journal of Psychiatry, 1994; 165(suppl 25):18-20.
2. Albright P, et al: Reduction of healthcare resource utilization and costs following the use of risperidone for patients with schizophrenia previously treated with standard antipsychotic therapy: a retrospective analysis using the Saskatchewan Health linkable database. Clinical Drug Investigation 1996; 11:289-299.

Poster 149 **Monday, October 5**
10:00 a.m.-11:30 a.m.

DURATION OF SSRI THERAPY: A CONSISTENT PATTERN

David S. Hutchins, M.B.A., M.H.S.A., *Researcher, Value Development Department, PCS Health Systems, Inc., 9501 East Shea Boulevard, MC-034, Scottsdale, AZ 85260;* Catherine Melfi, Ph.D.; William Signa, B.S.; Christopher H. Young, Ph.D.

SUMMARY:

Objective: This retrospective study examines the sensitivity to a variety of therapy duration measures for the relative rankings among fluoxetine, paroxetine, and sertraline.

Method: Prescription claims records were used to: (1) create cohorts of fluoxetine, paroxetine, or sertraline patients, (2) differentiate initiators (n = 21,480, no prior antidepressant use) from all patients (n = 128,046), and (3) produce duration measures. The duration measures included continuous days, persistent days, number of

refills, medication possession ratio, continuous compliant months, compliant months, and refill months.

Results: Relative to paroxetine or sertraline patients, fluoxetine initiators had significantly more continuous days, more persistent days, greater number of refills, larger medication possession ratios, more continuous compliant months, more compliant months, and more refill months. Sertraline initiators experienced longer durations of therapy than paroxetine initiators on all measures. Findings for all patients were qualitatively the same as for initiators, although existing differences were larger in magnitude. Duration differences among the fluoxetine, paroxetine, and sertraline cohorts became evident within the first 30 days of therapy (or prior to the first refill).

Conclusions: Fluoxetine patients experienced longer therapy duration than sertraline or paroxetine patients. This result is robust across a variety of different duration measures.

TARGET AUDIENCE:

Psychiatrists, and mental health facility administrators.

REFERENCES:

1. Depression Guideline Panel: Depression in primary care: volume 1. Detection and diagnosis. Clinical practice guideline, number 5. Rockville (MD): Dept. of Health and Human Services (US), Public Health Service, Agency for Health Care Policy and Research; 1993 Apr. AHCPR Publication No. 93-0550.
2. Katon W, VonKorff M, Lin E, Bush T, Ormel J: Adequacy and duration of antidepressant treatment in primary care. *Med Care* 1992; 30(suppl):67-76.

Poster 150 **Monday, October 5**
10:00 a.m.-11:30 a.m.

A RANDOMIZED, DOUBLE-BLIND PILOT STUDY CONTRASTING NEGATIVE SYMPTOMS AND FUNCTIONING IN SCHIZOPHRENIC PATIENTS TREATED WITH OLANZAPINE AND RISPERIDONE

Douglas R. Dolnak, D.O., *Senior Fellow, Department of Psychiatry, University of California at San Diego, 8950 Villa La Jolla Drive, #2243, La Jolla, CA 92037-0985;* Mark H. Rapaport, M.D.

SUMMARY:

One area of antipsychotic research that seems to be missing is systematic studies of the effects of antipsychotic medication on social and occupational functioning (Green, 1996). There is even less work investigating potential relationships between clinical factors (positive and negative symptoms) and functioning. This proposal gathers pilot data comparing and contrasting the effects of olanzapine and risperidone on functioning and investigates the correlations between changes in negative symptoms and functioning. We hypothesized that olanzapine would have superior efficacy against negative symptoms and functioning compared with risperidone.

Patients were 18-65 years of age, medically stable, and had a DSM-IV diagnosis of schizophrenia. Patients received a structured, clinical interview for DSM-IV, physical examination, and laboratory tests. Patients were seen once a week for the first month, then every two weeks for the second month. Efficacy and adverse events assessments were obtained at every visit. Functioning assessments, (Scale of Functioning-SOF) were obtained at baseline and final visits.

Other ratings did not demonstrate significant differences between the two groups and will be presented in the poster. A Pearson correlation will be used to assess the correlation between community functioning and negative symptoms at baseline.

REFERENCES:

1. Green MF: What are the functional consequences of neurocognitive deficits in schizophrenia? Am J Psychiatry 1996; 153:321-330.
2. Rapaport MH, Bazzetta J, McAdams LA: Validation of the Scale of Functioning in older outpatients with schizophrenia. American Journal of Geriatric Psychiatry 1996; 4:218-228.

Poster 151 **Monday, October 5**
10:00 a.m.-11:30 a.m.

A MULTINATIONAL SURVEY OF PATIENT SATISFACTION WITH LONG-TERM QUETIAPINE FUMARATE TREATMENT

Paul P. Yeung, M.D., M.P.H., *Medical Research and Communications Group, Zeneca Pharmaceuticals, 1800 Concord Pike, Wilmington, DE 19850;* Amir H. Kalali, M.D., *Central Nervous System Research Department, University of California at Irvine, 10201 Wateridge Circle, San Diego, CA 92121;* Johnathan S.E. Hellewell, M.D.; Sue Langham, Ph.D.

SUMMARY:

Patients' satisfaction with antipsychotic treatment is likely to be related to their experience of drug-related side effects; a negative subjective response to treatment can lead to non-compliance and less favorable outcomes. Quetiapine fumarate; a recently approved antipsychotic, is effective in treating the positive and negative symptoms of psychosis, is well tolerated, and does not differ

from placebo in the incidence of extrapyramidal symptoms (EPS) or elevations of plasma prolactin. The aim of this study was to assess patients' subjective experience of and satisfaction with quetiapine.

A seven-item questionnaire, designed to investigate patients' satisfaction with and acceptability of long-term treatment, was administered to the study population. The sample represents a cohort of patients who had been judged by investigators to benefit from entry into open-label trials of quetiapine. All patients had completed initial comparative trials and had been on quetiapine for at least six months. The study was noncomparative, nonrandomized and was not case controlled. Results are presented on 129 patients with a mean age of 51 years (range 18-19), 69 (53%) were males and 60 (47%) were females, and the mean duration of treatment was 20 months (range 6-47). The incidence of subjectively reported side effects was very low: 74% of patients reported no side effects and 23% reported only mild side effects. Other findings: 76% of patients were very or extremely satisfied with their treatment; 67% of the sample stated that there was nothing about quetiapine that they disliked; 97% of patients reported that they preferred quetiapine to previous medications; 98% of patients stated they would like to continue with quetiapine. The most common reasons given by patients for why they liked quetiapine was that it had few or no side effects and that it helped them relax and feel better in general. The majority of patients considered quetiapine to be better than previous antipsychotic medications. These results indicate a very high rate of satisfaction with and acceptability of quetiapine among the study population. This study suggests that patients not only value the efficacy and tolerability attributes of quetiapine, but also its long-term impact on their quality of life.

REFERENCES:

1. Arvanitis LA, Miller BG: The Seroquel trial 13 study group: multiple fixed doses of "Seroquel" (quetiapine) in patients with acute exacerbation of schizophrenia: a comparison with haloperidol and placebo. Biol Psychiatry 1997; 42:233-246.
2. Hirsch SR, Link CGG, Goldstein JM, Arvanitis LA: ICI 204,636: a new atypical antipsychotic drug. Br J Psychiatry 1998; 168 (suppl. 29):45-56.

Poster 152 **Monday, October 5**
10:00 a.m.-11:30 a.m.

SAFETY AND TOLERABILITY OF SWITCHING FROM CONVENTIONAL ANTIPSYCHOTIC THERAPY TO QUETIAPINE FUMARATE FOLLOWED BY ABRUPT WITHDRAWAL

Jeffrey M. Goldstein, Ph.D., *Medical Research and Communications Group, Zeneca Pharmaceuticals, 1800 Concorde Pike, Wilmington, DE 19850;* Lisa A. Arvanitis, M.D., *Senior Director, Medical Research and Communications Group, Zeneca Pharmaceuticals, 1800 Concord Pike, Wilmington, DE 19850;* Per T. Thyrum, M.D., Ph.D.; Chiao Yeh, Ph.D.

SUMMARY:

Switching from one antipsychotic therapy to another can lead to uncomfortable side effects, such as anticholinergic withdrawal, and an increase in psychosis. Quetiapine fumarate, a promising new atypical antipsychotic agent, is effective in treating the positive and negative symptoms of schizophrenia and has a favorable safety profile. This trial assessed the safety of abruptly switching from conventional antipsychotics to quetiapine and subsequent abrupt withdrawal of quetiapine. Fifty men or women between the ages of 18 and 60 with selected psychotic disorders were entered. Patients were in clinical remission for six months and had received one of the following antipsychotic therapies for at least one month: 1) haloperidol, 5 to 30 mg/day; 2) haloperidol, 5 to 30 mg/day plus an anticholinergic: 3) risperidone, 4 to 10 mg/day; or 4) thioridazine, 200 to 600 mg/day. At least 12 patients were recruited for each group. Prior antipsychotic therapy was continued until Trial Day 4, when it was abrupdy replaced with quetiapine (unblinded switch), titrated to 300 mg bid by Day 15 and maintained for at least 16 days before randomization (double blind) to abrupt discontinuation or maintenance of therapy. Safety assessments included the UKU Side Effect Rating Scale, Simpson-Angus Scale, and Abnormal Involuntary Movement Scale. Psychiatric assessment included BPRS and CGI. Abrupt switching from any of the four antipsychotic therapies to quetiapine was generally well tolerated, and patients remained clinically stable following switching with no change in mean BPRS and CGI scores. Only two (4%) of the patients had psychotic relapse. Most of the side effects were recognized effects of quetiapine titration. The abrupt withdrawal of quetiapine was also not associated with clinically important nonpsychiatric side effects. The results suggest that psychotic patients can be safely switched to quetiapine from conventional antipsychotic therapies and that quetiapine therapy can be safely discontinued when necessary.

REFERENCES:

1. Arvanitis LA, Miller BG: The Seroquel trial 13 study group: multiple fixed doses of "Seroquel" (quetiapine) in patients with acute exacerbation of schizophrenia: a comparison with haloperidol and placebo. Biol Psychiatry 1997; 42:233-246.
2. Hirsch SR, Link CGG, Goldstein JM, Arvanitis LA: ICI 204,636: a new atypical antipsychotic drug. Br J Psychiatry 1996; 168 (suppl. 29):45-56.

Poster 153 **Monday, October 5**
10:00 a.m.-11:30 a.m.

CLINICAL EXPERIENCE OF RISPERIDONE IN THE TREATMENT OF CHINESE PATIENTS WITH SCHIZOPHRENIA

Wei-Chung Mao, M.D., *Department of Psychiatry, Cheng-Hsin Medical Center, 45 Cheng-Hsin Street, Taipei 112, Taiwan;* Su Tung-Ping, M.D.

SUMMARY:

Introduction: The efficacy of risperidone has not been previously studied in a Chinese patient population. The aims of this open trial are to assess the global outcome of Chinese schizophrenic patients treated with risperidone and to compare the therapeutic effect of risperidone between patients who are treatment-naive and chronically ill.

Methods: Over the past year and a half, we obtained 36 patients (M : F = 15: 21) who had completed an eight-week trial of risperidone. Mean age, age at onset, and duration of illness (SD) are 30.3 (10.2) years, 23.5 (8.5), and 6.6 (5.4), respectively. Clinical Global Impression Scale (CGI) and exprapyramidal symptoms (EPS) were assessed at baseline, fourth week, and the endpoint of the clinical trial. We also defined risperidone responders by reduction of baseline symptoms at the 20% and 50% levels.

Results: During this empirical trial, 80% of patients responded well to risperidone treatment and one-fourth of patients had at least 50% symptom reduction from those at baseline. Treatment-naive patients have more favorable response than those who were chronically ill, which stayed the same after the factors of age, age of onset, and duration of illness were corrected. Sixty percent of patients met the criteria for responder at the 20% level symptom reduction after the one-month trial. Another 20% of patients were observed to continuously improve their symptoms to reach responder criteria at the endpoint. The optimal dose of risperidone for responders is 4 ± 1.5 mg/day. In addition, concomitant use of other neuroleptics during risperidone trial may be helpful during the acute exacerbated symptom phase. Ten patients (28%) had risperidone-induced EPS but with much less severity; four patients among them complained of akathisia.

Conclusion: These results are comparable with the studies of Caucasian patients. Future study requires a double-blind, prospective, and fixed-dose design to confirm the present results and to look for the minimally effective dose of risperidone in Chinese patients with schizophrenia.

REFERENCES:

1. Marder SR, Meibach RC: Risperidone in the treatment of schizophrenia. American J Psychiatry 1994; 151:825-835.
2. Bondolf G, Dufour H, Patris M, et al: Risperidone versus clozapine in treatment-resistant chronic schizophrenia: a randomized double-blind study. Am J Psychiatry 1998; 155:499-504.

Poster 154 **Monday, October 5**
10:00 a.m.-11:30 a.m.

CLINICAL AND QUALITY-OF-LIFE SUPERIORITY OF RISIPERIDONE OVER CONVENTIONAL ANTIPSYCHOTICS UNDER USUAL CARE CONDITIONS

Charles H. Merideth, M.D., *Affiliated Research Institute, 8880 Rio San Diego, Suite 1090, San Diego, CA 92108-4503;* Ramy A. Mahmound, M.D., M.P.H., *Director of Outcomes Research, Janssen Pharmaceutica and Research Foundation, 1125 Trenton Harbourton Road, Titusville, NJ 08560;* Luella M. Engelhart, M.A.; Luis F. Ramirez, M.D.

SUMMARY:

Real-world decision makers need to understand the outcomes patients may expect under "naturalistic" conditions of usual care. These may not be accurately predicted by results obtained in the contrived setting of ordinary clinical trials of drug efficacy. The usual care setting can maximally challenge a new drug by introducing a broad array of patients, providers, and treatment practices as well as effects of insurance and cost. No atypical antipsychotic has demonstrated clinical benefit over conventional agents in a large trial of this type.

We report long-term clinical and quality-of-life outcomes from a 684-patient, multi-center, prospective, randomized, effectiveness trial of the decision to treat with risperidone (RIS) versus conventional (CON) antipsychotics after relapse. Patients were followed for one year with minimal protocol-induced interference in psychiatric care to best approximate the "natural" conditions faced by decision makers.

Despite a surprising magnitude of no-drug intervals and homogenization of drug therapy, both of which would be expected to minimize differences between treatment arms, patients randomized to RIS had statistically superior PANSS (total, general psychopathology, positive, and negative symptoms), Barnes Akathisia, Simpson-Angus EPS, and mental quality-of-life scores (SF-36 MCS) when compared with CON patients over one year. The QOLI (Lehman) and SF-36 physical scale showed no difference.

TARGET AUDIENCE:

Psychiatrists, psychologists, nurse clinicians, and social workers.

REFERENCES:

1. Marder SR, Meibach RC: Risperidone in the treatment of schizophrenia. Am J Psychiatry 1994; 151:825-35.
2. Borison RL: Recent advances in the pharmacotherapy of schizophrenia. Harvard Rev Psychiatry 1997; 4:255-71.

Poster 155 **Monday, October 5**
10:00 a.m.-11:30 a.m.

WEIGHT GAIN ASSOCIATED WITH ATYPICAL ANTIPSYCHOTIC MEDICATIONS

Rohan Ganguli, M.D., *Professor of Psychiatry and Pathology, Department of Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213-2593;* Jaspreet S. Brar, M.D., M.P.H.: Zenia Ayrton, B.S.

SUMMARY:

Weight gain is a frequent consequence of treatment with antipsychotic medications and may be pronounced with clozapine use. In order to determine whether atypical antipsychotics have any advantage with respect to weight gain, we compared two cohorts of patients with DSM-IV schizophrenia who had just started treatment with either risperidone or olanzapine. Data regarding weight gain were culled from existing records of 100 patients (50 patients in each treatment group). Body weight and body mass index (BMI = weight (kg) ÷ height (meters squared) at the time of starting the new medication (baseline) was compared with the body weight and BMI following four to six months of treatment with the same medication. There were no significant changes in body weight (baseline = 83.1 kg ± 20.5, follow-up = 82.8 kg ± 19.9) or BMI (baseline = 29.6 ± 9.4, follow-up = 29.5 ± 9.1) in the group treated with risperidone. However, there were statistically significant increases in both body weight (baseline = 84.9 kg ± 25.0, follow-up = 87.1 kg ± 25.1; matched pair $t = 4.62$, $p < 0.001$) and BMI (baseline = 29.5 ± 7.4, follow-up = 30.3 ± 7.5; matched pair $t = 4.43$, $p < 0.001$) in the group treated with olanzapine. In this sample, treatment with risperidone was not associated with weight gain.

TARGET AUDIENCE:

Psychiatrists, and social workers.

REFERENCES:

1. Owens DG: Adverse effects of antipsychotic agents: do newer agents offer advantages? Drugs 1996; 51:895-930.
2. Beasley CM, Hamilton SH, Crawford AM, et al: Olanzapine versus haloperidol: acute phase results of the international double-blind olanzapine trial. European Neuropsychopharmacology 1997; 7:125-137.

Poster 156 **Monday, October 5**
10:00 a.m.-11:30 a.m.

MIRTAZAPINE VERSUS FLUOXETINE: EFFICACY ON SYMPTOMS ASSOCIATED WITH DEPRESSION

Charlotte Kremer, M.D., *Department of Medical Services, Organon Inc., 375 Mount Pleasant Avenue, West Orange, NJ 07052*

SUMMARY:

Aim: To compare the efficacy of mirtazapine and fluoxetine on depressed mood, as well as on anxiety, sleep, and retardation symptoms in depressed in patients and outpatients.

Methods: Patients with a major depressive episode (DSM-III-R), a baseline score of ≥ 21 on the 17-item HAMD, and ≥ 2 on depressed mood item, were randomized to a six-week treatment with either mirtazapine (n = 66; 15-60 mg/day) or fluoxetine (n = 67; 20-40 mg/day). Changes from baseline in depressed mood were assessed by item 1 ('depressed mood') of the HAMD, while anxiety disturbances, sleep disturbances, and retardation symptoms were respectively assessed by anxiety/somatization, sleep disturbance, and retardation factors of the HAMD. The efficacy analyses were performed on the Intent-to-Treat Group using the Last Observation Carried Forward method.

Results: On all efficacy variables treatment with mirtazapine has resulted in a larger magnitude of change from baseline than treatment with fluoxetine. During the first two weeks of treatment, the largest magnitude of change was observed in the anxiety/somatization and sleep disturbance factors. The changes in the "depressed mood" and the retardation factor were similar in both groups. From week two onward changes favoring mirtazapine were particularly prominent in the "depressed mood" item and retardation factor. The difference on the "depressed mood" item favoring mirtazapine reached statistical significance at week 4.

Conclusion: The results demonstrate that treatment with mirtazapine is superior to fluoxetine in improving

depressed mood. Pharmacological properties of mirtazapine, especially its specific actions on postsynaptic 5-HT receptors, may account for the consistent improvements in anxiety and sleep disturbances throughout the treatment period.

Poster 157 **Monday, October 5**
10:00 a.m.-11:30 a.m.

TOLERABILITY OF MIRTAZAPINE IN 15 MG VERSUS 30 MG INITIAL DOSE: A RANDOMIZED, DOUBLE-BLIND STUDY

Charlotte Kremer, M.D., *Department of Medical Services, Organon Inc., 375 Mount Pleasant Avenue, West Orange, NJ 07052;* Jon T.H. Helsdingen, M.D., *Department of MSD, NV Organon, Molenstraat 110, Oss 5340BH, The Netherlands;* Adjm Sitsen, M.D.

SUMMARY:

Objective: To assess the tolerability of two different initial doses of mirtazapine, outpatients with a DSM-IV diagnosis of a major depressive episode were randomly assigned to an ascending dosage regimen (n = 71; mirtazapine 15 mg for one week, followed by 30 mg for one week) or a fixed dosage regimen (n = 69, 30 mg for two weeks).

Methods: Tolerability was assessed by recording of adverse events (AEs), and using the computer-assisted interactive telephone system for daily ratings on the VAMRS scale, with "Alert/drowsy" factor as an index of a day-time sedation. Efficacy was assessed by the 17-HAMD and CGI, and effects on sleep by self ratings on the LSEQ, using the same computer-assisted system.

Results: Tolerability of both treatments was good. A total of three patients in each treatment group dropped-out; respectively, one and two patients because of adverse events. During the first treatment week, AEs were reported with a similar incidence in both groups: somnolence by 9.9% of patients in the 15 mg group and by 10.1% in the 30 mg group; respective values for dizziness were 4.2% and 8.7%. On the "Alert/drowsy" factor a similar level of a day-time sedation was registered in both groups after the first dose of study medication, with subsequent immediate increase in alertness to baseline values and approx. at day 10, to the level of "normal" state. In both groups the 17-HAMD scores decreased similarly at endpoint (-9.5 ± 5.9 and $-10.9 \pm 6,5$). On the LSEQ, 30 mg initial dose of mirtazapine was related to a statistically significantly longer duration of sleep at weeks 1 and 2, and to a significantly faster initiation of sleep at week 2.

Conclusion: There are no differences in tolerability of mirtazapine administered in initial doses of 15 or 30 mg, and both dosage regimens are well tolerated. The results on the LSEQ were in favor of the initial dose of 30 mg, with respect to onset and duration of sleep.

Symposium 1 **Friday, October 2**
8:30 a.m.-11:30 a.m.

THE CHALLENGE OF PSYCHIATRIC DIAGNOSIS IN PERSONS WITH DEVELOPMENTAL DISABILITIES

APA Consortium on Treatment Issues and the American Association on Mental Retardation

Richard J. Kessler, D.O., *Medical Director, Adult and Children with Learning Disabilities, Diagnosis and Treatment Center, 807 South Oyster Bay Road, Bethpage, NY 11714*; Leslie Rubin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to diagnose psychiatric disorders in persons with developmental disabilities.

SUMMARY:

Psychiatric disorders are overrepresented in persons with developmental disabilities. Yet significant, recurrent diagnostic problems bedevil the field. Some are related to characteristics of the population, such as their cognitive limitations and complicated medical problems, while others are connected to the diagnosticians themselves. Psychiatrists often are unfamiliar with this population, lack the needed developmental perspective, and fall prey to biases such as diagnostic overshadowing. Still other problems are caused by the relative inapplicability of our standard diagnostic criteria. Because an interdisciplinary team is often crucial in the evaluation and management of psychiatric disorders in this population, this symposium offers contributions from four different perspectives: psychology, neurology, developmental pediatrics and psychiatry. Each clinician will focus on a particular diagnostic problem germaine to his area of expertise respectively: (1) communication problems presenting as behavioral disturbance, (2) differentiating seizures from pseudoseizures, (3) medical problems presenting as psychiatric symptoms and (4) diagnosing schizophrenia.

TARGET AUDIENCE:

All health professionals.

No. 1A
COMMUNICATIVE FUNCTIONS AND BEHAVIORAL DIAGNOSIS

Daniel B. Crimmins, Ph.D., *Director, Department of Psychology, New York Medical College, 324 Cedarwood Hall, Valhalla, NY 10595*

SUMMARY:

Individuals with developmental disabilities clearly have the capacity to communicate their thoughts, feelings and reactions to the range of potentially distressing situations. Some are highly effective in this regard and are clearly understood by others. Many, however, use either idiosyncratic or ineffective means of communicating with others, at times resorting to problematic behaviors as a way of conveying distress. Unfortunately, this results in frustration for all involved. This presentation will focus on the relationship of behavior and communication, examining the reciprocal influences between individuals with developmental disabilities and those providing support to that person. This presentation will offer participants: (1) a perspective on behaviors as a means of communication, (2) potential strategies for assessing the function of behavior in social contexts, and (3) recommendations for support providers in teaching an individual to use more efficient and effective means of influencing others.

No. 1B
PRESENTATION OF COMMON MEDICAL PROBLEMS

Leslie Rubin, M.D., *Director, Division of Developmental Pediatrics, Emory University School of Medicine, The Marcus Center, 1605 Chantilly Drive, Suite 150, Atlanta, GA 30324*

SUMMARY:

Individuals with developmental disabilities often have a set of complex and chronic health-related problems. This likelihood is increased with increasing severity of the underlying pathology. One of the complicating features that challenges clinicians is that the individuals who have developmental disabilities may be unable to communicate as part of their set of problems. This makes taking a clinical history difficult and complicates the picture by the fact that the individuals may not remember their medical history. As clinical diagnoses of medical problems is dependent on obtaining a good oral history from the patient, it becomes critically important to appreciate the common medical problems that affect individuals with developmental disabilities, and it is equally important to be aware of and recognize how the symptoms may present. This presentation will provide an outline of the common medical problems associated with developmental disabilities and how these conditions may present.

No. 1C
SEIZURES AND PSEUDOSEIZURES: DIAGNOSIS AND MANAGEMENT

Norberto Alvarez, M.D., *Medical Director and Neurologist, Wrentham Developmental Center, Emerald Street, Wrentham, MA 02093*

SUMMARY:

Epileptic seizures are frequently seen in persons with developmental disabilities. Effective therapies are available whose benefits, despite side effects, have significant quality-of-life consequences. These medications are poorly effective when used to treat seizure-like behaviors (pseudoseizures). In these circumstances the negative effects of the medication outweigh any benefits. The educational objectives of this presentation are: (1) definition of epileptic seizures and pseudoseizures, (2) differential diagnosis of epileptic seizures, (3) differential diagnosis of pseudoseizures, (4) epidemiology of pseudoseizures, (5) diagnostic methods used in differential diagnosis, (6) case presentations.

Participants should be able to recognize the magnitude and importance of the problem of pseudoseizures in general and in persons with developmental disabilities in particular. The participant will become familiar with different methods available to document the diagnosis of pseudoseizures as well as their usefulness and limitations. Cases from personal experience will be discussed to document the problems encountered with these patients.

No. 1D
DIAGNOSING SCHIZOPHRENIA

Richard J. Kessler, D.O., *Medical Director, Adult and Children with Learning Disabilities, Diagnosis and Treatment Center, 807 South Oyster Bay Road, Bethpage, NY 11714*

SUMMARY:

Schizophrenia and atypical psychosis are perhaps the most overdiagnosed disorders in developmentally disabled persons, and neuroleptics are clearly the most overprescribed drugs. All the usual diagnostic difficulties with this population come into play, but problems in self-reflection and the reporting of subjective experience present a special obstacle when it comes to diagnosing schizophrenia. This presentation will briefly review the historical association between schizophrenia and mental retardation and suggest general diagnostic principles and strategies. Particular attention will be paid to differentiating schizophrenia from mania, delusional disorder, chronic PTSD, autism, and regressive and primitive behaviors. Case examples of patients with a variety of levels of intellectual functioning will be provided as will caveats for treatment with antipsychotic agents.

REFERENCES:

1. Bailey JS, Pyles DA: Behavioral diagnostics, in the treatment of severe behavior disorders. Edited by Cipani E. Washington: American Association on Mental Retardation, 1989.
2. Rogers P, Coleman M: Medical Care in Down Syndrome, Marcel Dekker, 1992.
3. Ramchandani D: Evaluation of pseudoseizures: a psychiatric perspective. Psychosomatics 1993; 34:70-79.

Symposium 2 **Friday, October 2**
8:30 a.m.-11:30 a.m.

TREATMENT OF DUAL DIAGNOSIS IN PUBLIC MANAGED CARE

Kenneth Minkoff, M.D., *Medical Director, Choate Health Management, and Medical Director, Arbour-Fuller Hospital, 92 Montvale Avenue, Suite 3200, Stoneham, MA 02180*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to demonstrate familiarity with national standards, practice guidelines, and workforce competencies for dual-diagnosis treatment under public sector managed care; to describe the basic principles of cost-effective treatment matching for dual-diagnosis patients; to identify models for subtyping individuals with comorbid disorders; to describe advantages and disadvantages of implementing integrated treatment models under public sector managed care; and to identify key factors in facilitating horizontal and vertical integration of services for people with co-occurring disorders.

SUMMARY:

Public sector managed care initiatives offer new opportunities to design integrated service systems for individuals with co-occurring psychiatric and substance use disorders, who often represent the highest utilizers of expensive acute service. Designing such services presents significant challenges, both conceptually and pragmatically, in linking models of integrated services delivery (such as continuous treatment teams) with capitated funding mechanisms and with new models for alternative "levels of care."

This symposium will present some of the latest conceptual and clinical work in this area: David Mee-Lee, M.D., a leader in the development of the ASAM Patient Placement Criteria for addictive disorders, will describe the application of these criteria in managed care settings and the development of new criteria for individuals with

comorbid disorders; Kenneth Minkoff, M.D., will present newly developed national standards and practice guidelines for dual-diagnosis treatment in managed care settings and the implementation of a public managed care dual-diagnosis case rate program; Doug Ziedonis, M.D., will discuss the implementation of a statewide plan for service integration and cost-effective treatment matching in Connecticut; Richard Ries, M.D., will present the integration of conceptual models for integrated service delivery with the delivery of dual-diagnosis services under public sector managed care in Washington; and Robert Quinlivan, L.C.S.W., will describe the implementation of integrated assertive community treatment under a new public managed care initiative in San Diego.

No. 2A
DUAL DIAGNOSIS PLACEMENT CRITERIA: THE AMERICAN SOCIETY OF ADDICTION MEDICINE'S EXPERIENCE

David Mee-Lee, M.D., *David Mee-Lee Training and Consulting, 3725 Lillard Drive, Davis, CA 95616-5071*

SUMMARY:

A workgroup on Co-Occurring Mental and Substance Use Disorders (dual diagnosis) was established November 1996, within the Coalition for National Clinical Criteria. Its goal was to develop placement criteria specific for dual-diagnosis individuals. The model used was the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition, (ASAM PPC-2). This paper discusses the dilemmas and design decisions in the process of eliciting wide input to: (1) broaden application of the ASAM PPC to dual-diagnosis individuals in the public sector, (2) elevate the importance of assessment in treatment and placement decisions, (3) clarify, modify, and develop criteria for a wide variety of dual-diagnosis individuals and severities, (4) collaborate widely to develop criteria that address individuals not only in the addiction treatment field, but also in the mental health and psychiatric fields.

The resulting approach focused on the interaction of level of care with severity and level of functioning within major diagnostic categories. Criteria describe multidimensional functioning utilizing six slightly modified assessment dimensions of the ASAM PPC: intoxication/withdrawal potential, biomedical conditions, emotional/behavioral conditions, treatment acceptance/resistance/readiness to change, relapse/continued use or problem potential, recovery environment.

No. 2B
NATIONAL STANDARDS OF CARE AND PRACTICE GUIDELINES

Kenneth Minkoff, M.D., *Medical Director, Choate Health Management, and Medical Director, Arbour-Fuller Hospital, 92 Montvale Avenue, Suite 3200, Stoneham, MA 02180*

SUMMARY:

As chair of the panel on Co-Occurring Disorders for the Center for Mental Health Services Managed Care Initiative, Dr. Minkoff will present the panel's work on developing national standards of care, practice guidelines, workforce competencies, and training curricula for dual-diagnosis treatment in public managed care systems. These materials are nearing completion and will be available for dissemination during 1998. In addition, Dr. Minkoff will discuss the application of these standards to developing models for matching treatment needs to types of intervention and service intensity, and the implementation of a pilot public managed care 65-day case rate program in Massachusetts, which demonstrated positive outcome (sober, med compliant) in nearly 50% of individuals at 90-day follow-up, for cost comparable to a single hospitalization. Finally, Dr. Minkoff will discuss the implementation of a statewide consensus-building process, jointly sponsored by mental health, substance abuse, and managed Medicaid entities, to develop model integrated service systems throughout the state.

No. 2C
THE CONNECTICUT DUAL DIAGNOSIS SERVICE SYSTEM

Douglas M. Ziedonis, M.D., *Associate Professor, Department of Psychiatry, Yale University, 34 Park Street, New Haven, CT 06525*

SUMMARY:

Few states have organized services for the dually diagnosed in the public sector. This presentation describes Connecticut's plan and implementation from a Task Force on Dual Diagnosis. The plan describes a need for continuum of care services, a model of care, a subtyping strategy, and training competencies. Connecticut has a new public managed care system dividing the state into five geographic networks. The networks provide all levels of care for mental health, dual-diagnosis, and addictions services. Their are nine dual-diagnosis subtypes based on the combination of severity of psychiatric and addiction disorders. Severity level is based on disability, disorder, and motivational level. The five CT networks provide services for all subtypes of

dually diagnosed. The model of care emphasizes the need to integrate addiction and mental health services and to value a range of approaches. Both harm reduction and abstinence goals are included in a staged manner. Dual-diagnosis training competencies and training curriculum will be described. The public sector must better manage the care of the dually diagnosed. The CT experience offers hope for both mental health and addiction staff to work together in developing a relatively unified approach to the dually diagnosed.

No. 2D
DUAL SUBTYPES AND TREATMENT MATCHING

Richard K. Ries, M.D., *Professor and Director, Outpatient Services, Department of Psychiatry, Harborview Medical Center, 325 Ninth Avenue, Box 359911, Seattle, WA 98104-2499*

SUMMARY:

There is a wide spectrum of severities for both mental illness and substance use problems. Merely identifying a patient as "dually diagnosed" does not communicate the relative severities of each problem, nor does it necessarily imply a treatment plan. This presentation will present a simple and practical method for subtyping dually diagnosed patients into several subgroups that require significantly different treatment approaches. These approaches will be outlined and data from both acute inpatient and long-term dual-disorder outpatient programs will be presented.

No. 2E
DUAL DIAGNOSIS: ASSERTIVE COMMUNITY TREATMENT IN PUBLIC SECTOR MANAGED CARE

Robert T. Quinlivan, L.C.S.W., *Director, Managed Care, Telecare Corporation, 3211 Jefferson Street, San Diego, CA 92110*

SUMMARY:

This presentation will feature a description of an assertive community treatment project operated within a public mental health managed care environment. The program, ACCESS, is funded by San Diego County Mental Health Services and is intended to serve the clients with the highest acute care costs in the public sector. The program is operated by the Telecare Corporation.

The presentation will describe the program philosophy of partnering with this group of individuals and will detail specific interventions aimed at reducing reliance on inpatient care. The presentation will focus on the major precipitants of inpatient admission, as well as efforts to treat the target population's co-occurring drug and alcohol disorders. The presentation will also describe the role of the team psychiatrist and innovative approaches to community psychiatry. Results of the project will be fully discussed and will review costs savings as well as clinical outcomes on a number of domains, including quality of life and symptomology.

REFERENCES:

1. Menolascino FA, Ruedrich SL, Golden CJ, Wilson TE: Diagnosis and pharmacotherapy of schizophrenia in the retarded. Psychopharmacology Bulletin 1985; 21:316-322.
2. McGee MD, Mee-Lee D: Rethinking patient placement: the human services matrix model for matching services to needs. J of Substance Abuse Treatment 1997; 14:141-148.
3. American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition (ASAM PPC-2), Chevy Chase, MD, 1996.
4. CMHS Managed Care Initiative—Panel on Co-Occurring Disorders Final Report. (in draft format)
5. Minkoff K: Program components of a comprehensive for seriously mentally ill patients, in New Directions for Mental Health Services, no. 50. San Francisco, Jossey-Bass, 1991, pp 13-26.
6. Ziedonis DM, Trudeau K: Motivation to quit using substances among individuals with schizophrenia: implications for a motivation-based treatment model. Schizophrenia Bulletin 1997; 23:229-238.
7. Ries RK: Clinical treatment matching models for dually diagnosed patients. Psychiatric Clinics of North America 1993; 16:167-175.
8. Ries RK, Sloan K, Miller N: Dual diagnosis: concept, diagnosis and treatment, in Current Psychiatric Therapy. Edited by Dunner D. Philadelphia: Saunders, 1997, pp. 173-180.
9. Quinlivan R: Cost savings and rehabilitation: compatible goals in for-Profit care for persons with serious mental illness? Psychiatric Services 1997; 48: 1269-1271.

Symposium 3 **Friday, October 2**
2:00 p.m.-5:00 p.m.

UPDATE: PSYCHIATRIC PATIENT EDUCATION

Therapeutic Education Association

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, Columbia, SC 29203

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe history, rationale, and methods in psychiatric patient education; describe relevant research and practice issues in psychoeducation; demonstrate importance of medication education for compliance; understand consumer perspective on education; and distinguish clinician and educator roles.

SUMMARY:

Psychiatric patient education, sometimes called psychoeducation, involves the content, process, and methods of teaching psychiatric patients/clients/consumers about their illness, its treatment, and what they can do to manage the illness and to grow toward recovery. The purpose of this symposium is to bring together several perspectives on this emerging field—psychiatrist, psychologist, pharmacist, consumer, and social worker. Presenters will provide participants information about current research in psychoeducation to draw attention to the complexities this research suggests exist in the practice of this philosophy and technique. A consumer panel member who is also a provider of education services will bring a unique perspective on the personal effects education can have, especially when delivered by another consumer. A pharmacist will discuss education about medications in relation to compliance/adherence to treatment regimens. Presenters will also give "nuts and bolts" advice on implementation of psychiatric patient education and discuss the similarities and differences between roles and functions of clinicians and educators. The symposium incorporates ample time for audience participation and discussion of issues raised by presentations of these diverse perspectives.

TARGET AUDIENCE:

Providers, consumers, and family members interested in psychiatric patient education.

No. 3A
PSYCHOEDUCATION: RESEARCH AND PRACTICE ISSUES

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, Columbia, SC 29203*

SUMMARY:

Psychiatric patient psychoeducation is both a specific intervention and a component of treatment and rehabilitation. This presentation will summarize representative controlled research that shows how specific education interventions relate to various outcome measures. The presenter will place patient psychoeducation in the context of motivational counseling and the stages of self-change. Implications for psychoeducation practice will be discussed.

No. 3B
PSYCHIATRIC PATIENT EDUCATION: WHY AND HOW

Cynthia C. Bisbee, Ph.D., *Clinical Director, Montgomery Area Mental Health Authority, 101 Coliseum Boulevard, P.O. Box 3223, Montgomery, AL 36109*

SUMMARY:

For many years, psychiatry did not educate its patients in the same way as patients with other illnesses received information about their symptoms, medications, and management of their disease. Psychiatric patient education has seen an expansion of major proportions over the past few years, spurred on by the family education movement, consumer advocacy, and JCAHO, among other forces. This presentation will give some of the history of development of this method, rationale for teaching patients, and "nuts and bolts" implementation information.

No. 3C
THE ROLE OF MEDICATION EDUCATION IN THE PATIENT-FAMILY MODEL

Maureen R. Prather, Pharm.D., *Clinical Education Consultant, U.S. Pharmaceuticals, Pfizer Inc, 3008 N. Narrows Drive, C-104, Tacoma, WA 98407*

SUMMARY:

The Patient-Family Education Model exemplifies the success of establishing a dynamic relationship between the mentally ill and their families. It provides a forum for accurate information regarding disease state and the appropriate use of medications. Multidisciplinary delivery of medication education can build a partnership matching clinical expertise with teaching expertise. This illustrates to both consumer and family the treatment team's commitment to medication education. It has been well documented that medication education provided by pharmacists has dramatically improved compliance. The impact of the novel antipsychotics on learning appears to be a direct result of the amelioration of negative symptoms in conjunction with improved side-effect profiles. Consumers are now effectively able to use the empowerment model to maximize opportunities in the

community for recovery. Aspects of care can be measured to show process and consumer satisfaction as well as clinical pathway implementation and pharmacoeconomic analysis.

No. 3D
MENTAL ILLNESS EDUCATION: A PERSONAL PERSPECTIVE

Diane McCarty, *Consumer Specialist and Personal Advocate, Central State Hospital, Powell, Building G, Milledgeville, GA 31062*

SUMMARY:

The education element was the most important part of my own recovery. Until I learned the difference between a symptom and a side effect, I could not communicate the most important parts of my illness to my doctor. After 35 years of family denial of something wrong with my brain, I had accepted my illness as a normal brain function experienced by people with mental illness. Being able to communicate symptoms, side effects, diagnosis, medications, etc., can make the difference between recovery and nonremission. To educate the full partnership (consumer, family, provider) with the same information transferred from a recovering person to one still experiencing symptoms not only educates, but gives hope as well as encouragement, which is very powerful in one's recovery. This presentation will discuss personal perspective, adapting the biopsychosocial model to all illnesses, training staff on importance of education to recovery, and the effects of mental illness education of consumers by consumers.

No. 3E
TRICKS OF THE TRADE: CLINICIAN TO EDUCATOR

Patricia L. Scheifler, M.S.W., *Director, Partnership for Recovery, P.O. Box 55053, Birmingham, AL 35255*

SUMMARY:

Clinicians are increasingly called upon to provide psychiatric patient and family education, yet clinical training leaves most of us ill prepared to be educators. This presentation will describe specific techniques to help mental health professionals become more effective in one-to-one patient and family education and in the classroom, where how we teach is nearly as important as what we teach.

REFERENCES:

1. Kemp R, Hayward P, Applewhaite G, Everitt B, David A: Compliance therapy in psychotic patients: randomized controlled trial. British Medical Journal 1996; 312:345-349.
2. Miller WR, Rollnick S: Motivational Interviewing. New York, The Guilford Press, 1991.
3. Bisbee CC: Educating Patients and Families about Mental Illness. Birmingham, AL, Partnership for Recovery, 1991, 1997.
4. Osmond H, Mullaly R, Bisbee C: The medical model and the responsible patient. Hospital and Community Psychiatry 1978; 29:522-524.
5. McCarty D: Consumers in Recovery. Presentation at the Georgia DMH/MR/SA Division Training Conference "Putting New Perspectives into Practice," Atlanta, GA, 1997.
6. Scheifler PL: Instructor's Manual, Team Care Solutions. Trenton, NJ: Eli Lilly and Company, 1997.

Symposium 4 **Friday, October 2**
2:00 p.m.-5:00 p.m.

LONG-TERM CARE FOR LONG-TERM ILLNESS

National Alliance for the Mentally Ill

Laura Lee Hall, Ph.D., *Deputy Director, Department of Research and Policy, National Alliance for the Mentally Ill, 200 N. Glebe Road, Suite 1015, Arlington, VA 22203*; Sue Davis, *National Alliance for the Mentally Ill*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium the participant should be able to understand the need for long-term care for all people with severe and persistent mental illnesses, the barriers to long-term care, the problems created by inadequate long-term care, and potential solutions to this problem.

SUMMARY:

Serious brain disorders, such as schizophrenia, are typically chronic illnesses, requiring ongoing treatment and care. For some individuals with these illnesses for whom current treatments are not fully effective and serious disability is fairly constant and enduring, structured and intensive supports are required for best quality of life possible. The symposium will present information on the personal and clinical reality of chronic, disabling mental illnesses, the barriers that prevent delivery of appropriate long-term care, and solutions to the long-term-care disaster. Family members, a clinician, and policy analysts will provide their perspectives.

No. 4A
WHY IS LONG-TERM CARE A FOUR-LETTER WORD?

Laura Lee Hall, Ph.D., *Deputy Director, Department of Research and Policy, National Alliance for the Mentally Ill, 200 N. Glebe Road, Suite 1015, Arlington, VA 22203*

SUMMARY:

It is well understood that serious brain disorders like schizophrenia are usually chronic illnesses requiring ongoing treatment and supports. Yet, the mental health system notoriously fails to meet the needs of people with these disorders, especially those individuals with the most severe and disabling conditions. After characterizing the long-term-care crisis, this presentation will describe the roadblocks to appropriate long-term care, including ideological (the lingering disbelief that chronic and disabling severe mental illness exists), scientific (the still-imperfect treatments for severe mental illnesses and absence of relevant epidemiologic, clinical, and cost data), professional (the resistance of providers to implement effective, long-term-care services), administrative (the public and private sector policy barriers), economic (the constant pressure to reduce costs), and social (continuing stigma and discrimination). Finally, the presentation will point to successful programs and consider the reasons for their success.

No. 4B
HOW THE LACK OF PROFESSIONAL SUPERVISION AND STRUCTURE IN COMMUNITY-BASED TREATMENT HAS NEGATIVELY IMPACTED THE OUTCOMES OF "THE FORGOTTEN POPULATION"

Curtis B. Flory, M.B.A., *President, Zircon Corporation Company, Inc., P.O. Box 3612, 140 Summit Street, Peabody, MA 01960-3612;* Rose Marie Friedrich, M.A., R.N.

SUMMARY:

There is growing evidence that there is a subgroup of persons with severe mental illness whose symptoms are largely untouched by current treatment or rehabilitation efforts and who may require life-long supervised living accommodations. "The forgotten population" consists of those who have the most severe, disabling, and chronic forms of mental illness. Their needs are often overlooked in the downsizing of state hospitals and in the planning and implementation of community services.

During a national study of 500 families and their ill family members, several individuals who are part of this subgroup were studied in detail. Their care was fragmented, and they moved many times over a 10-year period as a result of frequent and persistent relapses in their illness. Bob, Mary, and Sue are examples of these individuals and their case histories will be discussed. It became apparent that Bob, Mary, and Sue lacked structure in their community-based treatment. Therefore a study of community-based residences and nursing homes in Iowa and Massachusetts, which represented rural and urban environments, was undertaken. This study substantiated the premise that professional supervision and structure, key ingredients in care, are missing in smaller group homes, such as those characteristic of Massachusetts. Iowa's larger residential care facilities, which averaged 50 beds, demonstrated greater structure and professional supervision on-site. The absence of state and local recognition of the need for structured care in the community poses a major barrier to the care of "the forgotten population." Current policies stress rehabilitation and supported housing, which are attractive lower-cost alternative community-based care strategies. The econometrics of community-based care will be examined.

No. 4C
WHO'S HOME IN LONG-TERM CARE?

Jeffrey L. Geller, M.D., M.P.H., *Professor of Psychiatry, University of Massachusetts Medical Center, 55 Lake Avenue North, Worcester, MA 01655*

SUMMARY:

The proposition that a public system can provide long-term care must be superimposed upon the proposition that the same system can provide (and does provide) long-term treatment. In reviewing efforts over the past two decades, errors made in terms of individual patient care and treatment have included: (a) one size fits all, (b) there is a linear continuum of residential services, (c) moving persons with long-term illnesses into the community is enough to move them into the *community,* (d) intramural program issues supersede intermural system issues, (e) moving a person from one location of long-term care to another meets the needs of an individual with chronic mental illness more often than not, (f) what we're doing has never been done before, (g) we know what we're doing, and (h) when we do it, everyone who needs it gets care. While newer treatment interventions must be delivered to those without significant personal resources and with serious mental illness at the rate and with the same availability as those not as in need (i.e., parity and equity), achievement of this laudable goal will not obliterate the need for quality long-term care—at least not in our lifetimes. These issues will be discussed using specific examples from the lives of those who face each day with a chronic mental illness.

No. 4D
REMOVING POLICY ROAD BLOCKS TO LONG-TERM CARE

Donald L. Shumway, M.S.S., *Co-Director, Self-Determination, University of New Hampshire, 10 Ferry Street, Unit 14, Concord, NH 03301*

SUMMARY:

Policy and financing roadblocks to long-term care systems for persons with mental illnesses must be overcome. The challenge to those interested in administrative psychiatry is to reshape a system with our new understandings of brain diseases, consumer protection, cost savings, and the recovery potential of many individuals.

Financial and operational policy needs to be reshaped to engage participation of people with severe mental illness in decisions regarding their treatment and related support services. At the same time, the treatment potential of assertive community treatment and the new medications must become universally available for the most seriously ill, including those with co-occurring substance disorders. By replacing long-term hospitalization and partial hospitalization with supported living, peer-supported homes, crisis management, mentor programs, employment, and peer-mentored illness management, a shift in place of service will occur to lower-cost community and peer-supported programs.

To achieve this requires a cooperative effort and action plan. This session will announce an opportunity, funded by The Robert Wood Johnson Foundation, to engage a partnership with national stakeholders, states, and individuals to transform the current practice of reliance on inadequate and dependency creating, high-cost, outdated models of mental health delivery, toward an integrated combination of highly accessible consumer-supported services with a commitment to updated medical treatment.

REFERENCES:

1. Long-Term Care Decisions: Ethical and Conceptual Dimensions. Edited by Laurence B. McCullough and Nancy L. Wilson. Baltimore, Johns Hopkins University Press, 1995.
2. The Future of Long-Term Care: Social and Policy Issues. Edited by Binstock RH, Cluff LE, and Von Mering O. Baltimore, Johns Hopkins University Press, 1996.
3. Fisher W, Geller JL, Pearsall DT, et al: A continuum of services for the deinstitutionalized, chronically mentally ill elderly. Administration and Policy in Mental Health 1991; 18:397-410.
4. Torrey EF: Nowhere to Go: The Tragic Odyssey of the Homeless Mentally Ill. New York, Harper & Row, 1988.
5. Geller JL, Fisher WH: Transitional residences in the linear continuum: debunking the myth. American Journal of Psychiatry, 1993; 150:1070-1076.
6. Lyden J: Daughter of the Queen of Sheba. Boston, Houghton Mifflin, 1997.

Symposium 5 **Friday, October 2**
2:00 p.m.-5:00 p.m.

THE TREATMENT OF LATINOS WITH SCHIZOPHRENIA

American Society of Hispanic Psychiatry

Alex J. Kopelowicz, M.D., *Assistant Professor of Psychiatry, University of California at Los Angeles School of Medicine, 15535 San Fernando Mission Boulevard, Mission Hills, CA 91345*; Renato D. Alarcon, M.D., M.P.H., *Professor and Vice-Chairman, Department of Psychiatry, Emory University School of Medicine, and Chief, Psychiatry Service, V.A. Medical Center*; Robert Paul Liberman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize how to identify cultural influences in patients' lives and how to apply such information in clinical practice; describe the psychosocial techniques that have been proven effective for Latinos with schizophrenia and their families; and incorporate ethnopharmacologic principles into treatment decisions.

SUMMARY:

As the ethnic population of the U.S. continues to grow, so does the need for practitioners to address the array of psychological problems faced by ethnic groups. The challenge for mental health professionals is to acquire the knowledge and skills necessary to address these needs and problems, as well as to organize mental health services to treat ethnic groups in a sensitive, timely, and effective manner. This symposium is intended to help practitioners identify the relevant issues faced by one ethnic group, Latinos, and to provide some tools to facilitate the assessment, diagnosis, and treatment of this fastest growing ethnic minority group in the U.S.

No. 5A
EDUCATING FAMILIES OF LATINOS WITH SCHIZOPHRENIA

José M. Canive, M.D., *Assistant Professor of Psychiatry, University of New Mexico, 2100 Ridgecrest Drive, S.E., 116 G, Albuquerque, NM 87108-5128*

SUMMARY:

Certain aspects of Latino culture should be considered by clinicians working with the families of Latinos with schizophrenia. For example, the great majority of Latinos with a serious mental illness live with their families. Consequently, the Latino family expects to be actively involved throughout the therapeutic process, and family involvement in treatment has been recommended by prominent clinicians and investigators in cross-cultural issues. This presentation will focus on the goals of family psychoeducation and describe the effects of multifamily psychoeducational groups. The results of a study conducted by the author in Spain will be used to emphasize the limitations of traditional family psychoeducation for Latinos and will propose certain modifications designed to make the approach more culturally congruent.

No. 5B
ETHNOBIOLOGIC CONCERNS IN TREATING LATINOS WITH SCHIZOPHRENIA

Michael W. Smith, M.D., *Assistant Clinical Professor of Psychiatry, Harbor-UCLA Medical Center, 1124 W. Carson Street, B4 South, Torrance, CA 90502-2004*

SUMMARY:

Although there is a limited amount of research on pharmacotherapy with Latinos, the field is growing rapidly. This presentation will characterize pharmacological issues in the Latino population. Recent findings in the area of pharmacogenetics will be reviewed, including an ongoing study by the presenter and his colleagues at the UCLA Center for the Study of Ethnobiology. In addition, other factors influencing drug responsiveness (e.g., dietary habits, the use of alternative medications) will be examined. The clinical significance of this research for the optimal treatment of Latinos in cross-cultural settings will be highlighted.

No. 5C
FAMILY WARMTH AND THE COURSE OF SCHIZOPHRENIA OF MEXICAN AMERICANS AND ANGLO AMERICANS

Steven R. Lopez, Ph.D., *Associate Professor of Psychology, University of California at Los Angeles, Franz Hall, 3218, Los Angeles, CA 90095*

SUMMARY:

We examined the role of families' level of warmth and criticism and its relationship to patients' relapse within a nine-month period. A total of 40 Anglo-American families and 35 Mexican-American families, drawn from previous studies, participated in this research. We found that warmth was a significant predictor of relapse for Mexican-American patients but not for Anglo Americans. Specifically, those patients who returned to households marked by high warmth were less likely to relapse than those patients who returned to households marked by low warmth. Criticism was found to be a significant predictor for Anglo-American patients but not for Mexican-American patients. Consistent with previous expressed emotion research, patients returning to households characterized as high in criticism were more likely to relapse. These findings suggest that ethnicity and perhaps culture play a significant role in how family factors influence the course of schizophrenia.

No. 5D
SKILLS TRAINING FOR LATINOS WITH SCHIZOPHRENIA

Alex J. Kopelowicz, M.D., *Assistant Professor of Psychiatry, University of California at Los Angeles School of Medicine, 15535 San Fernando Mission Boulevard, Mission Hills, CA 91345*; Roberto Zarate, Ph.D.

SUMMARY:

Despite the demonstrated efficacy of skills training for individuals with schizophrenia, several questions remain regarding the generalizability of results across ethnicities, treatment settings, and from the classroom to the home environment. To address these concerns, we implemented a skills training intervention at a community mental health center serving predominantly Spanish-speaking individuals in Los Angeles. Skills training was conducted with the patients by the center's indigenous staff in Spanish. Additionally, key family members attended weekly generalization sessions in which they were taught the importance of giving opportunities, encouragement, and positive feedback to their ill relatives trying to implement these new skills. Post-training evaluations showed that patients were able to generalize the skills to their home environment and that they had significant decreases in symptomatology, particularly in negative symptoms. These findings suggest that a skills training technique, when coupled with a culturally congruent method aimed at promoting generalization of skills, can be utilized with a variety of populations, treatment settings, and social situations.

No. 5E
PREVALENCE, RISK FACTORS AND SERVICE USE IN LATINO YOUTH

Andrés J. Pumariega, M.D., *Professor and Chair, Department of Psychiatry and Behavioral Sciences, James*

H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70567, Hillrise Hall, Johnson City, TN 37614-9567

SUMMARY:

The prevalence of mental health problems in and needs of Latino adolescents have been increasingly studied over the past 10 years. This body of research indicates that Latino adolescents are at high risk for a multitude of morbidities related to serious emotional disturbance and mental illness. Substance abuse, suicidality, violence, school drop-out, and eating disorders are among these rising morbidities. A number of stressors have been shown to contribute to such risk, including cultural transition; changing values and family structure; poverty, discrimination, and marginalization; and lack of access to child mental health services, particularly culturally competent services. This presentation will review this literature, focus on results of studies of Mexican-American border youth and Cuban-American youth, which illustrate these factors, and discuss future research and service delivery needs. The field of child mental health needs to develop a research and health policy focus that will address the service and prevention needs of this increasing population of Americans into the next century.

REFERENCES:

1. Canive JM, Sanz-Fuentenebro J, Vazquez C, et al: Family environment predictors of outcome in schizophrenic patients in Spain: a 9-month follow up study. Acta Psychiatrica Scandinavica 1995; 92:371-377.
2. Lin KM, Poland RE, Wan YJ, Smith MW: The evolving science of pharmacogenetics: clinical and ethnic perspectives. Psychopharmacology Bulletin 1996; 32:205-217.
3. Weisman AG, Lopez SR: An attributional analysis of emotional reactions in Mexican- and Anglo-American cultures. Journal of Applied Social Psychology 1997; 27:223-244.
4. Kopelowicz A: Social skills training: the mediating role of culture. Journal of Psychopathology and Behavioral Assessment, in press.

Symposium 6 **Withdrawn**

Symposium 7 **Saturday, October 3**
8:30 a.m.-11:30 a.m.

THE IMPACT OF MANAGED CARE ON PUBLIC MENTAL HEALTH SYSTEMS

American Association of Community Psychiatrists

David A. Pollack, M.D., *Medical Director, Mental Health Services West, 710 S.W. Second Avenue, Portland, OR 97204-3112*; Kenneth Minkoff, M.D., *Medical Director, Choate Health Management, and Medical Director, Arbour-Fuller Hospital, 200 May Street, South Attleboro, MA 02703-5515*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the general principles of managed care and how they are theoretically applied to public mental health service systems. Participants will be exposed to practical examples of implementation of managed mental health care and should be able to distinguish among them in considering which models might be most applicable to their particular state or region.

SUMMARY:

Public-sector managed care is one of the most dramatic forces affecting the delivery, organization, and financing of community mental health services. Many systems are being pressured to demonstrate more efficient methods of service delivery while simultaneously having to demonstrate a commitment to quality of service. The mandate for publicly-funded organizations to prove that service is of sufficient quality may compromise their efforts to contain costs. Some providers consider that the principles of managed care are contrary to public mental health principles. Many have expressed concerns that the large managed behavioral health care companies will put interests in profit ahead of the concern for patients.

The purpose of this presentation is to identify some major issues related to public-sector managed care and the skills and processes required for local provider networks to form and become capable of obtaining Medicaid and other public contracts to provide care. The first set of presentations will cover theoretical and practical issues associated with understanding how managed mental health care can be provided for public-sector patients and how to achieve the formation of a competent local provider network. The final set of presentations will describe specific examples of local provider initiatives that have succeeded in obtaining public mental health contracts for managed care. A discussion will follow the formal presentations, with an emphasis on comparing the theoretical concepts with the practical realities.

No. 7A
PUBLIC SECTOR MANAGED CARE AND COMMUNITY MENTAL HEALTH

Kenneth Minkoff, M.D., *Medical Director, Choate Health Management, and Medical Director, Arbour-Fuller Hospital, 200 May Street, South Attleboro, MA 02703-5515*

SUMMARY:

The parallels between public-sector managed care and community mental health principles will be highlighted, comparing areas of perceived incompatability, the roots and evolution of community mental health ideologies, and proposing acceptable principles of public-sector managed care ideology.

No. 7B
HOW TO CREATE A LOCAL PROVIDER NETWORK

Barbara J. Mauer, M.S.W., C.M.C., *Principal, Managed Care Performance Project, 1809 7th Avenue, Suite 701, Seattle, WA 98101-1313*

SUMMARY:

Networks are a strategy to gain as much control as possible over the future. Putting a network together means convening public mental health organizations that in the past may have been competitors. What are the steps in creating a jointly held organization that can capitalize operations and manage financial risk? They include development of a shared vision, including a clinical design (how will enrollees be matched to the right care, at the right time? how will quality assurance and utilization management occur?), a business design (how will the business functions of the network be handled? how will network providers be reimbursed?), and a financial viability analysis (will we be able to provide the projected volumes of services at a cost that doesn't exceed revenues?) The purpose of this presentation is to review the steps and strategies that provider sponsored networks should use. The participants will learn how to think about financial risk from the perspective of the network itself as well as the providers and practitioners that make up the network. The presenter will identify the key steps in clinical, business, and financial design for managed care and define the domains that are critical to the clinical and financial design in order to test viability.

No. 7C
MEDICAID MANAGED CARE IN WESTERN PENNSYLVANIA

Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute and Clinic, and Former APA/Bristol-Myers Squibb Fellow, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

Academic medical centers across the country are attempting to adjust to the new world of managed care. For those centers that have historically provided significant levels of publicly funded care, the shift of Medicaid funding into managed care capitation has brought many challenges. This paper will focus on Allegheny County, Pennsylvania, and will explore the experiences and actions of Allegheny County, Western Psychiatric Institute and Clinic (WPIC), and its community partners in Community Care Behavioral Health Organization (CCBH) as they prepare for the advent of Medicaid managed care. The "added value" of being academic medical centers in the mandatory public sector will be emphasized by focusing on the capacity of academic providers to develop and promulgate "best practices" and innovations, to provide training and education, and to work in partnership with community providers, families, and consumers. Strategic decisions regarding the structure of CCBH/WPIC's response, such as its decision to remain not for profit and to participate in public/private partnerships will be discussed.

No. 7D
MEDICAID MANAGED CARE IN LOUISVILLE

Allan Tasman, M.D., *President-Elect, APA, and Professor and Chair, Department of Psychiatry and Behavioral Science, University of Louisville School of Medicine, Louisville, KY 40292-0001*

SUMMARY:

This session will focus on the efforts to develop a managed care contract by bringing together providers from the academic and public provider community in Louisville, Kentucky. The presentation will highlight the process and structure of the formation of such a coalition and will indicate the difficulties encountered in trying to learn the business of mental health care delivery in the age of managed care.

No. 7E
MEDICAID MANAGED CARE IN LOS ANGELES COUNTY

Jack M. Barbour, M.D., *Partner, Barbour & Floyd Medical Associates, 2610 Industry Way, Suite A, Lynwood, CA 90262-4028*

SUMMARY:

This presentation will describe the experience of a project to provide a capitated integrated services agency (ISA) in south-central Los Angeles. The goal has been to demonstrate that one agency having financial and clinical responsibility for coordinating integrated ser-

vices for persons with SPMI could be cost effective and could improve quality.

A private organization with roots in the community was formed by two local African-American psychiatrists who hoped to provide services in accord with the following principles: integrated and coordinated services, client-driven services, client empowerment, continuity of care in and out of the hospital, and cultural relevancy.

The presentation will summarize the results of the first several years of this project and the lessons learned regarding local providers operating an integrated prepaid delivery system.

REFERENCES:

1. Goldman W, Feldman S (eds): Managed Mental Health Care. New Directions for Mental Health Service; no. 59. San Francisco, Jossey-Bass, 1993.
2. Minkoff K: Public sector managed care and community mental health ideology, in Managed Mental Health Care in the Public Sector—A Survival Manual. Edited by Minkoff K, Pollack D. The Netherlands, Harwood Academic Publishers 1997 pp 13-24.
3. Mauer B, Jarvis D, Mockler R, Trabin T: How to Respond to Managed Behavioral Healthcare: A Workbook Guide to Your Organization's Success. Tiburon, CA, Centralink Publications, 1995.
4. AACP: Standards for Quality Management in Implementing Public Sector Managed Care Systems, 1997.
5. AACP: Standards for Quality Management in Implementing Public Sector Managed Care Systems, 1997.
6. Barbour J, Floyd R, Connery L: Capitated care management by community psychiatrists: LA County, in Managed Mental Health Care in the Public Sector: A Survival Manual. Edited by Minkoff K and Pollack DA. Harwood Academic Publishers, Newark, NJ, 1997.
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Symposium 8 **Saturday, October 3**
2:00 p.m.-5:00 p.m.

CHARACTERIZING PSYCHIATRY: FINDINGS FROM THE APA'S PRACTICE RESEARCH NETWORK

John S. McIntyre, M.D., *Chairperson, APA Steering Committee on Practice Guidelines, Past President, APA, and Chairperson, Department of Psychiatry, St. Mary's Hospital, 919 Westfall Road, Suite 210, Building C, Rochester, NY 14611*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium the participant should be able to understand the research aims of APA's Practice Research Network and understand major trends related to psychiatry and psychiatric clinical practice patterns and to be aware of recent clinical and services findings from PRN studies, including findings related to the impact of managed care on clinical practice.

SUMMARY:

This symposium will review findings from APA's Practice Research Network (PRN), a research initiative that aims to gather information on what's happening in the "real world" of psychiatry. PRN members (n = 750) work in the full range of practice settings (e.g., public hospitals, private practice, correctional facilities) and treat patients of all ages and with diverse psychiatric profiles. This symposium will present data from a number of network studies. The Study of Psychiatric Patients and Treatments (SPPT) generates data to systematically characterize PRN members, their practices, patient caseloads, and clinical treatment patterns. In addition, it provides detailed clinical and diagnostic data on PRN patients and the specific types and combinations of treatments provided. The National Survey of Psychiatric Practice (NSPP), a large national probability sample survey of APA members, provides data on critical clinical, financial, and other issues of importance to psychiatry. It collects nationally representative data on psychiatrists' professional activities, work settings, and patient caseloads.

The first presentation will review findings from the SPPT, including data on the types and combinations of treatments provided to patients with serious mental disorders (e.g., schizophrenia, bipolar disorder). The second presentation will highlight findings from the NSPP on the characteristics of psychiatrists. The third presentation will present data on how different systems of care influence clinical practice patterns in psychiatry.

TARGET AUDIENCE:

Clinicians and researchers.

No. 8A
CHARACTERIZING PSYCHIATRIC PATIENTS AND TREATMENTS

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

SUMMARY:

Findings from the PRN's patient-level Study of Psychiatric Patients and Treatments will be presented. This study, which is conducted annually, collects data to characterize PRN psychiatrists, their practices, patient caseloads, and clinical treatment patterns. This includes the

collection of detailed clinical and treatment data on a randomly selected sample of psychiatric patients. These data provide a valuable database to study trends in psychiatry and psychiatric clinical practice patterns. Because this study gathers detailed, patient-level data, the relationship(s) between psychiatrist, patient, and financing/services delivery factors and clinical treatment patterns can be assessed.

Data will be presented on the demographic and diagnostic characteristics of a large sample of psychiatric patients, including data on mental and general medical comorbidities. In addition, detailed data will be presented on the types and combinations of treatments provided to patients with serious mental disorders (e.g., schizophrenia, bipolar disorder), including data on treatment settings, specific treatments, and psychopharmacologic agents. Variations in the types of psychiatric patients and treatments utilized across different types of health plans and managed care organizations will also be presented.

No. 8B
CHARACTERIZING PSYCHIATRISTS

Deborah A. Zarin, M.D., *Deputy Medical Director, and Director, Office of Quality Improvement and Psychiatric Services, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005*; Ana P. Suarez, M.P.H.

SUMMARY:

Findings from the PRN's psychiatrist-level National Survey of Psychiatric Practice will be presented. This study is conducted annually to study critical clinical, financial, and other issues of importance in the field of psychiatry and to track changes in psychiatric practice over time. The principal objective of this study, which gathers data on a large, randomly selected sample of APA members, is to collect nationally representative data on psychiatrists' professional activities, work settings, and patient caseloads to create a scientific baseline for current and future research in the rapidly changing field of psychiatry. Approximately 1,500 APA members are randomly selected for study participation each year.

Key findings and trends related to psychiatrists' professional activities, practice settings, patient caseloads, and referrals as well as data on psychiatrists' participation in managed care plans and the financing and economics of psychiatric practice will be presented.

No. 8C
SYSTEMS OF CARE: IMPACT ON CLINICAL PRACTICE

Deborah A. Zarin, M.D., *Deputy Medical Director, and Director, Office of Quality Improvement and Psychiatric Services, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005*; Harold Alan Pincus, M.D.; Joyce C. West, M.P.P.

SUMMARY:

Findings from the Study of Psychiatric Patients and Treatments and the National Survey of Psychiatric Practice will be integrated to examine the impact of systems of care on clinical practice patterns. In particular, data examining the complex relationships between psychiatrist characteristics, practice setting, financing/service delivery factors, patients, and treatments will be presented.

At the patient level, variations in the types of treatments utilized across different types of health plans and managed care organizations will be discussed. In addition, data on the relationship between utilization management techniques/incentives and the treatments provided to psychiatric patients will be reviewed. At the systems level, data on how the characteristics of psychiatrists and their practices influence the treatment of patients across different diagnoses, practice settings, and financial arrangements will be presented.

REFERENCES:

1. West JC, Zarin DA, Pincus HA, McIntyre JS: Treatments provided to psychiatric patients. Psychiatric Services 1996; 47:693.
2. West JC, Zarin DA, Pincus HA, McIntyre JS: Characteristics of psychiatric patients. Psychiatric Services 1996; 47:577.
3. West JC, Zarin DA, Pincus HA: Clinical and psychopharmacologic practice patterns of psychiatrists in routine practice. Psychopharmacology Bulletin 1997; 33(1):79-85.
4. Zarin DA, Peterson BD, West JC, et al: Characterizing psychiatry: findings from the 1996 National Survey of Psychiatric Practice. American Journal of Psychiatry (in press, March 1998)
5. Zarin DA, Peterson BD, Suarez A, Pincus HA: Practice settings and sources of patient-care income of psychiatrists in early, mid, and late career. Psychiatric Services 1997; 48:1261
6. Zarin DA, Peterson BD, Suarez A, Pincus HA: Sources of patient-care income, work settings, and age of male and female psychiatrists. Psychiatric Services 1997; 48:1387
7. Stewart AL, Ware JE (eds): Measuring Functioning and Well-Being: The Medica Outcomes Study Approach. Durham, NC, Duke University Press, 1992
8. Pincus HA, Zarin DA, West JC: Peering into the "black box": measuring outcomes of managed care. Archives of General Psychiatry 1996; 53:870-877

Symposium 9 **Saturday, October 3**
2:00 p.m.-5:00 p.m.

TRAINING MULTIPLE DISCIPLINES IN THE COMMUNITY

American Association of Community Psychiatrists

Kathleen A. Daly, M.D., M.P.H., *Medical Director, Edmund D. Edelman Mental Health Center, 11080 West Olympic Boulevard, Los Angeles, CA 90064*; David L. Cutler, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the richness of training opportunities in community settings; to recognize obstacles in initiating community training experiences for students.

SUMMARY:

Community training experiences on interdisciplinary treatment teams have proven an effective means of providing psychiatrists with valuable tools needed to function in community settings. Psychiatrists trained on interdisciplinary teams have a much easier transition when working in community settings after residency. Interdisciplinary teams work cooperatively to address client needs that include medication, housing, family and social supports, rehabilitation, and psychosocial stress. Case managers from a variety of disciplines assess and manage cases, while each team member contributes expertise that broadens the perspective and scope of interventions. This approach becomes increasingly important as time directed toward clinical activities is managed by third party providers, and the most expensive providers need to have an impact that is both efficient and effective. Psychiatrists working alone cannot efficiently and effectively provide for the complex needs of the seriously and persistently mentally ill.

Training of professionals in other disciplines will most likely yield the same positive results that have been seen with psychiatry residents. Expanding this model to additional disciplines and exposing students earlier in their careers need to be essential parts of efforts to build the pool of mental health providers working in community and public settings.

This symposium will provide information on a variety of models of interdisciplinary training in several different settings. Presentations will focus on how to engage students of public health in mental health care, medical student clerkships in community settings, the role of nonmedical team members in training psychiatry residents, training multiple disciplines in a brief model of crisis intervention, and specialty training for social work interns and psychiatry fellows in the treatment of monolingual Spanish clients.

TARGET AUDIENCE:

Mental health providers of all disciplines interested in community-based training.

No. 9A
RESIDENCY TRAINING ON MULTIDISCIPLINARY TEAMS

Barbara A. Lagerbom, R.N.C.S., *Team Leader, Continuing Care Service, Massachusetts Mental Health Center, 74 Fenwood Road, Boston, MA 02115*; Colleen Byrnes, M.S.W.; Robert M. Goisman, M.D.

SUMMARY:

Massachusetts Mental Health Center is an urban public sector community mental health center and a participant in the Harvard Longwood Residency Program. The clinical services delivery system consists of five interdisciplinary teams whose goal is to plan and deliver comprehensive treatment to a chronically mentally ill population. Residents are assigned to outpatient clinical teams in their PGY 2, 3, and 4 years in varying capacities and time commitments. Team leaders are not M.D.s, although M.D.s are team members, and teams are not hierarchical.

The challenge for the resident of working as a "medication back up" or primary clinician is enriched by having information from other clinical sources, housing, day programs, and vocational services. The goal is to obtain a complete picture of the client's daily life and how the benefit of hearing about clients' behaviors in various settings allows the residents a comprehensive, broad understanding on which to base these clinical decisions. For residents, there is a great deal of learning from M.D.s as well as non-M.D.s. Residents also teach as team members and thus learn a great deal from their many varied experiences.

No. 9B
BRINGING COMMUNITY PSYCHIATRY TO MEDICAL STUDENTS: COMMUNITY PSYCHIATRIST AS PSYCHIATRY CLERKSHIP DIRECTOR

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

SUMMARY:

This presentation will outline some of the innovative changes the past year in the Case Western Reserve University School of Medicine psychiatry clerkship at University Hospitals of Cleveland. As a required clerkship

of all third-year medical students, the psychiatry clerkship is an ideal time to influence career choice for undecided students and cultivate interest in community psychiatry in students who have already expressed an interest in a career in psychiatry or primary care/community health. This is built upon relationships forged by the clerkship director working with first- and second-year medical students in clinical science programs, problem-based learning sessions, interviewing, mentoring, elective "medical apprenticeship programs," and the Mind Committee, the CWRU psychiatry component of the core curriculum for second-year medical students. New aspects of the clerkship include an increased amount of time spent in outpatient settings, primarily community mental health agencies, and a problem-based learning series that facilitates greater self-directed learning in third-year clerks.

TARGET AUDIENCE:

Medical students, residents, and faculty interested in community psychiatry education.

No. 9C
TEACHING PUBLIC HEALTH IN PSYCHIATRY

Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute and Clinic, and Former APA/Bristol-Myers Squibb Fellow, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

Psychiatric illness, like other illnesses, varies from population to population over time, space, and social structure. This suggests two things: (1) It is important to address the needs of varying populations differentially; and (2) It may be possible to design interventions for particular populations that impact on the distribution of psychiatric illness. Concepts of public health-incidence/prevalence, at-risk populations, health promotion and prevention, and community health needs assessment are applicable in psychiatry, though the usual focus of psychiatric practice is not population oriented. This presentation will describe concepts that serve to bridge the gap between public health and psychiatry. Examples of a "public health psychiatry," such as community support programming, substance abuse prevention, and community mental health promotion will be discussed. The impact of the Healthy Community movement in public health and medicine will be outlined. Finally, the paper will discuss the obstacles and opportunities to teach psychiatrists, mental health professionals, and public health workers how to take a population-oriented approach to psychiatry.

No. 9D
TRAINING MULTIPLE DISCIPLINES IN CRISIS INTERVENTION

Robin C. Kay, Ph.D., *Program Manager, Edmund D. Edelman Mental Health Center, 11080 West Olympic Boulevard, Los Angeles, CA 90064*; Kathleen A. Daly, M.D., M.P.H.

SUMMARY:

The Edmund D. Edelman Westside Mental Health Center is a directly operated facility of the Department of Mental Health in Los Angeles County. Social work interns were trained in a traditional community mental health center model until earthquake damage limited our ability to accommodate space needs for trainees. Our formal affiliation with UCLA and a move to a new facility lead to much broader training opportunities that now include:

- medical student clerkship and electives in community and cross-cultural psychiatry,
- community psychiatry rotation for all third year residents at UCLA-NPI,
- fellowships in community and cross-cultural psychiatry,
- internships for social work, art therapy, occupational therapy, and nursing students,
- crisis intervention training for psychology interns.

Our training in crisis intervention has proven an effective means of generating enthusiasm about work in the community among all students, even those trained in traditional long-term models of treatment. All disciplines at our setting are invited to participate in a weekly seminar that covers a broad range of topics about work in the community and on interdisciplinary teams. A four-week portion of that seminar is devoted to training in a formal model of crisis intervention. In addition, the series is offered as part of the UCLA-NPI residency core curriculum. Once the didactic portion of the training is completed, trainees are assigned clients in crisis for six consecutive 50-minute sessions and have one-on-one supervision about each case. All disciplines enjoy the exposure to clients who respond quickly and usually have a good outcome. In part the popularity of this experience may be explained by the recognition that this is a tool that managed care supports even in a private practice setting.

No. 9E
UCLA'S SPANISH-SPEAKING CLINIC: LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH COLLABORATION

Cynthia Telles, *University of California at Los Angeles, 760 Westwood Plaza, Los Angeles, CA 90024*; Kathleen A. Daly, M.D., M.P.H.

SUMMARY:

For over a decade, UCLA has provided an excellent and consistently subscribed training experience for social work interns in working with Spanish-speaking clients. A weekly training seminar and case conference provide a forum to discuss cultural issues as they relate to the manifestation of mental illness. An ongoing difficulty has been obtaining medication support for clients as the clinic is an elective for psychiatry residents and unpredictably subscribed. The clinic is the only UCLA-NPI clinic that accepts public funding (Medi-Cal) and as a result is more likely to care for clients with a complex and broad range of treatment needs. In contrast, the Los Angeles County Department of Mental Health (LAC DMH) at the nearby Edelman Westside Mental Health Center provides medication support and case management services to a large population of monolingual Spanish clients. Social work interns at this site gain experience working on interdisciplinary teams and providing case management services to the seriously and persistently mentally ill, but have limited access to psychotherapy cases and supervision. Recently the LAC DMH funded a psychiatric fellowship in Latino behavioral health. We believed that we could provide a broader training experience for both the social work intern and fellow and overcome shortcomings of both our treatment and training programs by collaborating to offer a combined training experience. The resulting training experience has provided a stimulating work environment.

REFERENCES:

1. Goisman RM, Byrnes C: Residency training on multidisciplinary teams at the Massachusetts Mental Health Center, in Proceedings of the AACDP-AADPRT Conference on the Impact of Economy and Health Care Delivery Changes on Psychiatric Residency Training. Edited by Talbott JA, Lomat JW, Beresin EV, et al. Baltimore, University of Maryland Department of Psychiatry, 1996, pp 180-182.
2. Hellman SJ: The continuing care service, in Serving the Chronically Mentally Ill in An Urban Setting. Edited by Shore MF, Gudeman JE. New Directions for Mental Health Services, no. 39, San Francisco, Jossey-Bass, Fall, 1988, pp 73-87.
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4. Straker M: Emergency psychiatry, in Treating Psychiatry and Behavioral Science. Edited by J, Yager Grune & Stratton, 1982.
5. American Psychiatric Association: A Guideline for a Medical Student Curriculum in Psychiatry and Behavioral Science, Washington, D.C., December, 1994.
6. Ruiz P: Issues in the psychiatric care of Hispanics. Psychiatric Services 1997; 48:539-540.

Symposium 10 **Sunday, October 4**
8:30 a.m.-11:30 a.m.

SOCIAL PSYCHIATRY'S MISSION: YEAR 2000

American Association for Social Psychiatry

Leah J. Dickstein, M.D., *Professor and Associate Chairperson of Academic Affairs, and Director, Division of Attitudinal and Behavioral Medicine, Department of Psychiatry and Behavioral Sciences, University of Louisville, 323 East Chestnut Street, Louisville, KY 40202*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize major social issues affecting appropriate psychiatric care for all patients across the life cycle such as youth in the juvenile justice system, gender, and advocacy issues.

SUMMARY:

Issues pertinent to social psychiatry have expanded exponentially in the past 50 years to include topics and groups that were not given major focus at the turn of the 20th century.

This symposium will focus on several such major issues, such as youth in the private practice system in need of mental health treatment, advocacy in general for all patients across the life cycle, and gender issues for women and men across the life cycle and in every socioeconomic, racial, ethnic, educational, and lifestyle category.

No. 10A
MULTIPLE GENDER ISSUES AFFECTING PSYCHIATRIC TREATMENT

Leah J. Dickstein, M.D., *Professor and Associate Chairperson of Academic Affairs, and Director, Division of Attitudinal and Behavioral Medicine, Department of Psychiatry and Behavioral Sciences, University of Louisville, 323 East Chestnut Street, Louisville, KY 40202*

SUMMARY:

As the 21st century approaches, all mental health professionals must be aware of the major and multiple gender issues affecting psychiatric treatment of women and men, from diagnosis, treatment needs in psychopharmacology and psychotherapy, and finally, to prognosis. This presentation will summarize the biopsychosocial, genetic, and pathophysiologic differences and similarities. It will include vignettes to highlight gender-related

diagnostic differences and medication differences, including initial general medical evaluation and psychotherapy issues, whether in individual, dyadic, or group therapy for short- or long-term treatment. With this knowledge, treatment outcome and cost can improve considerably.

No. 10B
DEVELOPING COALITIONS OF MENTAL HEALTH AGENCIES FOR ADVOCACY

Edward F. Foulks, M.D., Ph.D., *Associate Dean, Clinical Affairs and Graduate Medical Education, Tulane University Medical Center, 1430 Tulane Avenue, SL77, New Orleans, LA 70112-2699*

SUMMARY:

Management and treatment programs for people suffering from mental illness have been subjects of increasing legislative attention during the past decade. The political process has addressed such issues as deinstitutionalization, community mental health, parity of insurance coverage, Medicaid and uninsured provisions for treatment, public clinic formularies, and others. In this period, psychiatry can best advocate for quality programs when aligned with a variety of consumer and lay agencies that champion the welfare of the mentally ill. This paper will discuss strategies for developing successful coalitions of these groups and organized psychiatry.

No. 10C
MENTAL HEALTH SERVICES: COLORADO JUVENILE JUSTICE SYSTEM

Debbie R. Carter, M.D., *Department of Psychiatry, University of Colorado Health Services Center, 4200 E. Ninth Avenue, Denver, CO 80262*

SUMMARY:

The University of Colorado Health Sciences Center, the State of Colorado Division of Youth Corrections entered into a state-university collaboration project to increase coordinated mental health services. Over the past two years this collaborative effort has yielded a system of care, which is serving youth in all aspects of the juvenile justice system. Results of the project in providing services, creating linkages to other consumer and advocacy systems, and the state's mental health services will be reviewed.

No. 10D
PSYCHIATRIC CARE/SEXUAL ORIENTATION: BARRIERS/BRIDGES

Robert Paul Cabaj, M.D., *Medical Director, Department of Mental Health, San Mateo County, and Associate Clinical Professor of Psychiatry, University of California at San Francisco, One Mono Street, San Francisco, CA 94114-2305*

SUMMARY:

Gay men and lesbians use mental health services at a greater frequency than the general population. Nearly 50% of gay and lesbian patients report homophobia or overt discrimination in their mental health care. Surveys also report that gay and lesbian psychiatrists have observed poor care delivery to gay and lesbian patients and also report discrimination and poor treatment of themselves.

Efforts are underway to revenge and respond to such evidence of homophobia. Barriers to the care of gay, lesbian, and bisexual people must be overcome. Bridges are being built through education and outreach in medical schools and psychiatric residency training programs. More institutional and even legal support, however, will be needed to overcome this bias, prejudice, and discrimination in the delivery of psychiatric care.

REFERENCES:

1. Miller JB: Toward A New Psychology of Women 2nd edition. Beacon Press, Boston, 1983.
2. Pleck JH: Myths of Masculinity. The MIT Press, Cambridge, MA, 1981.
3. Cocozza JJ: Responding to the Mental Health Needs of Youth in the Juvenile Justice System. The National Coalition for the Mentally Ill in The Criminal Justice System, 1992.
4. McDaniel JS, Cabaj RP, Purcell DW: Care Across the Spectrum of Mental Health Settings: Working with Gay, Lesbian, and Bisexual Patients in Consultation-Liaison Services, Inpatient Treatment Facilities, and Community Outpatient Mental Health Centers in Textbook at Homosexuality and Mental Health. Edited by Cabaj RP, Stern TS. American Psychiatric Press Inc., Washington, DC, 1996. pp. 687-704.

Symposium 11 — Sunday, October 4 8:30 a.m.-11:30 a.m.

FAMILY-TO-FAMILY: EDUCATION THAT WORKS

National Alliance for the Mentally Ill

Laurie M. Flynn, M.A., *Executive Director, National Alliance for the Mentally Ill, 200 N. Glebe Road, Suite 1015, Arlington, VA 22203*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should have a greater knowledge of mental illnesses and their treatment, the side effects of treatment, how to care and respond to the needs of a family member with mental illness, and of treatments and supports that are available or should be available. They will have knowledge of NAMI's Family-to-Family education program, which addresses all these issues.

SUMMARY:

The research literature substantiates what the family members of individuals with serious brain disorders like schizophrenia know: information about the illnesses, their treatment, the side effects of treatment, coping with illness in a loved one, and accessing needed treatments and supports are desperately needed. Families who have made this journey are the best educators, providing accurate information tempered by the empathy of like experience and seasoned consumers and advocates in the local community. The symposium will describe NAMI's family education program, the experience of families and providers in California, and make a strong case for the need for all treatment systems and providers to implement NAMI's Family-to-Family education program.

No. 11A
THE NATIONAL ALLIANCE FOR THE MENTALLY ILL FAMILY-TO-FAMILY EDUCATION COURSE: AN OVERVIEW

Joyce C. Burland, Ph.D., *Director, NAMI Family-to-Family Education Program, 8 Park Place, Brattleboro, VT 05301*

SUMMARY:

The NAMI Family-to-Family Education Program is a unique peer model in family education operating nationally in 32 states and three provinces of Canada. The 12-week course is offered free in hundreds of communities across the country, with classes taught by trained NAMI family members. To date, 25,000 family members have completed the full 12 weeks of classes. Formerly known as the Journey of Hope family education course, the program is now sponsored and directed by the National Alliance for the Mentally Ill (NAMI) as part of its ongoing educational mission. The new name "Family-to-Family" reflects the most innovative aspect of the program—its reliance on NAMI family member teachers whose sensitivity in helping families deal with the trauma of serious brain disorder is a hallmark of the program's success.

This presentation will describe the program and report on the impact of the course upon the families who have gone through this empowering group experience. The multiple strengths of this peer education model will be explored, and its importance as a long awaited permanent community resource for families will be discussed. The presentation makes a compelling case for the acceptance and encouragement of the NAMI Family-to-Family Education Program among providers in the mental health community.

No. 11B
THE NATIONAL ALLIANCE FOR THE MENTALLY ILL FAMILY-TO-FAMILY EDUCATION PROGRAM IN CALIFORNIA

Brian Jacobs, *Program Director, NAMI Family-to-Family Education and Support Program in California, 203 Argonne Avenue, B-104, Long Beach, CA 90803-1735*

SUMMARY:

The NAMI Family-to-Family Education program in California is being sponsored by the California Department of Mental Health, various county departments of mental health, the National Alliance for the Mentally Ill, and the California Psychiatric Association. California's program has been hugely successful and will reach approximately 900 new families by 1998, the second year of operation. With little support and declining community resources. California families are burdened by psychiatric situations difficult for experienced clinicians. The NAMI Family-to-Family Education Program brings optimism to the despair experienced by families through a well-organized program of family education and support that offers information and coping skills families can use to help their ill loved ones, improve their personal lives, and contribute to mental health advocacy! Several family members will give examples of how the program has contributed to the well-being of their family and their ill family member.

No. 11C
PSYCHIATRY'S INVOLVEMENT IN THE NATIONAL ALLIANCE FOR THE MENTALLY ILL FAMILY-TO-FAMILY EDUCATION PROGRAM

Maria T. Lymberis, M.D., *Clinical Professor of Psychiatry and Behavioral Sciences, University of California at Los Angeles School of Medicine, 1500 Montana Avenue, #204, Santa Monica, CA 90403-1810*

SUMMARY:

This presentation focuses on the role of organized psychiatry in the NAMI Family-to-Family Education Program. The APA efforts through the APA Public Affairs Division as well as through the state or regional

psychiatric organizations will be discussed. The experience of the Southern California Psychiatric Society-sponsored Psychiatric Education & Research (PER) Foundation will be discussed. The significance of psychiatric organizational leadership in insuring the Family Education Program's success will be stressed. The role of the California Psychiatric Association will be emphasized.

REFERENCES:

1. Lefley HP, Johnson DL: Families as Allies in Treatment of the Mentally Ill, New Directions for Mental Health Professionals. American Psychiatric Press, Inc., Washington, D.C., 1990.
2. Hatfield AB, Lefley HP: Surviving Mental Illness: Stress, Coping, and Adaptation. The Guilford Press, New York, N.Y., 1993.
3. Woolis R: When Someone You Love Has A Mental Illness, A Handbook for Family, Friends, and Caregivers. G.P. Putnam's Sons, New York, N.Y., 1992.
4. Burland J: NAMI Family to Family Education Program, 1997.

Symposium 12 **October 4**
8:30 a.m.-11:30 a.m.

INNOVATIVE MODELS OF FAMILY AND PATIENT EDUCATION

Haya Ascher-Svanum, Ph.D., *Assistant Professor of Clinical Psychiatry, Indiana University, and Chief Psychologist, Carter Hospital, 2601 Cold Spring Road, Indianapolis, IN 46222*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe the unique features of a few innovative programs of patient and family education, and identify specific benefits of patient education that have been empirically validated.

SUMMARY:

A shift has occurred in the area of patient and family education, where this prevalent form of intervention has been transformed into a standard of care and an integral part of treatment, particularly for individuals with severe and persistent mental illness. A growing number of models have emerged in this area, presenting a multitude of programs that are offered by various mental health professionals as well as by peer consumers.

This symposium will initially offer a global view on the existing conceptual and practical models of patient and family education and venture on to describe in detail a few innovative programs. One of these innovative psychoeducational programs is the Mental Health Empowerment Project, which uses consumers to assist in the recovery of other consumers. Another innovative program, designed for the family, is the Supportive Family Training (SFT), which uses a transpersonal perspective designed to extend family education more deeply into the emotional and spiritual realm than conventional family interventions. And since the efficacy of family education has been repeatedly validated, this symposium will address efficacy issues in patient education, identifying specific beneficial outcomes, which have been studied in controlled research design, while pointing to ongoing challenges and opportunities.

TARGET AUDIENCE:

Professionals involved in patient/family education.

No. 12A
MODELS OF PATIENT AND FAMILY EDUCATION

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

SUMMARY:

Patient education may vary from remedial stage-learning based on a neurocognitive deficit model to training the patient in functional/resource assessment for self-management plans. Modules may emphasize state-of-the-art information about a major psychiatric disorder and its treatment, or selective education adapted to specific treatment goals. Didactic materials are typically interspersed with social skills and communications training, but ratios and emphases may vary according to diagnosis, functional level, developmental stage of illness, and similar variables. Type of agency and range of rehabilitation modalities are also germane to particular types of patient education.

Most of the research on families is based on family psychoeducation, which essentially focuses on patients' well-being, with relapse as the major outcome measure. Family education models typically focus on families' needs for information and support, with family well-being the major goal. Individual and multi-family models and education-support groups are discussed, with a description of consumer and family-led programs. Examples of generic components and specific differences will be presented, together with functional applications and relevant research findings.

No. 12B
THE MENTAL HEALTH EMPOWERMENT PROJECT

Edward Knight, Ph.D., *Chief Executive Officer, Mental Health Empowerment Project, Inc., 201 West 8th Street, Suite 380, Pueblo, CO 81003*

SUMMARY:

Although patient education has been customarily offered by various mental health professionals, a growing trend has emerged where consumers are becoming a major vehicle in the education and rehabilitation of other consumers. One such innovative peer-to-peer model of psychoeducation has been initiated in the form of interactive workshops, which provide information and skills building for recovery. This self-help modality is aimed at instillation of hope and empowerment, using Bandura's self-efficacy model, which has demonstrated that self-efficacy is best conveyed by peers. The presenter at this symposium is a consumer himself and the founder of the Mental Health Empowerment Project, which has started about 500 mutual support groups in New York state and about 100 in other states.

No. 12C
A TRANSPERSONAL APPROACH TO FAMILY SUPPORT AND EDUCATION

Sheila Shulman Le Gacy, M.A., *Director, Family Support and Education Center, Transitional Living Services, 239 West Fayette Street, Syracuse, NY 13202*

SUMMARY:

This workshop describes Supportive Family Training (SFT), an approach to family support and education that actively focuses on the suffering endured by families whose relatives have schizophrenia, bipolar disorder, or serious depression. Its transpersonal perspective, designed to free the energy of individuals who suffer by connecting them to the pain of the world, extends family education more deeply into the emotional and spiritual realm than conventional family interventions. The primary goals of SFT are to improve family coping, teach families to appreciate the importance of self-care, reduce their burden, and enhance their quality of life. Families are taught ways to care for their own needs at the same time that they learn to become more effective advocates for their ill relatives. The 12-week curriculum includes practical techniques that can be easily integrated into a variety of family interventions.

Supportive Family Training has been adopted in its entirety or has inspired many other family education models throughout the U.S. It is taught throughout New York state by professionals working in partnership with families as well as by teaching teams of family members. Its 500-page curriculum is being translated into Spanish. An independent evaluation of SFT by the Maxwell School of Public Administration at Syracuse University, which measured family satisfaction with the course, reported outstanding outcomes, with 97% of the participating families feeling empowered by their experience.

No. 12D
ON THE EFFICACY OF PATIENT EDUCATION

Haya Ascher-Svanum, Ph.D., *Assistant Professor of Clinical Psychiatry, Indiana University, and Chief Psychologist, Carter Hospital, 2601 Cold Spring Road, Indianapolis, IN 46222*

SUMMARY:

Patient education programs have become a highly prevalent form of intervention for the severely and persistently ill in various mental health settings. And while most programs are offered by a variety of mental health professionals, peer consumers are currently taking a growing active role in patient education.

Despite its prevalent use, only meager attempts have been made to study the efficacy of patient education. This presentation will review available outcome studies with a focus on education for persons diagnosed with schizophrenia. Selection of this specific subset of patient population is due primarily to the fact that most published studies relate to patients with schizophrenia, and to the finding that this area has produced more useful data through controlled research designs. This presentation will review, among others, studies on the effects of patient education on adherence to medication and other forms of treatment, social functioning, insight, attitudes toward medication, knowledge about the illness and its management, hope about the future, relapse rate, consumer satisfaction, and level of psychopathology. Reasons for current difficulties in delineating the true benefits of patient education will be discussed, along with specific suggestions for future outcome studies.

REFERENCES:

1. Koplewicz A, Liberman RP: Self-management approaches for seriously mentally ill persons. Directions in Psychiatry, August 24, 1994; 14, Lesson 17.
2. Hatfield AB (ed): Family interventions in mental illness. New Directions for Mental Health Services No. 62. San Francisco: Jossey-Bass, Summer, 1994.
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4. Cassel E: The nature of suffering and the goals of medicine. New England J Med 1982; 306:639-644.
5. Solomon P: Moving from psychoeducation to family education for families of adults with serious mental illness. Psychiatric Services 1996; 47:1364-1370.
6. Atkinson LM, Coia DA, Gilmour WH, Harper J: The impact of education groups for people with schizophrenia on social functioning and quality of life. Br J Psychiatry 1996; 68:199-204.
7. Ascher-Svanum H, Krause AA: Psychoeducational groups for patients with schizophrenia: a guide for

practitioners. Rockville, Maryland, Aspen Publishers, Inc., 1991.

Symposium 13 **Sunday, October 4**
2:00 p.m.-5:00 p.m.

REVIEW OF THE AMERICAN PSYCHIATRIC ASSOCIATION'S PRACTICE GUIDELINES

John S. McIntyre, M.D., *Chairperson, APA Steering Committee on Practice Guidelines, Past President, APA, and Chairperson, Department of Psychiatry, St. Mary's Hospital, 919 Westfall Road, Suite 210, Buiding C, Rochester, NY 14618*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand 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. Presentations will focus on practice guidelines on panic disorder (in press, 1998), delirium (slated for publication in winter 1999) and geriatric care (slated for publication in fall 1998).

SUMMARY:

The APA practice guidelines project has moved forward according to a previously approved process designed to result in documents that are both scientifically sound and clinically useful to practicing psychiatrists. On the basis of nationally recognized standards for the development of practice guidelines (sometimes termed "practice parameters"), APA guidelines reflect: (1) comprehensive literature reviews; (2) classifications of supporting evidence and the nature of recommendations; and (3) a series of revisions based on input from the Steering Committee, Work Group, Assembly, Board of Trustees, Joint Reference Committee, related APA components, and from psychiatric consultants, nonpsychiatrist experts, and representatives from related organizations. The final draft is approved by the Assembly and Board of Trustees.

This session will explore the treatment recommendations contained in practice guidelines on panic disorder, delirium, and geriatric care. 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 guidelines topics, and implications for the field.

No. 13A
APA PRACTICE GUIDELINE FOR THE TREATMENT OF PANIC DISORDER

Deborah Cross, M.D., *Associate Chairperson, Department of Psychiatry, Albany Medical Center, New Scotland Avenue, #A-164, Albany, NY 12208*

SUMMARY:

The Practice Guideline for Treatment of Panic Disorder seeks to provide guidance to psychiatrists who treat patients with panic disorder. It begins at the point where the psychiatrist has established that a patient has panic disorder and has evaluated the patient for the presence of comorbid psychiatric conditions as well as general medical conditions that could be important to treatment. First, treatment options, including psychiatric management, pharmacologic treatments, and psychosocial treatments, are reviewed along with the evidence for their efficacy. Second, issues to be considered in choosing and implementing these treatment options (including the factors that underlie the choice of treatment setting) are discussed. Finally, the ways in which particular clinical features of the patient's illness alter the general treatment recommendations are elucidated.

No. 13B
APA PRACTICE GUIDELINE FOR THE TREATMENT OF DELIRIUM

Philip S. Wang, M.D., D.P.H., *Instructor in Medicine, Brigham and Young Women's Hospital, and Department of Pharmaco-Epidemiology, Harvard Medical School, 221 Longwood Avenue, Room 341, Boston, MA 02115*

SUMMARY:

The Practice Guideline for the Treatment of Patients with Delirium is the final guideline in a series of three to address issues that primarily concern the geriatric population. Together with the Alzheimer's disease guideline and the geriatric care guideline, the guideline will be used as the basis for the ABPN recertification exam in geriatric psychiatry. The delirium guideline addresses both environmental and supportive interventions, as well as somatic interventions, used to treat patients with delirium.

No. 13C
APA PRACTICE GUIDELINE FOR GERIATRIC CARE

Dilip V. Jeste, M.D., *Professor of Psychiatry and Neurosciences, San Diego Veterans Affairs Medical Center, 3350 La Jolla Village Drive, San Diego, CA 92161-0001*

SUMMARY:

The Practice Guideline for Geriatric Care is different in its scope from the majority of guidelines developed by APA. The geriatric guideline will address special issues in diagnosis and assessment for geriatric psychiatry patients. For example, various psychosocial stressors pertinent to the elderly will be reviewed (e.g., family, loss, dependency, functional status, ADLs). Specific treatment principles will also be reviewed for this population as they relate to psychiatric management, psychosocial and pharmacologic treatments, and interactions with general medical conditions and their medications. In addition, the guideline will address the following specific disorders in the elderly: major depressive disorder, bipolar disorder, schizophrenia and related psychotic disorders, panic and related anxiety disorders, substance use disorders, sleep disorders, and personality disorders.

REFERENCES:

1 McIntyre JS, Zarin DA, Pincus HA: Practice guidelines and outcomes research, in Outcomes Assessment in Clinical Practice, Williams and Wilkens 1996.
2. American Psychiatric Association: Practice Guideline for Treatment of Patients with Panic Disorder. Am J Psychiatry, in press, 1998.
3. Zarin DA, Pincus HA, McIntyre JS: Editorial on practice guidelines. Am J Psychiatry 1993; 150:2.
4. American Psychiatric Association: Practice Guideline for Treatment of Patients with Alzheimer's Disease and Other Dementias of Late Life. Am J Psychiatry (suppl) 1997; 154:5.

Symposium 14 **Sunday, October 4**
2:00 p.m.-5:00 p.m.

SUCCESSFUL MENTAL HEALTH ADVOCACY IN STATE HEALTH REFORMS

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 symposium, the participant should be able to identify factors that have contributed to successful state mental health reform advocacy campaigns. Participants should also be aware of how psychiatrists can become active in the state-level mental health advocacy coalitions that conduct these types of campaigns.

SUMMARY:

The introduction of managed care principles into the public mental health system is a relatively new phenomenon, and yet one that has moved so swiftly that nearly all states have or are considering implementing some form of managed mental health care. While this change has an enormous impact on all stakeholders in the public mental health service system, our community is still learning how to advocate effectively during the state reform process.

To help accelerate that learning process, this symposium will present real-life examples of successful mental health advocacy campaigns in three states, which have taken place as part of the National Mental Health Association's State Healthcare Reform Advocacy Project. Presenters will examine how these campaigns were conducted and review the elements that led to achieving their goals, as well as describe the barriers that were faced. Through these case studies and an audience discussion, this symposium will also explore ways in which psychiatrists can become active in state mental health advocacy coalitions.

No. 14A
CASE STUDY: LOUISIANA

Mary D. Graham, B.A., *Senior Director of State Healthcare Reform, National Mental Health Association, 1021 Prince Street, Alexandria, VA 22314-2971*

SUMMARY:

The National Mental Health Association performed its first state health care reform training for Louisiana in April of 1996. Its focus, which involved consumers, clinicians, state officials, and others, was to assess the current mental health environment in Louisiana, create an informed coalition to work on advancing mental health principles in the state, and to enact meaningful change on two or three issues of particular importance.

Shannon Robshaw, executive director of the Mental Health Association in Louisiana, and other training participants formed the Mental Health Reform Coalition as a result of the training. With ongoing technical assistance from NMHA, including a second, advanced training in October of 1997, coalition members made meaningful progress advancing their objectives, including:

(1) Uniting behind broad-based parity, which resulted in successfully passing parity legislation through the state House of Representatives in 1997, obtaining approval for an actuarial study on the impact of parity, and conducting statewide advocacy training in early 1998.

(2) Pressuring the Department of Health and Hospitals to create a "hospital diversion plan" to redirect children in institutional settings far from their families to community-based mental health services, as well as

communicating with the Office of Mental Health, Medicaid, and clinicians on a regular basis to monitor the plan.

(3) Drafting a position paper on the Children's Health Insurance Program (CHIP) and testifying before the state legislative committee that oversees the CHIP program.

Perhaps the group's greatest achievement has been its ability to provide an ongoing, unified front to oppose mental health injustices and to push for the fair and appropriate treatment of persons with mental illness in Louisiana.

No. 14B
CASE STUDY: CALIFORNIA

Rusty Selix, *Executive Director, Mental Health Association in California, 1127 11th Street, Suite 830, Sacramento, CA 95814*

SUMMARY:

This presentation will highlight the success of the ACCESS Campaign by the Mental Health Association in California, focusing on its successful efforts, which, in 1997 added three new atypical antipsychotic medication to the Medicaid formulary, which at the time was considered the most restrictive in the nation.

The presentation will also highlight the evolution of the idea from its inception in 1995 and the formation of a coalition of mental health advocacy groups, including psychiatrists, mental health associations, community agencies, and AMI groups working with pharmaceutical manufacturers and a PRI grassroots firm.

The campaign emphasized an advocacy coalition. Each visit to legislators and to hear testimony included a triad of (1) psychiatrist with research and clinical expertise, (2) a consumer and/or family member with direct experience who could tell an emotionally powerful story, and (3) a expert legislative advocate who could combine medical and personal information into an effective call for a change in public policy.

The success of this effort shows the types of both clinical and financial evidence that is important in public policy issues, the value of coalitions, the strategies both legislative and press that were effective and how difficult, important, and powerful it is to show that the *cost of not providing* expensive new advances in mental health care is greater than the additional cost of providing the mental health care.

No. 14C
CASE STUDY: ILLINOIS

Cynthia Folcarelli, *Director of State Healthcare Reform, National Mental Health Association, 1021 Prince Street, Alexandria, VA 22314*

SUMMARY:

Illinois presents an example of the ongoing nature of Medicaid managed care advocacy. When the State of Illinois sought to expand its mandatory Medicaid managed care program for primary care (called MediPlan Plus) to include mental health and substance abuse services, the Coalition for Quality Mental Health Care in Illinois moved forward on several fronts. At a planning session facilitated by the National Mental Health Association, this advocacy Coalition developed three specific committees on clinical issues, contracting, and data. Each committee was charged with addressing both substantive issues and advocacy strategy issues, considering the role of the many policymakers involved. In this case, policymakers included the U.S. Health Care Financing Administration (HCFA) as well as the Illinois Governor's Office, Department of Public Aid, Office of Mental Health, and State Legislature.

As a result of this work, Coalition members were invited to participate in state-agency-appointed working groups that were developing Illinois' managed Medicaid plan. Key state legislators met with the coalition. HCFA considered Coalition comments in its feedback to the state on the managed Medicaid plan.

Late last year, the state abandoned its plan to extend mandatory managed care to Medicaid mental health services. Instead, the state opted to expand a voluntary managed care plan for these services that was already in place. Although MediPlan Plus was never implemented, the work that the Coalition did to prepare for it remains valuable, as it can now be used to hold the system accountable in the voluntary plans.

REFERENCES:

1. Folcarelli C: The Advocacy Life Cycle of a State Medicaid Waiver: Its Stages and Advocacy Opportunities. Alexandria, VA: Association for Ambulatory Behavioral Healthcare, 1997.
2. Gabriele R (Ed): Healthcare Reform: A Consumer, Family and Advocate Perspective. Alexandria, VA: National Mental Health Association, 1997.
3. Graham M: Best strategies for professional associations responding to managed care. Behavioral Healthcare Tomorrow, September 1997.
4. Kanapaux W (Ed): Dose of NMHA-style training helps advocates prepare for reform. Mental Health Weekly, October 13 1997; 7:39.
5. Pena A (Ed): Association trains groups to tackle managed care, forge coalitions. Mental Health News Alert, August 25 1997.
6. Pena A (Ed): Mastering managed care: mental health advocates, providers learning the language of health care reform. Mental Health News Alert, October 27 1997.

Symposium 15 **Sunday, October 4**
2:00 p.m.-5:00 p.m.

LOS ANGELES COUNTY HEALTH CRISIS OF 1995: A THREE-YEAR FOLLOW-UP

Joint Session with the California Psychiatric Association

Marc D. Graff, M.D., *Partner Physician, Department of Psychiatry, Southern California Permanente Medical Group, and Local Arrangements Consultant, APA Institute Scientific Program Committee, 18040 Sherman Way, Reseda, CA 91335*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to consider the role of alliances in changing systems and gain new perspectives about complex mental health delivery systems.

SUMMARY:

The purpose of this symposium is to present the social, economic, and systems issues that led to the Los Angeles County mental health crisis of 1995, and to examine subsequent developments.

This crisis, which almost resulted in the closure of Los Angeles County + University of Southern California hospital complex and the closure of the USC psychiatric residency program, was averted by an unique alliance of academicians from USC and UCLA; residents at USC; local and state organized medicine and psychiatry, including the Southern California Psychiatric Society, the California Psychiatric Association, and the Los Angeles County Medical Association; and members of the general public, including NAMI.

The Los Angeles County mental health system in 1998 remains a system with severe financial and political problems. The November 12, 1997, decision to rebuild the LAC + USC hospital as a 600-bed institution, downsizing it from its peak of 2,100 beds, the adoption of a new and complex Medical system, and tremendous changes in senior leadership in a variety of public systems, may portend yet another crisis in the near future.

No. 15A
BUILDING AN ALLIANCE WHEN CRISIS STRIKES

Marc D. Graff, M.D., *Partner Physician, Department of Psychiatry, Southern California Permanente Medical Group, and Local Arrangements Consultant, APA Institute Scientific Program Committee, 18040 Sherman Way, Reseda, CA 91335*

SUMMARY:

The enormous size and responsibilities of the Los Angeles County mental health system are hard to grasp. The second largest metropolitan area of the United States also has the second largest public health system in the U.S., and the Los Angeles County + University of Southern California hospital complex has been the largest teaching hospital in the country.

The proposed closure of the hospital complex on June 25, 1995, was followed by community and professional outcry and the formation of an unpredented alliance of interest groups.

As then president-elect of the southern California Psychiatric Society, the DB in the area, I acted to help this alliance by meeting with residents, participating in a press conference, coordinating with the California Psychiatric Association and the Los Angeles County Medical Association, giving interviews to reporters, consulting with legal counsel, contacting senior leadership in the APA, directly contacting some of the politicians involved in this decision, and working with CAMI, the California Alliance for the Mentally Ill.

The hospital remained open, helped by political and financial assistance. Organized psychiatry was a significant factor in this result.

No. 15B
MAINTAINING PUBLIC MENTAL HEALTH SERVICES IN 1995 AND BEYOND: THE RESIDENT PHYSICIAN'S ROLE

Calvin J. Flowers, M.D., *Medical Director, Pacific Clinics, 909 South Fair Oaks Avenue, Pasadena, CA 91105*

SUMMARY:

From the perspective of residents in the USC psychiatry training programs, the threatened closure of the LAC + USC hospital complex combined with the immediate prospect of the training program itself being closed, was a crisis of the first magnitude. We realized that we were an unique group and had to voice our concerns. To deal with this crisis it was necessary for the residents to come together and to organize ourselves and respond in a cohesive, timely, and effective fashion. Tasks were complex and manifold and included obtaining information about the nature of the crisis; forging a leadership structure to manage the crisis; delegating responsibilities to non-leadership residents; and influencing the various decision makers by alliances with other groups, public relations efforts including a major news conference, and direct action. These efforts and the processes involved were transformative experiences for all involved and provided an opportunity to grow from trainee to profes-

sional, from student to teacher, and from follower to leader.

Following the immediate crisis, it became imperative to stay informed about the political and budget issues that developed, to become proactive rather than merely reactive, and to reach out to the larger community including other resident physician groups, community groups, and other professional groups.

No. 15C
FACULTY REACTION TO A NEAR HOSPITAL CLOSURE

William Arroyo, M.D., *Past President, Southern California Psychiatric Society, and Department of Psychiatry, University of Southern California Medical Center, 1937 Hospital Place, Los Angeles, CA 91403*

SUMMARY:

The costs of maintaining the sprawling health care system of L.A. County spiraled during the last decade and current financing strategies became unfeasible.

Proposed plans included the total closure of LAC + USC Medical Center, and the elimination of psychiatric services, among others. During a two- to three-week period many faculty and staff engaged in planning for a very uncertain future. Their options extended from searching for other employment to merely hoping that their current position would be spared.

During what would normally be a transitional period to a new academic year, the level of tension and uncertainty undermined the usual sense of completion of the academic year, the graduation of residents, and preparations for brand new incoming residents. Crisis resolution strategies for the benefit of faculty, staff, and residents were the primary mode of operation. The disposition of patients in regard to future care as conducted by faculty, staff, and residents was haphazard.

Clear communication between the leadership, faculty, and residents was essential. Thoughtful and timely planning were also beneficial.

No. 15D
THE SURVIVAL OF PUBLIC/ACADEMIC PSYCHIATRY IN LOS ANGELES

Milton H. Miller, M.D., *Chairman, Department of Psychiatry, Harbor-UCLA Medical Center, 1000 West Carson Street, Torrance, CA 90509-9823*

SUMMARY:

What happened in Los Angeles was a re-run of the movie, High Noon. Massive budget curtailment impended and, as usual, mental health was everyone's second favorite charity. Closure of all university-affiliated psychiatric programs was announced (Harbor-UCLA, USC Psychiatric Hospital, Olive View Hospital, and King-Drew Hospital). But, as Samuel Johnson said, "The thought of death wonderfully concentrates the mind." Leaders of academic psychiatry in Los Angeles, the psychiatric society, and the psychiatric residents did arise to the challenge. The programs stayed together, avoided trying to save "their psychiatric institution" while letting others worry about themselves. They presented a common declaration: "What you propose will badly damage many, many people. You shouldn't do that. And, if it comes to that, please know we plan an epic struggle."

Mercifully, it didn't quite come to that.

A compromise evolved. The total number of beds decreased from 225 to 150. The psychiatric programs agreed to lower the length of stay from 15 days to 10 days. All programs retained enough budget to survive.

Three years later, the psychiatric programs are alive, stressed, proud, and trusting of each other and, in many ways, more competent in facing the crises that continue coming.

No. 15E
LEARNING FROM CRISES

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

SUMMARY:

Repercussions of the L.A. County mental health crisis of 1995 continue. Organized psychiatry played an important role during that difficult period by mitigating potentially adverse effects of closing major public psychiatric facilities through deft use of community education, alliance-building, political actions, and media attention. Three years later, underlying structural and fiscal realities continue to challenge our health care network.

The L.A. County health care system remains under federal pressure to move decisively toward decentralized and community-based health care facilities. Mandated changes in funding for Medi-Cal (Medicaid) mental health services place greater importance on avoidance of hospital over-utilization. The burgeoning use of community residential facilities for treatment of individuals with severe mental illness necessitates fuller integration of mental health programs into the community. Psychiatric training programs continue to adapt to the realities of fewer inpatient training resources, more scattered care sites, and pressures to provide specific services.

This state of affairs makes it imperative that we institutionalize the lessons learned in Los Angeles County in order to ensure that the direction of change in our

mental health system is not guided only by political tempests. Organized psychiatry can contribute a rudder through preservation of clinician/consumer alliances, championing academic training and appropriate clinical research, and effectively representing professional values.

REFERENCES:

1. Cornwell EE, et al: Health care crisis from a trauma center perspective: the LA story. JAMA, 1996; 276:940-944.
2. Borus JF: Economics and psychiatric education: the irresistible force meets the moveable object. Harv Rev Psychiatry 1994; 2:15-21.
3. Siegel B: Re-engineering the public hospital system: saving the safety net. Bull NY Acad Med, 1996 Winter.
4. Alexander B, et. al.: Changing structure to improve function: one academic health center's experience. Acad Med, 1997 Apr.
5. Hoffman LM: Housestaff activism: the emergence of patient-care demands. J Health Polit Policy Law 1982; 7:421-439.
6. Miller MH: Academic psychiatry and "The Public System": a point of view, in Working Together: State-University Collaboration in Mental Health. Edited by Talbott JA, Robinowitz CB. Washington, American Psychiatric Press, 1986, p.173.
7. Lamb HR: The new state mental hospitals in the community. Psychiatric Services 1997; 48(10):1307-1310.

Symposium 16 **Monday, October 5**
8:30 a.m.-11:30 a.m.

CULTURAL COMPETENCE: LESSONS FOR MANAGED CARE

American Association of Community Psychiatrists, Black Psychiatrists of America, American Society of Hispanic Psychiatry, and Black Psychiatrists Association of Maryland

Andrés J. Pumariega, M.D., *Professor and Chairman, Department of Psychiatry and Behavioral Sciences, James H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70567, Hillrise Hall, Johnson City, TN 37614-9567*; 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*; Pedro Ruiz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) recognize principles of cultural competence in mental health services, (2) identify how these principles can be applied in managed behavioral health services and systems.

SUMMARY:

Public mental health services are increasingly coming under state managed care programs contracted to behavioral care organizations. Since managed-care approaches were initially developed to serve primarily mainstream, middle-class, majority populations, there is concern that the special needs of the mostly poor and ethnic minority clients traditionally served under public or Medicaid-funded services will be ignored under these programs. However, there are potential benefits for clients of color in the flexibility offered under this new paradigm, especially for the inclusion of culturally competent and community-based, nontraditional services. This symposium presents conceptual and practical models for incorporating principles of culturally competent services into public behavioral care plans. The guidelines for culturally competent behavioral health services developed by the National Latino Behavioral Health Work Group and similar guidelines developed for Asian Americans, both sponsored by CMHS, will be presented. An African-American-operated behavioral health network serving inner-city populations will be presented as an example of implementation of cultural competence principles. Finally, Dr. Pedro Ruiz will lead the discussion of the implications of the integration of culturally competent approaches in these new models of care.

No. 16A
CULTURAL COMPETENCE GUIDELINES FOR MANAGED CARE

Andrés J. Pumariega, M.D., *Professor and Chair, Department of Psychiatry and Behavioral Sciences, James H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70567, Hillrise Hall, Johnson City, TN 37614-9567*; Josie Romero, M.S.W.; Hank Balderrama, M.S.W.; Javier Saenz, Ph.D.; Pablo D. Hernández, M.D.; Joseph Torres, M.S.W.; Marie Sanchez, M.A.

SUMMARY:

This presentation will summarize guidelines for public mental health managed care services, developed by the National Latino Behavioral Health Work Group, addressing the unique needs of Latino populations in the United States. The main principles within these guidelines are those of culturally competent services and community-based systems of care. Culturally competent services to Latinos incorporate traditional value orientations toward practical, family-centered, community-based care, and can result in higher quality, lower cost services. The presentation will briefly review the literature on

community-based mental health services for Latinos. It will then outline the main components of the guidelines: (1) System Guidelines (including cultural competence planning, governance, benefit design, quality assurance and improvement, and management of information) (2) Clinical Guidelines (access, triage and assessment, care planning, treatment services, case management, and linguistic support), and (3) Provider Competencies for working with Latino populations. Proposed outcome indicators for each of these domains will also be presented. The presentation will discuss NLBHWG's role within the CMHS Managed Care Initiative, the applicability of these guidelines to other populations of color, and strategies being developed for influencing policymakers at the state and federal level toward these guidelines.

No. 16B
SYSTEM CULTURAL COMPETENCE FOR ASIAN AMERICANS

Francis G. Lu, M.D., *Clinical Professor of Psychiatry, University of California at San Francisco, 1001 Potrero Avenue, San Francisco, CA 94110-3518*; Harriet G. McCombs, Ph.D.; Evelyn Lee, Ed.D.; Sue Stanley, Ph.D.

SUMMARY:

This presentation will focus on cultural competence guidelines for managed mental health services for Asian Americans. The results of two Center for Mental Health Services (CMHS) sponsored initiatives will form the basis of the presentation. They are the proceedings of a CMHS conference entitled Managed Care and Ethnic Minorities, held in Washington, D.C. on June 12-13, 1996, and a CMHS-sponsored document on cultural competence guidelines for managed mental health services for Asian Americans. First, the key evaluation areas for ethnic minorities in managed care will be briefly reviewed. They include access, information systems, economics and finance, system structure, human resources, clinical quality/standards of care, and the interface with the community and consumers. Secondly, specific recommendations from the guidelines document will be presented to illustrate how these evaluation areas apply to services with Asian Americans.

No. 16C
URBAN BEHAVIORAL HEALTH SYSTEM

Orlando R. Davis, M.D., *President and Chief Executive Officer, Urban Behavioral Health Associates, 2901 Druid Park Drive, Suite A-202, Baltimore, MD 21215*

SUMMARY:

This presentation will describe Urban Behavioral Health System (UBHS), a model for community-based delivery of mental health care.

Encouraged by one of the leading urban hospital administrators in the country, a group of inner city psychiatrists formed a psychiatric group and contracted to serve a community hospital, a community mental health center, and the only minority-operated HMO in the State of Maryland. The group is currently responsible for mental health and substance abuse services for 30,000 covered lives in inner city Baltimore. The group is minority owned and operated and is a certified Minority Business Enterprise in the City of Baltimore and the State of Maryland. Challenges, opportunities, and strategies for serving inner city populations by organizing multicultural community psychiatrists will be explored.

REFERENCES:

1. Cross T, Bazrov B, Dernsi R, Isaacs M: Culturally Competence Systems of Care for Children with *SED*. Wash, DC Georgetown University, CASS, 1989.
2. Cheing F, Snauder L: Community mental health and ethnic minority populations. Community Mental Health Journal. 1990; 26(3):277-291.
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4. Center for Mental Health Services. Cultural Competence Guidelines in Managed Care Mental Health Services for Asian Americans. 1997.
5. Pumariega AJ, Cross TL: Cultural competence in child psychiatry, in Basic Handbook of Child & Adolescent Psychiatry, Volume IV. In press, John Wiley Publishers.

Symposium 17 **Monday, October 5**
8:30 a.m.-11:30 a.m.

USE OF MULTIPLE DATA SOURCES IN SERVICE RESEARCH

Bonnie T. Zima, M.D., M.P.H., *Director of Training, Division of Child and Adolescent Psychiatry, University of California at Los Angeles, 300 Medical Plaza, Room 1414, Los Angeles, CA 90095*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be familiar with strategies for analyzing multiple data sources that are particularly relevant to children's mental health services research.

SUMMARY:

Five presentations highlight study design and methods pertinent to multi-informant/multi-source data management. Each study uses at least two different data sources within different sectors: prenatal care, special education, child welfare, mental health, juvenile justice, and general health.

Dr. Nageotte's presentation focuses on the extent to which treatment setting is associated with pregnant women's access to substance abuse treatment in the routine prenatal care context. She combines data collected from prenatal care providers and patients, both before and after the initial prenatal care visit. Dr. Bussing's presentation examines parental explanatory models of their children's ADHD, combining qualitative data collected from parents in focus groups and structured interviews (SCA-PI and DISC, 3.0). Dr. Rogers' presentation examines the referral of youth detained in a county corrections facility. He combines questionnaire data collected from juvenile corrections officers and CBCL-YSR data collected from the detained youth. Dr. Andeleman's presentation examines variations in quality of life, combining data gathered from individual interviews and focus groups with parents and adolescent recipients of liver transplants. Lastly, Dr. Zima's presentation examines variation in level of need for mental health services among children in out-of-home foster care placements in Los Angeles County. She combines structured interview data collected from foster parents and children with clinician diagnosis and service recommendations. Each of these presentations highlights the importance and necessity of utilizing multi-informant, multi-source data in examining mental health services issues relevant to children and their families.

No. 17A
PRENATAL CARE PROVIDER AND PATIENT: DO THEY AGREE?

Catherine A. Nageotte, M.D., *Assistant Professor of Psychiatry, University of Illinois at Chicago, 907 S. Wolcott Street, Chicago, IL 60612*

SUMMARY:

Objective: This study compares pregnant patients and their prenatal provider's reports of ATOD counseling in the first prenatal care visit.

Design and Methods: This is a cross-sectional study of a convenience sample of public health and managed-care contracted providers (N = 14 and 9, respectively) and their patients (N = 77 and 59, respectively) at the time of the first prenatal care visit of a study patient with a study provider. Patient and provider agreement on ATOD counseling is calculated using data from provider and patient post-visit encounter forms. Data derived from pre-visit patient screening questionnaires and provider background questionnaires contextualize the agreement findings.

Key Findings: Despite similar reported ATOD use patterns, pregnant women in managed care appear to be significantly less likely to receive ATOD counseling. While the majority of patients report receiving ATOD-specific education or advice, reported rates of ATOD-specific assessment and referral are extremely low in both groups. These low rates cannot be attributed to under-reporting such services, as their providers almost always agreed with them.

No. 17B
VARIATIONS OF ADHD TREATMENT BY SECTOR OF CARE

Regina Bussing, M.D., *Associate Professor of Psychiatry, University of Florida, Box 100177, Gainesville, FL 32610-0234*; Bonnie T. Zima, M.D., M.P.H.; Amy R. Perwien, B.A.; Thomas R. Belin, Ph.D.

SUMMARY:

Purpose: To examine variations in ADHD treatment by child characteristics and provider type.

Method: A cross-sectional, two-stage design identified children receiving ADHD treatment among a school district population of special education students. Parents reported ADHD treatments received within the preceding 12 months in the general health or the specialty mental health sector.

Results: About one-half of the children had been treated exclusively by generalists, one-quarter exclusively by mental health specialists, and the remaining children by both provider types. Children treated exclusively by generalists had fewer comorbid conditions, less impairment, and lower levels of family burden compared with children treated solely by mental health specialists. Compared with exclusive general health sector users, exclusive mental health sector users were more likely to be African American and to be older, whereas combined sector users were more likely to be of high SES backgrounds. Treatment patterns differed significantly by sector of care. Exclusive primary care use was characterized by fewer sessions per year, shorter session length, and more use of medication treatments without psychotherapies or school contact, compared with specialty mental health services.

Conclusion: Specialty mental health care for ADHD differs significantly from primary care approaches; future studies should address mechanisms for appropriate specialty referrals.

No. 17C
DETAINED YOUTH: STAFF ATTITUDES AND REFERRAL PATTERNS

Kenneth M. Rogers, M.D., *Instructor, Department of Psychiatry, University of South Carolina, 1800 Colonial Drive, P.O. Box 202, Columbia, SC 29202*; Bonnie T. Zima, M.D., M.P.H.; Elaine Powell, Ph.D.; Melissa Strock, B.A.

SUMMARY:

Objective: The purpose of this study is to examine the ability of juvenile corrections officers to recognize and make appropriate mental health evaluation/treatment referrals.

Method: 250 juvenile hall staff members were given a questionnaire that elicited their attitudes about mental health evaluation. Additionally 120 referred youth and 120 matched youth were administered the Child Behavior Checklist (CBCL) to test the level of psychopathology in the groups.

Results: The CBCL scores of the referred youth were significantly higher than those of the matched youth (i.e., more clinically significant). Staff members felt positively about mental health treatment and the majority (77%) stated that they would like more training about mental health issues.

Conclusion: The decision to refer youth for mental health services is often made by individuals who have little mental health training, but are willing to learn. However, this method of selecting detainees to be referred to mental health has identified the appropriate youth. Although objective screening measures are needed, training juvenile detention workers to recognize signs of mental illness is essential if mentally ill youth are to receive appropriate treatment.

No. 17D
QUALITY OF LIFE: INFORMANT PERSPECTIVES

Ross B. Andelman, M.D., *Research Fellow, Child Services Research Group, University of California at San Francisco, 44 Montgomery Street, Suite 1450, San Francisco, CA 94104-4602*; Clifford C. Attkisson, Ph.D.; Philip Rosenthal, M.D.

SUMMARY:

Objective: Consumer-based measures, such as quality of life, have gained prominence in outcomes research and have been advocated in the study of children with physical and mental disorders. Yet conceptualizing and measuring quality of life in children poses many challenges, including the integration of data from multiple informants.

Data: This study focuses on the perspectives of adolescent liver transplant recipients and their parents with regard to the recipients' quality of life. It uses focus group methodology to solicit their opinions about what comprises and influences quality of life for children in this population.

Results: The perspectives of each party are distinct with some areas of overlap. Adolescents tend to emphasize participation in school activities, peer rejection, and fear of medical complications. Parents tend to emphasize emotional development, access to medical care and information, and the impact on the family. Both groups express concerns about the long-term impact of medication.

Conclusions: In developing measures of quality of life for children, we must accommodate the differences in informant perspective. At the conclusion of this presentation, participants will be able to recognize the conceptual and practical issues inherent in informant choosing informants to develop quality of life instruments for children.

No. 17E
CHILDREN IN FOSTER CARE: WHO NEEDS SERVICES?

Bonnie T. Zima, M.D., M.P.H., *Director of Training, Division of Child and Adolescent Psychiatry, University of California at Los Angeles, 300 Medical Plaza, Room 1414, Los Angeles, CA 90095*; Regina Bussing, M.D.; Mel Widawski, M.D.; Aaron Kaufman, M.A.; Thomas R. Belin, Ph.D.

SUMMARY:

Objective: To examine the variation in the level of need for mental health services as assessed by dimensional measures, a structured diagnostic interview, and clinical evaluation among children living in foster care.

Methods: Two in-home interviews of 300 foster parents and children aged 6-12 years were conducted by trained lay interviewers and county clinicians.

Results: Almost one-third (31%) of the children tested in the clinical range for a behavior problem, 7% reported clinical symptoms of depression, 36% reported a high level of distress, and 78% were deemed by a clinician to have moderate or severe impairment in functioning.

Conclusion: Preliminary findings from this study suggest a wide discrepancy between clinician assessment of impairment as used in the existing system of care and mental health screening instruments. As policy recommendations for standardized mental health assessments are implemented, greater attention to how we define and assess need for mental health services is needed.

REFERENCES:

1. Serdula M, Williamson DF, Kendrick JS, Avda RF, Byers T: Trends in alcohol consumption by pregnant women: 1985 through 1988. JAMA 1991; 265(7):876-879.
2. Burns BJ, Costello EJ, Angold A, Tweed D, Stangle D, Farmer EMZ, Erkanli A: Children's mental health services use across sectors. Health Affairs. 1995; 14(3):147-159.
3. Bussing R, Zima BT, Perwien AR, Belin T, Widawski M: Children in special education programs: attention deficit hyperactivity disorder, use of services, and unmet need. American Journal of Public Health. In press.
4. Steiner H, Garcia IG, Matthews Z: Post-traumatic stress disorder in incarcerated juvenile delinquents. J Am Acad Child Adolesc Psychiatry. 1997; 36:357-365.
5. Delbecq AL, Van de Ven AH, Gustafson DH: Group Techniques for Program Planning: A Guide to Nominal Group and Delphi Processes. Middleton, WI, Green Briar Press, 1986.
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7. Rosenfeld AA, Pilowsky DJ, Fine P, Thorpe M, Fein E, Simms MD, Halfon N, Irwin M, Alfaro J, Saletsky R, Nickman S: Foster care: an update. J Am Acad Child Adolesc Psychiatry 1997;36:448-457.

Symposium 18 **Monday, October 5**
8:30 a.m.-11:30 a.m.

INNOVATIONS IN TRAUMA RECOVERY WORK

Maxine Harris, Ph.D., *Clinical Director, Community Connections, 801 Pennsylvania Avenue, S.E., #201, Washington, DC 20003*; Jeffrey L. Geller, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should recognize the importance of addressing trauma issues in the overall treatment of persons with diagnosed mental illness. Participants will also be able to evaluate the merits of three innovative approaches to trauma recovery.

SUMMARY:

The high prevalence of past and current sexual and physical abuse in the lives of women diagnosed with serious mental illness has now been well documented. Studies suggest that prevalence rates among such women who are also episodically homeless and substance addicted may exceed 90%. Existing case management and residential service interventions are not designed to address issues of trauma recovery. Three innovative approaches to trauma treatment are discussed. The first applies psycho-educational principles to a 33-week group intervention for women survivors. Issues of empowerment and interpersonal reconnection are discussed along with topics covering sexual, physical, emotional, and institutional abuse. The second innovation addresses the spiritual aspects of trauma recovery. Mental health professionals need to understand the various roles spirituality may play in recovery work in order to design culturally responsive assessment tools and interventions. The final innovation addresses the parenting concerns of trauma survivors. Focus group data from mothers and mental health case managers will be used to elaborate themes for mothers diagnosed with mental illness who are trauma survivors.

No. 18A
A PSYCHOEDUCATIONAL APPROACH TO TRAUMA RECOVERY

Maxine Harris, Ph.D., *Clinical Director, Community Connections, 801 Pennsylvania Avenue, S.E., #201, Washington, DC 20003*

SUMMARY:

To address the pressing needs of women at Community Connections for specific trauma recovery work, clinical staff, in consultation with consumer survivors, have developed a 33-topic social skills module on issues of sexual and physical abuse. The weekly sessions combine psycho-educational techniques with more experiential interventions in order to address issues such as female identity emotional and physical boundaries, techniques for self-care and self-soothing, and the relationship among trauma and psychiatric symptoms, substance addiction, and failed relationships. Preliminary pilot data suggest that women feel less victimized, more empowered, and better able to ask for what they need and want following completion of the social skills intervention. Women also report, more anecdotally, that after many years of treatment, the group experience has marked the first time that the real issues in trauma recovery have been addressed.

No. 18B
SPIRITUALITY AND RELIGION IN TRAUMA RECOVERY

Roger D. Fallot, Ph.D., *Co-Director, Community Connections, 801 Pennsylvania Avenue, S.E., #201, Washington, DC 20003*

SUMMARY:

Religion and spiritually intersect with the experience of trauma in complex ways. On one hand, both physical and sexual abuse may take place in ritualized or religious contexts. Further, religious ideology has often been used to justify abusive relationships and to protect perpetrators while blaming victims. On the other hand, for many trauma survivors religion and spirituality are central to their identity and offer uniquely important resources for recovery. In order to offer culturally responsive and comprehensive trauma services attuned to individual differences, mental health professionals need to understand the various roles spirituality may play in trauma recovery and empowerment. This paper presents a model for spiritual assessment, an examination of some specific functions of religion and spirituality in relation to trauma and recovery, and recommendations for incorporating spirituality in trauma programming. Assessment of the importance and role of spirituality in trauma survivors' lives should be done routinely and may be accomplished in straightforward ways. This in turn permits (as appropriate) the exploration of spirituality as a potential strengthening resource in trauma work. It also sets the stage for developing individual, group, and systems responses, which explicitly acknowledge the various functions of spirituality for survivors.

No. 18C
MOTHERS WITH MENTAL ILLNESS AND CHILDHOOD TRAUMA

Joanne Nicholson, Ph.D., *Associate Professor of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue, North, Worcester, MA 01655*

SUMMARY:

Mothers diagnosed with serious mental illness who are trauma survivors face a complex set of parenting issues. Women who were victimized as children are motivated by painful memories to keep their children safe. However, a lack of positive parenting role models and skills, combined with the vulnerabilities their mental illnesses bring, may contribute to women's stress. Mothers with mental illness whose children are abused may re-experience their own traumas. Their requests for help on behalf of their children may be disregarded or ignored because of their mental illness. When mothers with mental illness are unable to parent, children may be placed with grandparents who were abusive to their own children, or foster parents in whom mothers have no trust. Systems' policies, regulations, and procedures may "retraumatize" women with mental illness, who are not given respect as mothers or control over service planning for themselves or their children.

Focus group data from mothers and mental health case managers will be used to elaborate themes for mothers diagnosed with mental illness who are trauma survivors. Education and skills training material on trauma and domestic violence, developed as part of the NIDRR-funded "Parenting Options Project," will be presented.

REFERENCES:

1. Harris M (ed): Sexual Abuse in the Lives of Women Diagnosed with Serious Mental Illness. Harwood Academic Publishers, 1997.
2. Trauma Recovery and Empowerment: A Clinician's Guide for Working with Women in Groups. Free Press, 1998.
3. Fallot RD: Spirituality in trauma recovery, in Sexual Abuse in the Lives of Women Diagnosed with Severe Mental Illness. Edited by Harris M, The Netherlands: Harwood Academic Publishers, 1997.
4. Drescher KD, Foy DW: Spirituality and trauma treatment: Suggestions for including spirituality as a coping resource. The Clinical Quarterly, 1995; National Center for PTSD, 5:4-6.
5. Harris M. (Ed) with Landis CL: Sexual Abuse in the Lives of Women Diagnosed with Serious Mental Illness. The Netherlands, Harwood Academic Publishers, 1997.
6. Ritsher JEB, Coursey RD, Farrell EW: A survey on issues in the lives of women with severe mental illness. Psychiatric Services 1997; 48:1273-1282.

Symposium 19 **Tuesday, October 6**
8:30 a.m.-11:30 a.m.

MOBILE CRISIS SERVICES: THE WAVE OF THE FUTURE

Linda Sacco, C.S.W., *Program Coordinator, Mobile Crisis Unit, Community Mental Health Services, Visiting Nurse Service, 1601 Bronxdale Avenue, Bronx, NY 10462*; Leila B. Laitman, M.D., *Psychiatric Consultant, Community Mental Health Services, Visiting Nurse Service, 1601 Bronxdale Avenue, Bronx, NY 10462*; Neil Pessin, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe the advantages of mobile crisis services and to understand the importance of developing a model to evaluate the efficacy and cost-effectiveness of this mode of treatment.

SUMMARY:

Mobile crisis services (MCS) are now a widely accepted approach to the delivery of emergency mental health services. However, claims of efficacy and cost-effectiveness are based on little empirical evidence. Bet-

ter evaluation of this mode of service delivery is needed. Managed care makes this especially important in the current climate where efficiency/cost factors are of paramount importance in obtaining and maintaining funding for such programs. This symposium will look at the efficacy of MCS in New York City from several points of view. A representative from the funding source will describe the origin and mission of MCS in New York. This will be followed by three speakers describing components of a study conducted by the Visiting Nurse Service of New York's (VNS) mobile crisis service in the borough of the Bronx. Our study attempts to evaluate how this VNS service impacted upon patients, families, and the mental health system and how well it met the mission of its funder. The presentations will look at the areas of consumer satisfaction, referent satisfaction, and effects on the mental health system, e.g., changes in hospitalization rates. While we believe that mobile crisis services can provide efficacious, cost-effective, and quality management of psychiatric emergencies, we hope to present a model for evaluating these claims, which may be of use to providers, consumers, and funders interested in these important questions.

No. 19A
MOBILE CRISIS SERVICES IN NEW YORK CITY

Isaac Monserrate, C.S.W., *Assistant Commissioner, New York City Department of Mental Health, 93 Worth Street, New York, NY 10010*; Neal L. Cohen, M.D.; Michael S. Lesser, M.D.

SUMMARY:

Mobile crisis services in New York City were developed following a tragic incident in which an elderly mentally disabled woman was killed by police during an eviction proceeding. This situation may have been avoided had there been earlier recognition and treatment of her illness. In 1986, the New York City Department of Mental Health, Mental Retardation and Alcoholism Services (DMH) funded four mobile crisis teams. Eleven years later, DMH funds 20 mobile crisis teams and 16 homeless outreach teams via contracts with multiple providers. DMH, a city-chartered mayoral agency, also established the Office of Crisis Intervention Services. This office is charged with providing leadership and support to these teams, as well as coordinating, implementing, and reviewing requests for assistance for "at risk" mentally disabled persons in the community. Mobile crisis services can offer many advantages to patients, families, and the mental health system, such as improved access to services, early detection and treatment, decrease in costly inpatient stays, and better collaboration with law enforcement agencies. This presentation will describe the origins and mission of mobile crisis services in New York City and DMH's current expectations and methods for measuring mobile crisis service performance as delivered by DMH funded providers.

No. 19B
EFFICACY OF MOBILE CRISIS SERVICES: THE REFERENTS POINT OF VIEW

Linda Sacco, C.S.W., *Program Coordinator, Mobile Crisis Unit, Community Mental Health Services, Visiting Nurse Service, 1601 Bronxdale Avenue, Bronx, NY 10462*; Leila B. Laitman, M.D.; Neil Pessin, Ph.D.

SUMMARY:

It has long been believed that mobile crisis services (MCS) provide benefits to staff and community providers such as improved access to noncompliant patients, better cooperation with law enforcement agencies, and decrease in costly inpatient admissions. This presentation will describe a referent satisfaction survey conducted by the Visiting Nurse Service of New York's mobile crisis service in the borough of the Bronx. The study was undertaken to evaluate how well the service met the needs/expectations of referral sources. Referrals are received from mental health and medical professionals, community service agencies, hotlines, protective agencies, schools, police personnel, and family members. Their satisfaction with the service was measured via a semi-structured telephone interview six months after referring a patient to the MCS. A 27-item survey measured such areas as overall satisfaction with the intervention, response time, collaboration with the referent, improvement in the patient's compliance with treatment, decrease in hospitalizations, and improvement in the patient's quality of life. Fifty-four referents were responsive to the survey. It was found that 93% of the referents surveyed had very positive experiences with the mobile crisis team and felt that their patients benefitted in a variety of ways. This presentation will describe the study in detail, the specific benefits to patients and referents, ways in which referents were less satisfied, and implications for evaluation of mobile crisis services more generally.

No. 19C
MOBILE CRISIS EFFICACY: THE FISCAL POINT OF VIEW

Leila B. Laitman, M.D., *Psychiatric Consultant, Community Mental Health Services, Visiting Nurse Service, 1601 Bronxdale Avenue, Bronx, NY 10462*; Linda Sacco, C.S.W.; Neil Pessin, Ph.D.

SUMMARY:

The anecdotal belief that mobile crisis services save money by averting emergency room usage and inpatient admissions has been difficult to examine objectively. How can a program prove this? This question was investigated through the use of the Crisis Triage Rating Scale that allowed for a brief dispositional assessment of mobile crisis patients at risk for hospitalization. The scale rates patients in three critical areas associated with the need for admission: (1) dangerousness, (2) support system, and (3) ability to cooperate. Lower scores are consistent with greater risk and need for hospitalization. Charts of patients hospitalized and diverted from hospitalization (by subjective staff opinion) in 1996 were reviewed to look at and explain differences in how these groups scored on the rating scale. A baseline rating was established for the type of client the team saw as needing hospitalization. All cases seen in April, May, and June of 1997 were then reviewed with the rating scale to determine if mobile crisis intervention had diverted hospitalization. It was found that only 20% of cases seen were hospitalized. Another 20% were felt to have been diverted from hospitalization despite low scores on the rating scale. Finally, 30% of patients with mid-range scores were kept from deteriorating further, thus avoiding ER visits. Taking into account the cost of ER visits and inpatient beds per day, the efficacy of mobile crisis services from a fiscal point of view is demonstrated.

No. 19D
EFFICACY OF MOBILE CRISIS SERVICES: THE CONSUMER'S POINT OF VIEW

David C. Lindy, M.D., *Clinical Director, Community Mental Health Services, Visiting Nurse Service, 1250 Broadway, 3rd Floor, New York, NY 10001*; Linda Sacco, C.S.W.

SUMMARY:

Mobile crisis services are now widely regarded as essential elements of community mental health systems. However, relatively few studies have empirically examined the therapeutic efficacy and cost-effectiveness of mobile crisis. These issues are further complicated by the wide variety of programs that call themselves "mobile crisis services." Consumer satisfaction, as measured by retrospective patient and family assessments of their experiences as recipients of mobile crisis services, provide one methodology for testing mobile crisis efficacy across different programs. Indeed, two studies, each from very different mental health systems, have found high rates of consumer satisfaction. In our study of consumers of the mobile crisis service of the Visiting Nurse Service of New York, overall satisfaction was correlated with coping information provided, perceived helpfulness, and willingness to utilize services again. Satisfaction was further correlated with younger age, minority ethnicity, and being taken to a doctor or emergency room. Patients who were elderly, lived alone, or had attempted suicide were less likely to be satisfied, suggesting that these populations may require special consideration. Interestingly, satisfaction ratings were not affected by hospitalization, whether voluntary or involuntary. Using the same 26-item semi-structured telephone interview with recent mobile crisis clients in the Bronx, we will now present new consumer satisfaction data, which replicate these findings.

REFERENCES:

1. Zealberg J, Santos A: Comprehensive Emergency Mental Health Care. New York: WW Norton and Co, Inc. 1996.
2. Geller J, Fisher W, McDermeit M: A national survey of mobile crisis services and their evaluation. Psychiatric Services. 1995; 46(9):896-897.
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5. Lindy DL, Pessin N, Malgady RG, Cramer H, Feldman PH. Consumer satisfaction as a measure of efficacy for mobile crisis services. Submitted for publication, September 1997.

Workshop 1 **Friday, October 2**
8:00 a.m.-9:30 a.m.

PSYCHIATRY MEETS PREVENTIVE MEDICINE

Daniel P. Chapman, Ph.D., M.S.C., *Psychiatric Epidemiologist, Department of Health Care, Centers for Disease Control and Prevention, 4770 Buford Highway, N.E., M.S. K-45, Atlanta, GA 30341*; Donald K. Blackman, Ph.D.; J. Patrick Moulds, M.D.; Marc A. Safran, M.D.; Paul Z. Siegel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe common goals of psychiatry and preventive medicine and to describe different career options and training opportunities involving these disciplines.

SUMMARY:

Psychiatry and preventive medicine have allied objectives, as preventive medicine interventions are commonly behavioral in nature, while psychiatric diagnosis and treatment seek to prevent disability and suffering. The field of psychiatric epidemiology has received increased recognition as interest has grown concerning the cost-effectiveness of psychiatric treatment and the impact and prevalence of psychiatric disorders in the community. Postdoctoral training in preventive medicine affords psychiatrists and others opportunities to expand both research skills and clinical competencies useful to assess psychiatric disorders epidemiologically.

The Centers for Disease Control and Prevention (CDC) has many programmatic and investigative activities with behavioral or psychosocial emphases. This workshop will describe both research relevant to psychiatry conducted at CDC, as well as postdoctoral training opportunities available. The Epidemic Intelligence Service program provides two years of postdoctoral training in applied epidemiology under the supervision of scientists at CDC or in state and local health departments. Other training opportunities in preventive medicine of interest to psychiatrists will be described and the perspectives and experiences of audience members will be elicited.

REFERENCES:

1. Anthony JC, Eaton WW, Henderson AS: Looking to the future in psychiatric epidemiology. Epidemiol Rev 1995; 17:240-242.
2. Ebbington P: What's in a name? psychiatric epidemiology and social psychiatry at the turn of the century. Soc Psychiatry Psychiatr Epidemiol 1997; 32:1-2.

Workshop 2 **Friday, October 2**
8:00 a.m.-9:30 a.m.

RESPONDING TO DISASTER: LESSONS FROM HURRICANE FRAN 1997-1999

APA/Bristol-Myers Squibb Fellows

John Wallace, M.D., J.D., *1997-1999 APA Bristol-Myers Squibb Fellow, and Resident in Psychiatry, University of North Carolina, 425 Ridgecrest Drive, Chapel Hill, NC 27514-2107*; Thomas M. Haizlip, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify resources to provide mental health services after a disaster and to recognize issues in mobilizing these resources, including one's own personal involvement.

SUMMARY:

In September 1996, Hurricane Fran hit the rural North Carolina coast with winds of 115 mph and then continued inland for more than 130 miles to strike major urban areas, killing 22 and causing extensive damage. This workshop will examine the mental health response to the hurricane from two perspectives.

First, it will examine the community outreach to provide psychiatric assistance to victims both in the immediate aftermath and in the longer term, highlighting crisis response to children through local schools and the involvement of community groups who do not normally provide mental health services. Second, efforts to enhance the mental health response in the future will be considered, including giving greater roles to local community mental health centers and the recruitment of trained pools of psychiatric professionals.

Similarities and differences with other disaster responses will be brought up and elicited from the audience. Discussion of Hurricane Fran, thus, is designed as a catalyst to encourage the audience to discuss efforts they have faced or concerns they have about becoming involved in assisting after a disaster or trauma.

TARGET AUDIENCE:

Mental health professionals and community members.

REFERENCES:

1. Austin LS (ed): Responding to Disaster: A Guide for Mental Health Professionals. Washington, DC, American Psychiatric Press, Inc., 1992.
2. Ursano RJ, Fullerton CS, Norwood AE: Psychiatric dimensions of disaster: patient care, community consultation, and preventive medicine. Harvard Rev Psychiatry 1995; 3:196-209.

Workshop 3 **Friday, October 2**
8:00 a.m.-9:30 a.m.

IS THE CONCEPT OF SELF A WESTERN PHENOMENON?

Carolyn Okazaki, L.C.S.W., *Psychotherapist, University Counseling Services, California State University at Northridge, 18111 Nordhoff, Northridge, CA 91330*; Clayton L. Chau, M.D., *Chief Resident, Outpatient Mental Health Continuity Care Services, UCLA/SFV, and 1997-1999 APA/Bristol-Myers Squibb Fellow, 16111 Plummer Street, Building 25, Sepulveda, CA 91343*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the importance of cross-cultural issues in providing psychotherapy to Asian-American clients.

SUMMARY:

Ethnicity is a powerful influential force in determining cultural identity, an element in the development of individual identity. Although recent psychoanalysts such as Erikson and Klein have begun to develop a framework for understanding how the individual is linked to the ethnic group and society, the approach of Western psychodynamic theories could pose a dilemma in treating clients from the Asian-American subgroups where individualism or self is not the basis of human development.

For many young Asian Americans, especially those of first and second generation immigrants, growing up in America is a constant struggle and confusion where cultural traditions/beliefs collide with Western values. This workshop will open a dialogue among participants with experiences in treating Asian-American clients. It encourages the sharing of observations and approaches.

TARGET AUDIENCE:

All mental health professionals.

REFERENCES:

1. Tseng WS, McDermott JF: Culture, Mind and Therapy: An Introduction to Cultural Psychiatry. New York, Brunner/Mazel, 1981.
2. Yeh M: Growing up as an ethnic minority: an Asian-American perspective. Brown University Child & Adolescent Beh Let 1994; 10:8.

Workshop 4 **Friday, October 2**
10:00 a.m.-11:30 a.m.

MANAGING THE MENTAL HEALTH PRIMARY CARE INTERFACE IN THE PUBLIC SECTOR

American Association of Community Psychiatrists

David A. Pollack, M.D., *Medical Director, Mental Health Services West, 710 S.W. Second Avenue, Portland, OR 97204-3112*; Rupert R. Goetz, M.D.; Nada L. Stotland, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should have a greater appreciation of the need for better collaborative relationships between primary care providers and mental health providers. The participant should be familiar with the important conflicts and potential solutions associated with the interface.

SUMMARY:

Health care reform discussions and the advent of managed care in the public sector have brought the issue of the interface between mental health (MH) and primary care (PC) providers into greater focus and have forced the issue of collaboration to be addressed. Organized care delivery systems must have a smoother MH-PC interface in order to more effectively and efficiently meet the needs of patients and payers. This workshop will address some of the most critical issues associated with this interface and the broad concept of "interface management."

What primary care providers want from mental health providers is a key focus. This help may be in the form of consultation, improved access for referrals, or education about diagnosis or treatment methodologies so that PCPs can provide some mental health services more effectively. How do the communications and confidentiality issues between the two arenas get worked out? Now that many PCPs are in the role of gatekeeper, what conflicts arise around the mental health needs of patients and the referral or approval of payment for services, what are the types of linkage arrangements that can be developed to assure ongoing support and access to services, and what consultation models work best in the outpatient setting? What resources are available to assist PCPs in assessing the mental health needs of their patients, and how easy are they to use and will their use mean any improvement in the care of patients? These and other key questions will be addressed, with ample time for questions and shared experiences from the audience.

TARGET AUDIENCE:

Various mental health providers and administrators.

REFERENCES:

1. Pincus HA: Patient-oriented models for linking primary care and mental health care. Gen Hosp Psychiatry 1987; 9:95-101.
2. Pollack DA, Goetz R: Psychiatric interface with primary care. In Managed Mental Health Care in the Public Sector: A Survival Manual, edited by Minkoff K and Pollack DA. Harwood Academic Pub., Newark, NJ, 1997.

Workshop 5 **Friday, October 2**
10:00 a.m.-11:30 a.m.

CREATING CONSUMER-ORIENTED MULTIAGENCY PROGRAMS

Russell F. Lim, M.D., *Clinical Assistant Professor, Department of Psychiatry, University of California at Los Angeles, 11080 West Olympic Boulevard, Los Angeles, CA 90064*; Robert E. Hales, M.D., M.B.A.; Thomas J. Sullivan, L.C.S.W.; Alfred Rowlett, M.B.A., M.S.W.; John A. Buck; Dave Hosseini; Tina Wooton

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe: 1) the process of developing consensus between multiple agencies during the planning phase, 2) how multidisciplinary teams can be developed between university and community-based employees, 3) how consumer employees can work with professional staff, 4) the implementation of the university/community collaboration in a nonprofit contract clinic with a university-provided medical director.

SUMMARY:

Over the past five years, Sacramento County has developed a unique consumer-driven mental health system for adults. The planning and implementation of the system involved the cooperative efforts of consumers, family members, the Mental Health Board, community-based organizations, Sacramento County Division of Mental Health staff, and the University of California, Davis (UCD), and an intensive consumer-driven psychiatric rehabilitation program. The county provider agencies employ more than 10 consumers. Many of the system's psychiatrists have UCD faculty appointments and are employed by UCD. The ultimate goal is for all of the county agencies' psychiatrists and medical directors to be provided by UCD.

Presentations will be given by administrators of Sacramento County, UCD, and Turning Point, as well as consumers, and a UCD medical director of a contract nonprofit community outpatient psychiatry clinic. Issues discussed will be the challenges of balancing multiple agencies' needs and agendas while providing quality mental health services and training experiences. The audience will participate to describe their approaches to creating consensus among the agencies.

TARGET AUDIENCE:

Consumers, psychiatrists, and county administrators.

REFERENCES:

1. Douglas EJ, Faulkner LR, Talbott JA et al: Administrative relationships between community mental health centers and academic psychiatry departments: a 12-year update. American Journal of Psychiatry, 1994; 151:722-7.
2. Salzer MS: Consumer empowerment in mental health organizations: concept, benefits, and impediments. Adm Policy Ment Health, 1997; 24:425-34.

Workshop 6 **Friday, October 2**
1:30 p.m.-3:00 p.m.

CHRONIC DEPRESSION ROUNDTABLE

National Depressive and Manic-Depressive Association

Gabor I. Keitner, M.D., *Director, Mood Disorders Program, Department of Psychiatry, Rhode Island Hospital, 593 Eddy Street, Providence, RI 02903*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the signs and symptoms of chronic depression and major depression; to raise professional and public awareness of the damage done by chronic depression and chronic major depression; to expand and enhance their diagnostic skills; to realize these illnesses are brain disorders and not personality flaws.

SUMMARY:

The National Depressive and Manic-Depressive Association (National DMDA) workshop will present findings from its Chronic Depression Roundtable held on January 27, 1998. There will be eight topics presented, which are epidemiology and gender; comorbidity; course and outcome; psychosocial and family functioning; psychosocial treatments; pharmacologic treatments; vocational and economics; and positive outcomes. The Chronic Depression Roundtable aims to raise professional and public awareness of the damage done by chronic depression and chronic major depression. Also it aims to alert physicians to the signs and symptoms of these brain diseases and to differentiate among chronic depression, major depression, and other illnesses. Another goal is to expand and enhance the diagnostic skills of physicians related to chronic depression and chronic major depression. The Roundtable will focus primarily on raising awareness among physicians in general and subspecialty practice and to make the general public, as well as consumers, aware of the effects of these brain diseases.

TARGET AUDIENCE:

Physicians, psychiatrists, mental health educators, consumers and the public.

REFERENCES:

1. Chronic depression roundtable report. Psychiatric services, 1997; 42:1201-1211.
2. Dysthymia and the spectrum of chronic depressions. American Journal of Psychiatry, 1993; 12:461-65.

Workshop 7 **Friday, October 2**
1:30 p.m.-3:00 p.m.

CURRENT ISSUES RELATING TO SEXUALITY IN ASIAN-AMERICAN YOUTH

1997-1999 APA/Bristol-Myers Squibb Fellows

Clayton L. Chau, M.D., *Chief Resident, Outpatient Mental Health Continuity Care Services, UCLA/SFV, and 1997-1999 APA/Bristol-Myers Squibb Fellow, 16111 Plummer Street, Building 25, Sepulveda, CA 91343*; Helen Kim, M.D.; Steven J. Lee, M.D.; Marjorie E. Waldbaum, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the current problems facing Asian-American youth in terms of adolescent development.

SUMMARY:

Sexuality, gender, generation, race, and ethnicity are intricate interrelated elements of the adolescent development process of Asian-American youth whom in a variety of ways within many social contexts have been silenced and misrepresented. This workshop will focus on a few issues such as homosexuality, pregnancy, violence, and HIV/AIDS.

For many Asian teens, the interplay between cross-cultural issues and sexuality makes this an even more complex and difficult stage of development. Limited role models, peer acceptance/pressure, and lack of cultural support services potentiate the stress of struggling to form an identity. Furthermore, their own cultural restrictions and America's highly racialized and gendered social structure pose additional risks in term of suicide and violence.

The presenters hope to demonstrate the importance of cultural considerations when treating Asian-American youth. We will encourage participation of the audiences in exchanging experiences.

TARGET AUDIENCE:

All health care professionals.

REFERENCES:

1. Hu A: Sex, lies and Asian Americans. Asian Week, 1995; May.
2. The 1995 National Asian American Sex Survey. A Magazine, 1995; 23:31.

Workshop 8 **Friday, October 2**
3:30 p.m.-5:00 p.m.

CATHOLIC AND JEWISH WOMEN SURVIVORS OF NAZI CAMPS

APA Auxiliary

Debbie Lazarus, M.A., *President, APA Auxiliary, 5760 Big Canon Drive, Englewood, CO 80111*; Leah J. Dickstein, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand unique strengths of women to cope with indescribable, overwhelming, and unexpected trauma and to rebuild personal and work lives.

SUMMARY:

This presentation will offer insights into the personal experiences of over 100 Catholic and Jewish women survivors of the Nazi camps interviewed by the presenter in Poland, Israel, and the United States. An important common thread is that all came from strong, mentally healthy families to whom they were emotionally close and for whom they attempted to survive in order to reunite.

These women had constructively healthy and stable self-esteem, with trust in certain others and a will to survive, beyond their own needs. In camp, the women developed strong attachments to a few others, forming small "family" units to enable each other to survive unimaginable atrocities.

The women's experiences support the unique and common potential strengths of women in general and of women challenged to survive the incredible horrors they endured. Beyond their traumatic experiences, they built continued lives, often under difficult political systems, to bring joy, creativity, and love back into their lives.

REFERENCES:

1. Biglova K, Zdenek Matejcek, Dytrych: Remembering: Voices of Prague Jewish Women, Prague Jewish Community, Prague, Czechoslovakia, 1994.
2. Leitner I, Leitner IA: Fragments of Isabella, A Memoir of Auschwitz, Thomas Y Crowell Publishers, NY, 1978.

Workshop 9 **Friday, October 2**
3:30 p.m.-5:00 p.m.

PSYCHIATRIC SERVICES TO THE DEAF COMMUNITY

Jill N. Afrin, M.D., *Senior Psychiatrist, Department of Deaf Services, South Carolina Department of Mental Health, 1561 Sam Rittenberg Boulevard, Charleston, SC 29407*; Arthur B. Critchfield, Ph.D.; Roger C. Williams, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify the program components needed to effectively serve the deaf community at the state, regional, and local level.

SUMMARY:

The passage of the Americans with Disabilities Act and recent advocacy has focused renewed attention on the needs of the deaf community. The South Carolina Department of Mental Health has been recognized as a national leader in the delivery of services that are cost-effective, make use of current technology, and have a high degree of consumer satisfaction. The approach used has resulted in 50% savings in operating costs while increasing clients served threefold. The program has pioneered the use of telemedicine and regional service delivery with consumers who are deaf and hard of hearing. This workshop is geared towards individuals who have opportunities for determining program direction and management such as administrative staff and senior clinicians. The workshop will present the unique characteristics of the South Carolina system, with each presenter providing a different perspective on meeting the linguistic and cultural needs of the deaf community. Following the presentations, workshop attendees will have the opportunity to present their needs and seek assistance in applying the approach presented to their practice domain. This workshop will provide the tools for beginning to meet the mental health needs of the deaf community, an oft-overlooked population.

TARGET AUDIENCE:

Senior-level administrators and clinicians

REFERENCES:

1. Gore TA, Critchfield AB: The development of a statewide mental health system for deaf and hard of hearing. Journal of the American Deafness and Rehabilitation Association, 1992; 26:1-8.

Workshop 10 **Friday, October 2**
3:30 p.m.-5:00 p.m.

ALTERNATIVE TREATMENTS IN MENTAL HEALTH CARE

1997-1999 APA/Bristol-Myers Squibb Fellows

Elizabeth M. Oudens, M.D., *Psychiatry Resident, Department of Psychiatry, University of California at San Francisco, 401 Parnassus Avenue, Box R, San Francisco, CA 94124*; Regina T. Brown, M.D.; Kathy M. Vincent, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be familiar with several specific herbal treatments for mental health conditions, understand the history and basic principles of their use, recognize the current state of scientific research and government regulations in these areas, and be able to assess the pros and cons of using herbal medications.

SUMMARY:

"Alternative" medicine is traditional health care for 80% of the world. In the past few years the number of Americans interested in alternative medical treatments has grown exponentially. Community mental health providers frequently may encounter patients who are either using or requesting alternative methods of treatment. This workshop is designed to discuss the application of herbal medications in psychiatry, the principles of their use, their history in this country, the state of scientific research in this area, and the pros and cons of the use of herbal treatments. We will look specifically at St. John's wort and gingko biloba, two herbs currently used widely in the United States. We will describe the use of herbs in treating common psychiatric conditions including depression, anxiety, and dementia. Participants are encouraged to discuss their experiences with patients who are requesting or using herbal approaches to treatment.

TARGET AUDIENCE:

Mental health care clinicians working in community settings.

REFERENCES:

1. Spiegel D: Hypnosis, in American Psychiatric Press Synopsis of Psychiatry. Edited by Hales RE, Yudofsky SC. Washington, DC, American Psychiatric Press, Inc., 1991.
2. Linde K, et al: St. John's wort for depression-an overview and meta-analysis of randomised clinical trials. British Med J 1996; 313:253-258.

Workshop 11 **Friday, October 2**
3:30 p.m.-5:00 p.m.

SUICIDE IN A YOUNG ADULT THERAPY GROUP

Lawrence L. Kennedy, M.D., *Director, Partial Hospitalization Services, The Menninger Clinic, P.O. Box 829, Topeka, KS 66601*; Gabriella M. Adorno, M.S.; Abdel Mebed, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the value of group psychotherapy for young adult mentally ill patients, recognize the powerful effects of a group member's suicide and its ramifications in a treatment center with young adult mentally ill patients, and gain an understanding of the value of videotaping of a group psychotherapy.

SUMMARY:

Group psychotherapy is especially helpful to mentally ill adults aged 18 to 25 who feel displacement and isolation from their peer group. They experience not being either adolescent or adult and view themselves as "strange misfits" in the world. A group psychotherapy experience with this population provides a powerful tool that facilitates the development of a peer group experience. This can be particularly meaningful to young adults who have been hospitalized and are recovering.

Many of these individuals have made major suicide attempts or have had chronic patterns of suicidality. This workshop will show actual videotapes of such a group in which a suicide has occurred. The tapes will demonstrate how young adults use group therapy. A major feature of the tapes will have to do with the suicide of one member and its impact on the group and the therapists. These videotapes provide a unique look at such a major incident and the experience of very ill young adults in dealing with it.

In addition to the videotape there will be a short presentation of relevant clinical material and theory. Participants will be asked to engage in a discussion during the last one-third of the workshop.

TARGET AUDIENCE:

Clinicians in private practice and community mental health centers who are working with mentally ill young adults.

REFERENCES:

1. Buelow G: A suicide in group: a case of functional realignment. International Journal of Group Psychotherapy, 1994; 44:153-169.
2. Brandes NS, Moosbrugger L: A 15-year clinical review of combined adolescent/young adult group therapy. Int J Group Psychother 1985; 35:95-107.

Workshop 12 **Saturday, October 3**
8:00 a.m.-9:30 a.m.

PHYSICIAN-ASSISTED SUICIDE IN THE NETHERLANDS: HISTORICAL AND CULTURAL BACKGROUNDS, FACTS, POLICY

Herro F. Kraan, M.D., *Chief Psychiatrist, Psychiatric Hospital Twente, Broekheurnering 1050, Enschede, The Netherlands 7546TA*; Sytske Van Der Meer, M.D.; Rene De Veen, M.D.; Pieternel Kolling, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to gain information about the current Dutch practice in physician-assisted suicide which will foster debate about these postmodern medical, legal, and ethical issues, especially the psychiatrist's role.

SUMMARY:

The Dutch population (15 million) has 100% coverage of basic health (including palliative) care. Its booming economy is attributed to a democratic culture of consensus attained by negotiation between "agreed-upon disagreeing" parties (e.g., employers and trade unions; liberals and social democrats, etc.). During the last two decades, physician-assisted suicide (PAS) became a phenomenon of public debate and small-scale practice. It concerned intractable, terminal patients deciding to end their lives, in consensus with and assisted by their physician (e.g., general practitioner) and their relatives. Liable to severe punishment by the Dutch penal code, most cases were not reported to the Court or to health inspectors.

Over time, the number of cases increased (estimation: 3000/year), as did the reporting to the Court. However, prosecution did not follow in most cases, because of the application of "regulations of carefulness" by the assisting physician. These regulations were developed by advocate physicians and the Dutch Society for Voluntary Euthanasia, later gradually accepted by the Royal Dutch Society of Physicians and the Health Inspection. In 1994 the Dutch Supreme Court acquitted a psychiatrist for PAS in a nonterminal, severe case of depression. This verdict (not supported by the local medical court!) has entailed a nationwide discussion, geared to open reporting, to the installation of independent, mixed medical/ethical/juridical committees (advisory to the Court), and to further elaboration of the "regulations of carefulness" for both terminal and nonterminal patients. Removal of PAS from the penal code is not at stake.

TARGET AUDIENCE:

Psychiatrists, physicians and other disciplines in the mental health domain.

REFERENCES:

1. Dillmann R, Legemaate I: Euthanasia in the Netherlands: the state of the legal debate. Eur. Health Law, 1994; 1:81-87.
2. Hendin H: Seduced by death. doctors, patients and the Dutch cure. Issues in Law and Medicine, 1994; 10:123-168.

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

PURSUING A CAREER IN ADMINISTRATIVE PSYCHIATRY

American Association of Psychiatric Administrators

Gordon H. Clark, Jr., M.D., M.Div., *President, Integrated Behavioral Healthcare, and Medical Director, Behavioral Health Network of Maine, One Forest Avenue, Floors 2 & 3, Portland, ME 04101*; James M. Campbell, M.D.; L. Mark Russakoff, M.D.; Christopher G. Fichtner, M.D.; Mary Rorro, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify some of the multiple opportunities available in psychiatric administration and demonstrate a variety of ways one may prepare for such a role and continuously improve in it.

SUMMARY:

As treatment becomes more stringently managed in all psychiatric systems of care, psychiatric physicians are best able to make the challenging cost/quality decisions that are becoming ever more narrowly balanced. In order to make informed decisions in these and other areas of psychiatric administration, psychiatrists must develop the requisite administrative skills.

Presenters will briefly summarize how they prepared for and pursued their respective administrative paths, including early career, academic, general hospital, federal government, state system, community psychiatry, and private group practice. Substantial time will be allowed for audience participation.

TARGET AUDIENCE:

Psychiatric administrators and medical directors.

REFERENCES:

1. Talbott JA, Hales RE, Keill SL: Textbook of Administrative Psychiatry. Washington, DC, American Psychiatric Press, Inc., 1992.
2. American Psychiatric Association & American Association of Community Psychiatrists: Guidelines for Psychiatric Practice in State and Community Psychiatry Systems. Washington, DC, APA, 1995.

Workshop 14 **Saturday, October 3**
10:00 a.m.-11:30 a.m.

WORKING AND TEACHING IN THE COMMUNITY

Samuel Packer, M.D., *Associate Professor, Department of Psychiatry, University of Toronto, St. Michael's Hospital, 30 Bond Street, Toronto, ON, Canada M5B 1W8*; John H. Langley, M.D.; Mary E. Johnston, M.D.; Sharon S. Levine, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to develop effective consultation and education programs in community agencies, understand psychiatric residents' attitudes toward community psychiatry, and examine the experience of working in hostels.

SUMMARY:

Psychiatrists who work in the community face a number of challenges in setting up programs to provide services and educate psychiatric residents. This workshop describes the development of a general-hospital-based community psychiatry program that offers consultation, educational, and evaluation services to inner-city agencies. Following discussions with the executive director and staff about agency needs, services that are available through the department of psychiatry are delivered on site where appropriate. Some examples are direct clinical consultation to agency clients, setting up a series of staff development seminars, and helping agencies evaluate their programs. Psychiatric residents who are required to participate in these activities under supervision have found this experience rewarding.

The workshop will also describe a survey of Ontario psychiatric residents. It was found that community psychiatry residency rotations are often not a requirement. However, most respondents said that this type of training was necessary and felt that it provided clinical experience not available elsewhere. When not available, residents were innovative in gaining community experiences.

Audience members will be encouraged to comment on the material presented and to discuss their experiences working in the community.

TARGET AUDIENCE:

Psychiatrists, residents, and other mental health professionals.

REFERENCES:

1. Lamb HR, Bachrach LL, Goldfinger SM, Kass FI: Summary and recommendations. In: Lamb HR, Bachrach LL, and Kass FI (eds.): Treating the Homeless Mentally Ill. Washington, D.C.: American Psychiatric Association, pp. 1-10, 1992.
2. Brown DB, et al: Training residents for community psychiatric practice guidelines for curriculum development. Community Mental Health Journal, 1993; 29(3):271-283.

Workshop 15 **Saturday, October 3**
1:30 p.m.-3:00 p.m.

ASSESSMENT OF VIOLENCE IN THE HOMELESS

APA New York County District Branch's Study Group on the Homeless Mentally Ill

Katherine Falk, M.D., *Assistant Clinical Professor of Psychiatry, Columbia University, and President and Founder, Project for Psychiatric Outreach to the Homeless, Inc., 141 East 88th Street, New York, NY 10128-2248*; Alan D. Felix, M.D.; Howard W. Telson, M.D.; Diane L. Stone, M.D.; Gail Albert, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to have a better understanding of how to assess and predict violence and how to manage violent homeless mentally ill persons.

SUMMARY:

Issues of violence among homeless mentally ill persons have become of real concern in recent years as the prevalence of violence has increased in this population. A 1995 study demonstrated that the rate of violent crimes in New York City was 40 times higher and the rate of nonviolent crimes 27 times higher in the homeless mentally ill population than in the domiciled mentally ill population. In addition, this study showed that mentally disordered defendants had 40 times the rate of homelessness found in the general population.

The following characteristics have been shown to be useful in predicting the risk of future violence: the presence of substance abuse, antisocial personality disorder, criminal and violent history, younger age, and association with antisocial peers. Clinicians, public policy makers, and the police often deny the existence as well as the seriousness of the risk of violence in this population. Clinicians who are involved in the treatment of these individuals must become more aware of how to assess for risk of violence in their patients and also know how to better manage these patients.

TARGET AUDIENCE:

Psychiatrists, social workers, nurses and case managers who hear mentally ill homeless persons.

REFERENCES:

1. Harris GT, Rice ME: Risk appraisal and management of violent behavior. Psychiatric Services, 1997; 48:1168-1174.
2. Martell DA, Rosner R, Harmon RB: Base-rate estimates of criminal behavior by homeless mentally ill persons in New York City. Psychiatric Services 1995; 46:596-601.

Workshop 16 **Saturday, October 3**
1:30 p.m.-3:00 p.m.

ROLE OF THE PUBLIC PSYCHIATRIST AS MEDICAL DIRECTOR

Jules M. Ranz, M.D., *Director, Public Psychiatry Fellowship, Department of Psychiatry, New York State Psychiatric Institute, 722 West 168th Street, Box 111, New York, NY 10032*; Hunter L. McQuistion, M.D.; Anne C. Bauer, M.D.; Pamela A. Weinberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify essential components of programs designed to treat vulnerable populations, participate in the development of local Medicaid managed mental health initiatives, and advocate for appropriate program development and monitoring in public managed mental health initiatives.

SUMMARY:

The role of psychiatrists in community-based mental health organizations has been discussed in the literature for over 25 years, highlighting that psychiatrists have ceased to occupy positions as directors in these organizations and exploring the reasons for their widespread dissatisfaction with their roles in these agencies. An important development that has been almost entirely overlooked, however, is the widespread emergence of a new leadership role for psychiatrists during this period, the position of medical director.

The term "medical director" has come to include a variety of positions: (1) as agency executive director; (2) as agency clinical director; (3) as agency chief medical officer (or chief psychiatrist); (4) as program director (e.g. unit chief); (5) as clinical supervisor, and (6) as "token MD". Although in most of these positions the medical director role does not include extensive line authority over agency staff, it nevertheless offers substantial organizational power through a combination of

title status, proximity to the agency director, and legal responsibility.

This workshop will include a number of case presentations demonstrating how the position of medical director has emerged in community mental health organizations varying widely in size, including small clinical programs, large voluntary agencies, and state offices of mental health. The workshop will conclude with a discussion of the similarities and differences among these various medical director roles.

REFERENCES:

1. AACP Guidelines for Psychiatric Leadership in Organized Delivery Systems for Treatment of Psychiatric and Substance Disorders. Community Psychiatrist 1995; 9:6-7.
2. Diamond RJ, Foldfinger SM, Pollack DA, Silver M: The role of psychiatrists in community mental health centers: a survey of job descriptions; Community Mental Health Journal 1995; 31:571-77.
3. Ranz JM, Eilenberg J, Rosenheck S: The psychiatrists's role as medical director director: task distributions and job satisfaction. Psychiatric Services 1997; 48:915-20.

TARGET AUDIENCE:

Psychiatrists working in community-based mental health agencies.

Workshop 17 **Saturday, October 3**
3:30 p.m.-5:00 p.m.

MANAGED CARE AND THE PUBLIC SECTOR

APA Committee on Managed Care

Altha J. Stewart, M.D., *Chief Executive Officer, Amoore Health Systems, Inc., 7150 Crittenden Street, Philadelphia, PA 19119*; Joanne H. Ritvo, M.D.; Roy C. Wilson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify essential components of programs designed to treat vulnerable populations, participate in the development of local Medicaid managed mental health initiatives, and advocate for appropriate program development and monitoring in public managed mental health initiatives.

SUMMARY:

As more states move Medicaid recipients into managed care programs, policy makers are discovering that many practices developed by managed care organizations working with commercial populations are not easily generalized to more vulnerable and impaired populations. The challenge of providing more carefully managed, clinically appropriate, and cost-effective care will require increased collaboration between the public and private systems. Government payers must understand how to design managed systems of care that include traditional "safety net" features while achieving some of the desired cost savings. The programs must be sensitive to the special needs of the patients served and designed to meet these needs. Through contracts with managed care organizations, well-intentioned but inexperienced government workers must implement systems for delivery of high-quality services to Medicaid populations.

A discussion of guidelines developed to assist state agency decision makers and psychiatrists working in the public sector to develop appropriate service delivery systems will be an integral part of the workshop presentation. Workshop participants will be encouraged to present their experiences with Medicaid managed care programs and discuss opportunities for improvement with the presenters.

TARGET AUDIENCE:

Psychiatrists, other mental health professionals, and state mental health program administrators.

REFERENCES:

1. Austin MJ, Blum SR: Public sector planning for managed mental health care. Administration and Policy in Mental Health, 1995; 22:201-356.
2. American Psychiatric Association Office of Economic Affairs and Practice Management: Public Mental Health: A Changing System in an Era of Managed Care. Washington, D.C., APA, 1997.

Workshop 18 **Saturday, October 3**
3:30 p.m.-5:00 p.m.

IMPLEMENTING A PACT MODEL IN A HOSTILE ENVIRONMENT

David M. Band, M.D., *Clinical Director, Mobile Community Outreach Treatment Team, St. Elizabeths Hospital, 2700 Martin Luther King Avenue, S.E., Washington, DC 20032*; Stephen M. Goldfinger, M.D., *Vice Chairman, Department of Psychiatry, State University of New York, Downstate Medical Center, and Consultant, APA Institute Scientific Program Committee, 450 Clarkson Avenue, Brooklyn, NY 11203*; Eugene R. Wooden, R.N.; Debbie Allness, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize barriers and institute strategies to successfully implement the PACT model for a

mentally ill, urban, homeless, minority population with significant substance abuse, even in the presence of significant resistance.

SUMMARY:

A 1970 deinstitutionalization study by the National Institute of Mental Health found that 56% of inpatients at Saint Elizabeths Hospital in Washington, D.C. had no clinical need for 24-hour hospitalization. In December 1975 the Mental Health Law Project won a class-action lawsuit asserting the rights of patients to treatment in less-restrictive environments. The PACT program in the District of Columbia was finally initiated in July 1994. It received limited support and endured early failures, including high staff turnover and the departure of its first director. Appropriate staff and a court-mandated consultant were critical to successfully implementing the PACT model. Numerous activities, including medication management, representative payeeship, housing, funding, and medical supplies were creatively shifted to outside private organizations. Discussion with meeting participants will include their own strategies for overcoming similar obstacles and further ideas for outsourcing services for the chronically mentally ill.

TARGET AUDIENCE:

Mental health professionals involved/interested in the PACT model.

REFERENCES:

1. Morse GA, et al: An experimental comparison of 3 types of case management for homeless mentally ill persons. Psychiatric Services 1997; 48(4).
2. Dixon L, et al: Modifying the PACT model to serve homeless persons with severe mental illness. Psychiatric Services 1995; 46:684-688.

Workshop 19 **Sunday, October 4**
8:00 a.m.-9:30 a.m.

ROADS AND BRIDGES: ENGAGING THE HOMELESS MENTALLY ILL

David M. Band, M.D., *Clinical Director, Mobile Community Outreach Treatment Team, St. Elizabeths Hospital, 2700 Martin Luther King Avenue, S.E., Washington, DC 20032*; Lien A. Hung, M.D., *Medical Officer and Director, Homeless Outreach, St. Elizabeths Hospital, and Former APA/Bristol-Myers Squibb Fellow, 2700 Martin Luther King, Jr. Avenue, S.E., Washington, DC 20032*; Marcella Anne Maguire, Ph.D.; Michelle May, M.S.W.; Lyle B. Forehand, Jr., M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe a variety of approaches in engaging homeless, mentally ill individuals, including: 1) assessing an individual's repertoire of behaviors; 2) use of creative engagement techniques; 3) methods of maintaining engagement; and 4) training and education in engaging this needy population.

SUMMARY:

From our experience, hundreds of homeless individuals with severe mental illness in the District of Columbia are less than fully engaged in treatment. There are numerous public and private agencies and programs involved in the treatment of this population. The Homeless Outreach Program and the Mobile Community Outreach Treatment Team of the District Commission on Mental Health Services and Calvary Women's Shelter will present a variety of techniques that have successfully been used to engage this population and get them treatment. Each program uses unique, yet interrelated, interventions to assess and begin to work with individuals within their repertoire of behaviors and their own immediate needs and goals. After satisfying these primary wants and establishing relationships, more therapeutic behaviors and more sophisticated goals can then be mutually worked towards. Placing the clinical encounters at the clients' location and at their level is both the most difficult and most crucial part of the engagement process. And learning this process is one of the most difficult aspects of training in mental health. Clinical vignettes will be used to illustrate methods of engaging clients and of resolving barriers to establishing relationships, followed by discussion by of similar problems and solutions by attendees.

TARGET AUDIENCE:

Mental health professionals interested in the homeless, severely mentally ill.

REFERENCES:

1. Herinckx HA, et al: Assertive community treatment versus usual care. Psychiatric Services 1997; 48:1297-1306.
2. Diamond R, Factor R: Treatment resistant patients or a treatment resistant system? Hospital and Community Psychiatry 1994; 45:197.

Workshop 20 **Sunday, October 4**
8:00 a.m.-9:30 a.m.

FORENSIC MENTAL HEALTH IN POST-APARTHEID SOUTH AFRICA

E. Eugene Kunzman, M.D., *Psychiatrist, Jail Mental Health Services, Los Angeles Sheriff's Department of Jails, 1862 Warwick Road, San Marino, CA 91108-2522*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the effects of changes in mental health and rehabilitation within the correctional system of the Republic of South Africa, from the coercive and punitive practices of the apartheid era to the post-apartheid era of reconciliation and progress of de Klerk and Mandela.

SUMMARY:

In March 1997, I participated in a 10-member delegation, sponsored by the Citizen Ambassador Program, a program of People to People International, in an exchange program with the Republic of South Africa. Various jail and prison sites in South Africa were visited. Among these sites were the Western Cape Department of Correctional Services, Robben Island Prison (Nelson Mandela's home for 18 years), the South African Police Training College, and Brandvlei Prison and Juvenile Center—all in the Capetown area; the Orange Free State Department of Correctional Services, Grootvlei Prison, and an appellate court—all in the Bloenfontein area; Boovsens police station, the Correctional Services Museum at the Pretoria Prison, and the Staff Training College and Prison Industries of Zonderwater Prison—all in the Johannesburg area.

Time permitting, 80 to 120 slides of this excursion will be shown, accompanied by a presentation of historical and current information regarding the speaker's observations and experiences. The presentation is designed to allow participants to interact with the speaker.

TARGET AUDIENCE:

Mental health professionals who have interest in the current status of mental health and rehabilitation within the jails and prisons of post-apartheid South Africa.

REFERENCES:

1. S African Officers May Seek Amnesty in Biko Slaying, Los Angeles Times, January 28, 1998.
2. Gore Visits Jail Where Mandela Spent 18 Years, *Los Angeles Times,* February 17, 1997.

Workshop 21 **Sunday, October 4**
8:00 a.m.-9:30 a.m.

MEASURING QUALITY OF LIFE IN MANAGED CARE PROGRAMS

Shelley J. Levin, Ph.D., *Director of Research, Mental Health Association, 456 Elm Avenue, Long Beach, CA 90802*; David A. Pilon, Ph.D., *Director of Training, Village Integrated Services Agency, 456 Elm Avenue, Long Beach, CA 90802-2426*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) recognize the array of quality-of-life outcome measures available, (2) be able to choose the instrument(s) that best fit the participant's program's needs, and (3) understand how outcome measurement can be used to evaluate and enhance current service delivery.

SUMMARY:

The proliferation of managed care systems has forced community-based mental health programs to measure outcome of their services. Traditionally, mental health outcome measures have focused on clinical symptomatology. Community-based mental health programs, however, are charged with achieving both a decrease in symptomatology and an increase in quality of life for their clients. Unfortunately, the latter area has often been overlooked in outcome measurement. This workshop presents a discussion of the rationale and methodology for measuring quality of life for adults with severe and persistent mental illness enrolled in community-based mental health care programs operating in a managed care environment. Participants will have the chance to discuss the outcome measurement needs of their programs, and to receive feedback from the presenters and other participants regarding the selection and implementation of an outcome tracking system.

TARGET AUDIENCE:

Administrators, program directors, contract directors and grant writers.

REFERENCES:

1. Levin SJ: Disease management in-depth: the Village Integrated Service Agency. Behavioral Health Management 1997; July/August, 32-33.
2. Dickerson FB: Assessing clinical outcome: the community functioning of persons with serious mental illness. Psychiatric Services 1997; 48(7) 897-902.

Workshop 22 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

IMPLEMENTING GROUP THERAPY IN THE ELDERLY COMMUNITY

Mark R. Nathanson, M.D., *Associate Professor of Psychiatry, Geropsychiatry Fellowship, Columbia University for Geriatric/Gerontology Rehabilitation, 85 Fifth Avenue, Room 930, New York, NY 10003-3019*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe group therapy as an effective

treatment modality for the aging population who are mobile and can attend a nearby senior center or other facility in their environs. We will cover the basics including how to assess members, where and when to hold groups, and both supportive and insight-oriented techniques. The participants should know the value of groups for seniors, their effectiveness and strategies for implementation.

SUMMARY:

The elderly are increasingly making up larger percentages of the U.S. population and the frail elderly are the fastest growing segment of those 65 years and older. The risk of mental illness in the community elderly is considerable. Dementia of various types including Alzheimer's disease and multi-infarct dementia will affect up to 40% of the over 80-year-old group. Depression as a spectrum of pathology will considerably diminish functioning in over 35% of seniors at some time during their lives. Alcoholism, prescription drug abuse, panic, anxiety, and other disorders are common. In communities where densities of seniors live and attend senior citizen centers or activities, group therapy is an effective modality of assessment and treatment of large numbers of people in a brief time. This workshop will focus on such topics as how to plan a group in the community, what time and where to locate it, factors of appropriateness of group members, stages of group development, designing contracts, how to conduct supervision of cotherapists and others. The chairperson has over ten years of experience in organizing and running such groups and expects the participants to feel more comfortable with this modality and learn how to develop their own groups in their communities.

TARGET AUDIENCE:

All practitioners, particularly working with seniors in their community settings.

REFERENCES:

1. Anthony CR, Zarit SH, Gatz M: Symptoms of psychological distress among caregivers dementia patients. Psychology and Aging 1988; 3:245-248.
2. Goldstein MZ: Family involvement in treatment of the elderly. American Psychiatric Press, 1989.

Workshop 23 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

MANAGED CARE AND TREATMENT OF PATIENTS WITH BPD

Association for Ambulatory Behavioral Healthcare

Lawrence L. Kennedy, M.D., *Director, Partial Hospitalization Services, The Menninger Clinic, P.O. Box 829, Topeka, KS 66601*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) recognize characteristics of borderline patients that make them difficult to treat in short-term settings, (2) appreciate how programs such as partial hospitals may be particularly beneficial to borderline patients, and (3) understand the basic components of a partial hospital, which can treat these patients in a cost-effective manner.

SUMMARY:

Managed care is forcing shorter and shorter treatment of patients with borderline conditions. Hospitalization is for crisis treatment only, thus requiring new and innovative treatment approaches. This workshop will focus on particular characteristics of these patients, which make treatment in alternative settings such as partial hospital practical and cost effective. The basic components of such partial hospitals and a continuum of care will be presented. The workshop will be useful to clinicians in private practice as well as community mental health centers. Case examples will be presented. Participants will be invited to discuss the material during the last half hour of the workshop. Handouts will be used.

TARGET AUDIENCE:

Clinicians in private practice and community mental health centers.

REFERENCES:

1. Kennedy LL: Treatment of the borderline patient in partial hospitalization. The Psychiatric Hospital 1991; *22* (2), 59-67.
2. Paris J: The treatment of the borderline personality disorder in light of the research on its long-term outcome. Canadian Journal of Psychiatry Feb 1993; 38(1), Supplement 1, 528-534.

Workshop 24 **Sunday, October 4**
10:00 a.m.-11:30 a.m.

MEETING THE CHALLENGE: THE DUAL DIAGNOSIS PATIENT

American Academy of Addiction Psychiatry

Richard K. Ries, M.D., *Professor and Director, Outpatient Services, Department of Psychiatry, Harborview Medical Center, 325 Ninth Avenue, Box 359911, Seattle, WA 98104-2499*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the impact of illness severity, motivational stage, syndrome typology, and service de-

livery systems on treatment utilization and outcome in dually diagnosed patients.

SUMMARY:

The high prevalence of comorbid substance use disorders and other psychiatric disorders has been well documented. However, only recently have problems associated with the clinical treatment of this group been addressed. Care of these patients is challenging and must be carefully tailored to their specific needs: clinical practice demands specific treatments for specific disorders. This session will present recent research findings to inform novel approaches to inpatient and outpatient treatment. Four major areas will be addressed: (1) role of motivation in treatment outcome, (2) contribution of schizoprenia syndromes to capacity for treatment engagement and outcome, (3) severity of illness as a predictor of type and intensity of services received and relationship to outcomes, and (4) models for integrating mental health and addiction services. Clinical advances and potential new treatment models will be presented and discussed.

TARGET AUDIENCE:

Clinicians and researchers interested in dual diagnosis.

REFERENCES:

1. Hellerstein DJ, Rosenthal RN, Miner CR: A prospective study of integrated outpatient treatment for substance abusing schizophrenic patients.
2. Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse. New York, Golden Press, 1995; 23:16-30.

Workshop 25 **Sunday, October 4**
1:30 p.m.-3:00 p.m.

PSYCHIATRIC DIAGNOSIS AND TREATMENT IN MENTAL RETARDATION

Martin J. Lubetsky, M.D., *Associate Professor of Psychiatry, John Merck Program, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Room 669, Pittsburgh, PA 15213*; John J. McGonigle, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) understand assessment techniques in evaluating individuals with developmental disabilities and mental health problems, (2) understand differential diagnosis and treatment planning for these individuals, and (3) gain a working knowledge about medication and behavioral intervention and support options to treat individuals with this "dual diagnosis."

SUMMARY:

There is a growing need to develop expertise in the evaluation and treatment of individuals with developmental disabilities and mental health problems. Behavioral health care providers need to be trained to increase their knowledge base and service options in order to improve quality and effective care to this increasing population living in the community.

People with mental retardation are at higher risk for medical and mental illness. Studies have shown that psychiatric disorders occur in 30% to 42% of individuals with mental retardation. An underestimate of psychiatric illness in this population results from the past practice of acceptance of psychiatric symptoms as part of mental retardation, "diagnostic overshadowing."

Autistic disorder/pervasive developmental disorder is a neurobiologic disorder, which has core symptoms of impairment in social interaction, communication, imaginative play, and restricted repertoire of activities and interests. It has been reported that more than 70% of those with autism have an IQ below 70, and 25% or more have seizures.

This workshop will stimulate discussion regarding assessment, differential diagnosis, treatment planning, medication options, and behavioral interventions in working with individuals with developmental disabilities and mental health problems, presented by the John Merck Program, University of Pittsburgh Medical Center.

REFERENCES:

1. Aman MG, Singh NN: Psychopharmacology of the Developmental Disabilities. New York, Springer-Verlag, 1988.
2. Bregman JD: Current developments in the understanding of mental retardation. Part II: Psychopathology. Journal of the American Academy of Child and Adolescent Psychiatry 1991; 30:861-872.

Workshop 26 **Sunday, October 4**
1:30 p.m.-3:00 p.m.

ECT: RESIDENT, EDUCATION, CERTIFICATION AND HOSPITAL PRIVILEGING

Daniel F. Maixner, M.D., *ECT Program Director, Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Box 0120, Ann Arbor, MI 48109-0120*; Michelle B. Riba, M.D., *Member, APA Institute Scientific Program Committee, Member, APA Board of Trustees, and Associate Chair for Education and Academic Affairs, Department of Psychiatry, Michigan Medical Center, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0704*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will be provided an ECT training model for residents. Issues pertaining to training and subsequent privileging in ECT will be discussed.

SUMMARY:

In 1990 the American Psychiatric Association Task Force Report on ECT (1990) provided standards for ECT training for residents. These guidelines highlight the need for a comprehensive educational experience. This is especially important as the practice of ECT now includes continued advances in technology and the more frequent treatment of severely medically ill patients. There remains much discussion about privileging policies in ECT. Privileging still relies primarily on policies established by local medical directors and experience required for privileging varies.

During this workshop, an educational model for training residents in ECT will be presented. This model will emphasize providing an experience that can be applied to privileging residents prior to their graduation. Differences in privileging will be explored by the review of policies from regional hospitals in Michigan that conduct ECT. Further recommendations regarding privileging will also be discussed.

REFERENCES:

1. American Psychiatric Association: The practice of electroconvulsive therapy: recommendations for treatment, training, and privileging. Washington, DC, American Psychiatric Association, 1990.
2. Klapheke MM: Privileging in ECT [letter], Convulsive Therapy, 1990; 11:1, p. 57-8.

Workshop 27 **Sunday, October 4**
3:30 p.m.-5:00 p.m.

PSYCHIATRIC ASPECTS OF OLFACTION

Alan R. Hirsch, M.D., *Smell and Taste Treatment and Research Center, 845 North Michigan Avenue, Suite 990-W, Chicago, IL 60611-2201*; Darin D. Dougherty, M.D.; Thomas J. Trannel, M.D.; Iris R. Bell, M.D., Ph.D.; Robert Baron, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should gain an understanding of the importance of olfaction and odors on behavior and psychiatric disease, and acquire knowledge of the importance of olfaction/limbic system interaction and its effects on mood and thought processes.

SUMMARY:

This workshop will address the olfactory aspects of psychiatry. The olfactory lobe is the sensory system most intricately connected to the limbic system/emotional brain and hence, may be a neglected key to understanding unconscious motivation. Disease states with olfactory symptoms will be addressed including depression, schizophrenia, temporal lobe epilepsy, olfactory reference syndrome, dysmorphophobia, delusional disorder, post-traumatic stress disorder, and Alzheimer's disease. Olfactory influences in normal behavior will be explored with emphasis on pheromones, food preferences, hedonics, mother-infant bonding, and emotional state. Acetylcholine, dopamine, and norepinephrine balance and their effects on the olfactory/limbic system will be presented. The potential role of olfactory stimuli in diagnosis and therapy will be discussed including effects of olfactory evoked recall on the transference relationship, use of olfactory ability as an indicator of mesolimbic dopamine receptor sensitivity, and use of odorants to modulate affective states.

REFERENCES:

1. Hirsch AR, Tranel TJ: Chemosensory disorders and psychiatric diagnoses. J Neurol Orthop Med Surg 1966; 17:25-30.
2. Serby M, Larson P, Kalkstein D: Nature and course of olfactory deficits in Alzheimer's disease. Am J Psychiat 1991; 148:357.

Workshop 28 **Sunday, October 4**
3:30 p.m.-5:00 p.m.

COMMUNITY PSYCHIATRY IN A VETERANS AFFAIRS MEDICAL CENTER

Surinder S. Nand, M.D., *Chief, Psychiatry Service, V.A. Medical Center, Chicago West Side, and Associate Professor of Clinical Psychiatry, Illinois University at Chicago, 820 South Damen Avenue, Chicago, IL 60614*; Henry W. Dove, M.D.; Elizabeth R. Tomar, M.D.; Naomi A. Levy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participants should be able to identify essential components of community psychiatry training for psychiatry residents in an intensive psychiatry community care program in the V.A.

SUMMARY:

Program Requirements for Residency Education in Psychiatry state that "it is desirable that residents have didactive learning and supervised experiences in the delivery of psychiatric services in the public sector (such

as community mental health centers and public hospitals and agencies) . . .'' Psychiatry residency programs have used various models to meet this requirement. Intensive Psychiatry Community Care programs (IPCC) in the Veterans Medical Centers use the assertive community outreach and case management model to provide psychiatric services to the chronically mentally ill. We describe the development and progress of a unique educational and training program, which emphasizes community psychiatry training utilizing the IPCC as a training site. Two residents will describe their learning experiences in this component of their training and its applicability to their post-residency clinical work.

TARGET AUDIENCE:

Psychiatry residency training directors, chiefs of departments of psychiatry, and psychiatry residents.

REFERENCES:

1. Program Requirements for Residency Education in Psychiatry; Graduate Medical Education Directory: AMA 1997-1998; pages 251-258.
2. Dianomd RD, Stein LI, Susser E: Essential and nonessential roles for psychiatrists in community mental health center. Hospital and Community Psychiatry 1991; 42:187-189.

Workshop 29 **Sunday, October 4**
3:30 p.m.-5:00 p.m.

AFRICAN-AMERICAN COMMUNITIES AND MANAGED CARE

Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute and Clinic, and Former APA/Bristol-Myers Squibb Fellow, 3811 O'Hara Street, Pittsburgh, PA 15213*; Walter H. Smith, Jr., Ph.D.; Jan Boyd; John Lovelace, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should understand the opportunities and dilemmas public sector managed care presents to the African-American community and will learn about some potential ways of dealing with these.

SUMMARY:

The rise of public sector managed care is beginning to significantly impact on African-American communities across the country. Traditional mental health service systems have labored under a long history of institutional racism. There is some hope that, given its population-oriented focus and systems level approach, public sector managed care will more appropriately address the needs of African-American communities. However, there is also very serious doubt as to whether there will be any improvement in services at all, and some fear that services will get worse. Many are concerned that African-American-run provider agencies and individual practitioners will be cut out of the system of care. There are also fears that cost cutting will hold sway over quality, once again jeopardizing the vulnerable.

This workshop will address these issues, and others, as it considers the evolution of public sector managed care in Allegheny County. Efforts from within the African-American community to ensure the delivery of appropriate, culturally sensitive and diverse services will be highlighted. The county's policies on these issues and those of the new not-for-profit managed care company, Community Care Behavioral Health, will be considered. Active participation will be encouraged.

REFERENCES:

1. Shortell SM: Remaking Health Care in America: Building to Organized Delivery Systems. San Francisco, Jossey Bass, Inc. 1996.
2. Neighbors HW, Jackson JS (eds): Mental Health in Black America Thousand Oaks, CA, Sage Publications Inc., 1996.

Workshop 30 **Monday, October 5**
8:00 a.m.-9:30 a.m.

THE ART OF SERVICES RESEARCH IN CLINICAL SETTINGS

Hunter L. McQuistion, M.D., *Medical Director, Project Renewal, Inc., and Former APA/Bristol-Myers Squibb Fellow, 200 Varick Street, New York, NY 10014*; Andrew Rosenblum, Ph.D.; Daniel Herman, D.S.W.; Alan D. Felix, M.D.; Howard W. Telson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participant will learn the rationale, challenges, and rewards of intergrating services research into free standing clinical programs and will understand principles and techniques for successfully accomplishing this integration.

SUMMARY:

Because any given mental health and substance abuse program acquires a unique character, skill is required to integrate it with services and other outcome research. Such research is also increasingly sophisticated, and in one form or another, performing it is becoming necessary for the viability of many programs. To understand how to plan, set up, and maintain this research is therefore important to program administrators, as well as clinicians and researchers. This workshop will explore the satisfactions and challenges of services research by presenting the experiences of researchers and program managers who have integrated these universes.

After describing the building blocks of four major services research projects, the workshop panel will discuss a set of skills that involves using some basic principles and consequent techniques to meld research goals with the clinical program mission. This will include the characteristics of a services research site, crafting a grant, and hiring appropriate research personnel. The collabrative role of the program manager and clinician will also be discussed in detail. Relevant issues covered will include creating a research agenda, defining appropriate study variables, implementing the study protocol without disrupting clinical services, and meaningfully incorporating service staff into the project.

REFERENCES:

1. Twain D: Developing and implementing a research strategy, in Handbook of Evaluation Research. Edited by Struening EL, Guttentag M. Sage Publication, 1975.
2. Drake RE, Becker DR, Bartels SJ: Demystifying research: application in community mental health settings, in Practicing Psychiatry in the Community: A Manual. Edited by Vaccaro JV, Clark GH. American Psychiatric Press, 1996.

Workshop 31 **Monday, October 5**
8:00 a.m.-9:30 a.m.

BOUNDARY ISSUES IN COMMUNITY TREATMENT

Jaak Rakfeldt, Ph.D., *Associate Professor, School of Professional Studies, Southern Connecticut State University, Lang Social Work Center, 101 Farnham Avenue, New Haven, CT 06515*; Kenneth S. Thompson, M.D.; Joel S. Kanter, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to identify the complex, clinical, ethical, and safety issues that emerge in community treatment situations as well as to recognize the relationship between psychiatric practice and case management, and they should be better able to integrate these concepts into their clinical practice.

SUMMARY:

The workshop will explore the impact that more assertive community support services have had on complex boundary, ethical, clinical, and safety issues. Relevant literature will be reviewed, and an analysis of current practices will be provided. The workshop will feature a dialogue between a psychiatrist and a case manager who will discuss their efforts to grapple with these complex issues. The lessons that case management can teach psychiatry and vice versa will be emphasized. Workshop participants will be encouraged to join in this discussion, thus sharing their clinical experiences with complex boundary issues in assertive community support services.

TARGET AUDIENCE:

Mental health professionals, consumers and 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 32 **Monday, October 5**
10:00 a.m.-11:30 a.m.

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

The Project for Psychiatric Outreach to the Homeless

Gail Albert, Ph.D., *Executive Director, The Project for Psychiatric Outreach to the Homeless, Inc., and Assistant Clinical Professor, Mt. Sinai School of Medicine, 120 Riverside Drive, New York, NY 10024*; Katherine Falk, M.D., *Assistant Clinical Professor of Psychiatry, Columbia University, and President and Founder, Project for Psychiatric Outreach to the Homeless, Inc., 141 East 88th Street, New York, NY 10128-2248*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the need for psychiatric outreach, engagement, and on-site treatment of the homeless mentally ill person, and understand how to create a psychiatric system that is integrated with other homeless services and inpatient hospital units.

SUMMARY:

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

cation in other cities. PPOH uses resources already present, working through existing community-based social service agencies, hospital residency training programs, and volunteer psychiatrists to create a city-wide network of community-centered psychiatric treatment for the homeless in New York, which is solidly linked with inpatient hospital units. Outcome measures are provided, including changes in service needs, and placement and continuation in housing. Residency training directors faced with downsizing and the need for off-site community placements should attend, as well as anyone interested in/involved in improving their community's system of care for the homeless mentally ill. We will discuss/share common problems and we will brainstorm adaptations of our model for different communities.

TARGET AUDIENCE:

Residency training directors, and those working with the homeless.

REFERENCES:

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

Workshop 33 **Monday, October 5**
10:00 a.m.-11:30 a.m.

MENTAL HEALTH AND PRIMARY CARE: VETERANS AFFAIRS INITIATIVES

Laurent S. Lehmann, M.D., *Associate Chief Consultant for Psychiatry, Division of Mental Health, U.S. Department of Veterans Affairs, Veterans Health Administration, 810 Vermont Avenue, N.W., Washington, DC 20420-0002*; George W. Arana, M.D.; Bradford L. Felker, M.D.; Julian Ford, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to describe criteria for educational programs promoting primary care knowledge and skills for mental health professionals and describe initial outcomes of several projects involving mental health training and practice integrated with primary care.

SUMMARY:

Dr. Lehmann will introduce the workshop by reviewing activities ongoing in the Veterans Health Administration (VHA) since designed to enhance the participation of mental health clinicians in the delivery of primary care. Information about panel sizes and integration of comprehensive care in mental health primary care teams will be presented. Dr. Ford will discuss the Mental Health Primary Care Education Module, created to educate multidisciplinary staff on primary care issues. Included are plans for "mini residencies" for internists in mental health issues and for psychiatric staff on medical disorders. Dr. Arana will describe the innovative Psychiatric Residency Primary Care Education Program (PsyPCE), which was inaugurated at 20 affiliated VA medical centers in July 1998, to provide comprehensive medical, as well as mental health care, for their patients. Dr. Felker will discuss the initial findings on implementation of practice guidelines for major depressive disorder in primary care. Each presenter will have 15 minutes for his talk, followed by five minutes for discussion. There will be 20 minutes at the end of the workshop for questions and further discussion with the audience.

TARGET AUDIENCE:

Psychiatrists, psychologists, and others interested in mental health and primary care.

REFERENCES:

1. Shore J: Psychiatry at the crossroads: our role in primary care. Am J Psychiatry 1996; 153:1398-1403.
2. Felker BL, Yazel J, Short D: Mortality and medical co-morbidity among psychiatric patients: a review. Psych Services 1996; 47:1356-1363.

Workshop 34 **Monday, October 5**
1:30 p.m.-3:00 p.m.

ECT IN GERIATRICS: PRACTICE, MODERN USES AND LEGAL REGULATIONS

Jagannathan Srinivasaraghavan, M.D., *Department of Psychiatry, Veterans Affairs Medical Center, 400 Fort Hill Avenue, Canandaigua, NY 14424*; Donald P. Hay, M.D.; Raymond A. Faber, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should know the role of ECT in geriatric patients, the innovative uses of ECT, and variation in statutory regulation of ECT across the U.S.

SUMMARY:

The current health care delivery scene in the U.S. emphasizes shorter length of inpatient stay, faster recovery from illness, and decreased cost of care. With the routine use of general anesthesia, muscle relaxation, oxygenation during the procedures, seizure and cardiac monitoring, and brief pulse stimulus, modern ECT has become extremely safe. There is indication that the use of ECT is increasing in the geriatric population, given

its speed of action, efficacy, and relative safety. Dr. Hay will focus on specifics regarding the diagnosis and treatment of the geriatric patient with ECT. Further medical comorbidity and special practice techniques will be reviewed. Dr. Faber will discuss the use of ECT in treating movement disorders. ECT has particular utility in treating advanced Parkinson's disease when medications are less effective and side effects become substantial. ECT can also ameliorate drug-induced tardive dyskinesia and tardive dystonia. Videotaped examples of patients with the aforementioned movement disorders responsive to ECT will be presented. Dr. Srinivasaraghavan will discuss elements of informed consent, statutory regulations, malpractice, and risk management in the practice of ECT. Statutory regulations of ECT vary widely between different jurisdictions. California and Texas have stringent criteria for the use of ECT. A competent voluntary patient can receive ECT with a written informed consent. However, administering ECT to either de jure or de facto incompetent patients varies widely based on substituted judgment model or best interest of the patient model utilizing a guardian, next of kin, or court order. Malpractice associated with ECT is low; pointers to further reducing risk in the practice of ECT will be discussed.

REFERENCES:

1. Hay D: ECT in the medically ill elderly. Convulsive Therapy, 1989; 5:8-16.
2. Faber R, Trimble MR: A review of electroconvulsive therapy in parkinson's disease and other movement disorders. Movement Disorder, 1991; 6:293-303.

Workshop 35 **Monday, October 5**
1:30 p.m.-3:00 p.m.

ROLE OF COERCION IN PSYCHIATRIC SERVICES

Roger Peele, M.D., *Medical Director, Northern Virginia Mental Health Institute, and Liaison, APA Institute Scientific Program Committee, 3302 Gallows Road, Falls Church, VA 22042-3398*; Lynn C. DeLacy, M.S., R.N.; Lien A. Hung, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify the role of coercion in treating the psychiatrically ill.

SUMMARY:

Throughout the history of American psychiatry, the degree to which coercion should be used has been an issue. From the time a mentally ill person is encountered in the community, through the hospitalization and even upon return to the community, the role of coercion is often an issue.

After a brief overview, this workshop will explore the clinical, legal, and ethical issues in the use of coercion faced by professionals serving mentally ill people who are homeless.

Next there will be a succinct presentation on the place of coercion in a hospital setting, with a special focus on how to minimize the use of restraints and seclusion. A presenter will review how a hospital achieved a reduction of seclusion and restraint hours from about 1,000 a month to about 20.

The format of this workshop is to have three brief presentations, and to encourage questions and comments within presentations.

TARGET AUDIENCE:

All mental health disciplines.

REFERENCES:

1. Group for Advancement of Psychiatry: Forced into Treatment. Washington, APPI, 1993.
2. Morrison EF: The evolution of a concept: aggression and violence in psychiatric settings. Arch Psychiatric Nursing 1994; 8:245-253.

Workshop 36 **Monday, October 5**
1:30 p.m.-3:00 p.m.

CHILDREN'S CAREGIVERS AS MEMBERS OF THE HOME-BASED TEAM

Katherine Levine, C.S.W., *Program Coordinator, Community Mental Health Services, Visiting Nurse Service, 1601 Bronxdale Avenue, Bronx, NY 10462*; Annette Cutrino, C.S.W.; Jacquelyn Aamodt, C.S.W.; Cathy Gray, M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify the key components that need to be assessed in working with seriously emotionally disturbed children and their families in a home-based hospital diversion program.

SUMMARY:

Community-based mental health treatment for seriously emotionally disturbed children attempts to maintain such children at home whenever possible. While promoting family cohesion and the child's quality of life, this approach must be tied to careful, ongoing assessment of children who can be at risk for suicidal, homicidal, and other destructive behaviors. The Visiting Nurse Service of New York (VNS) operates a home-based child psychiatric service, which serves minority clients living in deprived, inner-city neighborhoods in

New York City. Five teams work intensively with children and their families in the home for typically four to six weeks, utilizing a psychoeducational/cognitive-behavioral approach. Clearly, a child's caregivers are crucial variables in determining the safety of maintaining him/her at home.

The VNS teams attempt to engage caregivers as members of the treatment team. This has become an important tool both diagnostically and therapeutically. Initial work with caregivers involves educating them as to the safety risks related to the child's illness; providing basic tools, such as when to page the team; and assessing the caregivers' capacity to utilize these safety measures. We have found this assessment to be useful in determining the viability of home-based care. A parallel method of engaging caregivers is the "family team meeting." This meeting attempts to determine goals for treatment as defined by the child and family; define important members of the "family," including neighbors, teachers, and local shopkeepers; and, in appropriate and realistic ways, make them all part of the team.

This workshop will include brief presentations describing the VNS child service in greater detail, as well as descriptions of the caregiver assessment, the family team meeting, and cognitive-behavioral tools. Audience participants will be encouraged to present their experiences working with this population. In addition, the group will be organized into a "family team meeting" so we can all get a better feeling for what this involves.

REFERENCES:

1. England M, Cole R: Building systems of care for youth with serious mental illness. Hospital and Community Psychiatry 1992; 43(6), p. 630.
2. Rutter M: Psychosocial resilience and protective mechanisms. American Journal of Orthopsychiatry 1987; 57(3), pgs. 316-331.

Workshop 37 **Monday, October 5**
3:30 p.m.-5:00 p.m.

YOUNG AND OLDER PSYCHIATRISTS: PARTNERS FOR THE FUTURE

Eugene J. Fierman, M.D., *Primary Care Psychiatry, Faulkner Hospital, Commonwealth Medical Psychiatric Association, Suite 5970, Boston, MA 02130*; Gregory G. Harris, M.D., M.P.H.; Ann L. Potter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participant should recognize opportunities presented by transgenerational, small group medical/psychiatric practice in a managed care environment.

SUMMARY:

This workshop presents a model of practice, which, through the partnership of two recent residency graduates and an established practitioner, has as its primary goal the delivery of high quality, flexible, medically oriented psychiatric service. The key to the operation of this practice is full equality of the partners, recognizing that psychiatrists of different generations bring different assets, which, over time, will foster a flow of business in which each partner has an equal stake. The current managed care environment continues to provide a niche for small practices with relatively low overhead and a non-bureaucratic operation. In occupying this niche, our model of practice allows the following advantages: control over one's scheduling, work life, billing and collections; opportunities for mutual learning and support across generations; ability to respond quickly to changes in the environment; an accessible relationship to medical colleagues; and the ability to engage in teaching and research as desired. In presenting this model of practice, the following issues will be explored: partnership and generational issues, business issues, clinical model, approach to parity, managed care and the pessimism engendered by training programs, lifestyle, and opportunities for creativity, as well as the limitations encountered. Presentations will be informal with active interchange with the audience encouraged.

TARGET AUDIENCE:

Recent residency graduates, residents, medical students and private practitioners.

REFERENCES:

1. Borus JF: The transition to practice seminar. Am J Psychiatry 1978 Dec; 135:1513-6.
2. Schlesinger M, Dorwart RA, Epstein SS: Managed care constraints on psychiatrists hospital practices: bargaining power and professional autonomy. Am J Psychiatry 1996 Feb; 153 (2):256-60.

Workshop 38 **Monday, October 5**
3:30 p.m.-5:00 p.m.

INVOLUNTARY PSYCHIATRIC HOME CARE

Howard W. Telson, M.D., *Director, Outpatient Commitment Program, Department of Psychiatry, Bellevue Hospital, New York University, 215 East 24th Street, Apt. 321, New York, NY 10010-3804*; David C. Lindy, M.D.; Madeleine M. O'Brien, M.D.; Neil Pessin, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the clinical, legal, and

ethical principles underlying outreach to and court-mandated psychiatric care and treatment for the seriously and persistently mentally ill living in the community.

SUMMARY:

The theory of paternalism asserts that the state has the right to restrict an individual's liberty when it is acting for the person's own good. This theory served as the traditional basis for the commitment of nonangerous mentally ill individuals to hospital care. Community care was offered on a voluntary basis, and was therefore available only to those who requested it.

Beginning in the 1960s deinstitutionalization became the dominant social policy and commitment laws were amended to allow for the forced treatment only of individuals who were deemed dangerous to self or others. As a result, many seriously and persistently mentally ill individuals who had limited insight into their need for treatment or who resisted or refused treatment entered the community, where many of them deteriorated and/or required repeated rehospitalizations. In the community they were evaluated by the police rather than by mental health professionals before receiving any care or treatment.

Over the past 30 years a number of clinical services, such as mobile crisis, intensive case management, and assertive community treatment, have been developed to meet the needs of the chronically mentally ill living in the community. All of these services require clinicians to see patients in their homes or other places of residence. While many patients respond to the outreach orientation of these services, some patients object to what they perceive to be an intrusion into their privacy and a meddling in their affairs. In addition, outpatient commitment has been developed as a legal mechanism to insure the delivery of clinical services, even when patients do not agree to them.

This workshop will examine the clinical, legal, and ethical theories underlying outreach-oriented treatment and services for seriously mentally ill individuals living in the community. It will explore both the benefits and the problems encountered by different clinical services that make uninvited and unwelcome home visits. It will also assess the value of outpatient commitment in delivering these services. Participants will be encouraged to share their views and experiences of outreach work and involuntary community treatment of the seriously mentally ill.

REFERENCES:

1. Esser AH, Lacey SD: Being at home with mental illness, in Mental Illness: A Homecare Guide, New York, John Wiley & Sons, 1989.
2. Tavolaro KB: Preventive outpatient civil commitment and the right to refuse treatment: can pragmatic realities and constitutional requirements be reconciled? Medicine and Law 1992; 11:249-267.

Workshop 39 **Monday, October 5**
3:30 p.m.-5:00 p.m.

COMMUNITY-BASED COMMITMENT: MAKING IT WORK

Christopher D. O'Keefe, M.A., *Assistant Coordinator, Intensive Case Management Services, The Mental Health Center of Greater Manchester, 401 Cypress Street, Manchester, NH 03101-9205*; Daniel P. Potenza, M.D.; William T. Rider, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to identify the resources needed by a CMHC to treat persons conditionally discharged from a hospital to a care provider. They will also have a sense of special issues involved in treating this population and how to address them.

SUMMARY:

Studies indicate that forms of outpatient commitment may be associated with treatment gains such that the coercive nature is justified by the protection from harm that it affords both community and client. There has been less written, however, about the resources and treatment modalities needed by the community provider to whom the person is committed and what issues the clinician is likely to encounter.

The state of New Hampshire allows persons to be conditionally discharged from a hospital to a community mental health center for up to five years. Such conditions often include medication compliance, adhering to treatment schedules, and refraining from behaviors that may be harmful to self or the community.

This panel will examine providing treatment to conditionally discharged patients from several perspectives. An administrator will explore the intra-agency systems required and the interagency coordination with the hospital and legal community. A psychiatrist will discuss decisions to pursue a conditional discharge for a client and the psychopharmacology involved. A treatment team coordinator will examine the special issues involved in working with someone committed to treatment and ways to address them. This workshop will be conducted using lecture, discussion, and audiovisual aids.

TARGET AUDIENCE:

Psychiatrists, clinical staff and administrators.

REFERENCES:

1. Geller JL: Clinical guidelines for the use of involuntary outpatient treatment. Hospital and Community Psychiatry 1990; 41:749-755.

2. Swartz MS, Burns BJ, Hiday VA, et al: New directions in research on involuntary outpatient commitment. Psychiatric Services 1995; 46:381-385.

Workshop 40 **Tuesday, October 6**
8:00 a.m.-9:30 a.m.

INNOVATIVE APPROACHES TO DELIVERING SERVICES

Andrea R. Bates, M.D., *Medical Director, Turning Point, Integrated Services Agency, 4600 47th Avenue #111, Sacramento, CA 95824*; Alfred Rowlett, M.B.A., M.S.W., *Director of Program Services, Turning Point, 3440 Viking Drive, #214, Sacramento, CA 95817*; Susan Steiber, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the strengths and weaknesses of the medical model and consumer-driven philosophy, and replicate successful models at the forefront of psychiatric service delivery including integrated services agencies, crisis residential treatment programs, and regional support teams, which have specialized treatment for specific subpopulations.

SUMMARY:

A community needs to utilize various models of mental health services to effectively treat people with psychiatric disabilities. The entire range of mental health programs has certain core components in common to be successful.

The specific programs are then developed and diversified and altered to meet unique needs dependent upon severity of illness, violence ptoential, substance abuse, developmental disabilities, etc. There are a variety of political pressures and ethical considerations when establishing community mental health services. What is the consumer-driven philosophy and what is a medical model of psychiatric care? Specific case examples will point out the difficulties with each model. A treatment model blending the best of each model will usually be ideal. Carrying out the philosophy needs to be structured on a case-by-case basis. A California integrated services agency will be examined in detail, reviewing outcomes over the past four years. There will be a discussion format with questions and case examples presented for ongoing audience participation throughout the 90-minute workshop.

REFERENCES:

1. Chandler D, et al: Client outcomes in two model capitated integrated services agencies. Psychiatric Services 1996; 47:175-180.
2. Quinlivan R, et al: Service utilization and cost of care for severely mentally ill clients in an intensive case management program. Psychiatric Services 1995; 46:365-371.

Workshop 41 **Tuesday, October 6**
8:00 a.m.-9:30 a.m.

PROGRAM DEVELOPMENT AND INTEGRATED TREATMENT ACROSS SYSTEMS FOR DUAL DIAGNOSIS: MENTAL ILLNESS, DRUG ADDICTION AND ALCOHOLISM

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

EDUCATIONAL OBJECTIVES:

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

TARGET AUDIENCES:

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

Workshop 42 **Tuesday, October 6**
10:00 a.m.-11:30 a.m.

EMPOWERMENT AND TRAUMA RECOVERY WITH WOMEN IN PRISON

Catherine M. Anderson, M.Ed., *Therapist, Community Connections, 801 Pennsylvania Avenue, S.E., Washington, DC 20003*; Deborah J. Bankson, M.S.W., *Therapist, Community Connections, 801 Pennsylvania Avenue, S.E., Washington, DC 20003*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) recognize the need for empowerment and trauma work with incarcerated women; (2)

recognize the factors present in a prison setting that are obstacles to effective treatment; and (3) understand what clinical techniques are useful in addressing these obstacles.

SUMMARY:

This workshop will address the issues of trauma and the effects it has on the lives of women in prison. The experience of physical, emotional, and sexual abuse is all too common among women in general, and among women who are incarcerated, in particular. Over the past several years, clinicians at Community Connections, have been working with trauma survivors who have experienced homelessness, symptoms of mental illness, and substance abuse. In response to the needs of these women, the clinicians developed a social skills group intervention that addresses issues of women's empowerment and trauma recovery. In the last three years Community Connections clinicians have adapted this intervention for working with women within the Maryland state prison system. One goal of this work is helping women see the connection between their trauma history and problems including substance abuse, prostitution, and violence. This workshop will describe the intervention and allow the audience an opportunity to role play a group session.

TARGET AUDIENCE:

Clinicians in corrections, diversion, and trauma recovery.

REFERENCES:

1. Harris M, Landis C (eds): Sexual Abuse Among Women Diagnosed with Severe Mental Illness. Harwood Academic Press, 1997.
2. Harris M (ed): Trauma Recovery and Empowerment Manual. The Free Press, (in press).

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SYLLABUS INDEX