2002 CME Syllabus and Proceedings Summary

American Psychiatric Association

CERTIFICATE OF ATTENDANCE

This certificate provides verification of your completion of educational activities at the 2002 Institute on Psychiatric Services.

This is to certify that

_____

Attended the 2002 Institute on Psychiatric Services of the
American Psychiatric Association
October 9–13, 2002
Chicago, IL

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

Paul S. Appelbaum, M.D.
APA President

Steven M. Mirin, M.D.
Medical Director

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

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

DAILY LOG FOR ATTENDANCE AT CME FUNCTIONS AT THE 54th INSTITUTE ON PSYCHIATRIC SERVICES OCTOBER 9-13 • CHICAGO, IL

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

DAY	TITLE OF SESSION	NUMBER OF HOURS	CME CATEGORY
	TOTAL		

HOW TO OBTAIN CME CREDIT

FOR THE

2002 INSTITUTE ON PSYCHIATRIC SERVICES

The American Psychiatric Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education (CME) for physicians. The APA certifies that the continuing medical education activities designated as category 1 for the 2002 Institute sessions meet the criteria for category 1 of the Physician's Recognition Award of the American Medical Association and for the CME requirements of the APA.

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

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

RECORDING CME CREDIT THROUGH THE *CME RECORDER*

APA members can record the number of category 1 hours they earn at the Institute on Psychiatric Services by completing the Computerized Evaluation Program on-site and entering their CME hours. The hours entered onsite through the computerized evaluation are maintained for APA members in the personal CME Recorder section of the APA Web site.

The CME Recorder (for APA members) maintains a record of CME credits, which are earned at APA annual meetings and entered through the Computerized Evaluation. It also records CME credits earned online through APA CME web site programs. APA members may view and print these records from their personal computers. Members also have the capability to enter hours earned at other CME activities into their Recorder account.

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

CME REQUIREMENTS FOR APA MEMBERS

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

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

(continued on next page)

CME REQUIREMENTS FOR APA MEMBERS

(Cont'd.)

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

Individual members are responsible for maintaining their own CME records and submitting a statement of their compliance with the requirement after completing the necessary 150 hours of participation. **APA certificates are issued only upon receipt of a complete report of CME activities.** To receive an APA certificate, you can submit a completed APA report form or use one of the alternate methods detailed below. The APA Certificate is reciprocal with the Physicians' Recognition Award (PRA) of the American Medical Association.

HOW TO EARN A CERTIFICATE FOR CME COMPLIANCE

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

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

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

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

- You may also **report your CME activities directly to the APA,** using the official APA report form. This form may be obtained from the APA Office of Education, 1400 K Street, N.W., Washington, DC 20005, or call (202) 682-6179 or filed electronically via the APA web site at **http:/www@psych.org.**

EXEMPTIONS

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

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

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

CONTINUING MEDICAL EDUCATION

SYLLABUS
AND
PROCEEDINGS SUMMARY

FOR THE

54th
INSTITUTE ON PSYCHIATRIC SERVICES

October 9–13, 2002

Chicago, IL

American Psychiatric Association
Institute on Psychiatric Services
1400 K Street, N.W.
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MISSION STATEMENT

VISION, MISSION, VALUES, AND GOALS of the INSTITUTE ON PSYCHIATRIC SERVICES

VISION

The Institute on Psychiatric Services of the American Psychiatric Association (the Institute) is a yearly educational meeting which focuses on the needs of the most vulnerable, disenfranchised, and difficult-to-serve patients.

MISSION

The mission of the Institute is to train and support psychiatrists to provide quality care and leadership through study of the array of clinical innovations and services necessary to meet the needs of individuals who suffer from serious mental illness, substance abuse, or other assaults to their mental health due to trauma or adverse social circumstances, in order to assure optimal care and hope of recovery.

VALUES AND GOALS

To fulfill this mission, the Institute holds an annual meeting each fall that focuses on clinical and service programs, especially those that provide a complex array of services and clinical innovations to meet the needs of the most difficult-to-serve patients. Such programs constitute the continuum of care, from state and general hospitals to community-based drop-in centers, and attempt to meet the needs of persons living in rural communities as well as the urban poor. The focus on more difficult-to-serve patients requires attention to the social and community contexts in which these patients are treated and reside. Contextual issues must be addressed because they operate as significant variables in the course of the psychiatric illnesses of certain patient populations such as those with severe and persistent mental illness, members of minority groups and those suffering economic hardships, most children and adolescents, the elderly, patients living in rural communities or in communities of immigrants, and patients treated in settings for physically or intellectually disabled individuals.

The Institute, therefore, fosters discussions of such issues as housing and vocational rehabilitation equally with innovative psychological treatments and pharmacotherapy. The clinical focus of the Institute is on innovations and adaptations of proven therapies as they are applied to the more difficult-to-serve populations. The Institute also serves as a forum for discussing systems of care, quality management, government policy, and social and economic factors as they have an impact on the most vulnerable patients.

The mission of the Institute is of particular significance to an important subset of APA members who are its prime constituents. This includes psychiatrists who identify themselves as in community practice, those involved in teaching community practice, those who serve in the public sector, such as staff working in state, community, and Veterans Affairs hospitals, community clinics, jails, or other community agencies, psychiatric administrators and those with a particular interest in the social issues that have an impact on patients. It is a goal of the Institute to provide a venue for relevant scientific programs that will retain such psychiatrists as valued members of the APA and attract colleagues who are not yet members. The Institute functions as a prime APA service to these important, devoted, and often isolated colleagues, many of whom are psychiatrists of color or international medical graduates. It is the goal of the Institute to reach out and encourage these psychiatrists to join the APA and attend this meeting. In turn, the APA will strive to ensure that the Institute serves as a professional home for these groups of colleagues.

Serving the populations that have been identified as the focus of the Institute involves collaboration with a wide variety of other professionals as well as with consumers, family members, and advocates. Therefore, an important part of the mission of the Institute is to encourage interdisciplinary and family member participation. Indeed, this mission has been an organizing principle of the Institute since its inception. Efforts will be made to further reach out to families, consumers, and allied professionals in the communities where meetings are held, and attention will be paid to ensuring their access to the Institute. The Institute is supportive of allied psychiatric organizations who share a similar vision and mission for which the Institute can serve as a scientific venue. It is part of the mission of the Institute to meet the needs of such allied groups for meeting times and space.

Course 1 **Wednesday, October 9**
9:00 a.m.-4:00 p.m.

MANAGEMENT AND TREATMENT OF THE VIOLENT PATIENT

Gary J. Maier, M.D., *Mendota Mental Health Center, 301 Troy Drive, Madison, WI 53704-1521*; Brad Smith, M.D.

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

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

REFERENCES:

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

Course 2 **Wednesday, October 9**
1:00 p.m.-5:00 p.m.

LIMIT SETTING WITH PSYCHIATRIC PATIENTS

Donald A. Misch, M.D., *Associate Professor of Psychiatry, Department of Psychiatry and Health Behavior, Medical College of Georgia, CB-1846, Augusta, GA 30912;* Lydia E. Weisser, D.O.

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

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

REFERENCES:

1. Rosenheck R.: Substance abuse and the chronically mentally ill: therapeutic alliance and therapeutic limit-setting [comment]. Community Mental Health Journal 31(3):283–285, 1995.
2. Welch HG, Bernat JL, Mogielnicki RP: Who's in charge here? Maximizing patient benefit and professional authority by physician limit setting. J Gen Intern Med 9(8):450–454, 1994.

Course 3 **Thursday, October 10**
8:00 a.m.-12 noon

ENGAGING RESISTANT AND HOSTILE PATIENTS IN PARTICIPATORY TREATMENT

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) identify ways for clinicians to better deal with resistance and hostility; 2) demonstrate skills to assess readiness and engage patients collaboratively; and 3) recognize ways to transform services to match interventions to patients' stage of change.

SUMMARY:

Resistance and hostility are not expected parts of many mental health and addiction patients' presentation. Yet many clinicians feel ill equipped to deal with resistance and hostility and try confrontation to "break-through denial" or passive styles of psychotherapy to explore psychodynamics and internal conflicts. The training of mental health and addiction treatment professionals frequently neglects strategies to engage patients into participatory treatment planning and how to finesse counseling skills to prepare people for change. This course is designed to help participants improve assessment and treatment of resistance and hostility in addiction and mental health patients and to become better acquainted with how people change. Faculty 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. The format of the course will provide the opportunity to build skills around the assessment, engagement, and treatment of patients who are at varying stages of readiness to change.

REFERENCES:

1. Baer JS, Kivlahan DR, Donovan DM: Integrating skills training and motivational therapies-implications for the treatment of substance dependence. Journal of Substance Abuse Treatment. Vol. 17. Nos. 1–2:15–23, 1999.
2. Levinson W; Gorawara-Bhat R; Lamb J: A study of patient clues and physician responses in primary care and surgical settings. JAMA. 284:1021–1027, 2000.

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

MED-PSYCH DRUG-DRUG INTERACTIONS

Scott C. Armstrong, M.D., *FAPM, Medical Co-Director, Tuality Forest Grove Center for Geriatric Psychiatry, and Associate Professor of Psychiatry, Oregon Health Sciences University at Portland, OR, 1809 Maple Street, Forest Grove, OR 97116;* Kelly Lynn Cozza, M.D., *Psychiatrist, HIV Division, Department of Medicine, Walter Reed Army Medical Center, Washington, DC, and Assistant Professor of Psychiatry, Uniformed Services University of the Health Sciences at Beth., Washington, DC 20307;* Neil Sandson, M.D.; Jessica R. Oesterheld, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) use tables, literature, and the Internet to understand and appreciate significant drug-drug interactions, and 2) gain practical knowledge of pertinent food, psychiatric, and nonpsychiatric drug interactions.

SUMMARY:

This course is designed for all psychiatrists, although particular attention will be given to psychiatrists who practice at the interface of psychiatry and medicine (i.e., medpsych or consultation-liaison psychiatry). The course will have four sections. Part I will be an overview of drug metabolism. Part II will detail each enzyme and the drugs that are metabolized by, inhibit, or induce the enzyme. Part III will include practical guidelines, case vignettes, and forensic/legal issues regarding drug-drug interactions. This section will also include reviewing Web sites in real time to help attendees appreciate Internet reference materials. Part IV will break down the cytochrome system by medical subspecialty (such as infectious diseases or neurology) and its interface with psychotropic drug-drug interactions. The course will also focus on pharmacokinetic/metabolic drug-drug interactions.

REFERENCES:

1. Flockhart DA, Oesterheld JR: Cytochrome P450-mediated drug interactions. Child Adolesc Psychiatric Clin N Am. 9(1):43–76, 2000.
2. Streetman DS, Bertino JS Jr., Nafziger AN: Phenotyping of drug-metabolizing enzymes in adults: a review of in-vivo cytochrome P450 phenotyping probes. Pharmacogenetics. 10(3):187–216, 2000.

Course 5 **Thursday, October 10**
9:00 a.m.-4:00 p.m.

BUILD YOUR OWN RELATIONAL DATABASE ELECTRONIC MEDICAL RECORD

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

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

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

REFERENCES:

1. Tang PC, LaRosa MP, Gorden SM: Use of computer-based records, completeness of documentation, and appropriateness of documented clinical decisions. Journal of the American Medical Informatics Association. 6:245–251, 1999.
2. Zielstorff RD: Online practice guidelines. Journal of the American Medical Informatics Association. 5:227–236, 1998.

Course 6 **Friday, October 11**
8:00 a.m.-12 noon

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

L. Mark Russakoff, M.D., *Director of Psychiatry, Phelps Memorial Hospital, 701 North Broadway, Sleepy Hollow, NY 10591;* Philip E. Veenhuis, M.D., *Medical Director, North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, 325 North Salisbury Street, Raleigh, NC 27603-1388*

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

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

REFERENCES:

1. Talbott JA, Hales ED, Eds., Textbook of Administrative Psychiatry: New Concepts for a Changing Be-

havioral System, 2nd Edition, Washington, DC: American Psychiatric Press, 2001.
2. Rodenhauser, P: Mental Health Care Administration: A Guide of Practitioners, Ann Arbor: University of Michigan Press, 2000.

Course 7 **Friday, October 11**
1:00 p.m.-5:00 p.m.

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

Kenneth M. Minkoff, M.D., *Medical Director, Choate Health Management, and Consultant and Trainer, Integrated Treatment Systems and Interventions for Co-Occurring Disorders, 12 Jefferson Drive, Acton, MA 01720*

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

This course will provide a basic introduction to the complex topic of co-occurring psychiatric and substance disorders, with the goal of assisting the practitioner to develop a systematic, integrated, conceptual framework that facilitates rational treatment planning and treatment matching, and permits the design of a comprehensive, continuous, and integrated system of care. The course will begin with a brief overview of the problem of dual diagnosis and the difficulties practitioners encounter in providing successful treatment. Using national consensus best-practice models based on available research, subtypes of the dual-diagnosis population and basic principles of successful intervention will be identified. These principles will emphasize the importance of empathic, hopeful, continuous, integrated treatment relationships, integrated dual primary phase-specific treatment matching, and appropriate balance of case management/care with empathic detachment and confrontation. Barriers to integrated treatment will be identified, and an integrated parallel disease and recovery model will be utilized as a mechanism to address those barriers. This model will then be utilized to illustrate the process of integrated assessment, treatment matching (including motivational enhancement interventions), and strategies for psychopharmacologic intervention. Participants are encouraged to bring clinical and programmatic problems and scenarios for illustrative discussion.

REFERENCES:

1. Drake RE, Essock SM, Shaner A, et al. Implementing dual diagnosis services for clients with severe mental illness. Psychiatric Services. 52:469–476, 2001.
2. Minkoff K. Developing standards of care for individuals with co-occurring psychiatric and substance abuse disorders. Psychiatric Services. 52:597–99, 2001.

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

ANTIPSYCHOTIC-INDUCED MOVEMENT DISORDERS: ASSESSMENT AND TREATMENT

Leonardo Cortese, M.D., *LMSC-Victoria Campus, London, Canada, 392 South Street, London, ON Canada N6A 4G5;* Richard Williams, M.D.; Michael Caligiuri, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) classify the types of movement disorders; 2) list clinical features, differential diagnosis, and risk factors of all four types of antipsychotic-induced movement disorders; 3) understand treatment modalities of all four types of extrapyramidal syndromes (EPS); 4) examine a patient for movement disorders; 5) identify EPS through video clips of patients with a vast array of movement disorders; and 6) understand the benefit of using instrumentation in the assessment of EPS.

SUMMARY:

Since the mid-1950s, antipsychotics have been the cornerstone of treatment for schizophrenia. Unfortunately, they have caused neurological side effects that, for some patients, have led to nonadherence and possibly, poor outcomes. These neuroleptic-induced, extrapyramidal syndromes (EPS) have consisted of motor and psychological disabilities of dystonia, parkinsonism, akathisia, and dyskinesia. They have been present not only in the acute form, but have progressed to the tardive phase in some vulnerable patients. Although there has been considerable attention paid to the assessment and treatment of EPS through the years, these difficulties have had a significant presence. EPS induced by first-generation antipsychotics have occurred in up to 50 percent to 70 percent of patients. Second-generation antipsychotics, due to their different receptor profiles, have decreased the onset of EPS considerably. Even in tardive

dyskinesia, perhaps the most disabling of EPS forms, the incidence has decreased from five percent with first-generation antipsychotics and from zero percent to two percent with second-generation antipsychotics. This course will present and enhance the assessment and management of neuroleptic-induced movement disorders. It will be of benefit to all clinicians involved in the treatment of patients prescribed neuroleptics. The presentation will review the classification, clinical features, differential diagnosis, risk factors, and treatment modalities of all four major types of movement disorders. Patient video clips will help to enhance identification of these disorders. The course will also provide instruction of a clinical examination on a real patient to assess movement disorders. As quantitative evaluations of movement disorders have been shown to be most beneficial, this course will present an assessment by instrumentation on a patient with EPS.

REFERENCES:

1. Casey DE: Will the new antipsychotic bring hope of reducing the risk of developing extrapyramidal syndromes and tardive dyskinesia? Int Clin Psychopharmacol. 12 Suppl 1:S19–S27, 1997.
2. Cortese L, Pourncher-Bouchard E, Williams E. The assessment and management of antipsychotic-induced adverse events. Can J Psychiatry. 43 Suppl 1:S15–S20, 1998.

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

DSM-IV-TR CULTURAL FORMULATIONS: DIAGNOSIS AND THERAPY

Russell F. Lim, M.D., *Clinical Assistant Professor of Psychiatry, University of California at Davis, School of Medicine, and Medical Director, Northgate Point, Regional Support Team, 601 West North Market Boulevard, #100, Sacramento, CA 95834;* Johannes C. Ndlela, M.D.; Candace M. Fleming, Ph.D.; Francis G. Lu, M.D.; Michael W. Smith, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) understand and describe the five parts of the *DSM-IV* outline for cultural formulation; 2) apply the cultural formulation to the treatment of African-American, Asian, Hispanic, and Native American patients; and 3) recognize how ethnicity affects psychopharmacology and psychotherapy.

SUMMARY:

The increasing cultural diversity in the United States, as shown by the United States census data, requires that clinicians understand cultural differences and how they affect diagnosis and treatment. From 1980 to 2000, the number of Asians in America increased by 230 percent, Hispanics by 142 percent, Native Americans by 139 percent, and African Americans by 32 percent, while Caucasians increased by only 11 percent. ACGME requirements for residents training in psychiatry now include a familiarity with cultural assessment. The publication of *DSM-IV* has added new emphasis to the influence of culture on diagnosis by including an outline for cultural formulation and a glossary of culture-bound syndromes. Culturally diverse individuals have special needs and require special skills and knowledge to receive appropriate and effective treatment. In 2001, the Surgeon General of the United States released a supplement of his report on mental health, titled "Culture, Race, and Ethnicity," which stated that "culture counts" in the diagnosis and treatment of the above four ethnic groups. Culturally diverse individuals have special needs, and clinicians require special skills and knowledge to treat them both appropriately and effectively. This course will present clinicians with a framework for the assessment of culturally diverse patients, as well as guidelines for psychopharmacology with these patients. Participants will attend two small groups that will discuss salient issues in the assessment of African-American, Asian, Hispanic, and Native American patients which will allow them to ask questions and to discuss their own cases in an in-depth manner. Faculty representing the various ethnicities from the University of California, San Francisco, Davis, and Los Angeles; the University of Colorado, and Columbia University will lead the discussions.

REFERENCES:

1. Canino I, Spurlock J: Culturally Diverse Children and Adolescents. Second Edition. New York, NY: Guilford 2000.
2. Association of American Medical Colleges: Medical School Objectives Project, Part I-III. Washington, DC: Association of American Medical Colleges, 1998, 1999.

Course 10 **Saturday, October 12**
9:00 a.m.-4:00 p.m.

PERSONNEL MANAGEMENT FOR CLINICIAN MANAGERS

Stephen M. Soltys, M.D., *Department of Psychiatry, University of South Carolina, 108 Glen Ridge Court, Irmo, SC 29063;* Thomas W. Hester, M.D.; Joseph J. Parks, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) effectively deal with personnel situations

which commonly confront a clinician-administrator, and 2) be familiar with related legal issues.

SUMMARY:

In order for a mental health organization to run effectively, employees from a range of disciplines must be recruited and motivated to work together as a team. However, some personnel may function in a disruptive manner. Clinicians in administrative positions quickly find that successfully motivating individuals to work with their coworkers requires personnel management skills, which are significantly different from the interpersonal clinical skills they have developed. In this highly interactive course, three psychiatrists with extensive senior management experience will help course participants develop the skills to deal with a range of personnel issues which commonly occur in private and public mental health settings. Techniques for effective recruitment, supervision, negotiating, discipline, and termination will be described with attention toward decreasing the risk of potential legal actions. Approaches toward motivating both professional and non-professional employees will be explained, as will the effects of managed care and downsizing on employee morale. Participants will be encouraged to share situations they have encountered for extensive discussion with course faculty.

REFERENCES:

1. Larson RC: Inappropriate workplace aggression: case examples. Psychiatric Annals. 28(5):253–259, 1998.
2. Long B: Sexual Harassment: A case of workplace aggression. Psychiatric Annals. 28:(5)260–264, 1998.

Course 11 **Saturday, October 12**
1:00 p.m.-5:00 p.m.

CORRECTIONAL PSYCHIATRY

Council on Psychiatric Services

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

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

This course in correctional psychiatry is a presentation of the Caucus of Psychiatrists Practicing in Criminal Justice Settings. Although it will be of interest to those who are considering practicing in correctional settings, it is primarily directed to an audience which has had some experience in correctional psychiatric practice and will cover intermediate and advanced topics in correctional psychiatry. Intermediate topics will include brief histories of corrections and correctional psychiatry, psychopharmacology in correctional settings and recent legal cases in this area. Advanced topics will include integrating medical and mental health services and other systems issues, managed care issues, accreditation and security personnel as members of the treatment team. Special attention will be given to the subjects of co-occurring disorders (especially alcoholism and drug dependence) and cross-cultural and cultural awareness in correctional psychiatry. Additional topics will include special resources and publications and national organizations of importance to correctional psychiatry such as the National Commission on Correctional Health Care and The American Correctional Association. Course attendees will be encouraged to raise clinical and administrative issues of concern to them. The faculty for this course, who are all members of the Executive Board of the Caucus, include leading educators, surveyors and practitioners in correctional psychiatry.

REFERENCES:

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

Debate 1 **Thursday, October 10**
3:30 p.m.-5:00 p.m.

RESOLVED: A PSYCHIATRIST'S OBLIGATION TO HIS OR HER PATIENT IS TO ADVOCATE FOR THE BEST CARE FOR THAT PATIENT REGARDLESS OF COST CONSIDERATIONS

American Association of Community Psychiatrists

Anita S. Everett, M.D., *Inspector General, Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services, 37 Canterbury Road, Charlottesville, VA 22903*; Nada L. Stotland, M.D., M.P.H., *Speaker, APA Assembly, and Professor of Psychiatry and Obstetrics and Gynecology, Rush Medical College, 5511 South Kenwood Avenue, Chicago, IL 60637-1713*; Ranganathan Ram, M.D., *430 Niagara Street, East Amherst, NY 14051*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) gain an understanding as to the ethics imbedded in clinical encounters and administrative projects; (2) gain an understanding as to the ethics of the psychiatrist as a clinician vs administrator; and (3) gain a framework through which to review clinical, administrative and advocacy roles.

AFFIRMATIVE SUMMARY:

The original principle that everyone is entitled to psychiatric health care, irrespective of means, has not changed. But with escalating health care costs and the advent of managed care there is an ever-increasing pressure on psychiatrists to factor cost of care. Psychiatrists often make the purchasing decisions for their patients, because the information and expertise needed to accomplish this is not often available to our patients. Patients who seek psychiatric care trust their doctor to make the most reasonable decisions. This ''trust'' is both the cornerstone of the doctor-patient relationship as well as a key therapeutic means. Because of this added dimension, the fiduciary obligation of the psychiatrist far exceeds a legal or contractual obligation.

Any departure from this principle amounts to bedside ''rationing.'' Government, insurers, and other third party payers have information and expertise they can use to make global decisions about the worthiness of specific health care services so that individual practitioners do not need to.

Alternate strategies that can alleviate the conflicts inherent in making cost based decisions, for example, by having a medical director make insurance coverage decisions for certain expensive, controversial procedures. The conventional practices of peer review and obtaining second opinions can be valuable assurances of objectivity in managed care settings. Permitting appeals to neutral experts is an important procedural safeguard, leaving individual psychiatrists out of the stranglehold of ''economic gerrymandering.''

NEGATIVE SUMMARY:

There is nothing magical or ordained about putting the good of an individual patient above all other considerations. There are a number of ways in which physicians are ethically required to consider social, as well as individual patients' benefit or harm. There are quarantine, immunization, and mandatory reporting of sexually transmitted diseases, gunshot wounds, and abuse. In many cultures, the family is the social unit, rather than the individual, and all individuals assume that family needs will take precedence over individual needs. Lastly, whether they consciously recognize it or not, every physician makes decisions during every moment of practice as to how to allocate resources. It is only Marcus Welby, a fictional television character, who could devoted whole days and weeks to the care of a single patient. Most patients could benefit from the full-time devotion of a doctor, but, with the possible exception of dynastic royalty, none gets it. We limit the time and resources devoted to each patient in order to see other patients, and to keep our personal or institutional practices viable. As long as we maintain the position that this is unethical, and delude ourselves that we consider only the needs of the patient before us, we will not be able to make ethical and rational choices about the allocation of resources.

REFERENCES:

1. American Hospital Association. Values in Conflict, Resolving Ethical Issues in Health Care, 2nd Ed.
2. American Medical Association. Code of Medical Ethics. 1997 edition.
3. Appelbaum PS, Grisso T: Assessing patients' capacities to consent to treatment. N Engl J Med 1988; 319:1635–8.
4. Beauchamp and Childress: Principles of Biomedical Ethics, 4th ed. Oxford University Press, 1994.
5. Fletcher, Lombardo, Marshall, and Miller: Introduction to Clinical Ethics. University Publishing Group, 1997.

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

RESOLVED: CULTURALLY COMPETENT TREATMENT SHOULD BE PROVIDED REGARDLESS OF COST

American Association of Community Psychiatrists

Russell F. Lim, M.D., *Clinical Assistant Professor of Psychiatry, University of California at Davis, and Medi-*

cal Director, Northgate Point, 601 West North Market Boulevard, #100, Sacramento, CA 95834; Fuat Ulus, M.D., *Presque Isle Psychiatric Associates, 1330 West 26th Street, Erie, PA 16508*; Andrés J. Pumariega, M.D., *Professor and Director, Child and Adolescent Psychiatry, James H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70567, Hillrise Hall, Johnson City, TN 37614-9567*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will be able to review the Limited English Proficiency service limitations imposed by ongoing compromise on mental health funds and the translator fees to be paid by the physicians.

AFFIRMATIVE SUMMARY:

The concept of culturally competent mental health services was developed by Cross, Bazron, Dennis, & Isaacs (1989) in their seminal monograph dealing with the impact on culture on systems of care for children with SED. In this monograph, they outlined the critical nature of working within the child and family's values, belief system, definition of normality/adaptation, and natural help-seeking modalities and approaches. Since that time, the concept of cultural competence in mental health services has been not only well accepted but also operationalized. Pumariega, et al. (1997) and the Four Ethnic/Racial Panels (1999) defined standards for culturally competent clinical practice in mental health based on best practices in the field, first for Latino populations and later for the main underserved ethnic/racial groups in the U.S. These standards outline the necessity of culturally competence in both clinical and systems practices for mental health systems of care. They present such practice as both efficient and effective with diverse populations. More recently, issues of discrimination and disparities have been pointed out by the Surgeon General (2001) and through such legal precedents as the Civil Rights Act of 1964 (which has been the main motivator for the recent LEP directives from DHHS). Evidence-based research by multiple investigators (Pumariega, 2001a, 2001b, and Surgeon General, 2001) points to the need for such practices in order to correct serious disparities in mental health services, primarily in access and assessment but also appropriate treatment.

The basis that will be presented for the requirement of culturally competent mental health services add up to the following: Not providing such services is (1) potentially illegal under Federal law, (2) is rapidly becoming malpractice given clinician consensus, and (3) is not cost-efficient or effective clinical practice. Although the tools and practices have not been fully developed and tested for culturally competent practice, such practice is imperative regardless of cost given the significance of the needs of populations involved.

NEGATIVE SUMMARY:

America is a beautiful country where people from different cultural backgrounds keep their diverse traditions while proudly calling themselves Americans. They are rightfully and equally entitled to receive quality medical and psychiatric care regardless of their backgrounds.

Constantly and continuously dwindling financial resources allocated for mental health, however, have been forcing organizations, facilities, and providers to review finances, hence the termination of some very needed services throughout the years.

One of the priority assessment areas has been the cost of the translation services provided for the patient population with limited english proficiency.

We cannot expect all Americans with diverse cultural backgrounds to be immediately fluent in English even after the reasonable period of time they spend in the US, e.g. a middle aged widow from the civil war-torn native land, an orphan from the overseas disaster, an elderly gentleman from the oppressive regime, etc. The question, however, is whether ALL the Americans who need translation services for their medical and mental needs share similar acutely dispositioned tragic backgrounds.

When and where do circumstances interfering with patients' ability to learn English enough to communicate with their providers STOP, and our expectations for them to learn the language of the country in which they live START?

This question is the hallmark of the debate's negative stand.

REFERENCES:

1. Cross T, Bazron B, Dennis K, Isaacs M: Towards a Culturally Competent System of Care for Children with SED. Washington, D.C.: Georgetown Technical Assistance Center, 1989.
2. Four Racial Ethnic Panels, (1999) Cultural Competence Standards for Managed Mental Health Services for Four Underserved\Underrepresented Racial\Ethnic Groups. Rockville, Md.: Center for Mental Health Services, Substance Abuse and Mental Health Administration, U.S. Department of Health and Human Services.
3. Pumariega AJ, Balderrama H, Garduno R, Hernandez M, Hernandez P, Martinez F, et al: Cultural Competence Guidelines in Managed Care Mental Health Services for Latino Populations. Boulder, Colo.: Western Interstate Commission for Higher Education, 1997.
4. Pumariega AJ: A rationale for culturally competent health services. BioMedicina 2001; 4(5): 207–214.
5. Pumariega AJ: Cultural Competence in Treatment Interventions. in Vance, H. & Pumariega, A.J. (Eds.) Clinical Assessment of Child and Adolescent Behavior. New York, Wiley & Sons, 2001; 19, pp. 494–512.

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

DEVELOPING A COMMUNITY PSYCHOEDUCATION PROGRAM

Therapeutic Education Association

Karen A. Landwehr, M.C., *Clinician and Educator, Comprehensive Mental Health Partnership, 1201 South Proctor Street, Tacoma, WA 98405*; Garry M. Vickar, M.D.; Cynthia C. Bisbee, Ph.D.; Patricia L. Scheifler, M.S.W.; Larry S. Baker, M.Div.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to define psychoeducation and discuss issues facing the mental health system in meeting the needs of the community for psychoeducation. The participant will have identified essential components of a model psychoeducation program for use in their clinical setting and will be aware of resources for curriculum, evaluation, and funding.

SUMMARY:

Psychoeducation has been shown to be an effective, yet overlooked, aspect of treatment for major mental disorders. However, the term psychoeducation has been bandled about as if everyone knows what is meant. Review of the literature suggests that the definition is not as clear as it might appear. Although mental health care providers have a clear mandate to treat and educate those already identified as mentally ill, there also exists a need to educate the public about the symptoms, diagnoses, and treatment needs inherent in mental illness in order to decrease stigma and facilitate access to psychiatric services. This session will attempt to define psychoeducation, what it is, and how it is used in the therapeutic setting and the responsibility the mental health system bears for educating consumers, families, and the general public about mental illness. The tasks involved in developing a psychoeducation program will be addressed, including team development, curriculum content, evaluation, and funding. Information regarding potential resources will be offered. By the end of the day, participants will have identified components of a model psychoeducation program for use in their clinical setting or community.

TARGET AUDIENCE:

Psychiatrists working in hospital or community agency settings, clinical directors, therapists, case managers, and nurses.

REFERENCES:

1. Power MS, McBride L: Psychoeducation, conceptual framework and practical considerations. J Prac Psychiatry Behav Health 1987; 1:18–27.
2. Bisher CC: Educating patients and families about mental illness. Frederick, MD, Aspen Publishers Inc., 1991.
3. Gingerich E. Golden S. Holley D, Nemaur J. Nurzolo D, Pollen L: The therapist as psychoeducator. Hosp Community Psychiatry 1988; 19:923–910.
4. Lelley MP, Wasow M: Helping families cope with mental illness. Chur, Switzerland Harwood Academic Publishers, 1994.

Full-Day Session 2 **Friday, October 11**
8:30 a.m.-5:00 p.m.

THE RECOGNITION AND TREATMENT OF PSYCHIATRIC DIMENSIONS OF HIV/ AIDS

APA Commission on AIDS

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

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

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

HIV both causes and exacerbates psychiatric disorders, affecting clinical assessment and treatment throughout the spectrum of psychiatric patients. This symposium will focus on information that psychiatrists and other mental health professionals can use to more effectively address current and future HIV mental health challenges. Faculty will present updated information on

new diagnostic tools and treatments, clinical assessment and treatment of neuropsychiatric disorders, psychosocial issues, risk reduction strategies, and the complex relationships between substance use, pain, sleep, and adherence. Clinical cases and discussion with the audience will allow for exploration of those issues most pressing to participants.

REFERENCES:

1. American Psychiatric Association: Practice Guideline for the Treatment of Patients with HIV/AIDS. Washington, DC, 2000.
2. Cournos F, Forstein M (eds.): New Directions for Mental Health Services: What Mental Health Practitioners Need to Know About HIV and AIDS. 2000 Fall; (87).
3. Krebs FC, Ross H, McAllister J, Wigdahl B: HIV-1-associated central nervous system dysfunction. Adv Pharmacol 2000;49:315–85.
4. Levine JM: Psychiatric aspects of HIV care. AIDS Clin Care 2001;13(11):101–9.

Full Day Session 3 **Saturday, October 12**
8:30 a.m.-5:00 p.m.

PSYCHIATRIC VECTORS OF THE HIV EPIDEMIC: FROM THEORY TO PRACTICE

Andrew F. Angelino, M.D., *Assistant Professor, Department of Psychiatry and Behavioral Sciences, Johns Hopkins School of Medicine, Baltimore, 4940 Eastern Avenue, A4C-461A, Baltimore, MD 21224*; Glenn J. Treisman, M.D., Ph.D., *Associate Professor, Department of Psychiatry and Behavioral Sciences, Johns Hopkins School of Medicine, Baltimore, 3396 Halcyon Road, Stevenson, MD 21153-0603*; Adam I. Kaplan, M.D., Ph.D.; Heidi H. Hutton, Ph.D.; Jeffrey Hsu, M.D.; Chiadikaobi U. Onyike, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize, diagnose, and treat common psychiatric disorders that act to fuel the HIV epidemic by increasing transmission and hindering adherence to treatment.

SUMMARY:

As the HIV epidemic moves toward its third decade, the role of psychiatry in prevention of transmission and treatment of infected individuals grows steadily. Surveys show that approximately 40% of HIV patients suffer from at least one mental disorder. The Johns Hopkins AIDS Psychiatry Service was developed early in the epidemic to address mental health issues in infected patients, and in the process, has elucidated mechanisms by which psychiatric disorders fuel the HIV epidemic. In this session, participants will learn the interaction of HIV infection with psychiatric diseases, endowments of temperament and personality, substance use disorders, and psychological reaction to life circumstances. This session is intended for any psychiatrist who interacts with HIV-infected patients, and for administrators who wish to devise services to care for this population. No previous knowledge of HIV medicine is required.

REFERENCES:

1. Angelino AF, et al: Management of psychiatric disorders in patients infected with human immunodeficiency virus. Clinical Infectious Diseases 2001; 33: 847–856.
2. Hutton H, et al: Personality characteristics and their relationship to HIV-risk behavior, compliance, and treatment. Primary Psychiatry 1999; 6: 65–68.
3. Lyketsos CG, Hanson AL, Fishman M, McHugh PR, Treisman GJ: Screening for psychiatric disorders in an HIV medical clinic: the importance of a psychiatric presence. International Journal of Psychiatry in Medicine 1994; 24: 103–113.
4. Treisman GJ, Fishman M, Schwartz J, Hutton H, Lyketsos CG: Mood disorders in HIV infection. Depression and Anxiety 1998; 7: 178–187.

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

SCHIZOPHRENIA: CUSTOMIZING TREATMENT OPTIONS

Supported by Pfizer Inc.

John W. Newcomer, M.D., *Department of Psychiatry, Washington University School of Medicine, 4940 Children's Place, Saint Louis, MO 63110-1002*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize that antipsychotics can have an impact on diabetes, describe abnormalities in glucose and lipid metabolism associated with certain newer antipsychotics, recognize atypical antipsychotic agents' effects on glucose metabolism and interventious to avoid metabolic adverse events and reduce medical comorbidity, describe first- and second-generation antipsychotics; and recognize long-term studies.

SUMMARY:

Patients with schizophrenia suffer from higher cardiovascular mortality rates as compared to the general population. Importantly, clinicians now have a wider range of options for treating schizophrenia, offering an opportunity to impact risk factors that may contribute to cardiovascular risk. Weight gain induced by treatment with antipsychotic medications has become an important concern. Disturbances in weight regulation can be associated with disturbances in glucose and lipid metabolism. Recent reports have detailed antipsychotic treatment-related disturbances in glucose metabolism, including clinical reports of new onset type 2 diabetes mellitus, exacerbations of existing diabetes mellitus, and diabetic ketoacidosis. Additional reports describe treatment-related increases in plasma triglycerides. The clinical relevance of these reports derives from evidence that increased adiposity, plasma glucose, and plasma lipids are all independent multivariate risk factors for cardiovascular disease (e.g., myocardial infarction and stroke). While new antipsychotics offer great potential, only limited information regarding their long-term efficacy is currently available from controlled clinical trials. During this symposium, Dr. Nina Schooler will review evidence supporting first-generation antipsychotics in long-term treatment and examine the use of second-generation antipsychotics. She will review the long-term studies (more than six months) that compare clozapine with both typical and atypical antipyschotics. Dr. David Henderson will review the effect of antipsychotic medications on glucose metabolism. Dr. John Newcomer will further discuss the link between diabetes and antipsychotics, and the importance of monitoring schizophrenic patients for hyperglycemia, dyslipidemia, and weight gain. The overall aim of this symposium is to educate clinicians concerning the long-term benefits of antipsychotic treatment, while addressing the public health goal of minimizing cardiovascular risk factors in an often overlooked population.

No. 1A
FINDING THE LINK BETWEEN DIABETES AND ANTIPSYCHOTICS

John W. Newcomer, M.D., *Department of Psychiatry, Washington University School of Medicine, 4940 Children's Place, Saint Louis, MO 63110-1002*

SUMMARY:

Type 2 diabetes is associated with abnormalities in glucose and lipid metabolism. Abnormalities in glucose regulation and type 2 diabetes are more prevalent in patients with schizophrenia than in the general population. Increased adiposity can decrease insulin sensitivity and antipsychotics can increase weight and adiposity, with different antipsychotics producing different degrees of weight gain. However, changes in glucose regulation can also occur without differences in adiposity. Treatment with antipsychotic medications, particularly certain newer agents, has been associated with abnormalities in glucose and lipid metabolism, including diabetic ketoacidosis (DKA), hypertriglyceridemia, new-onset type 2 diabetes, and aggravation of preexisting type 1 and type 2 diabetes. Sensitive and validated assessments from several laboratories indicate differences in insulin resistance associated with different antipsychotic treatments. Drug-related abnormalities in glucose and lipid metabolism and weight regulation could increase risk for acute (e.g., DKA) and long-term (e.g., cardiovascular disease) complications. Notably, research over the past 20 years indicates a progressive and continuous relationship between plasma glucose and cardiovascular risk, so that increases in plasma glucose even below the level of diabetes have been associated with increased cardiovascular risk (e.g., myocardial infarction and stroke). Patients taking antipsychotics should be monitored for hyperglycemia, dyslipidemia, and weight gain, and clinicians and caregivers should be alert to the potential for acute complications such as DKA.

REFERENCES:

1. Haupt DW, Newcomer JW: Hyperglycemia and antipsychotic medications. J Clin Psychiatry 2001, 62 (Suppl 27):15–26.

No. 1B
ATYPICAL ANTIPSYCHOTICS: ENHANCING CARDIOVASCULAR AND METABOLIC HEALTH

David C. Henderson, M.D., *Associate Director, Psychotic Disorders Program, and Assistant Professor of Psychiatry, Harvard Medical School, 25 Staniford Street, Boston, MA 02114*

SUMMARY:

Several medications may potentially cause significant weight gain and impair glucose metabolism, including centrally acting alpha blockers, beta blockers, corticosteroids, cyclosporine, phenytoin, phenothiazines, atypical antipsychotic agents, thiazide diuretics, and oral contraceptives containing norgestral. Glucocorticoids are thought to impair glucose utilization with insulin resistance occurring at both receptor and postreceptor sites. Valproate has been shown to induce a metabolic syndrome characterized by centripetal obesity, hyperinsulinemia, lipid abnormalities, polycystic ovaries, and hyperandrogenism in women with epilepsy. Patients receiving human immunodeficiency virus-1 protease inhibitors often develop impaired glucose tolerance or diabetes, which may attribute to insulin resistance. Patients treated with clozapine and olanzapine have developed elevated fasting serum insulin levels, which suggest insulin resistance. Insulin resistance can be due to abnormalities at any step in the entire insulin action sequence (eg, receptor defects or postreceptor defects in insulin action). Agents may decrease insulin-sensitive glucose transporters (GLUT). GLUT 4 is a transporter that mediates the bulk of insulin-stimulated transport activity. Chronic exposure to high concentrations of glucose and insulin reduces the subsequent ability of insulin to maximally stimulate glucose transport by inhibiting transporter translocation. Alternatively, antagonism at serotonin 5-HT 1A receptors by atypical antipsychotic agents may decrease pancreatic B-cell responsiveness to blood sugar levels. This presentation will review several medications, including atypical antipsychotic agents, and their effects on glucose metabolism along with possible mechanisms. Additionally, interventions to avoid metabolic adverse events and reduce medical comorbidity will be discussed.

REFERENCES:

1. Henderson DC, Cagliero E, Gray C, Nasrallah RA, Hayden DL, Schoenfeld DA, Goff DC: Clozapine, diabetes mellitus, weight gain, and lipid abnormalities: a five year naturalistic study. American Journal of Psychiatry 2000;157:975–981.
2. Henderson DC, Cagliero E, Borba CP, Hayden DL, Schoenfeld DA, Goff DC: Atypical antipsychotic agents and glucose metabolism: Bergman's MINMOD Analysis, in Proceedings of the National Clinical Drug Evaluation Unit Annual Convention, Boca Raton Florida, 2000.

No. 1C
SCHIZOPHRENIA TREATMENT GOALS: LONG-TERM CONTROL

Nina R. Schooler, Ph.D., *Director of Psychiatry Research, Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004*

SUMMARY:

Long-term treatment goals for managing patients with schizophrenia include preserving clinical gains achieved during acute care, preventing symptom exacerbation, furthering improvements in psychopathology, enhancing social and vocational functioning, and improving quality of life. Unfortunately, many of these goals have been elusive. Treating frequently identified negative symptoms in patients with schizophrenia is critical to improving long-term outcomes. The second-generation atypical antipsychotics promise to improve long-term outcomes through several mechanisms, including enhanced efficacy for negative symptoms and improved relapse prevention. After reviewing the evidence supporting first-generation antipsychotics in long-term treatment, the presentation will examine second-generation antipsychotics. Three comparisons are of interest: new antipsychotics versus placebo, new antipsychotics versus first-generation medications, and new antipsychotics versus each other. New antipsychotics offer great potential; however, only limited information is currently available regarding long-term outcomes from controlled clinical trials. The presentation will conclude with a review of long-term studies (longer than six months) that compare clozapine with both typical and atypical antipsychotics. Clinicians now have greater options for treating schizophrenia with antipsychotic medications. Treatment decisions must involve both awareness of data from carefully controlled research and a clinical assessment of the needs of the individual patient.

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

CRITICAL ELEMENTS TO ACHIEVING EFFECTIVENESS WITH PHARMACOTHERAPY

Supported by AstraZeneca Pharmaceuticals

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize how effectiveness is different from efficacy, and how it can be achieved in the pharmacotherapy of various psychotic and nonpsychotic disorders receiving atypical antipsychotics.

SUMMARY:

Pharmacotherapy is an indispensable component of the biopsychosocial management of serious psychiatric disorders. All pharmacotherapeutic agents that are widely used in psychiatric patients have efficacy that was demonstrated via FDA-regulated placebo-controlled clinical trials. However, symptomatic efficacy over short-term (six weeks) studies in research settings does not necessarily predict the "effectiveness" of a drug when it is used on a large scale for prolonged periods in the "real world". In this symposium, Dr. Richard Smith will focus on the principles of effectiveness and its importance to clinicians who seek optimal treatments for patients with various medical comorbidities and/or social complexities. Dr. Gary Sacks will focus on adherence with therapy as a critical component of achieving effectiveness in the pharmacotherapy of serious, recurrent disorders such as bipolar disorder. Dr. Lili Kopala will focus on tolerability to medications in schizophrenia as a key objective achieving clinical improvement that may result from adverse side effects (e.g., movement disorders, obesity, sexual dysfunction, etc.). Finally, Dr. Henry Nasrallah will describe the rapidly expanding spectrum of (off-label) uses and effectiveness of atypical antipsychotics in non-psychotic populations who may be susceptible to various side effects.

At the end of the symposium, those in attendance will recognize the various elements to achieving effectiveness with pharmacotherapy and how to maximize the therapeutic potential of psychopharmacological interventions.

TARGET AUDIENCE(S):

Psychiatrists, neurologists, primary care physicians, pharmacists, nurses, psychologists, social workers

No. 2A
DEFINING EFFECTIVENESS: BALANCING THE NEGATIVES WITH THE POSITIVES

G. Richard Smith, Jr., M.D., Marie Wilson Howells *Professor and Chair, Department of Psychiatry, University of Arkansas Medical School, 4301 West Markham, Slot 554, Little Rock, AR 72205*

SUMMARY:

Once diagnosis is made, the most pressing question facing the physician is "How do I treat my patient?" This question is one of "effectiveness," of whether a treatment will work for my patient given his/her complexities, comorbidities, and social situation. Effectiveness information in psychiatry is relatively rare. Much more abundant information is available about "efficacy," of whether a treatment is better than placebo for highly selected patients in randomized controlled trials, which often do not include patients similar to those seen in clinical practice. Unfortunately, the most efficacious treatment for a condition may not be the most effective treatment for a given patient. This presentation will assist the psychiatrist in choosing the most effective treatments for his/her patients by understanding efficacy, effectiveness, and efficiency as well helping him/her learn how to obtain effectiveness information to inform treatment as decisions.

REFERENCES:

1. Andrews G: Efficacy, effectiveness, and efficiency in mental health service delivery. Australian Journal of Psychiatry 1999; 33:316–322.

No. 2B
STRATEGIES FOR IMPROVING TREATMENT ADHERENCE

Gary S. Sachs, M.D., *Director, Department of Psychiatry, Harvard Medical School, Massachusetts General Hospital, 50 Staniford Street, 5th Floor, Boston, MA 02114*

SUMMARY:

Bipolar disorder is a common condition complicated by impaired social and occupational function and substantial risk for suicide as well as periods of mood abnormality. Treatment reduces the frequency of these complications, but many bipolar patients choose to discontinue treatment. After reviewing factors affecting the concordance between the psychiatrist's treatment plan and that actually followed by the patient, this presentation offers an overview of collaborative care strategies used to enhance concordance in the Systematic Treatment Enhancement Program for Bipolar Disorder.

Collaborative care prioritizes the therapeutic alliance between clinician, patient, and supports, and is based on the principle that each party in the alliance makes important contributions to the patient's care, and should be treated respectfully. The physician must make the plan clear and communicate the importance of each element in the recommended treatment regimen and expectable adverse effects. At critical treatment decision points, the clinician is responsible for offering a range of appropriate treatment options. The patient is responsible for making the effort required to process the information and for choosing from the Menu of Reasonable

Choices presented. Informed family members, in turn, can help by supporting the patient in a constructive, positive manner. A written collaborative care plan is recommended.

REFERENCES:

1. Sachs GS: Bipolar mood disorder: practical strategies for acute and maintenance phase treatment. J Clin Psychopharmacol 1996; 16 (2 Suppl 1): 32S–47S.

No. 2C
ACHIEVING EFFECTIVENESS IN FIRST-EPISODE PSYCHOSIS

Lili C. Kopala, M.D., *Department of Psychiatry, Dalhousie University, 5909 Veterans Mem. Way, Rm4083 Lane BldgOE11, Halifax, NS Canada B3H 2E2*

SUMMARY:

Optimizing treatment of a first episode of psychosis influences long-term management of illness. The primary aim of treatment is to achieve rapid remission using the most effective and best tolerated treatment. Studies have suggested that patients are more responsive to treatment during their first episode but are more sensitive to the side effects of EPS. Treatment strategies that minimize the risk of side effects are extremely important. Morbidity and mortality of schizophrenia can be diminished for patients treated early and consistently with second-generation antipsychotics. Second-generation medications administered during the early phases of illness are likely to have a beneficial impact on patient-perceived tolerability and can improve adherence. Recovery is related to the number and severity of relapses and thus success in the initial treatment phase influences the long-term course (Kasper, 1999).

Current data indicate that one year of consistent treatment with these newer antipsychotics results in 8% rehospitalizations compared with previously reported annual rates of 50% (Kopala, in preparation). Most importantly, there was a reduced suicide rate for the population studied. Negligible levels of neurotoxicity, in the form of EPS, were observed along with a reduction in preexisting baseline motor abnormalities. Data will be presented.

REFERENCES:

1. Frangou S, Byrne P: How to manage the first episode of schizophrenia [letter]. BMJ 2000;321:522–3.
2. Kopala LC, Good KP, Fredrikson D, et al: Risperidone in first-episode schizophrenia: improvement in symptoms and pre-existing extrapyramidal signs. Int J Psychiatry Clin Prac 1998;2:S19–S25.
3. Oosthuizen P, Emsley RA: First-episode psychosis: lessons from 15 years of research. Primary Care Psychiatry 2001;7(1):19–24.

No. 2D
EFFECTIVENESS OF ATYPICALS ACROSS THE SPECTRUM OF USES

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

SUMMARY:

Atypical antipsychotics are now used for a wide spectrum of psychiatric disorders other than schizophrenia. Physicians are discovering that many axis I, axis II, and axis III disorders can be improved with the first-line atypical antipsychotics currently approved for use in schizophrenia: risperidone (since 1994) olanzapine (since 1996), quetiapine (since 1997) and ziprasidone (since 2001). Further, patients of all age groups, (children, adolescents, adults, and elderly) appear to benefit symptomatically from the addition of small to moderate doses of atypical antipsychotics to the medication regimen they are receiving for several nonpsychotic disorders. This presentation will discuss the effectiveness of these emerging off-label uses of atypical antipsychotics.

An important aspect of treating non-schizophrenic populations with atypical antipsychotics is that they can be particularly susceptible to some of the side effects of these atypical antipsychotics. Poor tolerability or low patient acceptance usually leads to poor adherence, which undermines the effectiveness of the atypicals. For example, adolescents are likely to experience sexual dysfunction secondary to hyperprolactinemia. Patients with borderline personality disorder or with treatment-resistant depression may be at risk for significant weight gain/obesity, which would offset the improvement in the psychiatric disorder. Elderly patients with behavioral agitation secondary to neurodegenerative disorders are likely to experience EPS with some atypicals. Certain ethnic groups (African Americans and Asians) tend to have a higher proportion of slow metabolizers, and they may also develop adverse effects and refuse to comply even if they experience symptomatic relief. Strategies to increase effectiveness will be discussed.

REFERENCES:

1. Glick ID, Murray SR, Vasudevan P, Marder SR, HURJ: Treatment with atypical antipsychotics: new indications and new populations. J Psychiat Research 2001; 35:187–191.

Industry-Supported Symposium 3 **Thursday, October 10 6:30 a.m.-8:00 a.m.**

CRITICAL ISSUES IN THE OPTIMAL USE OF ATYPICAL ANTIPSYCHOTICS IN TREATING SCHIZOPHRENIA

Supported by AstraZeneca Pharmaceuticals

Rajiv Tandon, M.D., *Professor of Psychiatry and Director, Schizophrenia Program, University of Michigan Medical Center, 1500 East Medical Center Drive, UH 9C-9150, Ann Arbor, MI 48105-0120*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand how to optimally use and dose the new generation antipsychotics in various clinical settings; recognize the various differences and similarities among the atypical antipsychotics and their side-effect profiles.

SUMMARY:

The newer generation of antipsychotics has seemingly revolutionized the treatment of psychotic disorders. Following the lead of clozapine, four other "atypical" agents (risperidone, olanzapine, quetiapine, and ziprasidone) have become available. Collectively, these agents constitute about 80% of all antipsychotics prescribed in the U.S.A. As these "atypical" antipsychotics are increasingly utilized, several questions have arisen about how to best use them in various clinical settings. Are they all the same? If not, what are the meaningful differences between them? Are the newer agents clozapine-like in otherwise treatment-refractory patients? If the newer antipsychotics are different, can they be combined? Are there reasons to utilize combinations of newer plus older agents? Are all the agents equivalent with regard to their adverse effect profile? If the major virtue of the newer generation is their reduced liability for extrapyramidal side effects (EPS), what does one do when EPS occur while using them? What have we learned about using them optimally? How does one dose them? These questions will be addressed in the symposium. Presenters will summarize all pertinent clinical research data and collated clinical experience as they consider these issues. The discussion period will address questions, encourage audience input/opinion, and further develop these important themes.

TARGET AUDIENCE(S):

Psychiatrists, neurologists, primary care physicians, pharmacists, nurses, psychologists, social workers

No. 3A
HOW DOES ONE OPTIMALLY DOSE ATYPICAL ANTIPSYCHOTICS?

Rajiv Tandon, M.D., *Professor of Psychiatry and Director, Schizophrenia Program, University of Michigan Medical Center, 1500 East Medical Center Drive, UH 9C-9150, Ann Arbor, MI 48105-0120*

SUMMARY:

The newer generation of antipsychotics provide a broader spectrum of efficacy and a generally more benign adverse effect profile than the older generation of typical or conventional antipsychotics. As these agents improve several domains of schizophrenic pathology rather than focusing on controlling positive symptoms, they are encouraging more optimistic treatment expectations than were achievable with the older generation antipsychotics. While these newer agents are less liable to cause motor side effects than the older antipsychotics, they do cause various other adverse effects. Optimal dosing has been found to be the key to optimizing the benefit/side-effect ratio of these agents. Mistakes have been made in initial dosing of each of these agents. This should not be surprising in view of ongoing controversies about optimal dosing of typical antipsychotics despite their use for almost 50 years. Although there is significant patient heterogeneity with regard to optimal dose and a variety of disease- and patient-specific factors influence "the right dose," clinical research data and systematic clinical practice have elucidated optimal dosing strategies for each of the five currently-available atypical antipsychotic agents: clozapine, risperidone, olanzapine, quetiapine, and ziprasidone. These data will be summarized and specific recommendations made about optimal dosing of each of these agents in different patient populations.

REFERENCES:

1. Geddes J, Freemantle N, Harrison P, Bebbington P: Atypical antipsychotics in the treatment of schizophrenia: systematic overview and meta-regression analysis. BMJ 2000;321:1371–6.

No. 3B
IS CLOZAPINE STILL THE GOLD STANDARD IN THE REFRACTORY PATIENT?

Peter F. Buckley, M.D., *Professor and Chair, Department of Psychiatry, Medical College of Georgia, 1515 Pope Avenue, Augusta, GA 30912-3800*

SUMMARY:

The management of patients with severe treatment-refractory (TR) schizophrenia has become more complex due to an increasing number of available effective antipsychotic agents. Previously, such patients were treated with various combinations of typical antipsychotics along with mood stabilizers and/or benzodiazepines, with a goal of augmenting the poor response to monoth-

erapy. Clozapine's distinct indication for TR schizophrenia may have rendered such practices obsolete. Current limited evidence of clozapine's superior comparative efficacy when compared with other atypical antipsychotics suggests that clozapine may be the drug of choice for TR schizophrenia. Even so, up to 30% of TR patients will respond poorly to clozapine, and others will discontinue its use due to side effects. Some patients and physicians may be reluctant to try clozapine even in the setting of a failed response to other agents. This presentation will review the relative efficacy of clozapine and each of the atypical antipsychotics in patients with TR schizophrenia, with the goal of achieving optimal pharmacologic management.

REFERENCES:

1. Chakos M, Lieberman J, Hoffman E: Effectiveness of second-generation antipsychotics in patients with treatment-resistant schizophrenia: a review and meta analysis of randomized trials. Am J Psychiatry 2001;158:518–526.

No. 3C
PARTIALLY RESPONSIVE AND TREATMENT-RESISTANT SCHIZOPHRENIA

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

SUMMARY:

The pharmacological treatment of patients with schizophrenia has changed markedly over the last decade. With the introduction of clozapine and the subsequent development and marketing of the atypical antipsychotics, the expectation for the level of treatment response has been raised.

There has been a marked improvement in the tolerability of the new compounds and they have demonstrated efficacy in areas such as negative symptoms, mood symptoms, and cognitive symptoms where the typical antipsychotic agents were less effective. Despite these real tangible advantages there remains a very large cohort of patients who are partially responsive and some who remain treatment resistant.

This lecture will focus on many of the factors that can contribute to patients who have only a partial response or are treatment resistant. The factors that may contribute to some of the partial response will be examined including noncompliance, comorbid conditions, and drug interactions. Studies and interventions will be examined to minimize the number of refractory patients and help to convert partial responders to responders.

REFERENCES:

1. Taylor DM, Duncan-McConnell D: Refractory schizophrenia and atypical antipsychotics. J Psychopharmacol 2000;14(4):409–18.

No. 3D
ANTIPSYCHOTICS IN PATIENTS WITH MOVEMENT DISORDERS

Joseph H. Friedman, M.D., *Professor and Chief, Division of Parkinson's Disease and Movement Disorders, Department of Neurology, Brown University, Memorial Hospital, 111 Brewster Street, Pawtucket, RI 02806*

SUMMARY:

Movement disorders are not an uncommon problem in patients being treated for psychotic problems. Neuroleptics induce parkinsonism, tardive dyskinesia syndromes, and acute disorders. In addition, patients with Parkinson's disease (PD) develop drug-induced psychoses, while patients with schizophrenia may develop PD. Lewy body dementia patients have parkinsonism and psychotic symptoms and are overly sensitive to dopamine blocking drugs. Alzheimer's patients develop parkinsonism as well. The effects of atypical antipsychotics have been studied more closely in PD than in the other disorders mentioned. It is my contention that the results in PD extrapolate to these other "EPS vulnerable" populations. Risperidone, which causes dose-dependent parkinsonism, is poorly tolerated according to some, but not all, reports on drug-induced psychosis PD, due to worsened motor function. Olanzapine worsens motor function in about 40% of PD patients and was poorly tolerated in two published double blinded trials. Clozapine improves psychosis without worsening motor function, as reported in two double blind placebo controlled trials and multiple open label reports. Quetiapine appears to be slightly less effective than clozapine without worsening motor function. Unfortunately no double blind trials support quetiapine's use. Clozapine and quetiapine are the antipsychotics of choice for patients with motor disorders.

REFERENCES:

1. Wirshing WC: Movement disorders associated with neuroleptic treatment. J Clin Psychiatry 2001;62 Suppl 21:15–8.
2. Mohr E, Hildebrand K, Mendis T, De Deyn PP: Worsening of motor function in Parkinson's disease: a "typical" response to "atypical" antipsychotic medications. Neurology 2001;56(9):1249–50.

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

BIPOLAR DISORDER ACROSS THE LIFE SPAN

Supported by Abbott Laboratories

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize bipolar disorder in adolescents, adults, and geriatrics; understand clinical management of bipolar disorder in adolescents, adults, and geriatrics.

SUMMARY:

The focus of interest for many years in bipolar disorder has been on adults, primarily young adults with the disorder in terms of age of onset, diagnosis, and clinical management. Emerging data in the last several years has brought new attention to issues of bipolar disorder across the lifespan. Many children develop bipolar disorder in early life, which is often unrecognized or misdiagnosed as ADHD or substance abuse. Clinical trial data on adolescent bipolar disorder can help the clinician in this process. When correctly diagnosed, there are new data treatments for adolescent bipolar disorder. With regard to adults, new strategies have emerged for acute management of patients presenting with mania or depression. Strategies for mania include more rapid stabilization. Strategies for depression include new medications. Geriatric bipolar disorders include longstanding patients with early onset illness, those with onset in late life (often secondary to general medical disorders), and those with dementia with bipolar symptoms. Each patient group involves somewhat different management strategies.

No. 4A
BIPOLAR DISORDERS IN CHILDREN AND ADOLESCENTS

Karen D. Wagner, M.D., *Division of Child and Adolescent Psychiatry, University of Texas, 301 University Boulevard, Galveston, TX 77555-0188*

SUMMARY:

Accurate diagnosis of bipolar disorder in youths is essential, yet making this diagnosis in children is often difficult. The features of bipolar disorder in children differ from those of adolescents. Bipolar disorder in this age group may be unrecognized or misdiagnosed. Comorbid conditions frequently complicate the course of this disorder. Bipolar disorder has significant adverse effects on a child's emotional, social, and academic functioning. Unfortunately, there are very little controlled data about the treatment of this disorder. Mood stabilizers, such as lithium and divalproex, are frequently used to treat this disorder and there is increasing interest in the use of atypical antipsychotics and newer anticonvulsants. This presentation will focus on the diagnosis and treatment of bipolar disorder in youths. New research findings related to treatment will be presented and medication strategies will be discussed.

REFERENCES:

1. Geller B, Zimerman B, Williams M, Bolhofner K, Craney JL, Delbello MP, Soutillo CA: Diagnostic characteristics of 93 cases of prepubertal and early adolescent bipolar disorder phenotype by gender, puberty and comorbid attention deficit hyperactivity disorder. J Child Adoles Psychopharmacology 2000;10(3):157–164.

No. 4B
NEW STRATEGIES IN MANAGING ADULT BIPLOAR DISORDER

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

SUMMARY:

Over the last several years, new data have emerged that have led to new strategies in the management of bipolar disorder in adults. Several approaches have been demonstrated to be effective in more rapid stabilization of acutely manic patients; including rapid loading with divalproex, use of olanzepine, and various medication combinations. With regard to depression, treatment should begin with optimization of mood stabilizer dosage in patients already on mood stabilizers. In patients not on maintenance medications, initiation of lithium or lamotrigine treatment should be undertaken. In addition, a number of specific psychosocial approaches are of substantial usefulness in helping patients with bipolar disorder.

REFERENCES:

1. Work Group on Bipolar Disorder, Robert M.A. Hirschfeld, M.D., Chair, et al: Practice Guideline for the Treatment of Patients With Bipolar Disorder, submitted 2002.
2. Hirschfeld RMA, Allen MH, McEvoy J, Keck PE, Russell J: Safety and tolerability of oral loading divalproex sodium in acutely manic bipolar patients. J Clin Psychiatry 1999; 60(12): 815–818.

No. 4C
BIPOLAR DISORDER IN THE ELDERLY

Industry-Supported Symposium 5

Thursday, October 10
12 noon-1:30 p.m.

Charles L. Bowden, M.D., *Professor of Psychiatry and Pharmacology, University of Texas Health Science Center at San Antonio, 7703 Floyd Curl Drive, San Antonio, TX 78229-3900*

SUMMARY:

Recognition and treatment of bipolar spectrum disorders in the elderly deals with three overlapping patient groups. Early onset bipolar disorder almost always continues into the late years of life with essentially unchanged illness course. A smaller but important group of patients develop bipolar disorders in late life, often secondary to general medical disorders, with mixed manic symptoms predominating. Elderly persons with dementias often have symptoms that are within the extended bipolar spectrum. The increased use of mood stabilizers in patients with dementias has been influenced by a somewhat more symptom-based than syndrome-based consideration in treatment planning. This stems from broad evidence that behavioral disturbances common to several differing disorders often respond to a single agent. Among elderly patients, an additional factor in symptom-based treatment decisions is that multiple medical problems and complex effects of several medications often stymie efforts at unequivocal diagnosis of a single syndrome. Impulsivity and aggression are most common behavioral disturbances triggering prescription of mood stabilizers in patients with dementia. Impulsivity and aggression, though often linked, are not synonymous or always related. Indirect evidence suggests that mood stabilizers may have more specific benefits on impulsive, unpremeditated and generally inappropriate behaviors than directly on aggression. Among mood stabilizers, most recent studies in the elderly have been conducted with divalproex, with open and controlled trials indicating efficacy with generally good tolerability. Reports indicate that dose and serum level ranges for divalproex in the elderly are variable, with some patients requiring the same ranges as employed for younger persons with bipolar disorder, but others obtaining most benefit with somewhat lower doses. Lithium and carbamazepine have also shown efficacy, although tolerability has constrained extensive use. The limited but consistent evidence of efficacy has encouraged further study of these three agents, as well as of more recently introduced putatively mood stabilizing drugs.

REFERENCES:

1. Nelson JC (ed): Geriatric Psychopharmacology, Marcel Dekker, New York, 1998.

DEPRESSIVE SUBTYPES: THE MULTIPLE FACES OF DEPRESSION
Supported by Organon Inc.

J. Craig Nelson, M.D., *Professor, Department of Psychiatry, Yale University, 20 York Street, EP10-835, New Haven, CT 06504*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) recognize various subtypes of major depressive disorder and be familiar with the management options available to clinicians, (2) summarize the results of the studies comparing the efficacy of different antidepressant classes in the treatment of these depressive subtypes.

SUMMARY:

Unipolar major depressive disorder (MDD) is characterized by highly variable clinical presentations, which may represent a challenge to clinicians in terms of both recognition and management. Although efforts to subtype MDD over the past few decades have been at times inconclusive, a few subtypes have consistently predicted either preferential responsiveness to certain therapeutic agents and/or poorer response to standard antidepressant treatments. This symposium will focus on such subtypes and will provide an overview of the evidence in support of their clinical usefulness. Dr. Jonathan Stewart will begin the symposium with a review of the validity of the DSM-IV subtype of MDD with atypical features, of the obstacles to its recognition in clinical practice, and of the treatment decision implications. Dr. Craig Nelson will present the results of the controlled studies concerning patients with anxious depression, and will review the management options for clinicians. He will also discuss the findings of those studies, which have suggested greater efficacy of dual-action antidepressants compared with single-action antidepressants in melancholic MDD and the possible neuropharmacologic basis for the differential efficacy. Finally, Dr. Linda Carpenter will present the results of recent studies on MDD with psychotic features and will discuss the treatment decisions that clinicians face with this population.

REFERENCES:

1. Stewart JW, McGrath PJ, Rabkin JG, Quitkin FM: Atypical depression. A valid clinical entity? Psychiatr Clin North Am 16(3): 479–495, 1993.

No. 5A
ATYPICAL DEPRESSION: AN OFTEN UNDER-RECOGNIZED CONDITION

Jonathan Stewart, M.D., *1051 Riverside Drive, New York, NY 10032*

SUMMARY:

Atypical depression was coined to label depressed patients who did not respond to the treatments effective for melancholia, tricyclic antidepressants (TCA) and ECT, but still benefited if treated with a monoamine oxidase inhibitor (MAOI). Based on early descriptions, the Columbia group prospectively defined a syndrome expected to respond to an MAOI but not a TCA. The criteria for this syndrome included significant mood reactivity plus at least two of the following: hyperphagia, hypersomnia, leaden paralysis (extreme lethargy), and pathologic rejection sensitivity. Several treatment studies demonstrated that patients meeting these criteria were significantly more likely to respond to phenelzine (a MAOI) than to imipramine (a TCA). Compared with depressed patients having melancholic features, those with atypical features have earlier age of onset, more chronic illness, more family history of depressive disorder but less family history of severe depressive illness, without the biologic abnormalities typical of melancholia. Because these treatment, course of illness, familial, and biological differences argued for the validity of atypical depression as a distinct entity, an atypical features modifier of major depression and dysthymic disorder was included in DSM-IV. Since 1994, epidemiologic studies have suggested that atypical depression accounts for at least 25% of depressed patients. Biologic studies have further validated its uniqueness, and further treatment studies have assessed the role of more recent treatments. Finally, recent investigations suggesting that the uniqueness of atypical depression may be limited to patients having both a chronic course and an early onset of depressive symptoms suggest that the addition of course of illness criteria warrant consideration for DSM-V.

REFERENCES:

1. Bielski RJ, Friedel RO: Prediction of tricyclic antidepressant response: a critical review. Archives of General Psychiatry 1976; 33:1479–89.

No. 5B
MELANCHOLIC AND ANXIOUS DEPRESSION

J. Craig Nelson, M.D., Professor, *Department of Psychiatry, Yale University, 20 York Street, EP10-835, New Haven, CT 06504*

SUMMARY:

Anxious depression has been defined two ways—as unipolar depression with high levels of anxiety or unipolar depression with comorbid anxiety disorders. In either case, anxious depression is common and has been associated with greater severity, functional impairment, chronicity, and less favorable response to antidepressants. Most treatment studies of anxious depression have failed to show significant differences in response to various antidepressants. Yet there are indications of differences in emergent anxiety during treatment with various antidepressants. In addition, the concomitant use of antianxiety drugs in clinical practice is quite common but may be less frequent with some agents. Melancholia, another subtype of depression, has a long history. Recently, since the introduction of the SSRIs, there has been debate about whether melancholic or endogenous depression responds better to a selective antidepressant or to a dual action agent. Sometimes the debate has pitted the SSRI against the tricyclics (TCAs), but the first TCA showing superiority was clomipramine, a dual action agent. The controversy has also considered whether "severe depression" is a better distinction than melancholia. Ian Anderson, in a review of 103 studies comparing SSRIs and TCAs, concluded that the only patient characteristic related to response was "inpatient status." This presentation will review these diagnostic concepts. Their diagnostic value in inpatients and outpatients will be considered. In fact, it appears that these are overlapping concepts and that severe melancholic inpatients may be the group most likely to show treatment differences. Within individual outpatient studies, the melancholic distinction and the severe distinction have seldom been useful in predicting treatment differences. Although relatively few inpatient comparison studies have been conducted, several of these studies have reported differences favoring the dual-action agent. Recently, meta-analyses have been reported suggesting that the dual-action agents venlafaxine and mirtazapine are each more effective than a selective serotonin agent. These meta-analyses included outpatient studies. It is possible that the size of the difference between treatments is smaller in outpatients and requires the pooled data and a meta-analysis to detect a difference. The implications of these finding for the clinician treating depressed patients will be addressed.

REFERENCES:

1. Danish University Antidepressant Group: Citalopram: clinical effect profile in comparison with clomipramine. A controlled multicenter study. Psychopharmacology 1986;90:131–138.
2. Fava M, Rosenbaum JG, Hoog SL, Tepner RG, Kopp JB, Nilsson ME: Fluoxetine versus sertraline and paroxetine in major depression tolerability and effi-

cacy in anxious depression. Journal of Affective Disorders 2000; 59:119–126.

No. 5C
PRACTICAL APPROACHES TO PSYCHOTIC DEPRESSION

Linda L. Carpenter, M.D., *Assistant Professor of Psychiatry, Brown University, 345 Blackstone Blvd, Providence, RI 02906*

SUMMARY:

Numerous studies in the past three decades have characterized the subtype of major depression that is accompanied by delusions or other psychotic features. The presence of psychosis in depression is associated with longer episode length and higher rates of relapse and recurrence; distinct abnormalities in hypothalamic-adrenocortical (HPA) axis function; and a variety of other biological findings from neuroendocrine, brain imaging, and sleep studies. Treatment studies have shown psychotic depression predicts infrequent response to placebo, poor response to antidepressant monotherapy, and good response to ECT or an antidepressant plus an antipsychotic. Taken together, these findings support the notion that psychotic depression represents a unique disorder with a high level of morbidity.

Until recently, there were only two prospective, double-blind, controlled trials investigating the efficacy of antidepressant-antipsychotic combination pharmacotherapy. Yet this constitutes the currently accepted and most universally applied "standard of care" for psychotic depression. Established treatment guidelines have been based on uncontrolled studies of ECT and studies using tricyclic antidepressants (TCAs) and conventional antipsychotic drugs, which are not frequently chosen as first-line agents today. A growing literature from Italy suggests preliminary efficacy of selective serotonin reuptake inhibitor (SSRI) monotherapy for psychotic depression, but questions have been raised about the role of diagnostic heterogeneity as a possible confound in recent research on psychotic depression. A multicenter, controlled trial investigating the efficacy and safety of combination fluoxetine-olanzapine was recently completed. A multicenter, controlled trial of the glucocorticoid receptor antagonist mifepristone is currently underway. The results from these and other clinical research regarding psychotic depression will be critically reviewed.

REFERENCES:

1. Schatzberg A, Rothschild AJ: Psychotic (delusional) major depression: should it be included as a distinct syndrome in DMS-IV? Am J Psychiatry 1992;149:733–745.

Industry-Supported Symposium 6 **Thursday, October 10 6:00 p.m.-9:00 p.m.**

OPTIMIZING PATIENT OUTCOMES: SCHIZOPHRENIA MANAGEMENT IN THE ACUTE PHASE

Supported by Pfizer Inc.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss ways to help psychiatrists successfully map a course for patients through the acute phase of schizophrenia management, including optimal outcomes, assessment and diagnosis, most advantageous medication regimen in an emergency situation, and successful navigation through the time period after a patient's acute episode.

SUMMARY:

Schizophrenia is a complex disorder with many different phases requiring individualized treatment. For many patients with schizophrenia—particularly those experiencing an acute exacerbation of symptoms—the emergency room setting is their first point of clinical contact; it is often within this setting that their initial diagnosis is made and antipsychotic treatment is initiated.

During this symposium, the faculty will address the management of schizophrenia with regard to the acute phase, and will provide strategies for optimizing patient outcomes. Dr. Daniel Casey will begin with a discussion of ways to improve patient outcomes by monitoring and managing the overall health of patients with schizophrenia. He will also examine the role of atypical antipsychotic medications in the context of physical health. Ms. Grad Green, MSN, RN, CS, will follow with a discussion of the assessment and differential diagnosis of acute psychosis in patients with schizophrenia.

Dr. Alan Mendelowitz will continue with an exploration of new options in acute psychotic agitation, including a comparison of benzodiazepines, typical antipsychotics, and atypical antipsychotics, and will review the benefits and limitations of oral vs. intramuscular administration. Dr. Peter Weiden will conclude with a discussion of concepts that lead to stabilization after an acute psychotic episode. He will also discuss features that facilitate a successful transition to the maintenance phase of care and adherence to a multidimensional treatment program.

No. 6A
OPTIMIZING PATIENT OUTCOMES IN PATIENTS WITH SCHIZOPHRENIA

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

SUMMARY:

In recent years, the overall health of patients with schizophrenia has become a growing concern. Data show that patients with schizophrenia receive less medical care than the general population and have significantly higher morbidity and mortality rates from physical diseases. Their risk ratio for death from natural causes is approximately 2.5 compared with the general population. Multiple risk factors contribute to this problem: approximately 75% of patients with schizophrenia smoke more than two packs of cigarettes per day compared with about 25% of the general population. Additionally, patients with schizophrenia have higher rates of obesity (higher body mass index [BMI]), which correlate with higher rates of diabetes and cardiovascular diseases.

While the atypical antipsychotic medications substantially improve multiple domains of mental health, they have a complex impact on the physical health of patients with psychosis. For example, some drugs are associated with weight gain and abnormalities in glucose and lipid metabolism, while others are not. Thus, new cases of diabetes and cardiovascular diseases are emerging, and existing cases are becoming more difficult to manage.

During this presentation, these data will be reviewed and strategies for monitoring and managing these overall health issues will be presented.

REFERENCES:

1. Casey DE: The relationship of pharmacology to side effects. Journal of Clinical Psychiatry 1997; 58(suppl 10): 55–62.

No. 6B
ASSESSMENT AND DIAGNOSIS OF ACUTE PSYCHOSIS

Grad C. Green, C.N.S., *Central Nervous System Team Leader, San Francisco General Hospital, 1001 Potrero Avenue, Room 1B20, San Francisco, CA 942110*

SUMMARY:

Assessment and diagnosis of acute psychosis in the emergency room and crisis center setting remains an important clinical challenge. The initial assessment of patients in this setting requires the clinician to consider a broad range of psychiatric illnesses, all of which can present with psychotic agitation.

A typical presentation of acute psychosis may include incoherent speech, disorganized behavior, irritability, delusional thoughts, impaired sense of reality, and self-harm or harm to others. While a definitive psychiatric diagnosis may take months to make, a presentation of psychosis requires immediate intervention and alleviation of symptoms.

An immediate goal is to rule out medical etiology and determine whether the psychosis stems from a functional or an organic cause. Functional disorders are those with no organic basis, such as schizophrenia or depression. Organic brain disorders have an identifiable pathology or are the result of a structural abnormality, such as a brain tumor.

During this lecture, various psychotic presentations will be discussed. Cognitive and neurologic assessment tools, diagnostic evaluations, and rating scales—all essential to the assessment and diagnosis of acute psychosis—will also be reviewed.

REFERENCES:

1. Allen MH, Currier GW, Hughes DH, et al: The Expert Consensus Guideline Series: Treatment of Behavioral Emergencies. Postgrad Med Special Report. 2001;(Mat):1–90.
2. Upfold J: The triage and initial assessment of mental health patients in the emergency room. Emergency Psychiatry 2001; 7(1): 14–17.

No. 6C
ACUTE PSYCHOTIC AGITATION: EXPLORING NEW OPTIONS

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

SUMMARY:

Treating agitated psychiatric patients in the emergency room setting requires rapid evaluation, accurate assessment, and quick decision making. The decision as to whether the patient requires medication or can respond to support must be carefully reviewed. Initiating an optimal medication regimen in the emergency room, therefore, is an important clinical decision. The need to quickly control severe symptoms must be carefully balanced with a treatment algorithm that considers both safety and effectiveness.

The present management of acute psychotic agitation differs greatly among clinicians. During this presentation, initial treatment strategies to control psychotic agitation will be reviewed. The utilization of intramuscular agents, including benzodiazepines (eg, lorazepam), stan-

dard antipsychotics (eg, haloperidol), combination treatment and atypical antipsychotics (eg, olanzapine and ziprasideone) will also be discussed.

The new-generation antipsychotic drugs offer patients antipsychotic efficacy with an improved tolerability and EPS side-effect profile. This is vitally important in helping patients remain compliant after they have improved. The potential of an intramuscular atypical antipsychotic in the management of acute psychotic agitation will also be discussed.

No. 6D
AFTER THE ACUTE EPISODE. NOW WHAT?

Peter J. Weiden, M.D., *Director of Schizophrenia Research, State University of New York Downstate Medical Center, 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203*

SUMMARY:

The aftermath of an acute psychotic episode is treacherous. The patient may look better but remains fragile. Clinicians must balance competing goals of safety with rapid return to the community. Complications in the weeks and months ahead include continued psychiatric and medical problems, immediate readmission, homelessness, and suicide.

This presentation will review some recent outcome data on the time period following the acute episode, which is known as the stabilization period. I will show some data on the time course of symptom reduction over the stabilization period with conventional antipsychotics, and contrast this with data from the newer atypical agents. I will then review studies on rates of discontinuity of care during transition to outpatient care, and review studies designed to improve continuity of care after discharge. Finally, I will review the rates and risk factors for some of the common complications following discharge (e.g. post-psychotic depression), and some strategies that can help patients successfully navigate the stabilization period.

REFERENCES:

1. Grunebaum MF, Weiden PJ. Olfson M: Medication supervision and adherence of persons with psychotic disorders in residential treatment settings: a pilot study. Journal of Clinical Psychiatry 2001; 62(5):394–399.
2. Kopelowicz A, Wallace CJ, Zarate R: Teaching psychiatric inpatients to re-enter the community: a brief method of improving the continuity of care. Psychiatric Services 1998; 49:1313–1326.

Industry-Supported Symposium 7 **Thursday, October 10 6:00 p.m.-9:00 p.m.**

COMBINATION THERAPY IN BIPOLAR DISORDER: WHAT TO ADD, HOW, AND WHEN

Supported by GlaxoSmithKline

Robert L. Findling, M.D., *Professor of Pediatrics and Adolescent Health, and Director, Division of Child and Adolescent Psychiatry, University of Cleveland Medical Center, 11100 Euclid Avenue, Cleveland, OH 44106-5080*; Joseph R. Calabrese, M.D., *Director, Mood Disorders Program, Case Western Reserve University, 11400 Euclid Avenue, Suite 200, Cleveland, OH 44106-3986*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to use combinations of medications in the treatment of bipolar disorder (both type I/II and both juvenile/adult) based upon practical considerations such as what should be started first and what second, and how long one is to wait before starting additional medication-changes.

SUMMARY:

Bipolar disorder is almost never treated with a simple uncomplicated regimen of one medication, and medical treatment without a behavioral treatment plan is rarely effective. Polypharmacy has emerged as the standard of care in most treatment settings despite the limited availability of controlled trial data. Combination therapy is necessary to minimize a patient's risk to self and others, to hasten the onset of therapeutic effect, and to minimize the likelihood of cycling into the opposite phase of the illness during the first three months of treatment. Monotherapies with lithium, an anticonvulsant, an atypical antipsychotic, or an antidepressant are almost never considered an adequate strategy to accomplish the above objectives. This symposium will provide an evidence-based discussion of very specific clinical issues regarding the medical management of bipolar disorder including what medications and in which settings should be considered the foundation for treatment, what medications should be added second, and in what doses and when. Combination therapy in the acute management of bipolar depression, the acute treatment of mania, and in long-term prophylaxis will be the focus of the symposium. Presentations will address bipolar I and II disorder, concurrent psychosis, comorbid anxiety, and comorbid alcohol/drug abuse in both children and adults.

TARGET AUDIENCE(S):

Practicing psychiatrists

No. 7A
COMBINATION THERAPY IN ACUTE BIPOLAR DISORDER

Melvin D. Shelton, M.D., Ph.D., *Assistant Professor, Case Western Reserve University Hospitals, 11400 Euclid Avenue, Suite 200, Cleveland, OH 44106*

SUMMARY:

To adequately treat bipolar disorder, it is necessary to address both manic/mixed symptoms "from above," and depressive symptoms "from below," without increasing the risk of mood switches. There is no single agent equally efficacious in the simultaneous treatment of both bipolar phases, so medication combinations have become the treatments of choice, and different combinations are indicated for different phases of the illness. Treatment of the depressive phase has been particularly difficult to address adequately, and it has been recognized that some forms of bipolar disorder are notable for the predominance of depression. Since 1996, general bipolar treatment guidelines have evolved; using a modified Rand consensus evaluation technique, these have been sharpened in 1999 and 2001 (Suppes, et al), and include medication combinations as first-line treatments for acute bipolar depression. Depending on severity, progression, and current phase of illness, these include various combinations of divalproex, lithium, carbamazepine, lamotrigine, atypical antipsychotics, non-heterocyclic antidepressants, and ECT as first-line therapies. Taken together, these and other treatment modalities possess considerable efficacy in both phases of bipolar disorder, but identification of a single agent with bimodal efficacy would meet a significant unmet need.

REFERENCES:

1. Ketter T, Calabrese JR: Stabilization of mood from below versus above baseline in bipolar rapid cycling: a new nomenclature. J Clin Psychiatry, in press.
2. Sachs G, Printz D, Kahn D, Carpenter D, Docherty J: The Expert Guidelines Series 2000; medication treatment of bipolar disorder 2000. Postgrad Med 2000; April Supp:1–109.

No. 7B
COMBINATION THERAPY IN ACUTE MANIA

David J. Muzina, M.D., *Department of Psychiatry, Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland, OH 44195*

SUMMARY:

Medications available for the treatment of acute mania are expanding rapidly, although only three medications carry indications from the FDA for treatment of the manic phase of bipolar disorder (lithium, divalproex, and olanzapine). At this time, lithium, divalproex, and carbamazepine are considered mood-stabilizing medications for patients with bipolar disorder and are commonly regarded as the foundation of treatment of an acute manic episode. However, overall response rates in acute monotherapy treatment trials with these three agents indicate that adequate remission from acute mania reaches only 50% to 60%. This supports the clinical experience of frequent failure of monotherapies for acute mania. Data from randomized controlled trials suggest that carbamazepine, typical antipsychotics, and other atypical antipsychotics also are effective antimanic agents. Other augmenting agents include lamotrigine, topiramate, benzodiapines, other anticonvulsants, calcium-channel blockers, and high-dose thyroid hormone. Research regarding clinical predictors of response to some monotherapies may guide initial treatment strategies as may more specific subtypes of the bipolar disorder itself. Treatment strategies for acute mania will be reviewed, focusing on rational uses for various combination drug therapies in an algoryhthmic approach. Future research is needed to investigate the overall safety and efficacy of these combination pharmacotherapies for acute mania.

REFERENCES:

1. Frye MA, Ketter TA, Leverich GS, Huggins T, Lantz C, Denicoff KD, Post RM: The increasing use of polypharmacotherapy for refractory mood disorders: 22 years of study. J Clin Psychiatry 2000; 61(1):9–15.

No. 7C
LONG-TERM COMBINATION THERAPY

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

SUMMARY:

Informed combination therapy or the polypharmacy of bipolar disorder has become the standard of care, and particularly in patients with treatment-refractory variants such as those with mixed states, rapid cycling, or psychotic symptoms. There is emerging consensus that if one follows a patient on monotherapy for sufficiently lengthy periods of time, the patient will eventually require augmentation with another agent to maintain full remission. The controlled acute and longitudinal divalproex bipolar data, the placebo-controlled acute multidose lamotrigine bipolar depression data, the open pro-

spective longitudinal data assessing spectrum of efficacy of each of these drugs, and the recent placebo-controlled long-term lamotrigine maintenance data provide a rationale for regimens of combination therapy including lithium, divalproex, the atypical antipsychotic agents, and lamotrigine. These agents appear to possess a spectrum of activity that complements each other.

Cancer chemotherapy has for many years included complex regimens of multiple medications possessing complementary spectrum of mechanisms and clinical efficacy. Bipolar disorder and its variants are accompanied by such morbidity and mortality as to merit similar such aggressive pharmacotherapeutic approaches. This presentation will review practical clinical issues regarding the use of these medications in combination, including specific recommendations as to what to use, how much to use, when, and how.

REFERENCES:

1. Calabrese JR, Bowden CL, Woyshville MJ: Lithium and the anticonvulsants in bipolar disorder, in Bloom FE, Kupfer DJ, eds. Psychopharmacology: The Fourth Generation of Progress. CD-ROM Version 3, http://www.acnp.org/citations/GN401000106, 2000.

No. 7D
CHILDHOOD AND ADOLESCENT PRESENTATIONS

Robert L. Findling, M.D., *Professor of Pediatrics and Adolescent Health, and Director, Division of Child and Adolescent Psychiatry, University of Cleveland Medical Center, 11100 Euclid Avenue, Cleveland, OH 44106-5080*

SUMMARY:

There is a growing body of evidence to support the use of pharmacotherapy in the treatment of children and adolescents with bipolar disorder. However, there are fewer data available to inform practitioners about how best to medicate pediatric-aged patients with bipolar illness. This is likely due to the fact that more children and teenagers may suffer from bipolar illness than was previously appreciated.

What data do exist about medication monotherapy suggest that several agents including lithium carbonate, divalproex sodium, carbamazepine, and olanzapine may all have roles in the treatment of juvenile bipolarity. However, it has recently become better appreciated that a substantial proportion of youths with bipolar illnesses do not necessarily respond optimally to drug monotherapy. For this reason, clinicians have begun to examine what role combination pharmacotherapy should play in the medication management of children and adolescents with bipolar disorder. Several different combination therapy strategies have been considered in this population with varying degrees of success.

The purpose of this talk is to review what is known about the safety and effectiveness of combination pharmacotherapy in juvenile bipolarity. New research data pertaining to this topic will also be considered.

REFERENCES:

1. Findling RL, Gracious BL, McNamara NK, Youngstrom EA, Demeter CA, Branicky LA, Calabrese JR: Rapid, continuous cycling and psychiatric comorbidity in pediatric bipolar I disorder: Bipolar Disord 2001:3:202–210.

Industry-Supported Symposium 8 — **Friday, October 11 12 noon-1:30 p.m.**

EXPLORING THE FACETS OF DEPRESSION: EXAMINING MEDICAL AND PSYCHIATRIC COMORBIDITIES

Supported by Pfizer Inc.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the impact of depression on patients with heart disease; recognize that the treatment of depression in patients with heart disease changes morbidity and mortality; and review the differential diagnosis and treatment options for patients with comorbid depression and anxiety disorders.

SUMMARY:

The management of depression is often complicated by comorbid medical and psychiatric disorders. Recognition of comorbidities permits more comprehensive treatment planning and selection of specific treatments that address these complexities. This symposium will examine the relationship between depression and cardiovascular disease and the relationship between depression and anxiety disorders. Depression is common in patients with preexisting cardiovascular disease as well as a risk factor for future cardiovascular problems. Evidence shows that managing depression with appropriate medications can reduce the risk of increased morbidity and mortality from comorbid cardiovascular disease. Anxiety disorders and depression are often comorbid, and the presence of comorbid anxiety and depression substantially influences treatment selection and clinical management. Proper diagnosis of comorbid anxiety disorders and depression allows for the selection of an

appropriate treatment option. With careful diagnosis of comorbid disorders and optimal treatment that addresses both conditions, better outcomes can be achieved.

TARGET AUDIENCE(S):

Psychiatrists

REFERENCES:

1. Roose SP, Devanand D, Suthers K: Depression: treating the patient with comorbid cardiac disease. Geriatrics 1999;54(2):20–1, 25–6, 29–31.
2. Goodnick PJ, Hernandez M: Treatment of depression in comorbid illness. Expert Opin Pharmacother 2000;1(7):1367–84.

No. 8A
DEPRESSION AND COMORBIDITY

Alexander H. Glassman, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive Unit 116, New York, NY 10032*

SUMMARY:

Depression is comorbid with many conditions; however, the basis of the comorbidity varies depending upon the medical condition. With Parkinson's disease, depression may actually be secondary to the anatomic lesion in the striatum. On the other hand, in many medical conditions, depression may be an understandable reaction to a serious medical condition. In the instance of comorbid depression and AIDS, both of these factors may play a role. Cardiovascular disease and depression not only coexist more often than one would expect, but depression undoubtedly alters the course of cardiovascular disease. There is no question that middle-aged healthy individuals with depression, followed for long periods of time, will show a higher incidence of new heart-related conditions. After a heart attack, stroke, unstable angina, or heart failure, those individuals with comorbid depression will experience three or four times greater morbidity and mortality.

As it is established that depression and cardiovascular disease are often comorbid and comorbidity predicts a more malignant outcome, the essential questions are how comorbidity alters morbidity and mortality and if treating depression can reduce this increased risk. Evidence is beginning to accumulate that suggests drug treatment of depression can result in better cardiovascular outcomes. Future research should examine the reasons behind these results.

REFERENCES:

1. Glassman AH, Shapiro PA: Depression in the course of coronary artery disease. Am J Psychiatry 1998;155:4–11.

No. 8B
ANXIETY DISORDER AND COMORBID DEPRESSION

Andrew W. Goddard, M.D., *Professor of Psychiatry, Indiana University, 550 North University Boulevard, Indianapolis, IN 46202*; Amit Anand; Susan Ball; Anantha Shekhar, M.D., Ph.D.; Christopher J. McDougle, M.D.

SUMMARY:

Patients with major depression often suffer from comorbid conditions such as anxiety disorders. Results from the National Comorbidity Survey demonstrate that in a 12-month period, 51% of patients with major depressive disorder were additionally diagnosed with an anxiety disorder, such as posttraumatic stress disorder, generalized anxiety disorder, social anxiety disorder, or panic disorder. The presence of anxiety symptoms can have a substantial effect on a patient's clinical presentation and prognosis. Patients with comorbid depression and anxiety disorders tend to experience more severe symptoms, use more health care resources, and have a worse prognosis than those with a single diagnosis. Conditions such as social anxiety disorder are invariably underrecognized in clinical settings and are therefore undertreated, and, when major depression is also present, are even less likely to be accurately diagnosed. The greater impairment experienced by patients with comorbid diagnoses can manifest as a heightened severity of symptoms, severely reduced quality of life, and longer time to recovery. Recognition of these comorbidities permits more comprehensive treatment planning and selection of specific treatments that address these complexities.

REFERENCES:

1. Kessler RC, et al: Comorbidity of DSM-III-R major depressive disorder in the general population: results from the US national comorbidity survey. Br J Psychiatry 1996; 168(suppl 30):17–30.

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

LITHIUM IN MAJOR AFFECTIVE DISORDERS: AN UPDATE

Supported by GlaxoSmithKline

Frederick K. Goodwin, M.D., *Director, Psychopharmacology Research Center, George Washington University Medical Center, 2300 I Street, N.W., Roff Hall, Room 514, Washington, DC 20037*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to recognize factors in patients at risk for suicide;

describe the differential diagnoses associated with patients at risk for suicides; discuss the risks and benefits of different treatments for this condition; and develop appropriate treatment approaches for patients at risk for suicide

SUMMARY:

Suicide is a tragic and potentially preventable problem. Almost 90% of those who kill themselves have a diagnosable and treatable mental or substance abuse disorder. Patients with mood disorders are at particularly high risk for suicide. Patients with this disorder treated with lithium have been found to have lower rates of suicide leading to the hypothesis that lithium may have a specific anti-suicidal effect. Since treatments for mental disorders in general have not been shown to be notably effective in suicide prevention, it is important to consider new information about the effectiveness of lithium and other potentially effective agents.

No. 9A
LITHIUM IN PSYCHIATRY: PRACTICAL CONSIDERATIONS

James Walter Jefferson, M.D., *Clinical Professor of Psychiatry, University of Wisconsin Medical School, 7617 Mineral Point Road, Suite 300, Madison, WI 53717*

SUMMARY:

Lithium has been in the mainstream of psychiatry for many years. It remains the drug of choice for bipolar mood disorder, is the mainstay of augmentation therapy for resistant depression, and has a number of less well substantiated but promising psychiatric and nonpsychiatric uses. Issues not fully resolved include optimum serum levels for acute and maintenance treatment, the ideal dosage schedule, risks inherent in its use in the elderly and during pregnancy, and managing nonresponders. While uncommon, lithium poisoning continues to kill and maim, and greater attention needs to be paid to its prevention, diagnosis, and treatment. The potential side effects of lithium are many, yet most are tolerable or easily managed. Attention will be focused on the more common and troublesome side effects including neurologic, endocrine, renal, and dermatologic. Finally, certain drugs interact by altering renal lithium clearance and increasing or decreasing serum lithium levels. The angiotensin converting enzyme (ACE) inhibitors are the most recent additions to this group.

REFERENCES:

1. Jefferson, JW, Lithium, in Dukes MNG, Aronson JK (eds): Meyler's Side Effects of Drugs, 14th ed, Eisevier Science BV, 2000; 86–94.
2. Jefferson, JW, Greist JH, Lithium. in Sadock BJ, Sadock VA (eds). Kaplan Sadock's Comprehensive Textbook of Psychiatry, 7th ed, Philadelphia, Williams & Wilkins, 2000, pp. 2377–2390.

No. 9B
WHERE DOES LITHIUM FIT IN THE TREATMENT OF BIPOLAR DISORDER TODAY?

Frederick K. Goodwin, M.D., *Director, Psychopharmacology Research Center, George Washington University Medical Center, 2300 I Street, N. W., Roff Hall, Room 514, Washington, DC 20037*

SUMMARY:

Lithium, the most extensively studied mood stabilizer, is the only psychopharmacologic agent that has been shown in placebo-controlled trials to prevent recurrences of manic and depressive episodes when used as a maintenance treatment. It is also the only treatment that has been demonstrated to decrease suicide risk in bipolar patients. Placebo-controlled studies have shown that anticonvulsants, such as carbamazepine and valproate, have antimanic efficacy and may also have antipsychotic efficacy, especially in more refractory bipolar episodes. The antipsychotics have also shown efficacy against mania. The treatment of breakthrough depressive episodes remains the most common clinical problem. The antidepressant effect of lithium will be compared with other putative mood stabilizers. Also, the role of adjunctive mood stabilizers versus antidepressants for the management of this problem will be discussed.

REFERENCES:

1. Ghaemi SN, Goodwin FK: Long-term naturalistic treatment of depressive symptoms in bipolar illness with divalproex vs. lithium in the setting of minimal antidepressant use. J of Affective Disorders 2001; 65, 281–287.
2. Goodwin FK, Ghaemi SN: The impact of mood stabilizers on suicide in bipolar disorder: a comparative analysis. CNS Spectrums—The International Journal of Neuropsychiatric Medicine 2000; 5 2 (suppl 1).

No. 9C
NEUROPLASTICITY AND CELLULAR RESISTANCE IN BIPOLAR DISORDER

Husseini K. Manji, M.D., *Chief, Laboratory of Molecular Pathophysiology, Room B1 EE16 49 Convent Dr., MSC 4405, Bethesda, MD 20892*

SUMMARY:

The molecular and cellular mechanisms by which mood stabilizers may exert their beneficial effects has been the focus of extensive recent search. Signal transduction pathways play a critical role in regulating the functional balance between neurotransmitter systems, and it has been found that the chronic administration of the two structurally highly dissimilar agents, lithium and valproate (VPA), regulate the PKC signaling pathway in a strikingly similar manner. This has led to the investigation of PKC inhibitors in the treatment of acute mania, and preliminary clinical studies suggest that PKC inhibitors may represent a novel class of improved therapeutic agents for BD.

New genomics and proteomics technologies are also being utilized to facilitate the identification of genes that are regulated by mood stabilizers. Thus, lithium and VPA have recently been demonstrated to robustly increase the expression of the cytoprotective protein bc1–2 in the CNS. Consistent with these effects, both VPA, and in particular lithium, have been demonstrated to exert marked neuroprotective effects in a variety of preclinical paradigms. To determine if lithium also exerts neurotrophic effects in the human brain in vivo, studies have utilized proton magnetic resonance spectroscopy to quantitate the levels of NAA (a putative marker of neuronal viability and function). Four weeks of lithium treatment produced a significant increase in NAA levels, effects which were localized almost exclusively to gray matter. To determine if lithium's neurotrophic effects would also lead to neuropil increases, brain tissue volumes were examined using high resolution three-dimensional MRI and validated quantitative brain tissue segmentation methodology. This study revealed an extraordinary finding that chronic lithium significantly increases total gray matter content in the human brain of patients with BD. Together with the recent morphometric studies demonstrating cell loss and atrophy in BD, these results suggest that a reconceptualization about the pathogenesis of BD, as well as the role of lithium, may be warranted.

REFERENCES:

1. Ikonomov OC, Manji HK: Molecular mechanisms underlying mood stabilization in manic-depressive illness: the phenotype challenge. Am J Psychiatry 1999; 156(10):1506–14.
2. Knable MB: Schizophrenia and bipolar disorder: findings from studies of the Stanley Foundation Brain Collection. Schizophr Res 1999; 39(2):149–52; discussion 163.
3. Manji HK, Lenox RH: The nature of bipolar disorder. J Clin Psychiatry 2000; 61 Supp 13:42–57.

No. 9D
THE EFFECT OF LITHIUM TREATMENT IN SUICIDE RATES IN BIPOLAR DISORDER

Leonardo Tondo, M.D., *Lecturer on Psychiatry, 145 Pinckney # 612, Boston, MA 02114*

SUMMARY:

Suicide, a serious problem in our society, generally occurs as a consequence of untreated or inadequately treated psychiatric illness, principally severe depression and bipolar disorder (lifetime risk 15% to 19%). In bipolar disorder, the great majority of suicides occur during a depressed or mixed episode.

There is now an impressive body of evidence that lithium treatment is associated with a dramatic reduction in suicide in bipolar and recurrent unipolar illnesses. There are no comparable data for other putative mood stabilizers although one prospective study of 380 bipolar patients randomly treated with lithium or carbamazepine reported no suicide events in the lithium group and nine (five deaths, four serious attempts) in the carbamazepine group ($p<.01$). The intriguing question is whether this lithium effect reflects a specific anti-suicide effect in addition to its role in preventing or attenuating episodes.

REFERENCES:

1. Tondo L, Baldessarini RJ, Hennen J, Floris G, Silvetti F, Tohen M: Lithium treatment and risk of suicidal behavior in bipolar disorder patients. J Clin Psychiatry 1998; 59: 405–414.
2. Tondo L, Baldessarini RJ: Suicide: an overview. Medscape Internet Publications (http://www.medscape.com/Medscape/psychiatry/ClinicalMgmt/CM.v03/public/index-CM.v03.html), 2001, pp 1–18.

Industry-Supported Symposium 10 — **Friday, October 11 6:00 p.m.-9:00 p.m.**

MANAGING PATIENTS ON ANTIPSYCHOTIC MEDICATIONS: WHAT IS THE STATE-OF-THE-ART?

Supported by Bristol-Myers Squibb

Jean-Pierre Lindenmayer, M.D., *Clinical Director, Manhattan Psychiatric Center, and Clinical Professor of Psychiatry, New York University School of Medicine, 60 Remsen St, Brooklyn, NY 11201-3453*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss adverse events that interfere with achieving optimal acute and long-term remission/recovery for a variety; (for schizophrenic and bipolar

disorder) define strategies for minimizing adverse events at the initiation and throughout the course of therapy to optimize the safety, tolerability, and adherence with treatment regimens; discuss treatment options for managing different symptom dimensions at different stages of schizophrenia; review pharmacological and clinical differences among conventional, atypical, and combined therapies for schizophrenia.

SUMMARY:

In recent years, huge strides have been made in neuroscience, pharmacology, and medical imaging that advanced the understanding and care of patients with schizophrenia and psychotic disorders. In addition, there is a growing number of evidence-based pharmacological and psychosocial treatments that can be tailored to fit the needs of patients. Four nationally recognized academic psychiatrists will report on clinical challenges to and potential solutions for the effective management of a spectrum of psychotic disorders. Bryan Roth, MD, PhD, will discuss the mechanism of action of antipsychotic medications, specifically exploring the stabilization of neurotransmitter systems in the treatment of psychotic disorders. Philip Janicak, MD, will discuss new options for the treatment of the spectrum of symptoms in schizophrenic patients, through the use of the newer class of drugs: atypical antipsychotics. Jean Pierre Lindenmayer, MD, will present assessment and management strategies that apply to the treatment of psychotic, disorders as well as associated comorbid conditions. Paul Keck, MD, will present a critical analysis of the current management of bipolar disorder.

TARGET AUDIENCE(S):

Psychiatrists who treat patients with psychotic disorders and bipolar disorder.

No. 10A
STABILIZATION OF NEUROTRANSMITTER SYSTEMS IN THE TREATMENT OF PSYCHOTIC DISORDERS

Bryan L. Roth, M.D., Ph.D., *Associate Professor of Psychiatry, Biochemistry and Neurosciences, 10900 Euclid Avenue, Room W438, Cleveland, OH 44106-4936*

SUMMARY:

Traditionally, the pathophysiology of schizophrenia has been best explained by specific neurochemical alterations which mediate particular core symptoms of schizophrenia. Thus, research in schizophrenia has been fueled by an iterative approach whereby advances in pharmacologic therapy lead to refined disease models, leading to further developments of pharmacologic compounds. Based on this research, changes in dopaminergic, serotonergic, and glutamatergic systems have been implicated as neurochemical effectors of the pathogenesis of schizophrenia. While dopaminergic hyperactivity in the mesolimbic dopamine pathway has been correlated with positive symptoms, the negative (and possibly cognitive) symptoms are thought to result from a decreased functional activity of dopamine in the prefrontal cortex.

It is not surprising, then, that all of the currently available effective pharmacotherapies for schizophrenia modulate dopaminergic transmission. The conventional (typical) antipsychotic drugs are potent D2-dopamine receptor antagonists. Although conventional antipsychotic drugs effectively reduce the positive symptoms of schizophrenia, typical antipsychotic drugs minimally improve negative symptoms and may, indeed, exacerbate them. In addition, nonselective dopamine blockade with these agents causes a variety of adverse effects, particularly extrapyramidal symptoms (EPS) and tardive dyskinesia. The newer, atypical agents are also D_2-dopamine receptor antagonists, though they are have significantly lower propensities to induce EPS and tardive dyskinesia, and are more effective at reducing negative symptoms than conventional antipsychotics. The precise pharmacologic basis for atypicality is unknown, although relatively high affinity for 5-HT_{2A} receptors and relatively weak D_2-dopamine receptor affinity is important. Unfortunately, conventional atypical antipsychotic drugs are associated with weight gain and metabolic changes that can have serious medical consequences (e.g. increased risk for cardiovascular disease and diabetes). The pharmacologic basis of these adverse metabolic effects is not clear, though recent studies suggest that interactions with histamine and adrenergic receptors are involved (Kroeze et al, submitted).

Aripiprazole, an atypical antipsychotic drug with a novel mechanism of action has recently been developed. Aripiprazole has a unique mechanism of action in that it interacts with D_2 receptors as a partial agonist and *not* as an antagonist. Aripiprazole is also a potent partial agonist at 5-HT_{1A} receptors and an antagonist at 5-HT_{2A} receptors. Because of its partial agonist properties, aripiprazole is hypothesized to act as a dopamine-serotonin system stabilizer and thus represents a novel atypical antipsychotic drug predicted to have fewer side effects than conventional atypical antipsychotic drugs.

REFERENCES:

1. Arnt J, Skarsfeldt T: Do novel antipsychotics have similar pharmacological characteristics? A review of the evidence. Neuropsychopharmacology 1998; 18(2):63–101.
2. Kapur S, Zipursky RB, Remington G: Clinical and theoretical implications of 5-HT2 and D2 receptor occupancy of dozapine, risperidone, and olanzapine

in schizophrenia. Am J Psychiatry. 1999; 156(2):286–93.

No. 10B
TREATING THE SPECTRUM OF SYMPTOMS IN SCHIZOPHRENIA

Philip G. Janicak, M.D., *Professor of Psychiatry, Medical Director, 1601 West Taylor Street, Chicago, IL 60612*

SUMMARY:

The presentation of schizophrenia is diverse and complex, with symptoms ranging from severe depression to paranoid delusions. Thus, successful treatment of schizophrenia requires the management of a broad spectrum of symptoms including positive and negative symptoms and cognitive deficits. Conventional antipsychotics provide relief of acute psychosis, which consists primarily of positive symptoms. Clinical management of negative symptoms such as social withdrawal and alogia, however, often calls for adjunctive therapy. Conventional antipsychotics, however, are not optimal for long-term treatment due to the neurological adverse events associated with them. With the introduction of atypical antipsychotics, there are new options for the treatment of the spectrum of symptoms in schizophrenic patients. This newer class of drugs offers effective reductions in both positive and negative symptoms with fewer extrapyramidal side effects. The broad range of symptoms presented in schizophrenia and the comparative effects of conventional and atypical drugs, as well as combined and adjunctive therapies will be reviewed during this presentation.

REFERENCES:

1. Geddes J, Freemantle N, Harrison P, Bebbington P: Atypical antipsychotics in the treatment of schizophrenia: systematic overview and meta-regression analysis. BMJ, 2000; 321:1371–1376.
2. Janicak P, Davis J, Preskorn S, Ayd, Jr F: Principles and Practice of Psychopharmacotherapy, 3rd Ed., 2001; Lippincott, Williams, Wilkinson, Philadelphia, Pa: pp 83–192.

No. 10C
OPTIMIZING OUTCOME ACROSS THE SCHIZOPHRENIA SPECTRUM

Jean-Pierre Lindenmayer, M.D., *Clinical Director, Manhattan Psychiatric Center, and Clinical Professor of Psychiatry, New York University School of Medicine, 60 Remsen St, Brooklyn, NY 11201-3453*

SUMMARY:

A number of evidence-based therapies for a variety of psychiatric disorders have recently been introduced. At the same time, the knowledge base of the biological, psychosocial, and developmental basis for many psychiatric disorders has greatly expanded. As a result, clinicians now have a number of innovative and effective treatments to choose from in treating their patients with psychiatric disorders. The goal of therapy is to ensure acute and long-term recovery while optimizing the safety and tolerability of treatments and, thereby, improve adherence to treatment. The use of systematized management strategies both at the initiation of therapy and throughout the course of therapy are the most likely to bring about successful outcomes. To this end, assessment and management strategies will be presented that apply to the treatment of psychotic, disorders as well as associated comorbid conditions. These strategies are designed to reinforce the goal of optimizing both efficacy and safety/tolerability.

REFERENCES:

1. Zajecka J: Strategies for the treatment of antidepressant-related sexual dysfunction. J Clin Psychiatry 2001;62(Suppl 3):35–43.

No. 10D
CURRENT MANAGEMENT OF BIPOLAR MANIA: A CRITICAL ANALYSIS

Paul E. Keck, Jr., M.D., *Biological Psychiatry Program, University of Cincinnati, Albert Sabin Way, ML559, Cincinnati, OH 45267*

SUMMARY:

The treatment of acute mania in patients with bipolar disorder has progressed from bromides in the mid-19th century through electroconvulsive therapy in the 1930s, lithium and chlorpromazine in the 1950s, carbamazepine in the 1970s, and valproate in the 1990s, to the increasing use of atypical antipsychotics over the past decade. Mood stabilizers lithium, divalproex sodium, olanzapine, and carbamazepine are considered cornerstones of treatment for an acute manic episode and are frequently continued after resolution of the episode for subsequent prophylaxis. The response rates with these agents usually range from 50% to 60%. Because of the limited response and potentially serious adverse effects associated with mood stabilizers, particularly lithium, newer mood stabilizers have been developed. The newer agents showed promise in limited open-label studies, but none demonstrated efficacy for treatment of patients with manic or mixed episodes in randomized double-blind trials. Since mood stabilizers do not have the full range of clinical effects necessary for management of bipolar disorder,

antipsychotic agents and benzodiazepines are commonly used as adjunctive therapy during acute episodes. In 1994, the American Psychiatric Association published guidelines on the treatment of mania with antipsychotics. They advised that adjunctive use of benzodiazepines or neuroleptics may be used to manage symptoms of agitation or psychosis while awaiting the full effects of a primary mood stabilizer or to augment the effects of a mood stabilizer. Conventional antipsychotics are widely used for treatment of mania, but their use is associated with an unfavorable tolerability profile. Extrapyramidal symptoms in particular seem to be more common with low doses of antipsychotic agents in patients with mania than in those with schizophrenia. The more favorable adverse effect profile of atypical antipsychotics has encouraged their use in bipolar disorder. Several agents from this class have been studied in randomized clinical trials and found to be effective for treatment of acute manic episodes in patients with bipolar disorder.

REFERENCES:

1. Chou JC, Zito JM, Vitrai J, Craig TJ, Alingham BH, Czobor P: Neuroleptics in acute mania: a pharmacoepidemiologic study. Annals of Pharmacotherapy 1996;30:1396.

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

ATTAINING REMISSION IN ANXIETY AND DEPRESSION

Supported by Wyeth Pharmaceuticals

Philip T. Ninan, M.D., *Department of Psychiatry, Emory University, 1841 Clifton Road, NE, 400 North, Atlanta, GA 30329*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) recognize the value of remission over response, (2) assess treatments in anxiety and depression for the likelihood of achieving remission, and (3) understand the neurobiological underpinnings of remission and wellness.

SUMMARY:

A paradigm shift is occurring in the treatment of anxiety and depressive disorders. The focus of treatment is now becoming the achievement of remission, rather than simply response. Remission implies reduction in symptoms to within the population range of normality, with subsequent return of functional capabilities. This symposium will explore issues related to the concept of remission. Additionally, the likelihood of achieving remission in the anxiety disorders like GAD and panic disorder, as well as in major depression in clinical trials will be presented.

Exciting and explosive advances in the neurosciences allow the examination of the functional anatomy and pathophysiology leading to a new understanding of anxiety and depressive disorders. Such a 'conceptual scaffold' can enhance our clinical observation, open novel treatment approaches and target our interventions to specific dimensions of these illnesses, making the achievement of remission more likely.

Dr. Thomas Schwartz will examine issues related to defining remission in the various disorders and evaluate clinical studies for the likelihood of achieving remission.

Dr. Philip Ninan will present conceptual advances in the understanding of the neural circuitry and sequenced activation of different anatomical sites in the expression of depressive and anxiety disorders. An examination of the potential mechanisms of achieving benefit from treatment will be examined and distinctions between response remission, recovery and wellness will be explored.

TARGET AUDIENCE(S):

Mental health professionals

No. 11A
REMISSION: THE GOLD STANDARD IN THE TREATMENT OF DEPRESSION AND ANXIETY

Thomas L. Schwartz, M.D., *159 Richfield Ave, Syracuse, NY 13205-3116*

SUMMARY:

Both anxiety and depressive disorders are becoming more easily diagnosed and treated as clinician education has improved and as antidepressant medications have become safer to use over the last two decades. The research standard is to see if an antidepressant medication can result in a 50% reduction in depressive symptoms. This does not match the "real" clinical world where patients need a much better response to their medications. Some investigators are beginning to look at symptom "remission" or "wellness" as a better endpoint in research, as well as in the real world. This presentation will cover the history of antidepressant and anxiolytic development and research, and provide a provocative look at the available data when "remission" is used as a research standard and also as the clinical standard of care amongst older and newer medications.

REFERENCES:

1. Stahl S: Essential Psychopharmacology: Neuroscientific Basis and Practical Applications (2nd Ed.). Cambridge University Press, 2000.

No. 11B
PATHWAYS TO WELLNESS

Philip T. Ninan, M.D., *Department of Psychiatry, Emory University, 1841 Clifton Road, NE, 400 North, Atlanta, GA 30329*

SUMMARY:

The diagnostic categories in the DSM-IV are based on reliably measurable signs and symptoms. However, the validity of these diagnostic distinctions is only indirectly supported. At the same time, currently available treatments have only modest benefits. For additional advances in treatment to occur, mechanisms of disease must be synthesized with the diagnostic nomenclature. Thus, it is critical to develop a model of the functional anatomy, pathophysiology, and ultimately etiology of illnesses such as anxiety and depressive disorders. Challenges include our limited ability to study the functioning brain with appropriate spatial and temporal resolution, as well as developing a better understanding of interactions with endocrine, immunological, and other systems.

The recent explosion of knowledge in the neurosciences allows the development of a conceptual framework of the normal functioning of the brain from perception to the experience of emotions to cognition. Bottom-up and top-down sequences allow flexibility of response in normative conditions. Pathology is the limitation of choice to a stereotypic repertoire of emotional, cognitive, and behavioral responses.

Conceptual advances in treatment allow the staging of treatment benefits into response, remission, recovery, and wellness. Brain-based models of pathology also allow conceptualizing the potential mechanisms of treatment response. Such advances are critical in developing better medication and psychotherapeutic treatments that enhance the likelihood of achieving wellness.

REFERENCES:

1. Ninan PT, Berger J: Symptomatic and syndromal anxiety and depression. Depression and Anxiety 2001;14:79–85.

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

UNRECOGNIZED PREVALENCE OF BIPOLAR DISORDER AND WHAT WE CAN DO ABOUT IT

Supported by GlaxoSmithKline

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize the magnitude of the unmet need in the recognition and treatment of bipolar I and II disorder across the life cycle, including a recent estimate of prevalence in the general population, new developments in children/adolescents, and new data regarding long-term prophylaxis.

SUMMARY:

According to the WHO, bipolar disorder is the sixth leading cause of disease-based disability in the world, yet its impact on patients and family is vastly underappreciated. Although the prevalence of bipolar I disorder is approximately 1%, the prevalence of bipolar spectrum disorders is in the range of 3% to 5%. During this symposium, Dr. Hirschfeld will present new data on the prevalence and impact of bipolar I and II disorder obtained through a recently completed population-based study of 127,000 individuals. Dr. Youngstrom will then present new data on novel strategies to diagnose bipolar disorder in children and adolescents. Dr. Findling will provide an update on the pharmacotherapy of bipolar disorder in children and adolescents, and Dr. Calabrese will present new data regarding the long-term prophylaxis of bipolar disorder in adults.

TARGET AUDIENCE(S):

Practicing psychiatrists who treat children, adolescents, and adults.

No. 12A
TRUE PREVALENCE AND IMPACT OF BIPOLAR I AND II DISORDERS

Paul E. Keck, Jr., M.D., *Professor of Psychiatry and Pharmacology, Department of Psychiatry, University of Cincinnati, P.O. Box 670559, 231 Bethesda Avenue, Cincinnati, OH 45267-0559*

SUMMARY:

Although the prevalence of bipolar I disorder is widely reported as 1%, the prevalence of bipolar spectrum disorders is considerably higher, perhaps in the range of 3% to 4%. Bipolar spectrum disorders include bipolar I, bipolar II, and bipolar not otherwise specified. A recent community survey of over 127,000 adult Americans matched to U.S. Census data variables found a prevalence of 3.7% using the Mood Disorder Questionnaire as the screening instrument. Among these 3.7% of Americans with the diagnosis of bipolar spectrum disorder, only one in five had actually been given a diagnosis of bipolar disorder by a health professional, whereas half had been given a diagnosis of depression. This means that 80% of individuals with bipolar spectrum

disorders in the community were either undiagnosed or misdiagnosed. The implications of this are severe. Those with bipolar spectrum disorders are suffering substantial psychosocial impairment in a number of areas, including marriage, work performance, social life, family life, and usage of medical services. This presentation will outline and describe these findings.

REFERENCES:

1. Hirschfeld RMA, Williams JB, Spitzer RL, Calabrese JR, et al: Development and validation of a screening instrument for bipolar spectrum disorder: the mood disorder questionnaire. Am J Psychiatry 2000; 157(11): 1873–1875.
2. Hirschfeld RMA, Calabrese JR, Weissman MM, Reed M, et al: Lifetime prevalence of bipolar spectrum disorder in the United States, submitted 2001.

No. 12B
EARLY RECOGNITION OF BIPOLAR DISORDER IN CHILDREN AND ADOLESCENTS

Eric Youngstrom, M.D., Ph.D., *Assistant Professor, 11100 Euclid Avenue, Hannah Pavillion, Cleveland, OH 44106*

SUMMARY:

Bipolar disorder is difficult to diagnose accurately in children and adolescents; yet early, accurate identification is crucial. Several factors complicate recognition in juveniles. There has been a lack of empirically supported screening instruments for youths, and the widely used behavior checklists do not include specific scales for hypomanic symptoms. Bipolar disorders also are rare, frequently comorbid with other disorders, share symptoms with more common diagnoses such as ADHD and depression, and may have their presentation change across the age span.

This talk addresses the issue of detection and differential diagnosis of juvenile bipolar disorder, emphasizing the interpretation of inexpensive self-report, parent-report, and clinician ratings that can help detect bipolar disorder and rule it in or out. From a clinical standpoint, one of the shortcomings of most published research is that it presents statistics quantifying group differences and not individual classification. Clinicians, on the other hand, need to make decisions about the diagnosis and treatment of individual cases. We introduce two ways to evaluate an assessment tool's value for making real-life clinical decisions. Results indicate that screening devices may be used to improve decisions involving juvenile bipolar disorder, resulting in diagnostic sensitivity, specificity, and efficiency in the .75 to .95 range.

REFERENCES:

1. Youngstrom EA, Findling RL, Danielson CK, Calabrese JR: Discriminant validity of parent report of hypomania and depressive symptoms on the General Behavior Inventory. Psychol Assess 2001;13:267–76.

No. 12C
NEW DEVELOPMENTS IN THE PHARMACOTHERAPY OF BIPOLAR DISORDER IN CHILDREN AND ADOLESCENTS

Robert L. Findling, M.D., *Professor of Pediatrics and Adolescent Health, and Director, Division of Child and Adolescent Psychiatry, University of Cleveland Medical Center, 11100 Euclid Avenue, Cleveland, OH 44106-5080*

SUMMARY:

There is a growing appreciation that bipolar disorder may be more common in children and adolescents than previously believed. As young people with bipolar disorder are often times quite impaired and experience substantial suffering as a result of their illness, effective treatments are needed for this population.

When compared with the data that pertains to pharmacotherapy of bipolar disorder in adults, the amount of information that relates to the medication management of bipolar disorder in youths is substantially smaller. This is unfortunate because it has been shown that what is applicable to the pharmacotherapy of adults is often times not applicable to the treatment of youngsters.

Several compounds including lithium, anticonvulsants, and atypical antipsychotics have shown promise as potentially being safe, effective interventions. In addition, there is also a growing body of information to suggest that treatment with more than one medicine, combination therapy, may also have a role in the acute management of pediatric bipolarity. As bipolar disorder is a chronic condition and is associated with substantial morbidity, maintenance treatments for this illness also need to be identified.

This presentation will be a state-of-the-art update about the pharmacotherapy of juvenile bipolar disorder.

REFERENCES:

1. Chang KD, Ketter TA: Special issues in the treatment of paediatric bipolar disorder. Expert Opinion on Pharmacotherapy 2001; 2:613–622.

No. 12D
LONG-TERM PROPHYLAXIS OF BIPOLAR DISORDER

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

SUMMARY:

Bipolar disorder is a highly recurrent disorder with a prevalence of about 1.6% for the bipolar I subtype and more than 3% when other forms are included. Nine out of 10 patients with an initial mood episode experience subsequent mood episodes. These episodes are typically characterized by significant cognitive and behavioral dysfunction and it is now recognized that each mood episode increases the risk of future recurrences and worsens prognosis. On the bases of studies conducted primarily between 1960 and 1970, lithium has been the cornerstone of maintenance therapy for bipolar disorder, but its efficacy in open and blinded, randomized maintenance studies of the last 15 years has been consistently below 50%. The FDA has not approved a drug for the prophylaxis of bipolar disorder in over 30 years and there exists a need for alternatives to lithium that have been shown to be effective and well-tolerated. This presentation will use clinical algorithms to discuss the long-term prevention of bipolar disorder and then present new data regarding long-term comparisons of lamotrigine and lithium to placebo in the prevention of mood episodes associated with bipolar I disorder in recently manic and recently depressed patients.

REFERENCES:

1. Calabrese JR, Bowden CL, Sach G, Yatham L, Behnke K, Mehtonen O-P, Montgomery P, Ascher J, Paska W, Earl NL, DeVeaugh-Geiss J, for the Lamictal 605 Study Group: A placebo-controlled 18-month trial of lamotrigine and lithium maintenance treatment in recently depressed patients with bipolar I disorder. Submitted to Archives of General Psychiatry.
2. Bowden CL, Calabrese JR, Sachs G, Yatham LN, Akthar-Asghar S, Hompland M, Montomery P, Earl N, Smoot TM, DeVeaugh-Geiss J for the Lamictal 606 Study Group: A placebo-controlled 18 month trial of lamotrigine and lithium maintenance treatment in recently manic or hypomanic patients with bipolar I disorder. Archives of General Psychiatry. In Press.

INNOVATIVE PROGRAMS: SESSION 1 CONNECTIONS TO COMMUNITY

Innovative Program 1 Wednesday, October 9 3:30 p.m.-5:00 p.m.

A COMMUNITY-BASED SOCIAL SKILLS PROGRAM FOR PEOPLE WITH MENTAL ILLNESS

Nancy Mann, R.N., *Clinical Nurse, Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109*; Mona Goldman, Ph.D., *Research Investigator, Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Box 0120, Ann Arbor, MI 48109*; Rajiv Tandon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) understand how to implement an effective social skills program and (2) understand the design of the Life Skills program—an efficient, versatile, community-based program.

SUMMARY:

This presentation describes Life Skills, an innovative, psychosocial skills training program for people with severe mental illnessess, and discusses its implementation in a variety of community-based settings. The deficits in social and life skills that are a major component of schizophrenia, impair the ability to work, enjoy a social life, and live independently. Although psychosocial skills programs have shown promise in improving these deficits, few have been adopted in community-based settings. The variety of administrative structures and client needs in these settings require programs that are comprehensive, efficient, and flexible. Life Skills is a 20-session social skills training program designed to embody these characteristics. Its procedures are clearly delineated in a teacher's manual and student workbooks. A variety of learning paradigms are used including didactics, role play, discussion, homework, and in-vivo practice. Emphasis is placed on creating a safe, supportive environment in which clients are encouraged to participate. Lessons include practical skills such as problem solving, money management, communication, employment, and disease management. The program has been effectively implemented in a variety of settings. This will be described.

REFERENCES:

1. Liberman RP, Wallace CJ, et al: Innovations in skills training for the seriously mentally ill: the UCLA social and independent living skills modules. Innovations & Research 1993; 2:43–60.
2. Bustillo JR, Lauriello J, et al: The psychosocial treatment of schizophrenia: an update. Am J of Psychiatry 2001; 158:163–175.

Innovative Program 2 Wednesday, October 9 3:30 p.m.-5:00 p.m.

BRIDGING THE HOMELESS SERVICES GAP : THE PROJECT OUTREACH PROGRAM

Timothy D. Florence, M.D., *2001–2002 APIRE/Janssen Fellow, and Clinical Instructor of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Box 0116, Ann Arbor, MI 48109*; Mark C. Holter, Ph.D., *Assistant Professor of Social Work, University of Michigan, 1080 South University, Box 1106, Ann Arbor, MI 48109*; Mona Goldman, Ph.D.; Lisa M. Becks, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) describe effective engagement and treatment strategies for homeless persons with severe mental illness and (2) understand the design, implementation, and evaluation of Project Outreach.

SUMMARY:

In many small cities and rural communities, the needs of homeless persons with severe mental illness have been inadequately addressed, and treatment programs targeting this population have been understudied. Model programs in large urban centers may or may not effectively translate to such locales. Successfully implemented in a small urban area, the Project Outreach Team (PORT) is designed to (1) engage untreated homeless mentally ill persons, (2) provide treatment based on the PACT model, and (3) transition clients after psychiatric stabilization into the public mental health system. Program objectives are to improve access to care, improve clinical and functional outcomes, and shift the provision of services from acute-care settings to community-based sites. Validated research instruments are used at enrollment and every three months over an 18-month period to assess clinical status, functional and quality of life outcomes, and client satisfaction. Housing status and service utilization are tracked monthly. Forty subjects with psychotic and major mood disorders are thus far enrolled, with a refusal rate of 33%. Baseline measures suggest serious functional impairment and prevalent substance use and medical disorders. Longitudinal evaluation is under way. The successful implementation of PORT suggests that a single team can provide engagement, treatment, and bridging services for the homeless mentally ill in a small urban center.

TARGET AUDIENCE:

Community mental health clinicians, homeless advocates

REFERENCES:

1. Lehman AF, Dixon LB, et al: A randomized trial of assertive community treatment of homeless persons with severe mental illness. Arch Gen Psych 1997; 54:1038–43.
2. Susser E, et al: Preventing recurrent homelessness among mentally ill men: a ''Critical Time'' intervention. Am J Public Health 1997; 87:256–262.

Innovative Program 3 Wednesday, October 9 3:30 p.m.-5:00 p.m.

OPTIMISM, CELEBRATION, AND BIOPSYCHOSOCIAL REHABILITATION

Peggy A. Wilson, D.N.S., *Clinical Nurse Specialist, San Francisco Mental Health Rehabilitation Facility, 887 Potrero Avenue, San Francisco, CA 94110*; Jennie Hua, M.S., *Vocational Rehabilitation Specialist, San Francisco Mental Health Rehabilitation Facility, 887 Potrero Avenue, San Francisco, CA 94110*; Connie Truong, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify opportunities for creative use of resources to enhance functioning and foster hope in individuals with severe mental illness.

SUMMARY:

Optimism about recovery and community reintegration for individuals with severe mental illness is an essential concept in psychosocial rehabilitation. Within psychosocial rehabilitation, traditional psychiatric interventions, like diagnosis, psychopharmacology, psychotherapy, and inpatient hospitalization, can be coordinated with the ''creative use of other resources in pursuit of enhancing functioning, fostering hope, and helping a person create meaningful identity.'' (McQuiston, et al., 2000) The Mental Health Rehabilitation Facility (MHRF), a psychiatric skilled nursing facility, provides biopsychosocial rehabilitation services to citizens of San Francisco with severe and persistent mental illness. In November 2001, the MHRF celebrated its fifth anniversary, and held an open house celebration to welcome the mental health community. The anniversary was also seen as a vehicle to create opportunities for MHRF residents: for mastery and competence, for normalized personal relationships with peers and staff, and for vocational and social skill development. It also created opportunities for MHRF staff: for the therapeutic use of self, to solidify links with community-based vocational programs, and to educate the greater community about the recovery trajectory. This presentation discusses how the anniversary was used to enhance resident vocational and social opportunities, foster collaboration between agencies, decrease stigma, and create a feeling of celebration shared by the residents and professional staff.

TARGET AUDIENCE:

Psychiatrists, social workers, psychiatric nurses, psychologists

REFERENCES:

1. Bachrach LL: Psychosocial rehabilitation and psychiatry. American Journal of Psychiatry 1992; 149 (11):1455–1463.
2. McQuiston HL, Goisman RM, Tennison CR: Psychosocial rehabilitation: issues and answers for psychiatry. Community Mental Health Journal 2000; 36 (6):605–616.

INNOVATIVE PROGRAMS: SESSION 2 ORGANIZATIONAL MODELS FOR COMMUNITY CARE

Innovative Program 4 Thursday, October 10 10:00 a.m.-11:30 a.m.

INTEGRATING PHYSICAL AND BEHAVIORAL HEALTH CARE: THE WASHTENAW COMMUNITY HEALTH ORGANIZATION EXPERIENCE

David L. Neal, M.S.W., *Assistant Professor of Social Work, Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109*; Karen K. Milner, M.D., *Assistant Clinical Professor of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0020*; Frederick C. Blow, Ph.D., *Assistant Professor of Psychiatry, University of Michigan, 400 East Eisenhower Parkway, Ann Arbor, MI 48108*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss strategies and projects designed to facilitate the integration of physical and behavioral health care.

SUMMARY:

The Washtenaw Community Health Organization (WCHO), a public managed care organization established by county and university entities, was designed to integrate behavioral health services and primary and specialty care for Medicaid recipients and indigent clients residing in Washtenaw County. A number of inno-

vative projects have been developed to facilitate this integration. Specifically, a health screening questionnaire designed to be completed online by the client with assistance from the case manager as needed, has been developed to identify at-risk behaviors that predispose to medical illness and screen for symptoms indicative of physical disease. Additionally, CareWeb, the university hospital's electronic medical record, is available to psychiatrists working at the Washtenaw County Community Mental Health (WCCMH) to ensure the sharing of clinical information relative to client care. A centralized data integration warehouse has also been developed to assimilate information obtained from WCCMH, the WCHO, the University of Michigan Health System, and the Michigan Center for Diagnosis and Referral in order to decrease fragmentation of care and avoid duplication of costs. The impact of these and other innovative projects on the integration of physical and mental health care for recipients will be discussed.

TARGET AUDIENCE:

Psychiatrists, nurses, case managers, and administrators involved in providing services to individuals with severe and persistent mental illness.

REFERENCES:

1. Dixon L, Postrado L, Delahanty J, Fischer PJ, Lehman A: The association of medical comorbidity in schizophrenia with poor physical and mental health. J Nerv Ment Dis 1999; 187: 496–502.
2. Druss BG, Bradford WD, Rosenheck RA, Radford MJ: Quality of medical care and excess mortality in older patients with mental disorders. Arch Gen Psychiatry 2001; 58:565–572.

Innovative Program 5 Thursday, October 10 10:00 a.m.-11:30 a.m.

THE K-AXIS V AS A TOOL FOR COORDINATING CONTINUITY OF CARE FROM A FORENSIC HOSPITAL PROGRAM

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate basic understanding of the K-Axis tool, and to consider its efficacy as a tool facilitating continuity of care.

SUMMARY:

The purpose of this presentation is to describe the Kennedy Axis V (K-Axis V) and review pilot data concerning its psychometric properties as well as its applications as a tool for facilitating continuity of care from a forensic inpatient unit to various settings. It is intended for the multidisciplinary hospital treatment team member, as well as the researcher or hospital administrator interested in multidimensional clinical outcomes measurement and continuity of care. A clinician-rated measure of patient function, the K-Axis provides behavioral anchors for the rating of eight functional domains (psychological and social skills, violence, ADLs, substance abuse, medical impairment, ancillary problems, and global functioning (GAF-Equivalent)). Data are being collected on a co-ed, adult, pre-trial forensic hospital unit using a repeated measures design. Initial analyses suggest the K-Axis V relays valuable information relevant for coordinating care during institution transfers. In sum, the K-Axis V appears to provide a straightforward, clinically relevant, multidimensional description of patient functioning well suited for tracking inpatient treatment progress and outcome.

REFERENCES:

1. Black JL, Jumes MT: The Kennedy Axis V as a Treatment Planning Tool. Presentation to the American Psychiatric Association Institute on Psychiatric Services, Orlando, FL, October 12, 2001.
2. Higgins J, Purvis K: A comparison of the Kennedy Axis V and the Global Assessment of Functioning Scale J of Psychiatric Practice 2000; 6:84–90.

Innovative Program 6 Thursday, October 10 10:00 a.m.-11:30 a.m.

COMMUNITY GATEKEEPER TRAINING: A MODEL FOR SUICIDE PREVENTION

Steven E. Pflanz, M.D., *Chief, Mental Health Services, F.E. Warren Air Force Base, U.S. Air Force, 68-A Fort Warren Avenue, Cheyenne, WY 82001*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand one community's approach toward the primary prevention of suicide and the importance of implementing a state-wide suicide prevention program.

SUMMARY:

Suicide is the eleventh leading cause of death in America, claiming roughly 30,000 lives each year. On average, someone takes his or her own life every 18 minutes in the United States. Suicide rates are especially

high amongst men and the elderly. The greatest tragedy of suicide is that it is often preventable. Suicidal individuals give warning signs. If people pay attention to these warning signs and intervene with appropriate mental health care, lives can be saved. The state of Wyoming has implemented a comprehensive suicide prevention plan targeted at reducing suicides across the state. One key component of this plan is the Community Gatekeeper Training Program. This program teaches key members of the community, known as gatekeepers, about the risk factors for and causes of suicide, as well as how to refer suicidal individuals for emergency mental health care. These gatekeepers include physicians, nurses, clergy, lawyers, prison staff, law enforcement officers, school personnel, coaches, youth workers, and individuals working with senior citizens in a wide variety of settings. It is felt that this training will make gatekeepers, who occupy positions of trust in the community, better able to recognize individuals suffering from suicidal ideation and more likely to refer these individuals for necessary psychiatric care. It is believed that this training will increase the likelihood of suicidal individuals being recognized and treated and will, therefore, reduce the number of suicide deaths.

TARGET AUDIENCE:

General psychiatry

REFERENCES:

1. Koivumaa-Honkanen H, et al: Life satisfaction and suicide. Am J Psychiatry 2001; 158: 433–439.
2. Placidi GP, et al: Anxiety in major depression: relationship to suicide attempts. Am J Psychiatry 2000; 157:1614–1618.

INNOVATIVE PROGRAMS: SESSION 3 COMMUNITY EDUCATION

Innovative Program 7 Thursday, October 10 1:30 p.m.-3:00 p.m.

FOSTERING COMMUNITY PARTNERSHIPS: INITIATIVES IN COMMUNITY PSYCHIATRY EDUCATION

Richard C. Christensen, M.D., *Clinical Associate Professor, and Director, Community Psychiatry Program, University of Florida College of Medicine, and Former APA/Bristol-Myers Squibb Fellow, 280 19th Avenue, South, Jacksonville Beach, FL 32250*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate an understanding of how academic medical centers can partner with community-based agencies in order to develop and implement service-learning initiatives in community psychiatry education.

SUMMARY:

In the past decade, promotion of community-based education has become a prominent theme within academic medicine and across the allied health professions. The very foundation of this innovative form of education is the development of a balanced partnership between the academic program and the community, resulting in a reciprocity between serving the identified health needs of a particular population and meeting defined educational objectives. Nowhere is this approach more relevant and evident than in the field of community psychiatry where new educational initiatives are frequently based upon fostering collaborations with the academic program and community-based agencies.

This presentation will describe the planning, development, and implementation of an innovative program of service-learning in community psychiatry at the University of Florida. Under the auspices of the Community Psychiatry Program, a partnership was established between the academic program, an urban-based center for the homeless in Jacksonville, Florida, and the Northeast Florida Area Health Education Center (AHEC). Through a blending of mutual needs and goals among the partners, an initiative was created that provides psychiatric services for the homeless mentally ill, while simultaneously creating a service-learning opportunity in community psychiatry for psychiatry residents, physicians in family medicine, and medical students.

TARGET AUDIENCE:

Psychiatry residents, medical students, medical educators, community providers

REFERENCES:

1. Christensen RC: Service-learning in medical education: teaching psychiatry residents how to work with the homeless mentally ill, in Creating Community Responsive Physicians: Concepts and Models for Service-Learning in Medical Education. Edited by Seifer S, Hermanns K, Lewis J. American Association for Higher Education, 2000, pp 55–62.
2. Christensen RC: Resident education in community psychiatry: a model of service learning. Psychiatric Services, in press.

Innovative Program 8 Thursday, October 10 1:30 p.m.-3:00 p.m.

TEAM TEACHING: INCLUDING CONSUMERS AND FAMILIES IN COMMUNITY MENTAL HEALTH CENTER PSYCHOEDUCATION

Jeff Capobianco, M.A., *Coordinator of Family and Consumer Education, Washtenaw County Community Men-*

tal Health Center, 2140 Ellsworth Road, P.O. Box 8645, Ann Arbor, MI 48107; Reimar Scholler, B.A., *Family Education Coordinator, National Alliance for the Mentally Ill of Washtenaw, 1100 North Main Street, Ann Arbor, MI 48104*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the components of a best practice community mental health center-based family and consumer education program.

SUMMARY:

The perspective of the consumer, family member, and professional are each needed and useful components in the understanding of mental illness recovery. The Family & Consumer Education & Support (FACES) program weaves these perspectives into culturally sensitive curricula focused on the development of the skills necessary for recovery. Each perspective is represented in the facilitation team, modeling the importance of collaboration. The FACES program has the following three components: multiple family psychoeducation groups (MFPG), family skills training, and consumer leadership training. Each component follows best practice guidelines and is evaluated for effectiveness. The MFPG model is based on the work of McFarlane and brings together consumers, any supportive person/family member the consumer identifies, trained National Alliance for the Mentally Ill family members, and the consumers' mental health providers (e.g. case manager, psychiatrist) for bimonthly groups. The family skills training course is based on the NAMI Family-to-Family program and focuses on building the family members' understanding of, and skills to cope with, mental illness. Finally, the consumer leadership training focuses on building the consumers' assertiveness skills focusing on active participation in their treatment and community. The FACES program is an example of evidenced-based, best practice, for consumer and family psychoeducation.

TARGET AUDIENCE:

Case managers, consumers, family members, nurses, occupational therapists, psychiatrists, psychologists, social workers. A background that includes knowledge of CMHC services will be helpful.

REFERENCES:

1. Dixon L, Steward B, Buland J, et al: Pilot study of the effectiveness of the Family-to-Family education program. Psychiatric Services 2001;52:965–967.
2. Dixon L, McFarlane W, Lefley H, et al: Evidence based practices for services to families of people with psychiatric disabilities. Psychiatric Services 2001;52:903–910.

Innovative Program 9 Thursday, October 10 1:30 p.m.-3:00 p.m.

A COMMUNITY-BASED GROUP APPROACH FOR SEVERE AND PERSISTENT MENTAL ILLNESS

Liza Nuernberg, B.A., *Social Worker, Washtenaw Community Mental Health Center, 2140 East Ellsworth, Ann Arbor, MI 48108*; Joann Heap, M.S.W., *Senior Clinical Social Worker, Department of Psychiatry, University of Michigan Health System, 900 Wall Street, Box 0722, Ann Arbor, MI 48109-0722*; Karen K. Milner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the complicated features of group delivery to a multi-diagnostic population of community mental health consumers and appreciate the organizational advantages and client benefits of this model.

SUMMARY:

This presentation will outline the specifics of how to develop and operate a Wellness Group. A Wellness Group is an interdisciplinary, community-based, innovative group work approach in a community mental health center (CMH), serving chronic, persistent, and multiply-diagnosed mentally ill adults. The philosophy of the group is: (1) to promote positive social interaction in a consistent, safe environment, (2) to teach and encourage self-care with regard to mental and physical health, (3) to build and maintain positive relationships, and (4) to learn how to access and negotiate community resources. The group is open and ongoing, and is led by a facilitator who is a case manager. Referrals are made verbally by any member of any treatment team with the CMH system to the facilitator. Clients may have any diagnosis and may attend group unless they are intoxicated, overtly psychotic, or planning to imminently harm themselves or others. Initially, the facilitator works toward promoting group cohesion and creating a safe environment. Eventually group members assist the facilitator in development of the group format and implementation of group norms. Specific examples will be provided. Patients' reactions to the group will also be discussed.

TARGET AUDIENCE:

Community practitioners treating SPMI

REFERENCES:

1. Bustillo J, et al: The psychological treatment of schizophrenia. Am J Psychiatry 2001; 158:163–75.
2. Kraus G, Reynolds DJ: The "A-B-C's" of the Cluster B's. Clin Psychol Rev 2001; 21:345–73.

INNOVATIVE PROGRAMS: SESSION 4 FROM YOUTH TO ADULTHOOD: ALTERNATIVES TO HOSPITALIZATION

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

A COST-EFFECTIVE APPROACH TO THE DEINSTITUTIONALIZATION OF SEVERELY MENTALLY ILL YOUNG ADULTS

Peggy A. Wilson, D.N.S., *Clinical Nurse Specialist, San Francisco Mental Health Rehabilitation Facility, 887 Potrero Avenue, San Francisco, CA 94110*; Jennifer Baity Carlin, L.C.S.W.; Burt Kirson, L.M.F.T.; John Butts, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the factors contributing to the cost of psychiatric services for young adults with severe mental illness.

SUMMARY:

The mental and behavioral disorders of adolescence are very costly to society in both human and financial terms. The 2001 World Health Report on Mental Health does not estimate the aggregate disease burden of these disorders, noting that such calculations would be complex because many of the disorders can be precursors to much more disabling disorders during later life. In an urban, publicly-funded psychiatric skilled nursing facility offering biopsychosocial rehabilitation to individuals with severe and persistent mental illness, we are seeing increasing numbers of young adults (from 18 to 25 years old) with extensive institutional histories. These young people seem unable to tolerate a subacute level of care, and due to aggressive and self-harmful behaviors, are unable to transition to community living. This paper presents a cost analysis of the services required for three severely mentally ill young adults, and proposes a model of services that is both cost effective and appropriate for this population.

TARGET AUDIENCE:

Psychiatrists, social workers, psychiatric nurses, psychologists

REFERENCES:

1. World Health Organization: The World Health Report 2001. Mental Health: New Understanding, New Hope. World Health Organization, Geneva, Switzerland, 2001.
2. Pinfold V: Building up safe havens...all around the world: users' experiences of living in the community with mental health problems. Health & Place 2000; 6:201–212.

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

A CLINICAL RESEARCH FOR SYSTEMATIC FAMILY THERAPY IN CHINESE CHILDREN'S FAMILY

Mingyu Deng, M.D., *Research, International Association of Chinese Medical Specialists and Psychologists, and Editor in Chief, International Chinese Psychosomatic Medicine Journal, 43-21 215th Place, First Floor, Bayside, New York, NY 11361*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to explore the clinical research for the techniques of Systematic Family Therapy (SFT) to compare the difference and relative factors of applying techniques in children and adult family members.

SUMMARY:

Methods: A total of 86 families with index patient were interviewed and intervened by systematic family therapy techniques. The process of each therapeutic or follow-up interview was recorded by color video cameras and high sensitive audio recording system. A self-designed scale was used for feedback.

Results: The rate of follow-up was 67.8 % in the children's family and the rate of cure was 85.6 %. The clinical symptom and social function of childhood behavior and emotional disorder were improved. The interview techniques such as circular questions, difference questions, forward questions, feedback questions, positive annotation, dediagnosis were applicable to adolescent family. The intervention techniques such as symptoms prescription, odd-even day exercise, keep a secret diary, water gun exercise, were accepted in childrens' family. The techniques were influenced by many factors.

Conclusions: It was different to apply the techniques of SFT in childrens' family and in adult family. The techniques are suitable for Chinese childrens' family and can be generalized and applied.

REFERENCES:

1. Deng MY, Li F, Deng M, et al: The Research Used to Guidance of Group for Treatment of Social Competition Dysfunction on America-Chinese Academic Students. International Chinese Psychosomatic Medical Journal, 2001, 3(1): 16.

2. Deng PR, Liu YH: Comparative study between children and adult persons with schizophrenia. International Chinese Neuropsychiatry Medical Journal 2001, 2(1): 15.

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

A RANDOMIZED, CONTROLLED TRIAL OF AN ALTERNATIVE TO HOSPITALIZATION IN THE VETERANS ADMINISTRATION SYSTEM

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

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

Short-Term Acute Residential (START) is a well-established alternative to acute psychiatric inpatient treatment located in San Diego. Over the past 20 years, START facilities have been providing an inpatient alternative for up to 75 voluntary adult patients each day. The programs have a patient-centered and psychosocial rehabilitation focus. Staffing is multidisciplinary and includes registered psychiatric rehabilitation providers, mental health rehabilitation specialists, psychiatrists, psychologists, social workers, and nurses. The average length of stay at a START program is about 10 days. The final results from a randomized clinical trial comparing outcomes for veterans receiving treatment either at START or the VA hospital inpatient unit will be presented. Patients were assessed at admission, discharge, and two, six, and 12 months after discharge.

Instruments included SCID I and II diagnostic data, Alcohol Severity Index, SCI-PANSS (Structured Clinical Interview for Positive and Negative Syndrome Scale), SF-36V (Short-Form-36 for Veterans), and the QWB (Quality of Well Being). Assessment of patient satisfaction and patients' perspectives on their care will be based on the Perceptions of Care and the Ward Atmosphere Scale.

TARGET AUDIENCE:

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

REFERENCES:

1. Hawthorne WB, Green EE, Lohr JB, Hough R, Smith PG: Comparison of outcomes of acute care in short-term residential treatment and psychiatric hospital settings. Psychiatric Services 1999; 50(3):401–406.
2. Gerteis N, Edgman-Levitan S, Daley J, Delbanco TL (eds): Through the patient's eyes: understanding and promoting patient-centered care. San Francisco, Jossey-Bass, 1993.

INNOVATIVE PROGRAMS: SESSION 5 PROVIDER EDUCATION

Innovative Program 13 **Friday, October 11**
3:30 p.m.-5:00 p.m.

AN AMBULATORY THIRD-YEAR PSYCHIATRY CLERKSHIP IN COMMUNITY MENTAL HEALTH

Patricia A. Santy, M.D., *Adjunct Clinical Associate Professor, Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109*; Karen K. Milner, M.D., *Assistant Clinical Professor of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0020*; Tamara L. Gay, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the essential components of an ambulatory psychiatry clerkship in community medicine, and understand the different emphases of a community-based psychiatric clerkship in comparison to an inpatient psychiatric clerkship.

SUMMARY:

Traditionally, third-year medical students at the University of Michigan Medical School have been assigned to hospital-based inpatient services to fulfill a required one-month rotation in psychiatry. Last year, Washtenaw County Community Mental Health (WCCMH), in conjunction with the department of psychiatry, developed an ambulatory psychiatry third-year medical student clerkship based at the community mental health center, and designed to allow students to see a broad spectrum of clients across a variety of community mental health sites. The clerkship is organized into "core" and "optional" activities from which third-year medical students plan their schedule for the month. In addition to a re-

quired "core" in the Psychiatric Emergency Services, students select three additional "core" activities from options that encompass the full range of community services. Students may also select several "optional" activities to enhance their experience and improve their grade. To date, all the community sites have received overwhelmingly positive comments from students. Students convey that the rotation has enabled them to see mentally ill patients as individuals, not just diagnoses. Preliminary data demonstrate that students in the community setting do as well—if not better—on psychiatry self-exams than students that complete their psychiatry clerkship in more traditional settings.

TARGET AUDIENCE:

Medical educators in psychiatry and anyone interested in educating medical students in clinical psychiatry.

REFERENCES:

1. Christensen RC: Introducing community psychiatry to medical students. Academic Medicine 1996; 71:575.
2. Walters K, Buszewicz M, Raven P: An integrated model for teaching psychiatry in the community. Academic Medicine 2001; 76:563–564.

Innovative Program 14 **Friday, October 11 3:30 p.m.-5:00 p.m.**

A MULTIDISCIPLINARY TREATMENT MODEL FOR PATIENTS WITH HEPATITIS C

Gregory C. Mahr, M.D., *Division Director, Consultation-Liaison Psychiatry, Henry Ford Hospital, 2799 West Grand Boulevard, Detroit, MI 48202*; Terri Belville-Robertson, Ph.D., *Psychologist, Consultation-Liaison Psychiatry Division, Henry Ford Hospital, 2799 West Grand Boulevard, Detroit, MI 48202*; Anne K. Eshelman, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should demonstrate a clear understanding of the psychological issues involved in the treatment of Hepatitis C.

SUMMARY:

Hepatitis C currently affects about 4 million Americans. Patients with hepatitis C have significant problems with depression and anxiety. Baseline data from this project show HADS depression scores above 8 in 11% of the population, and HADS anxiety scores above 8 in 31% of the population. Because the treatments for Hep C—interferon and ribavirin—have significant side effects related to mood and anxiety, the screening and treatment of mood and anxiety symptoms in this population is particularly important.

The authors describe an interdisciplinary treatment model involving a psychological screening, individual and group therapy, and psychopharmacological intervention in a large hepatitis C treatment program in an urban academic setting. Key elements of the intervention model include detailed assessment, extensive use of support groups, and rapid but very brief and focused psychopharmacological intervention. The program has remained financially self-sustaining in a challenging fiscal environment and a population that is more than 50% capitated. Outcome and financial data are presented and examined.

The content of this presentation will be of interest to consultation/liaison psychiatrists and psychologists, as well as those with administrative responsibility for med-psych programs and clinics. No special background is required.

REFERENCES:

1. Dieperink E, Willenbring M, Ho SB: Neuropsychiatric symptoms associated with hepatitis C & Interferon Alpha: a review. AM J Psychiatry 2000; 157:867–876.
2. Zdilar D, Franco-Bronson K, Buchler N, Locala JA, Younossi ZN: Hepatitis C, Interferon Alfa, and depression. Hepatology 2000; 31:(6)1207–1211.

Innovative Program 15 **Friday, October 11 3:30 p.m.-5:00 p.m.**

TAPES FROM THE DEAD

Roger F. Spencer, M.D., *Professor, Department of Psychiatry, University of North Carolina, CB-7160, Chapel Hill, NC 27599-7160*; Theresa A. Yuschok, M.D., *Department of Psychiatry, Durham VA Medical Center, 2712 Circle Drive, Durham, NC 27705-5727*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand some of the pitfalls in making and taking psychotherapy referrals.

SUMMARY:

This short play illustrates some issues that make the process of referral interesting and sometimes tricky for young psychiatrists and residents. The main character has some patients foisted upon her by a dying older colleague, a situation she can hardly refuse but arousing her ambivalence. She then falls asleep and dreams about one of the patients who substitutes an alternative presentation of herself, which is factually correct but has a more favorable slant. The psychiatrist is then awakened by a phone call from a second patient, who also is able

to at least arouse the psychiatrist's interest by flattering her and denigrating the former therapist's treatment.

My approach is called "stealth teaching" and consists of showing the residents and students something interesting for them to figure out in an active way, rather than presenting the information in the usual manner. I use myself and other psychiatrists as actor/participants to dramatize the issues.

TARGET AUDIENCE:

Students, residents, and faculty

REFERENCES:

1. Lawes C, et al: Influences on decisions to refer at university counseling centers. J of College Student Psychotherapy 1999; 14:59–68.
2. Zuriff GE: The art of referral in a university mental health center. J of College Student Psychotherapy 2000; 15(1):43–57.

INNOVATIVE PROGRAMS: SESSION 6 TELEPSYCHIATRY

Innovative Program 16 Saturday, October 12 10:00 a.m.-11:30 a.m.

THE INTRODUCTION OF TELEPSYCHIATRY INTO A PSYCHIATRIC EMERGENCY SERVICE

Donald R. Brada, M.D., *Clinical Associate Professor, Department of Psychiatry, University of Kansas at Wichita, 1010 North Kansas Street, Wichita, KS 67214-3199*; John Marker, R.N., *Manager, Department of Behavioral Health Services, Via-Christi Medical Center, 8901 East Orme, Wichita, KS 67207*

EDUCATIONAL OBJECTIVES:

At the conclusion of the session, the participant should be familiar with the past and present use of telepsychiatry in a psychiatric emergency service and should be more familiar with the equipment, logistics, training requirements, and regulatory issues pertaining to the use of televideo in a psychiatric emergency service.

SUMMARY:

The presenters will briefly describe their psychiatry emergency service prior to changes that were necessitated by the move of their psychiatric inpatient program to a remote location and they will discuss the changes in needs resulting from that geographic move. They will then present a brief review of the history and experience in telepsychiatry as it has been used in emergency psychiatry. They will then describe the modified psychiatric emergency service after the addition of televideo. That description will include comments on equipment (hardware and software), logistics, staff training, and regulatory issues. The presenters will then discuss their evaluation of the effectiveness of the telepsychiatry component including results of surveys of staff and patient/consumers and a comparison of person-to-person to televideo emergency assessments. They will then discuss the possibilities for future applications of telepsychiatry in their locale.

TARGET AUDIENCE:

The target audience for their innovative program presentation will be psychiatric physicians and residents, other physicians, nurses, psychologists, and social workers with an interest in psychiatry and/or telepsychiatry.

REFERENCES:

1. Hilty D, Nesbitt T, Hales R, Anders T, Callahan E: The use of telemedicine by academic psychiatrists for the provision of care in the primary care setting. http://www.medscape.com/Medscape/psychiatry/journal/2000/v05. n02/mh447-01.html
2. Rohland B, Salch S, Rohrer J, Romitti P: Acceptability of telepsychiatry to a rural population. Psychiatric Services 2000; 51: (5), 672–674.

Innovative Program 17 Saturday, October 12 10:00 a.m.-11:30 a.m.

TELEMEDICINE IN THE PSYCHIATRY RESIDENCY PROGRAM

Lydia E. Weisser, D.O., *Assistant Professor of Psychiatry, Department of Psychiatry and Behavioral Health, Medical College of Georgia, 1120 15th Street, EA-100, Augusta, GA 30912*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to recognize the value of telemedicine as a teaching tool. They should be aware of the potential of telepsychiatry in delivery of mental health services.

SUMMARY:

The Medical College of Georgia (MCG) has been involved in telemedicine since 1991 and has been incorporating telemedicine into the psychiatry residency program since 1998. Since the inception of the Telemedicine Center, more than 6,500 medical consultations have taken place, with psychiatry being the most requested specialty. To date, more than 1,700 telepsychiatry encounters have occurred. MCG psychiatry residents are given the opportunity to participate in telepsychiatry clinics beginning at the PGY-2 level. To date, ten residents have been involved and have rated the experience quite favorably. One-to-one real-time supervision is pro-

vided, giving residents immediate feedback and opportunity for consultation with the attending. This session will briefly discuss the types of telemedicine equipment utilized, the varieties of outpatient problems encountered, and the overall benefits to residents. The use of telemedicine as a teaching tool will be discussed. The target audience would include anyone interested in learning more about current technological advances in the delivery of health care. No prior experience with telemedicine is required.

REFERENCES:

1. Ruskin PE, et al: Reliability and acceptability of psychiatric diagnosis via telecommunication and audiovisual technology. Psychiatric Services 1998; 49:1086–88.
2. Brown F: A survey of telepsychiatry in the USA. J of Telemedicine and Telecare 1995; 1:19–21.

Innovative Program 18 Saturday, October 12 10:00 a.m.-11:30 a.m.

A STATEWIDE TELEPSYCHIATRY PROGRAM FOR THE DEAF

Dorothea L. De Gutis, M.D., *Department of Psychiatry, Northwestern University, Institute for Clinical Psychiatry, 5225 Old Orchard Road, Suite 45, Skokie, IL 60077-1027*; Toby S. Perlman, Ph.D., *Manager of Deaf Programs, Advocate Health Systems, 4801 West Peterson, Chicago, IL 60646*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand how telepsychiatry works, know its advantages and disadvantages, and decide its applicability for use in their community.

SUMMARY:

This presentation will show the audience a telemedicine program for the deaf and hard of hearing that links the state. This program is used for direct service for psychiatric assessment and medication management. It is also being used for psychiatric consultation with psychiatrists who work with the deaf, but have a limited knowledge of the issues involved with treating deaf clients.

This program services the deaf community in sites located throughout the state. They are able to access quality care with professionals who are knowledgable with deaf culture and language.

The presentation will link in real time two telemedicine sites, show the audience what equipment is necessary, and how the technology is used. It will also discuss limitations of the technology.

Other uses for this type of set-up will be explored, such as links to rural areas where there is not currently psychiatric access.

No prior knowledge is necessary for this innovative program. Anyone interested in seeing the technology and/or in exploring the possibility of setting up a similar program with his or her agency or municipality is invited.

REFERENCES:

1. Gustke SS, Balch DC, West VL, Rogers LO: Patient satisfaction with telemedicine. Telemedicine Journal 2000; 6(1), 5–13.
2. Whitten P, Zaylor C, Kingsley C: An analysis of telepsychiatry programs from an organizational perspective. Cyberpsychology and Behavior 2000; 3(6), 911–916.

Leadership and Career Development Seminar 1 **Friday, October 11 3:30 p.m.-5:00 p.m.**

ACCULTURATION OF INTERNATIONAL MEDICAL GRADUATES

Nalini V. Juthani, M.D., *Training Director, Bronx Lebanon Hospital, 17 Pheasant Run, Scarsdale, NY 10583*; Albert C. Gaw, M.D.; Yevgenia Aronova, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to recognize and implement the various strategies that assist IMGs in the acculturation process.

SUMMARY:

The acculturation process can be a formidable challenge for IMG residents and ECPs starting their practice in the United States. IMGs coming from abroad face simultaneous cultural challenges in their personal, family, and professional lives.

In this workshop, presenters from Indian, Asian, and Russian backgrounds will describe their experiences of how physicians from different cultures of the world learn to thrive within American culture. Topics such as the physician-patient relationship, verbal and nonverbal communication, learning the U.S. medical care system, and developing leadership and networking skills, will be discussed. The resident participant on the panel will describe the challenges faced by IMGS in dealing with patients, supervisors, and the mental health system at large.

Several strategies used by supervisors of IMGS will be discussed and audience participation will be encouraged.

TARGET AUDIENCE:

IMG residents and early career psychiatrists

REFERENCES:

1. Gibson M: Accomodation Without Assimilation. Cornell University Press, 1998.
2. Fiscella K, Frankel R: Overcoming cultural barriers: International Medical Graduates in the United States. JAMA 2000; 183 (13):p1751.

Leadership and Career Development Seminar 2 **Saturday, October 12 8:00 a.m.-9:30 a.m.**

MAKING THE MEDIA WORK FOR YOU

Nada L. Stotland, M.D., M.P.H., *Immediate Past Speaker, APA Assembly, and Professor of Psychiatry and Obstetrics and Gynecology, Rush Medical College, 5511 South Kenwood Avenue, Chicago, IL 60637-1713*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to conduct a successful media interview. Participants will work, hands on, with different case scenarios for interviews. Participants will come away with the skills they need to teach the public about psychiatry, and to demonstrate what accessible, honest, caring, and knowledgeable professionals psychiatrists are.

SUMMARY:

As experts in mental health, psychiatrists are often sought after by the media. However, most psychiatrists are not formally trained in how to speak to members of the press, and may feel intimidated, and worry that they will look funny on camera, or will be tripped up by a trick or hostile question. In this special session targeted toward members in training and early career psychiatrists, participants will learn how to communicate with the media and the public. This will be a highly interactive workshop, with attendees participating in videotaped mock interviews. This workshop will cover the specifics of conducting an interview, and will offer tips on such topics as managing stress and positioning in front of the camera. Different interviewing scenarios will be discussed. This workshop will help build young psychiatrists' communication skills, and will enable them to better draw upon their extensive medical knowledge and convey information to the public through the media with accuracy, confidence, empathy, and care.

TARGET AUDIENCE:

Residents and early career psychiatrists

REFERENCES:

1. Stotland NL: Psychiatry, the law, and public affairs. J Am Acad Psychiatry Law 1998;26(2):281–7.
2. Sabbagh LB: Managing the media interview. Compr Ther 1998;24(1):33–5.

Leadership and Career Development Seminar 3 **Saturday, October 12 10:00 a.m.-11:30 a.m.**

LEADERSHIP WORKSHOP FOR EARLY CAREER PSYCHIATRISTS

APIRE/Janssen Early Career Psychiatrist Fellows

Intikhab Ahmad, M.D., *2001–2002 APIRE/Janssen Fellow, and Staff Psychiatrist, Logan Mingo Area Mental Health Center, Route 10, Three Mile Curve, P.O. Box 176, Logan, WV 25601*; Timothy D. Florence, M.D.; Brenda P. Hines, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to make informed choices regarding careers in public-sector psychiatry based on experiences shared and advice given by Janssen Public Policy Fellows.

SUMMARY:

Each year a cadre of fellows is selected to participate in the APIRE/Janssen Public Policy Program at the IPS. These early career psychiatrists are dynamic, emerging leaders in the field of public-sector psychiatry.

In this interactive workshop, several current fellows will present information on their innovative programs. They will also give advice and guidance from their own experience regarding transitions from residency to early career psychiatry, and will describe what influenced their decision to embark on a career in public-sector psychiatry. Special interests of the presenters include the delivery of mental health services to the homeless, rural psychiatry, cultural competence, complementary and alternative medicine, chronic mental illness, and comorbid substance abuse.

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

TARGET AUDIENCE:

Residents and early career psychiatrists

REFERENCES:

1. Pollack DA, Cutler DL: Psychiatry in community mental health centers: everyone can win. Community Ment Health J 1992; 28(3): 259–67.
2. Brauzer B, Lefley HP, Steinbook R: A module for training residents in public mental health systems and community resources. Psychiatr Serv 1996; 47(2): 192–4.

Leadership and Career Development Seminar 4 **Saturday, October 12 1:30 p.m.-3:00 p.m.**

THE OTHER SIDE OF THE MOUNTAIN: FROM RESIDENCY TO REALITY

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) describe the differences between the structured learning of residency program and continuing medical education in the "outside world," (2) describe critical factors and limitation of clinical preparation in residency training, and (3) describe three dimensions well covered, and three not covered, in training.

SUMMARY:

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

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

REFERENCES:

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

Leadership and Career Development Seminar 5 **Saturday, October 12 3:30 p.m.-5:00 p.m.**

THE UNWRITTEN RULES FOR SUCCESS AS A COMMUNITY PSYCHIATRIST

Charles W. Huffine, Jr., M.D., *Member, APA Institute Scientific Program Committee, Assistant Medical Direc-*

tor for Child and Adolescent Programs, King County Mental Health Division, and Past President, American Association of Community Psychiatrists, 3123 Fairview Avenue, East, Seattle, WA 98102-3051; Susan Bailey, M.D.; Scott McCormick III, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify principles and methods that will enable them to shape their careers in public practice settings. They will be able to select such practical advice from presentations on rural and urban community practice, child and geriatric practice, and practice focused on seriously mentally ill adults.

SUMMARY:

For residents and early career psychiatrists interested in community psychiatry, negotiating a job in a publicly funded clinic or finding a role in a community-based treatment setting can be daunting. Psychiatrists may be offered jobs that offer only a narrow scope of duties, often limited to diagnosis and medication management. These presentations will expand Dr. Huffine's presentations at the 2000 IPS and 2001 APA annual meeting: "How to Avoid Being a Psychotech Slave Chained to the Pill Box." Three psychiatrists who have found excellent careers in community practice will share their principles and methods for forging a successful community practice. Each presenter is at a different stage in their career trajectory. Each has very different types of practices, ranging from urban to rural, working with children and adolescents to adults and older adults, and each comes from different regions of the country with different rules and circumstances. The purpose of sharing these experiences is to define the "unwritten rules" of community practice—those essential items that one does not learn in residencies that enable one to create a gratifying community practice experience. It is expected that this presentation will be of special interest to residents and ECPs.

TARGET AUDIENCE:

Residents and ECPs

REFERENCES:

1. Ranz L, Stueve A: The role of the psychiatrist as program medical director. Psychiat Serv 1998; 49: 1203–1207.
2. Birecree E, Cutler D: What makes a community psychiatrist? Community Mental Health J 1998; 34 (4): 433–5.

Lecture 1 **Wednesday, October 9**
10:00 a.m.-11:30 a.m.

THE ROLE OF STATE PROTECTION AND ADVOCACY SYSTEMS IN SAFEGUARDING AND ADVANCING THE RIGHTS AND SAFETY OF CHILDREN AND ADULTS WITH MENTAL ILLNESS

Zena Naiditch, *Equip for Equality, 11 East Adams, #1200, Chicago, IL 60603*; Marsha D. Koelliker, J.D., *Public Policy Director, Equip for Equality, 11 East Adams, #1200, Chicago, IL 60603*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants have an overview of state protection and advocacy systems (P&As), understand rights protection and enforcement mechanisms available through P&As, and become familiar with common rights violations and barriers to full inclusion of people with mental illness in society.

SUMMARY:

Each state has an independent organization designated by its governor to administer the federally mandated Protection and Advocacy (P&A) system for people with mental illness and other disabilities. After a brief overview of the national P&A system, major accomplishments of Equip for Equality (EFE) on behalf of people with mental illness will be reviewed, including key litigation, an in-depth study on the use of physical restraints in state-operated psychiatric hospitals, legislation enacted to address the use of restraint and seclusion (''time out'') in public schools, and legislation regarding due process protections and availability of mental health professionals for individuals subject to involuntary, emergency psychiatric exams. EFE's new Abuse Investigation Unit, a national, five-year demonstration project, will also be discussed. Finally, opportunities for the psychiatric community to collaborate with the individual state P&A systems will be considered.

REFERENCES:

1. The State of Restraint Utilization in the New Millennium: Practical Recommendations for Positive Intervention, Equip for Equality, 2001
2. Not Our Problem: Executive and Legislative Response to Violence in State-Operated Institutions in Illinois, Final Report, Equip for Equality, 1996

Lecture 2 **Wednesday, October 9**
10:00 a.m.-11:30 a.m.

HOW TO SUSTAIN AMERICAN MEDICINE AND PSYCHIATRY

Adolf Meyer Award

Herbert Pardes, M.D., *President and Chief Executive Officer, New York Presbyterian Hospital, and Past President, American Psychiatric Association, 161 Fort Washington Avenue, New York, NY 10032*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to inform regarding both challenges and ways of addressing those challenges for psychiatry, medicine, and our health care system.

SUMMARY:

Psychiatry in the last 40 years has moved from medicine's fringes to its mainstream. Responsible factors include strengthened research, better treatments, increasing citizen advocacy and destigmatization, demonstration of mental illness' impact on health care as illustrated by the World Health Organization's findings, and linkage of psychiatric illness to coronary disease, etc. Today, psychiatry is more like a core medical discipline.

How can psychiatry help address medicine's challenges? These include issues such as health care cost versus the nation's appetite for service, the 40+ million underinsured, reimbursement problems, e.g., failure to support comprehensive approaches to disease.

Psychiatry embraces exciting areas of research, i.e., brain and behavior. Psychiatry's uniqueness in its focus on personal interaction and behavior along with biology can bring more to medicine's efforts to develop a quality medical system.

This lecture will review psychiatry's place in medicine and its contribution to the nation's health care evolution and knowledge of health and disease.

REFERENCES:

1. Pardes H: Presidential address: defending humanistic values. American Journal of Psychiatry 1990; 147:1113–1119.
2. Pardes H: The future of the academic medical center in the era of managed care. Academic Medicine 72:97–102.

Lecture 3 **Wednesday, October 9**
10:00 a.m.-11:30 a.m.

EFFECTIVE STRATEGIES FOR SHAPING PUBLIC POLICY

Steven M. Mirin, M.D., *Medical Director, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, participants should acquire an understanding of APA's public policy agenda, and recognize and understand the tools/mechanisms that a professional association can use to shape public policy.

SUMMARY:

The last two decades have been characterized by enormous change in how health care is financed and delivered. Nowhere have these changes been more dramatic than in the care of people with mental illness, where cutbacks in public and private sector expenditures have been dramatic. Managed care, coupled with discriminatory constraints on insurance coverage, have decreased access to care and increased the financial burden for individuals needing psychiatric care.

In response, professional associations, like the American Psychiatric Association, have allied with a growing consumer advocacy movement in seeking parity of insurance coverage for the care of people with mental illness, protecting patient rights, and preserving the privacy of medical records.

Successful implementation of APA's state and national policy agenda has required a multifaceted approach employing a variety of strategies and tactics. This lecture will outline the philosophy behind APA's approach to shaping public policy, illustrated by some case studies on how this approach has impacted policy debates in Washington and in state houses across the nation.

REFERENCES:

1. The Dance of Legislation. Seattle, University of Washington Press, Vo l. 7, November 2000
2. What Have Medical Lobbyists Done for You Lately? Medical Economics 2000;46–60

Lecture 4 **Wednesday, October 9**
1:30 p.m.-3:00 p.m.

UNDERSTANDING COMMUNITY ASSETS: CIVIL SOCIETY AS THE SOURCE OF WELL BEING

John L. McKnight, *Professor and Co-Director, Asset Based Community Development Institute, and Director, Program of Community Studies, Institute for Policy Research, Northwestern University, 1217 Judson Avenue, Evanston, IL 60202-1316*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to define the relationship between civil society and health status.

SUMMARY:

The primary determinants of health status are factors that are largely beyond the powers of medical tools. Therefore, well being depends upon non-medicalized environments. These environments are heavily influenced by the non-institutionalized relationships defined by civil society. Understanding civil society and how it grows in healthful capacity is critical to increasing the healthfulness of local communities.

REFERENCES:

1. Building Communities From the Inside Out, ACTA Publications, 4848 N. Clark St., Chicago, IL 60640
2. McKnight J: The Careless Society, Basic Books, 1995, New York

Lecture 5 **Wednesday, October 9**
1:30 p.m.-3:00 p.m.

PSYCHIATRIC DISORDERS AMONG DELINQUENT YOUTH: IMPLICATIONS FOR SERVICES AND PUBLIC HEALTH POLICY

Linda Teplin, Ph.D., *Director, Psycho-Legal Studies Program, and Professor, Department of Psychiatry, Northwestern University Medical School, 710 North lake Shore Drive, #900, Chicago, IL 60611*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to demonstrate how changes in public policy have affected the mental health services provided to youth, specifically, to understand how managed care and welfare reform may have caused the "criminalization" of many poor and minority youth with psychiatric disorders; to present the prevalence of specific psychiatric disorders and comorbidity among detained youth; to understand the scope and types of services needed in juvenile justice facilities and in the community.

SUMMARY:

Advocacy groups, researchers, and public policy experts believe that the juvenile justice system has become the only alternative for many poor and minority youth with psychiatric disorders. Yet, without accurate epidemiologic data, juvenile detention facilities cannot allocate their resources and design programs to meet the needs of their detainees.

This lecture presents epidemiologic data from the Northwestern Juvenile Project, the first large-scale longitudinal study of mental health needs and outcomes of detained youth. In this sample of 1,829 randomly selected detainees, nearly two-thirds of males and three-quarters of females had one or more psychiatric disorders. Nearly one-half of juveniles had substance abuse or dependence. Subjects also had high rates of comorbidity.

The juvenile justice system may have become the only alternative for many poor and minority youth with psychiatric disorders. Effective treatments for this popu-

lation are needed within the juvenile justice system as well as in the community.

REFERENCES:

1. Teplin LA, Abram KM, McClelland GM, et al: Psychiatric Disorders in Youth in Juvenile Detention. Archives of General Psychiatry, in press.
2. U.S. Department of Health and Human Services: Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, DC, USDHHS, 2000.

Lecture 6 **Wednesday, October 9**
3:30 p.m.-5:00 p.m.

139 YEARS AND COUNTING: PSYCHIATRY'S ROLE IN THE EMANCIPATION OF PEOPLE OF AFRICAN DESCENT

Michelle O. Clark, M.D., *Associate Clinical Professor of Psychiatry, University of California at San Francisco School of Medicine, and Program Psychiatrist, S.C.H.A.R.P., 295 Fell Street, #A, San Francisco, CA 94141-0123*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will become familiar with the impact of the institution of white supremacist racism on the mental health of U.S. Africans, and will be given strategies to employ in mental health treatment U.S. Africans.

SUMMARY:

The practice of white supremacist racism that lead to the institution of racial slavery in the United States created vicissitudes with continued impact on the psyche of U.S. Africans today. The prevention of cultural continuity, destruction of basic social roles, and the dehumanization that was necessary in this practice created sets of attitudes and values that persist through the present. The manifestations of this "post trauma of slavery disorder" present as health disparities still. In addition to structural impediments known as institutional racism, personal prejudice and lack of knowledge continue to impede would-be assistance on the part of mental health practitioners today. It is imperative if we are to facilitate health that we apply an "anthro-bio-psycho-socio-spiritual" approach in our work with this group. This lecture will present an analysis of the impact of the institution of slavery and provide strategies to use in treatment practice.

REFERENCES:

1. Rethinking Fanon. Edited by Gibson N. Amherst, NY, Humanity Books, 1999.
2. Patterson O: Rituals of Blood: Consequences of Slavery in Two American Centuries. Washington, DC, Civitas Counterpoint, Perseus Book Group, 1998.
3. Mental Health of Minorities: Supplement to the Surgeon General's Report on Mental Health. Department of Health and Human Services, 2001.

Lecture 7 **Wednesday, October 9**
3:30 p.m.-5:00 p.m.

CULTIVATING RESILIENCY IN YOUTH

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will be able to list at least five principles that cultivate resiliency in youth, describe how to build resiliency, and describe how "toughening" prevents "learned helplessness" in animals.

SUMMARY:

After outlining the characteristics of resiliency, Dr. Bell will review various factors: biologic (intellectual ability, personality traits, and toughness); psychological (*intrapsychic attributes*—adaptive mechanisms such as ego resiliency, motivation, humor, hardiness, and perceptions of self; *emotional attributes*—emotional well-being, life satisfaction, optimism, happiness, trust, dispositional optimism, dispositional hope; *cognitive attributes*—cognitive styles, causal attribution such as an internal locus of control and blame, world view or philosophy of life, and wisdom; *spiritual* attributes, and *attributes of posttraumatic growth*); social (interpersonal skills, interpersonal relationships, connectedness, and social support); and environmental (such as positive life events and socioeconomic status) that promote resiliency. Dr. Bell will also review more esoteric characteristics of resiliency such as: (1) having a sense of Atman, (2) developing kokoro, (3) having a totem, and (4) being able to cultivate chi.

REFERENCES:

1. Bell CC: Cultivating resiliency in youth. Journal of Adolescent Health 2001; 29:375–381.
2. Bell CC, Gamm S, Vallas P, et al: Strategies for the prevention of youth violence in Chicago public schools, in School Violence: Contributing Factors,

Management, and Prevention. Edited by Shafii M, Shafii S. Washington, DC, American Psychiatric Press, 2001, pp. 251–272.

Lecture 8 **Thursday, October 10**
8:00 a.m.-9:30 a.m.

WHY DOES COGNITIVE BEHAVIOR THERAPY WORK IN SCHIZOPHRENIA?

Peter J. Weiden, M.D., *Director of Schizophrenia Research, State University of New York Downstate Medical Center, 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will learn that controlled clinical trials demonstrate that cognitive-behavioral therapy is beneficial when persistent symptoms of schizophrenia do not fully respond to antipsychotic medication; specific techniques that might lead to symptom benefits, and how these techniques challenge some kinds of "medical model" psychoeducation as it is practiced in the United States today; how some techniques, such as normalization of symptoms and placing symptoms in the context of a stress-vulnerability model, are more consistent with a continuous model of psychosis; and that a continuous model of psychosis is better for psychologic interventions, while a categorical understanding of psychotic symptoms is more appropriate for making a diagnosis.

SUMMARY:

The notion that delusions or hallucinations are amenable to any kind of psychologic intervention seems to contract the very nature of psychosis itself. For example, if a delusion is defined as a "a false conception and persistent belief unconquerable by reason in something that has no existence in fact," then, by definition, a delusion could not be altered in by any psychotherapeutic intervention. Recent data suggest that it is not that simple. A series of controlled studies comparing cognitive-behavioral therapy, modified to deal with some of the core psychotic symptoms of schizophrenia, can actually reduce psychotic symptoms over and above control groups receiving supportive therapy. These studies suggest that some kinds of specific psychologic interventions can help reduce the severity of the psychotic symptoms.

If so, how do they work? Some of the theoretical basis of cognitive-behavioral therapy techniques are based on the understanding that what is called psychosis is an extreme end of a continuum of perceptual, sensory, or self-regulatory experiences. The person with the psychotic symptoms, then, may be viewed as a person having a maladaptive reaction to an understandable stress. Or, from another vantage, the person has a problem with regulation of thoughts and perceptions, rather than a fundamental schism between reality and fantasy.

What helps reverse the symptoms? Some of the techniques arising from this theoretical framework include normalization, which helps the patient feel less isolated and misunderstood. The overall stigma can be reduced. If the person is on a continuum of beliefs, there is the potential to gradually introduce alternate points of view, as long as they are not too distant from the current point of view.

It seems that a categorical (yes/no) understanding of psychosis is necessary to make practical decisions regarding diagnosis and medication intervention. However, the fact that techniques based on cognitive-behavioral principles can be effective for reducing psychotic symptoms supports a model that psychosis is a kind of maladaptive self-regulation of beliefs and perceptions.

REFERENCES:

1. Bustillo JR, Lauriello J, Horan WP, Kieth SJ: The psychosocial treatment of schizophrenia: an update. American Journal of Psychiatry 2001; 158:163–175.
2. Sensky T, Turkington D, Kingdon D, et al: A randomized controlled trial of cognitive-behavioral therapy for persistent symptoms of schizophrenia resistant to medication. Archives of General Psychiatry 2000; 57:165–172.
3. Weiden PJ, Havens LL: Psychotherapeutic management techniques in the treatment of outpatients with schizophrenia. Hospital and Community Psychiatry 1994; 45:549–555.

Lecture 9 **Thursday, October 10**
8:00 a.m.-9:30 a.m.

BEREAVEMENT AFTER VIOLENT DYING

Edward K. Rynearson, M.D., *Clinical Professor of Psychiatry, University of Washington, and Medical Director, Homicide Support Project, 8807 Woodbank, N.E., Bain Island, WA 98110*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will learn to evaluate risk factors for non-accommodation to violent dying, to describe and define non-accommodation to violent dying, and to learn principles of intervention for non-accommodative responders.

SUMMARY:

Violent dying from accidental, suicidal, and homicidal events accounts for nearly 10% of annual deaths in the U.S. and is the number-one cause of death before age 40. Loved ones and family members are at risk for developing a dysfunctional combination of trauma and

separation distress—trauma distress to the intrusive replay of a violent dying (rarely witnessed) and separation distress to the irrevocable loss of someone loved.

In 1989 a community-based support project for family members after violent dying was initiated in Seattle. To date, we have treated over 1,000 family members and developed a systematic screening protocol followed by focused, time-limited individual and group interventions. This project has been supported by grants from the Department of Justice, including a recent training grant to replicate this project, now available in 20 cities across the U.S.

This workshop offers a conceptual, dynamic model of bereavement after violent dying and protocols for screening and focused interventions for adult family members unable to accommodate with clinical illustrations and pre/post data from an open trial of the interventions on 64 subjects.

REFERENCES:

Rynearson EK: Psychotherapy of bereavement after homicide. Journal of Psychotherapy Practice and Research Fall 1994; 341–347.

Rynearson EK: Bereavement after homicide. A comparison of treatment seekers and refusers. British Journal of Psychiatry 1995; 166:507–510.

Rynearson EK: Psychotherapy of Bereavement after Homicide: Be Offensive. In Session: Psychotherapy in Practice 1996; 2:47–57.

Rynearson EK: Retelling Violent Death. Philadelphia, Brunner-Routledge, 2001.

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

WHAT DID SEPTEMBER 11 TEACH US ABOUT TRAUMA AND LOSS IN CHILDREN?

Francine Cournos, M.D., *Professor of Clinical Psychiatry, College of Physicians and Surgeons, Columbia University, 1051 Riverside Drive, #112, New York, NY 10032*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to examine from the perspective of effective disaster response some of the interventions put in place for children in New York City following September 11, to explore how adult perceptions of trauma mediate the nature of the services that are provided to children, and to outline major areas of unmet need for trauma-related services for children.

SUMMARY:

The September 11 attack on the World Trade Center brought about an intense mobilization of resources in New York City, focused on helping children cope with the violent events. This included assisting children who experienced the loss of a loved one, especially a parent; those who directly witnessed the attack; and all those in the metropolitan area who were exposed to the event.

My thesis is that outreach to traumatized children is mediated by the capacity of adults to define an event as traumatic, to sympathize with affected children, and to conceptualize and carry out a helpful response. The initiatives following September 11 highlight not only a path to successful intervention at times of disaster, but also the difficulties we face in conceptualizing and implementing mental health responses for children experiencing severe private traumas such as abuse, neglect, and abandonment.

REFERENCES:

Post-Traumatic Stress Disorder in Children. Edited by Eth S, Pynoos RS. Washington DC, American Psychiatric Publishing Inc., 2001.

Chemtob CM, Taylor TL: Treatment of traumatized children, in Treating Trauma Survivors with PTSD. Edited by Yehuda R. Washington DC, American Psychiatric Publishing Inc., 2002.

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

HUMILITY IN PSYCHIATRIC LEADERSHIP: A PATH TO MEDICAL AUTHORITY

Clifton R. Tennison, Jr., M.D., *Chief Clinical Officer, Helen Ross McNabb Center, Knoxville, TN, 1520 Cherokee Trail, Knoxville, TN 37920*

EDUCATIONAL OBJECTIVES:

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

Attendees will be able to demonstrate an understanding of the importance of ethical behavior, and therefore humility, to the establishment of psychiatric authority, as evidenced by the failures of coercion, and by the successes of cooperation and recovery made more readily accessible through educated and supported choice.

SUMMARY:

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

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

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

REFERENCES:

HH Dalai Lama, Cutler HC: The Art of Happiness: A Handbook for Living. New York, Riverhead Books, 1998.

Moffic HS: The Ethical Way: Challenges and Solutions for Managed Behavioral Healthcare. San Francisco, Jossey-Bass Publishers, 1997.

Lecture 12 **Thursday, October 10**
1:30 p.m.-3:00 p.m.

USING MENTAL HEALTH PLANNING COUNCILS TO IMPROVE MENTAL HEALTH SERVICES

Mark Heyrman, J.D., *Clinical Professor of Law, University of Chicago, 6020 South University Avenue, Chicago, IL 60637*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to provide an understanding of the law governing state mental health planning councils and show how planning councils may be used to: (1) increase funding for mental health services, (2) help coordinate the the provision of mental health services, (3) resolve conflicts among mental health service providers and advocates, and (4) increase awareness among public officials about mental illness and the need for mental health services.

SUMMARY:

Psychiatrists and mental health professionals have not taken advantage of the existence of mental health councils as vehicles to improve mental health services. In many states there is little coordination between the state mental health department, private psychiatric hospitals, and the criminal justice system, which has become a major provider of mental health services. However, in order to receive federal mental health block grant funds, each state must create a mental health planning and advisory council. Under federal law, each council must include mental health providers and primary and secondary consumers. The council must include "representatives of the principal state agencies with respect to mental health, education, vocational rehabilitation, criminal justice, housing, and social services and...public and...private entities concerned with the need, planning, operation, funding, and use of mental health services." A council is required to evaluate the allocation and adequacy of mental health services throughout the state, monitor the provision of services, and serve as an advocate for both adults and children with mental illnesses. Because the council is a federally mandated entity, it may speak with authority about inadequate funding, lack of coordination, and other deficiencies in the state mental health system. It can lobby state and local governments for more funding or changes in state laws or local ordinances relating to persons with mental illness.

REFERENCES:

Planning Councils 101. National Association of Mental Health Planning and Advisory Councils, Alexandria, VA.

Raismes, et al: The Evolution of Federal Mental Health Planning Legislation, NAMHPAC, 1996.

Mental Illness in Prisons and Jails, 7 U. Chi. Roundtable 113, 2000.

Lecture 13 **Thursday, October 10**
3:30 p.m.-5:00 p.m.

THE COST OF STIGMA

Gayle M. Franzen, *President, GTC Investments, L.L.C., Real Estate Development Company, One Oakbrook Terrace, Suite 600, Oakbrook Terrace, IL 60181*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will better understand the economic and financial impact of the stigma associated with mental health illnesses.

SUMMARY:

Years of research, studies, professional papers, and economic studies have been published regarding the

economic or financial impact of the "stigma" associated with mental health illnesses. As a nonprofessional in the mental health community, I have read several of these studies and without exception the same general conclusions are reached; the loss of productivity in the workplace is enormous. If repeated studies on the cost of stigma have drawn the same basic conclusions, why then do major parts of the business and political communities not accept these conclusions? Why does there seem to be such a deep divide on this issue that most people in this room accept and know as fact?

Having spent many years in public service and as a sufferer of a mental health illness, I believe that the one single word answer to the questions just asked is "stigma." The inability to admit that one suffers from a mental illness because of the social stigma attached to mental illness ultimately continues to reinforce the stigma itself. But my purpose today is not to be redundant and discuss the obvious; my purpose here today is to discuss the personal costs of that horrid word: stigma!

Lecture 14 **Friday, October 11**
8:00 a.m.-9:30 a.m.

ADOLESCENT SEXUALITY

Cynthia J. Telingator, M.D., *Training Director, Division of Child and Adolescent Psychiatry, and Instructor in Psychiatry, Cambridge Hospital, Harvard Medical School, 6 Bigelow Street, Cambridge, MA 02139*

EDUCATIONAL OBJECTIVES:

To define and clarify the differences between gender identity, gender role, and sexual orientation; to familiarize oneself with stage theory of homosexual development, and discuss limitations of these theories; and to learn techniques for facilitating comfort in talking to adolescents about sexuality and gender identity.

SUMMARY:

Sexual development neither begins nor ends with adolescence. However, the exploration of one's sexuality as well as one's gender identity takes on great significance during this time. It is a journey traveled through a multitude of paths, over a prolonged period of time. This lecture will attempt to review some contemporary beliefs about the process of sexual development including gender identity, gender role, and sexual orientation. Many adolescents are exploring their sexual orientation without being limited by socially defined constraints. It is important for clinicians to be aware of the richness, as well as the risks, of exploration at this critical time in the adolescent's development. Clinicians must not avoid talking to adolescents about their sexual history or their gender identity in order to assess how to best serve them. This lecture will review these topics and attempt to give the clinician some basic tools to use with adolescents around issues of sexuality.

REFERENCES:

Blythe M, Rosenthal S: Female adolescent sexuality. Obstetrics and Gynecology Clinics of North America, 2000; 27:125–141.

Martin A: Learning to Hide: the Socialization of the Gay Adolescent Adolescent Psychiatry: Developmental and Clinical Studies. Edited by Feinstein S, Looney J. University of Chicago Press, 1982.

Bradley S, Zucker K: Gender identity disorder: a review of the past 10 years. Journal of the American Academy of Child and Adolescent Psychiatry 1997; 36:872–880.

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

HOW HAVE MENTAL HEALTH PATIENTS, CONSUMERS, AND PAYERS FARED UNDER MANAGED BEHAVIORAL HEALTH CARE?

Richard Frank, Ph.D., *Margaret T. Morris Professor of Health Economics, Department of Health Care Policy, Harvard Medical School, 180 Longwood Avenue, Boston, MA 02115-5899*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to assess how consumers, patients, and payers have dealt with managed care.

SUMMARY:

I will describe some major impacts of managed behavioral health care in terms of access to care, the financial protection offered to households, premium costs, and quality of care. The study will discuss economic forces and provide empirical analyses of impacts of managed care.

REFERENCES:

1. Frank RG, McGuire TG, Normand SL, Goldman HH: The value of mental health services at the systems level: the case of treatment for depression. Health Affairs 1999; 18: 71–88.
2. Rosenthal MR, Berndt ER, Donohue JM, et al: Promotion of prescription drugs to consumers. New England Journal of Medicine 2002; 346:498–505.

Lecture 16 **Friday, October 11**
10:00 a.m.-11:30 a.m.

FROM EVIDENCE TO PRACTICE: WHAT WE KNOW AND WHAT IT WILL TAKE TO USE IT

William R. McFarlane, M.D., *Director of Research, Department of Psychiatry, Maine Medical Center, 22 Bramhall Street, Portland, ME 04102-3134*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to identify the leading practices for which there is strong evidence of efficacy; know the principal barriers to implementation of evidence-based practices; assess the issues that drive and impede adoption of best practices; identify examples of successful programs that assisted practitioners in adopting best practices; and identify empirically derived predictors of successful implementation.

SUMMARY:

Over the past two decades, several treatment and rehabilitation models have been developed that in carefully controlled clinical trials and field applications have yielded unprecedented improvements in outcome for patients and their families. This is especially true in schizophrenia and the other psychotic disorders. The approaches include medical algorithms for antipsychotic medications, family psychoeducation, assertive community treatment, supported employment, cognitive-behavioral and interpersonal therapies for depression, and several others. Several of the psychosocial treatments are over 20 years old and remain largely unused by American practitioners. The lecture will review this history, describe new efforts to understand this disturbing trend, and give examples of successful attempts to institute best practices in mental health systems. It will conclude with new directions to improve the outcomes for both patients and practitioners.

REFERENCES:

1. McFarlane WR, McNary S, Dixon L, et al: Predictors of dissemination of family psychoeducation in community mental health centers in Maine and Illinois. Psychiatric Services 2001 in press.
2. McFarlane WR, Dunne E, Lukens E, et al: From research to clinical practice: dissemination of New York State's family psychoeducation project. Hospital and Community Psychiatry 1993; 44:265–70.

Lecture 17 **Friday, October 11**
1:30 p.m.-3:00 p.m.

DOMESTIC VIOLENCE, TRAUMA, AND MENTAL HEALTH

Carole L. Warshaw, M.D., *Director, Domestic Violence and Mental Health Policy Initiative, Cook County Hospital, and Associate Professor of Medicine, Rush University, 3428 North Janssen Avenue, Chicago, IL 60657-1322*

EDUCATIONAL OBJECTIVES:

This presentation will provide: (1) an integrated framework for addressing the mental health needs of survivors of violence against women, (2) a critical overview of the current scientific literature on domestic violence and mental health, (3) a discussion of collaborative models for addressing the health, mental health and advocacy needs of survivors of abuse and violence, and (4) a discussion of critical issues central to developing an integrated response to the traumatic sequelae of domestic violence.

SUMMARY:

Over the past two decades there has been a growing awareness of the prevalence and impact of intimate partner abuse among women seen in mental health settings. Yet despite recognition of the traumatic effects of domestic violence, collaborative models for addressing these issues have been slow in developing. This has been due, in part, to the differing perspectives of advocates and mental health providers and to the lack of an integrated framework that addresses both the social and psychological needs of battered women. This presentation will describe three-year findings of the Domestic Violence and Mental Health Policy Initiative, a project designed to build collaboration between the public mental health system and domestic violence advocacy programs in Chicago and to create a national consensus process to develop integrated models, practice guidelines, and policy recommendations for addressing the mental health and advocacy needs of domestic violence survivors and their children. Results of a multitiered needs assessment will be presented, and ongoing work in six critical policy areas will be discussed.

REFERENCES:

Warshaw C: Women and violence, in Psychological Aspects of Women's Health Care: The Interface Between Psychiatry and Obstetrics and Gynecology. Edited by Stotland N, Stewart D. Washington DC, American Psychiatric Association Press, 2001
Dutton MA: Empowering and Healing the Battered Woman. New York, NY, Springer, 1992.

Lecture 18 **Friday, October 11**
1:30 p.m.-3:00 p.m.

CORRECTIONAL MEDICINE AND PUBLIC HEALTH

James B. Mc Auley, M.D., M.P.H., *Associate Professor of Medicine and Pediatrics, Rush University, 2800 South California Avenue, Chicago, IL 60608*

EDUCATIONAL OBJECTIVES:

Upon completing this session, the attendee will understand the basic epidemiology of health issues in correctional settings in the United States; understand the impact of public health interventions in correctional settings upon the community at large; and be able to begin to develop a plan for their specific role in their local correctional health system.

SUMMARY:

The United States incarcerates persons at a greater rate than any other developed nation (>600/100,000), with over 2 million people behind bars at any point in time. Approximately 30% of persons are in jails, and the remainder are in prisons. Jails typically house pretrial detainees and those sentenced to short stays. Prisons house individuals convicted and sentenced for greater than a year. Persons in jails come from the most marginalized population groups in the United States—minority, poor, and the mentally ill. These same populations are afflicted with a disproportionate share of health problems. Interventions aimed at addressing these problems can aid the individual patient and help the community as well. In Chicago, at Cook County Jail, we have begun to develop several programs of intervention: screening and treatment for sexually transmitted infections; community linkage for persons with HIV/AIDS; community linkage for persons with mental illness; tuberculosis diagnosis, treatment, and follow-up; and PAP screening for women, and programs for victims of domestic violence. Results of these programs as well as barriers to success will be discussed.

REFERENCES:

Freudenberg N: Jails, prisons, and the health of urban populations: a review of the impact of the correctional system on community health. Journal of Urban Health 2001; 78:214–35.

Hammett TM: Making the case for health interventions in correctional facilities. Journal of Urban Health 2001; 78:236–40.

Lecture 19 **Friday, October 11**
3:30 p.m.-5:00 p.m.

THE IMPACT OF SUPPORTIVE HOUSING FOR HOMELESS PERSONS WITH SEVERE MENTAL ILLNESS ON THE USE AND COSTS OF PUBLIC SERVICES

Dennis Culhane, Ph.D., *Associate Professor of Social Welfare Policy, Center for Mental Health, University of Pennsylvania, 3535 Market Street, Philadelphia, PA 19104*

EDUCATIONAL OBJECTIVES:

Attendees will learn about the prevalence and dynamics of homelessness, including among people with mental illness; the evolution of housing programs for people with mental illness and the policy context for the New York/New York initiative; combined case-control and pre-post method used to evaluate the New York\New York initiative; the aggregate cost of homelessness among people with severe mental illness, across the public health, corrections, and shelter systems in New York City; the reductions in services associated with placement in supportive housing; the cost-offsets associated with housing placement; and the policy issues raised by the prospect of further public investment in supportive housing.

SUMMARY:

This session describes the impact of public investment in supportive housing for homeless persons with severe mental disabilities. Data on 4,679 people placed in such housing in New York City between 1989 and 1997 were merged with data on the utilization of public shelters, public and private hospitals, and correctional facilities. A series of matched controls who were homeless but not placed in housing were similarly tracked. Regression results reveal that persons placed in supportive housing experience marked reductions in shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated. Prior to housing placement, homeless people with severe mental illness used an average of $40,449 per person per year in services (1999 dollars). Housing placement was associated with a reduction in services use of $16,282 per housing unit per year. Annual unit costs for supportive housing are estimated at $17,277, for a net cost of $995 per unit per year over the first two years of placement.

REFERENCES:

Culhane DP, Metraux S, Hadley TR: Service use reductions associated with the placement of homeless people with severe mental illness in supportive housing. Housing Policy Debate 2002; 13(1).

Kuhn R, Culhane DP: Applying cluster analysis to test of a typology of homelessness: results from the analysis of administrative data. American Journal of Community Psychology 1998; 17:23–43.

Lecture 20 **Saturday, October 12**
8:00 a.m.-9:30 a.m.

ILLINOIS SCHOOL CRISIS ASSISTANCE TEAM PROJECT: A VOLUNTEER MODEL TO DEPLOY CRISIS INTERVENTION SERVICES TO COMMUNITIES

Jan Holcomb, B.S., R.N., *Chief Executive Officer, Mental Health Association in Illinois, 188 West Randolph, Suite 2225, Chicago, IL 60601*; Carol Wozniewski, M.A., *Director, School Crisis Assistance Team, Mental Health Association in Illinois, 188 West Randolph, Suite 2225, Chicago, IL 60601*

EDUCATIONAL OBJECTIVES:

After the presentation, participants will have an understanding of the difference between crisis intervention and direct counseling; know why there is a need for volunteers and professionals to be trained in crisis intervention; have an understanding of the need for collaboration within communities, organizations, and professions in responding to critical incidents; learn how crisis intervention services help to lessen the effects of emotional trauma on individuals and communities in the immediate aftermath of a traumatic incident; and have an understanding of the key steps to organize a volunteer crisis assistance team within their community.

SUMMARY:

This workshop will review the purpose and goals of a crisis intervention team, why mental health is an essential component to the team, the need for mental health professionals to be trained and skilled to provide crisis intervention services, the importance of collaboration between various organizations in the community, and the components of developing a volunteer-based network to provide sound and stable crisis intervention services to communities during and following a traumatic incident. The presenters will focus broadly on these issues, utilizing experiences of their services in Illinois as well as their work in New York and New Jersey in response to the tragic events of 9-11-01.

REFERENCES:

Young M: The Community Crisis Response Team Training Manual, Second Edition. Washington, DC, NOVA, 1998.

Brock SE, Lazarus PJ, Jimerson SR: Best Practices in School Crisis Prevention and Intervention. Bethesda, MD, NASP Publications, 2002.

Lecture 21 **Saturday, October 12**
10:00 a.m.-11:30 a.m.

PUTTING PUBLIC HEALTH INTO PUBLIC PSYCHIATRY: WHAT IS THE PHYSICIAN-COMMUNITY RELATIONSHIP?

Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute and Clinic, Assistant Professor of Psychiatry, University of Pennsylvania Medical Center, and Former APA\Bristol-Myers Squibb Fellow, 3811 O'Hara Street, Room E-516, Pittsburgh, PA 15213*

EDUCATIONAL OBJECTIVES:

After listening to this lecture, participants will have an understanding of the physician-community relationship, appreciate the importance of public health in public psychiatry and vice versa, and consider ways to deepen their connections with the community.

SUMMARY:

Psychiatry can be among the most private of pursuits. We focus on private troubles. Yet these problems often have a social root and require a systemic solution—private concerns are often public issues. Is it enough for us to focus on one patient at a time? Or, in order to be effective, does our profession need to broaden its focus to include populations, communities, and social issues? If so, how might it do this?

Psychiatrists must not only focus on the molecular. We must also join the new public health movement. We are uniquely poised to grasp its new conceptual tools: the social determinants of health, social capital, social processes of inclusion/exclusion, health disparities, broadened definitions of health promotion and prevention, and new ideas about leadership and advocacy. Using the relational theory of medical practice, suggestions will be offered as to how psychiatrists might begin to practice at the community level.

REFERENCES:

Textbook of Community Psychiatry. Edited by Thernicroft G, Szmukler G. New York, Oxford University Press 2001.

Heifetz RA: Leadership Without Easy Answers. Belknap Press of Harvard Cambridge Ma, University Press, 1994.

Lecture 22 **Saturday, October 12**
1:30 p.m.-3:00 p.m.

SERVING CHALLENGING CHILDREN AND FAMILIES IN A COMMUNITY-BASED ENVIRONMENT

Karl Dennis, *Director, Kaleidoscope, 1279 North Milwaukee Avenue, Chicago, IL 60611*

EDUCATIONAL OBJECTIVES:

Participants in this training will upon completion of the workshop, understand the history, and philosophy of the Wraparound process, be familiar with the elements of Wraparound, understand the process of delivering unconditional, strength-based care in a community-based environment to children and families with mental health needs.

SUMMARY:

Through the use of humor and storytelling, Karl Dennis, retired executive director of Kaleidoscope Inc. and a pioneer of the Wraparound process, and unconditional care services, will share his insights and experiences working with challenging children in a no-decline, no-punitive-discharge, community-based environment.

To serve all children referred in an unconditional environment requires creativity, flexibility, and stubbornness—all traits associated with Kaleidoscope and its director. Dennis will share his experiences working with biological families, relative-care families, foster parents, and the children they all serve. The workshop will also explore the elements of Wraparound, its history, and commitment to create an array of services that integrates all of the helping professionals.

REFERENCES:

Pumariega AJ, Nace D, England MJ, et al: Community-based systems approach to children's managed mental health services. Journal of Children and Family Studies 1997; 6:149–164.

Durlak LA, Wells AM: Primary prevention mental health programs for children and adolescents: a meta-analysis review. American Journal of Community Psychology 1997; 25:115–52.

Lecture 23 **Saturday, October 12**
1:30 p.m.-3:00 p.m.

THE ROLE OF PSYCHIATRY IN DISASTER RESPONSE

Craig L. Katz, M.D., *President, Disaster Psychiatry Outreach, and Director of Psychiatric Emergency Services, Mount Sinai Hospital and Medical Center, 118 East 93rd Street, New York, NY 10128-1663*

EDUCATIONAL OBJECTIVES:

To learn more about the psychiatric syndromes and symptoms that are associated with disasters, the potential psychiatric interventions in the aftermath of disasters, public health and systems issues associated with psychiatric response to disasters, and issues of disaster prevention and planning in which psychiatrists and mental health professionals might play a role.

SUMMARY:

A range of issues with regard to disaster psychiatry will be presented from the perspective of Disaster Psychiatry Outreach (DPO), a charitable organization devoted to providing psychiatric care to people affected by disasters to promoting education, outreach, and policy development in support of this clinical mission. The phenomenology, treatment, mitigation, and prevention of psychiatric disorders or symptoms associated with disasters will be discussed. Screening and public health issues will also be addressed. Possible roles for psychiatrists in disaster planning and perhaps even prevention will be considered. Examples will be drawn from the clinical and academic experiences of DPO, including from its work at several aviation disasters, in the 2001 El Salvador earthquakes, and after 9/11. Attendees will be encouraged to think creatively about how they might contribute their professional skills and knowledge to domestic and international disasters.

REFERENCES:

Gordon, Farberow, Maida: Children & Disasters. Taylor & Francis, 1999.

Ursano RJ, McCaugheym BG, Fullerton CS: Individual and Community Responses to Trauma and Disaster. New York, Cambridge University Press, 1994.

Lecture 24 **Saturday, October 12**
3:30 p.m.-5:00 p.m.

HOUSE CALLS TO THE HOMELESS: A SUCCESSFUL MODEL OF CARE IN THE COMMUNITY

Katherine Falk, M.D., *Clinical Assistant Professor of Psychiatry, Columbia University College of Physicians and Surgeons, New York State Psychiatric Institute, and President and Founder, Project for Psychiatric Outreach to the Homeless, Inc., 74 Trinity Place, Suite 800, New York, NY 10006*

EDUCATIONAL OBJECTIVES:

At the conclusion of the lecture, the participant should be able to understand the nature of working with mentally ill homeless persons in the community; the variety of programs in the community; psychiatry training is-

sues; issues of empathy and compassion in working with this population; and how to teach empathy and compassion to psychiatry residents.

SUMMARY:

There are 30,000 people who are homeless in New York City on any given night, including 12,000 children. Approximately one-third of all single, homeless adults and 15 percent of homeless women with children suffer from severe and persistent mental illness, which has contributed to their homelessness. However, they are among the least likely to receive mental health treatment and are among the most difficult to manage using traditional mental health approaches.

The Project for Psychiatric Services to the Homeless has shown that psychiatry works. The most important things that we have learned in our 16 years of operation is that psychiatrists need to be part of an overall rehabilitation team of many people and many different skills; that compassion and patience is a requirement; that the treatment needs to be tailored for each individual; and that all services, including psychiatric services, need to be provided on site.

REFERENCES:

Cohen NL, McQuiston H, Edgar J, et al: Training in community psychiatry: new opportunities. Psychiatric Quarterly 1998; 69:107–116.

Susser E: Working with people who are mentally ill and homeless: the role of a psychiatrists, in Homelessness: A Prevention-Oriented Approach. Edited by Jahiel R. Baltimore, The Johns Hopkins University Press, pp. 207–217.

Lecture 25 **Sunday, October 13**
10:00 a.m.-11:30 a.m.

WHAT CHANGES HAVE MOST IMPACTED PUBLIC PSYCHIATRISTS OVER THE PAST FIVE YEARS?

Jules M. Ranz, M.D., *Director, Public Psychiatry Fellowship, and Clinical Professor of Psychiatry, Columbia University, 1051 Riverside Drive, P.O. Box 111, New York, NY 10032*

EDUCATIONAL OBJECTIVES:

People who attend this lecture will learn what effect recent changes in the field have had on public psychiatrists, as reported in a survey of members of the American Association of Community Psychiatrists, and whether these changes are differentially experienced by psychiatrists who function as medical directors compared with those who function as staff psychiatrists, and those who function in hospital-based compared with community settings. Demographic factors and salary differences will also be explored.

SUMMARY:

In the mid 1990s, Dr. Ranz conducted several surveys of Columbia University Public Psychiatry Fellowship alumni. As reported in three Psychiatric Services articles, these surveys demonstrate that medical directors perform a significantly greater variety of tasks and report significantly greater job satisfaction compared with staff psychiatrists. The performance of administrative tasks correlates highly with overall job satisfaction. In the late 1990s, Dr. Ranz conducted an expanded survey on a much larger sample of members of the American Association of Community Psychiatrists (AACP) and the American Association of Psychiatric Administrators (AAPA). The results of these surveys replicated those in the previous surveys, and were reported in three recent peer-reviewed publications.

This year Dr. Ranz initiated a new survey, examining factors impinging on public psychiatrists over the past five years. Areas examined include scientific and clinical activities, economic developments, organizational changes, information systems, advocacy, and changing populations. AACP members were asked to rate the extent to which they have experienced specific changes in each of these areas. The results will be presented.

REFERENCES:

Ranz JM, Stueve A, McQuistion HL: The role of the psychiatrist: job satisfaction of medical directors and staff psychiatrists. Community Mental Health Journal 2001; 37: 525–539.

Ranz J, Stueve A, Rosenheck S: The role of the psychiatrist as medical director: a survey of psychiatric administrators. Administration and Policy in Mental Health 2000; 27:299–312.

Medical Update 1 **Wednesday, October 9**
1:30 p.m.-3:00 p.m.

NEWEST TRENDS IN OBESITY: SURGICAL OPTIONS

Kenneth Printen, M.D., *Past President, Chicago Medical Society, 800 Austin, Suite 403, West Tower, Evanston, IL 60202*

No CME materials have been provided for this session; therefore only Category 2 credit will be offered for this session.

Medical Update 2 **Thursday, October 10**
1:30 p.m.-3:00 p.m.

ALTERNATIVE MEDICINE: UPDATE FOR PSYCHIATRISTS

Martha H. Howard, M.D., *Private Practice, 706 West Junior Terrace, Chicago, IL 60613*

EDUCATIONAL OBJECTIVES:

Participants will be able to: (1) identify the benefits of using a multisystems analysis model rather than a problem-oriented, symptom-identification/pharmaceutical application model in taking a history and applying a treatment approach for psychiatric patients; (2) identify nutritional and environmental factors that affect mental status; (3) identify herbal preparations and supplements that affect mental status.

SUMMARY:

Many conditions that affect mental status of patients are "below the radar" of much of the common problem-oriented diagnostic and treatment approach in clinical medicine. At worst, this approach misses circumstances of a patient's life that are the real cause of his or her illness. This puts patients at further risk for illness, and practitioners at risk for losing patients.

A multisystems approach has the advantage of being congruent with the best of scientific inquiry. It is now common knowledge that our concept of "independent variables" is outdated. In systems theory, all variables are examined in the context of their multiple, systemic interactions. A good doctor needs to be like a good ecologist—someone whose "radar" is aware that, for example, the mercury content of Lake Michigan whitefish is high enough to make it imperative to warn pregnant women against eating them in order to protect against irritability, attention deficits, and lowered school performance in their children.

Significant numbers of patients are now chronically exposed to poor indoor environments, industrial pollutants, toxic nutrients, or deficient nutrients, which affect their mental status. It does not make sense to treat them with an exclusively pharmaceutical approach while they continue to be exposed to the nutritional and environmental factors that are the principal causes of their illnesses. In addition, significant numbers of patients have underlying undiagnosed autoimmune and/or endocrine disorders that affect their mental status. It is, therefore, important to identify those factors and assist the patient in modifying them. In order to do this, it is also important to know which foods, nutritional supplements, and herbs can enhance mood and mental performance.

REFERENCES:

1. Sahelian R: Mind Boosters: A Guide to Natural Supplements That Enhance Your Mind, Memory and Mood. New York, St. Martin's Griffin, 2000.
2. Blaylock R: Excitotoxins: The Taste That Kills Santa Fe. Health Publishing, 1997.

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

UROLOGY ISSUES OF WOMEN IN TRANSITION

Herbert Sohn, M.D., *Urology Department, University of Illinois, 4640 Marine Drive, Chicago, IL 60640*

No CME materials have been provided for this session; therefore only Category 2 credit will be offered for this session.

Medical Update 4 **Saturday, October 12**
10:00 a.m.-11:30 a.m.

LABORATORY INVESTIGATIONS: THEIR RELEVANCE TO PSYCHIATRY

William Werner, M.D., *Vice President of Medical Affairs, Illinois Masonic Medical Center, 836 Willington Avenue, Chicago, IL 60657*

EDUCATIONAL OBJECTIVES:

At the conclusion of this update, the participant should be able to (1) identify laboratory tests that should be considered in all patients presenting with psychiatric disorders, (2) determine which laboratory tests are clinically indicated based on a patient's psychiatric presentation and treatment course, (3) recognize when the results of laboratory tests may indicate the presence of significant medical disorders.

SUMMARY:

Physical illness may present with signs and symptoms of psychiatric disorders. Patients with mental illness may develop medical conditions that complicate the burden of their psychiatric disease. This update will review the

clinical purpose of laboratory testing to investigate the possibility of an organic syndrome in patients presenting with psychiatric symptoms. Appropriate screening tests will be considered based on specificity, sensitivity, and the patient population being evaluated. Selection of laboratory tests should be considered based on a clinical purpose, such as disease screening, case finding, disease monitoring, evaluating the effects of treatment, or monitoring the effects of medication. The probability of any single test result identifying a disease state will be discussed, with particular attention to ''normal results,'' defined as 95% range of values. The goal will be to order the right laboratory test in the right patient at the right time.

REFERENCES:

1. Wallach J: Interpretation of Diagnostic Tests. Philadelphia, Lippincott Williams & Wilkins, 2000.
2. Medical Consultation. The Internist on Surgical, Obstetric and Psychiatric Services. Edited by Kammer WS, Gross RJ. Baltimore, Williams and Wilkins, 1990.

POSTER SESSION 1

Posters 1–61

Poster 1 **Thursday, October 10**
4:00 p.m.-5:30 p.m.

THE DEVELOPMENT OF ROLES AND SKILLS IN ADULTS DIAGNOSED WITH SCHIZOPHRENIA

Victoria Schindler, Ph.D., *Assistant Professor of Occupational Therapy, The Richard Stockton College of New Jersey, P.O. Box 195, Pomona, NJ 08240*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) describe a rehabilitation intervention, Role Development, designed to assist individuals diagnosed with schizophrenia to develop social roles and the task and interpersonal skills nested in these roles; (2) describe a research study that examined the effectiveness of Role Development; (3) discuss the possibility of implementing Role Development with his/her patients.

SUMMARY:

The purpose of this poster is to present a research study that examined the effectiveness of a rehabilitation intervention, Role Development, in comparison with an activity program in the development of task and interpersonal skills and social roles in adults diagnosed with schizophrenia.

Participants were 84 ethnically diverse adult males confined to a forensic facility (42 men each in the Role Development and activity programs). A pretest-posttest design with repeated measures follow-up at four, eight and 12 weeks was used. Data collection instruments included three rating scales and one self-perception checklist. Eighteen rehabilitation staff members were trained in Role Development.

Data analysis included quantitative and qualitative results. Statistical analyses indicated that participants in the Role Development program showed significantly greater improvement in the development of task skills, interpersonal skills, and role functioning in comparison with participants in the activity program. Qualitative data from staff focus groups and patient interviews supported the findings.

This study is important because it demonstrated that individuals with severe and persistent mental illness are willing and able to develop skills and roles. As important, rehabilitation staff, especially paraprofessional staff, are willing and able to successfully learn and implement a theory-based intervention that ultimately helps their patients.

REFERENCES:

1. Mosey AC: Psychosocial components of occupational therapy. New York, Raven Press, 1986.
2. Stuve P, Menditto AA: State hospitals in the new millenium: rehabilitating the "Not ready for rehab players." New Directions for Mental Health Services 1999; 84: 35–46.

TARGET AUDIENCE:

All mental health practitioners working with individuals diagnosed with schizophrenia.

Poster 2 **Thursday, October 10**
4:00 p.m.-5:30 p.m.

QUALITY OF LIFE IN SCHIZOPHRENIA: SELF-REPORT AND CLINICAL ASSESSMENT

Patricia A. Russo, Ph.D., *Director of Outcomes, Research, and Econometrics, The MedStat Group, Inc., 4301 Connecticut Avenue, N.W., Suite 330, Washington, DC 20008*; Mark Smith, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the inter-relation between self-reported and clinically assessed quality of life in persons with schizophrenia.

SUMMARY:

Objective: Examine relationship between self-reported and clinically assessed quality of life (QoL) and determine the role of clinical symptoms for U.S. Schizophrenia Care and Assessment Program (SCAP) participants.

Methods: Data obtained at 12-month assessment (n= 908). Clinical instruments: QLS, MADRS, PANSS, AIMS. Self-report data from the SCAP Health Questionnaire (Life Satisfaction: Depression). Regression conducted.

Results: Correlation between subjective and objective scales was significant (magnitudes from 0.2 to 0.6). QLS significantly and inversely impacted by PANSS ($p<0.001$) and MADRS ($p<0.001$) Unlike QLS, self-reported LifeSat was impacted by MADRS ($p<0.001$) and not by symptoms (PANSS The magnitude of effect of MADRS was 38% greater on LifeSat than on QLS. Significance of clinical symptoms and QLS subscales diminished in the presence of MADRS.

Conclusions: The relationship of self-report to clinical assessment is of interest given the current climate of

participatory treatment planning and outcome milestone achievement. The observed interrelation suggests that among these patients, self-reported information about life satisfaction could supplement development of treatment-planning regimens Results indicate that patients' assessment of quality of life depends more on level of depression than primary disease symptomology. The observed mediating effect of depression suggests that there may be an indirect effect of symptoms on QoL.

REFERENCES:

1. Fitzgerald PB, Williams CL, Corteling N, et. al: Subject and observer-rated quality of life in schizophrenia. Acta Psychiatrica Scandinavica 2001; 102: 387–392.
2. Atkinson M, Zibin S, Chuang H: Characterizing quality of life among patients with chronic mental illness a critical examination of the self-report methodology. American Journal of Psychiatry 1997; 154:1, 99–105.

Poster 3 **Thursday, October 10**
4:00 p.m.-5:30 p.m.

ADVANCES IN THE DIAGNOSIS OF MENTAL RETARDATION/ DEVELOPMENTAL DISABILITIES

Michael A. Bluestone, Ph.D., *Director, Psychological Services, Southern Maryland Regional Office, Developmental Disabilities Administration, 312 Marshall Avenue, Suite 700, Laurel, MD 20707*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to diagnose more accurately mental retardation, developmental disabilities, and concomitant psychiatric disorders.

SUMMARY:

There is a rapidly growing focus on differential diagnosis of mental retardation/developmental disabilities and accompanying psychiatric disorders as a first step in the development of effective psychiatric treatments. The rate of psychiatric disorder in the MR/DD population may be four to five times greater than in the general population. It has been estimated that 40% to 70% of individuals with mental retardation have diagnosable psychiatric disorders. Recent reports support the thesis that persons with mental retardation have the same range of mental disorders as the general public. Additionally, developmentally disabed individuals may present with emotional, behavioral, interpersonal, or adjustment problems that do not constitute major psychiatric disorders. In 1992, the American Association on Mental Retardation changed the definition of mental retardation to reflect adaptation to the environment and interaction with others, thus balancing I.Q. with functional abilities. A step by methodology will be presented for accurate differential diagnosis consistent with DSM-IV. The need to make accurate diagnoses is critical as a prerequisite to treatment planning including psychopharmacological, psychotherapeutic, and behavioral interventions.

REFERENCES:

1. American Association on Mental Retardation: Mental Retardation: Definition, Classification, and Systems of Supports. 9th Edition, 1992.
2. Reiss S: Handbook of Challenging Behavior: Mental Health Aspects of Mental Retardation. IDS Publishing Corp, Worthington, Ohio, 1994.

TARGET AUDIENCE:

All professionals working with and interested in MR/DD.

Poster 4 **Thursday, October 10**
4:00 p.m.-5:30 p.m.

CLINICIAN AND PATIENT CONCERNS ABOUT ANTIPSYCHOTIC MEDICATION SIDE EFFECTS

Jeff C. Huffman, M.D., *Psychiatry Resident, Massachusetts General Hospital, 15 Parkman Street, Boston, MA 02114-2696*; William F. Pirl, M.D.; Mark A. Blais, Psy.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) recognize the similarities and differences between patients' and clinicans' concerns about antipsychotic medication side effects, and (2) identify the importance of discussing side-effect concerns with patients who are being prescribed antipsychotics.

SUMMARY:

Background: When psychiatrists decide which of the antipsychotics to prescribe for their patients, they must make judgments about which antipsychotic side effects are the least aversive. To our knowledge, no study had compared treaters' and patients' personal concerns about the side effects of antipsychotics and how these concerns affect prescribing patterns.

Methods: Five antipsychotic side effects (tardive dyskinesia, weight gain, new-onset diabetes, cognitive slowing, and akathisia) were chosen by interdisciplinary consensus to be the most aversive antipsychotic side effects. Surveys were distributed to 57 mental health staff (31 psychiatrists) and 20 psychiatric inpatients currently re-

ceiving antipsychotics, asking them to rank the side-effects in terms of their aversiveness.

Results: There were no statistically significant differences between clinicians and patients regarding side-effect rankings. However, treaters rated tardive dyskinesia as the most aversive side effect, while patients rated new-onset diabetes as most aversive. There were no significant differences in side-effect rankings between treaters who prescribe risperidone most frequently and those who prescribe olanzapine the most, despite significant differences in side-effect profiles between these medications.

Conclusions: This pilot study indicates that mental health clinicians and patients generally have similar concerns about side-effect profiles of antipsychotics. This study also indicates that decisions about antipsychotic prescriptions are more complicated than simple comparisons of side-effect profiles.

REFERENCES:

1. Voruganti L, Cortese L, Oyewumi L, et al: Comparative evaluation of conventional and novel antipsychotic drugs with reference to their subjective tolerability, side-effect profile, and impact on quality of life. Schizophr Res 2000;43:135–45.
2. Cabeza IG, Amador MS, Lopez CA, et al: Subjective response to antipsychotics in schizophrenic patients: clinical implications and related factors. Schizophr Res 2000;41:349–355.

TARGET AUDIENCE:

Prescribers of antipsychotic medications.

Poster 5 **Thursday, October 10**
4:00 p.m.-5:30 p.m.

RELIGIOUS COMMITMENT IN MULTIPLE SUICIDE ATTEMPTS

Bogdan P. Sasaran, M.D., *Assistant Professor of Psychiatry, State University of New York, Stony Brook University Hospital, and Assistant Professor of Psychiatry, Mt. Sinai Medical School, Elmhurst Hospital Center, SUNY T-10, Suite 020, Stony Brook, NY 11794-1101*; Shereen A. Morse, M.D., *Resident, Department of Psychiatry, State University of New York, Stony Brook University Hospital, SUNY T-10, Suite 020, Stony Brook, NY 11794-1101*; Luminita E. Sasaran, M.D.; Timothy E. Essington, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand that new consideration should be given to religious activity—or lack of—in male patients with multiple suicide attempts.

SUMMARY:

Introduction: Although there have been many reports about the role of religion in psychiatry and particularly in suicide, these issues remain vague and often overlooked during emergency evaluations. Religion appears to have a protective factor; however, the level of religious commitment in suicidal patients needs further research.

Method: We reviewed the charts of 36 suicidal, nonpsychotic patients who were evaluated in our emergency services. A case-control-study (N=28) was done to correlate the number of suicide attempts with religious activity.

Results: The patients that exhibited suicide attempts (SA), (77.7%), were divided into two groups: a (n=14) with single SA, and B (n=14) with multiple SA. Being male and nonreligious was associated with increased numbers of attempts (OR 6.2, p=.04), even when the groups were mixed with suicidal patients with no attempts (n=8, OR 2.5). Passive religiousness was associated with an increased risk of having multiple SA (OR 2.6) when compared with active religiousness.

Conclusion: Sustained religious activity in nonpsychotic, suicidal patients was associated with decreased number of suicide attempts. Nonreligious males are at increased risk to present with multiple suicide attempts. Our preliminary data suggest that assessing a patient's level of religious commitment should be incorporated in our evaluations.

REFERENCES:

1. Neeleman J, Halpern D, Leon D, et al: Tolerance of suicide, religion, and suicide rates; an ecological and individual level study in 19 Western countries. Psychol Med 1997; 27:1165–71.
2. Hilton SC, Fellingham GW, Lyon JL: Suicide rates and religious commitment in young males in Utah. Am J Epidemiol 2002; 155:414–19.

TARGET AUDIENCE:

Psychiatrists, therapists, nurses, social workers, spiritual advisers.

Poster 6 **Thursday, October 10**
4:00 p.m.-5:30 p.m.

A STUDY OF PREVALENCE OF PROBLEMATIC INTERNET USE IN A SPANISH SAMPLE OF INTERNET USERS

José María Otín-Grasa, M.D., *Department of Psychiatry, Hospital de Día Lluria, Roger De Lluria #68, Barcelona, Spain 08009*; Lourdes Estevez-Vaticon, M.D., *Department of Psychiatry, Hospital 12 de Octubre, Avenida de Andalucia, Km. 5400, Madrid, Spain 28041*; Carmen

M. Bayón-Pérez, M.D., Ph.D.; Alberto Fernández-Liria, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, participants will be able to understand that problematic Internet use is associated with a greater risk of personality disorder.

SUMMARY:

Objective: To study the prevalence of "subjects at risk" and "subjects with pathological Internet use" in a sample of online users. To analyse the dimensions of personality that characterize this sample and its relationship with the use of the web (chat, forum, gambling, internet shopping, internet sex etc.)

Material and Method: Men and women who connected to the web page "adictosainternet.com" during a period of three months (July–September 2001). Subjects answered the screening questionnaire about Internet use (adapted from the one developed by Young) and questions related to other problematic behaviors and the use of other substances. Personality was assessed by the Inventory of Temperament and Character Inventory revised (TCI-R).

Results: The total sample was 2,573. The prevalence of subjects at risk was 38.7% and the one of subjects with pathological Internet use was 8.8%. 71.4% of the sample were men, and 78% of the sample was younger than 35 years old. A total of 200 subjects with problematic Internet use completed the TCI-R. These subjects scored low in self-directedness and cooperativeness compared with normative data in Spanish general population. In the temperament dimensions, they scored high in novelty seeking and low in reward dependence.

Conclusions: Problematic Internet use is associated with a greater risk of personality disorder. In addition, these subjects are prone to be impulsive and aloof.

REFERENCES:

1. Estévez L, Bayón C, Pascual A, García E: Adicción a Internet. Presentación de un caso clinico. Archivos de Psiquiatría 2001; 64 (1): 81–90.
2. Shapira NA, Goldsmith TD, Keck PE, Khosla UM: Psychiatric features of individuals with problematic internet use. J Affect Disord 2000; 57 (1–3): 267–72.
3. Young KS: Internet addiction: symptoms, evaluation and treatment, L. VandeCreek & T. Jackson (Eds): Innovations in Clinical Practice: A source book. Sarasota FL, Professional Resource Press, 1999.

TARGET AUDIENCE:

General psychiatrists.

Poster 7

Thursday, October 10
4:00 p.m.-5:30 p.m.

EVOLUTION OF RESEARCH TRENDS THROUGH INTERNATIONAL AND SPANISH PSYCHIATRIC PUBLICATIONS

Natalia Sartorius-Calamai, M.D., *Department of Psychiatry, Hospital 12 Octubre, Avenida de Andalucía, Km. 5400, Madrid, Spain 28041*; Lourdes Estevez-Vaticon, M.D., *Department of Psychiatry, Hospital 12 de Octubre, Avenida de Andalucía, Km. 5400, Madrid, Spain 28041*; José María Otín-Grasa, M.D.; Enrique García-Bernardo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be able to understand the dramatic evolution of psychiatric research trends in the last 15 years.

SUMMARY:

Objective: Different topics investigated in psychiatry in the last 15 years are described, and how they shifted from a psychological and clinical interest focus to a genetic, mollecular, and especially a pharmacological one. A special mention to Spanish publication is described.

Material and Methods: The first 10 psychiatric publications, with the highest impact factor in 1985, are reviewed, monitorized, and compared with the first 10 in 1999. Investigation articles contents are reviewed. This method is especially adapted for Spanish publications.

Results: Impact factor dramatically changes from 1985 to 1999. Contents of articles shifted from clinical and psychological interest to mollecular, genetic, and pharmacological. Similar results are found in Spanish publications.

Conclusions: Interest in psychiatric investigation and trends have drastically changed in the last 15 years. This is especially evident in Spain. Further studies are needed to assess the underlying reasons for this dramatic evolution.

REFERENCES:

1. Akil II, Watson SJ: Science and the future of psychiatry. Archives General Psychiatry 2000;57 (1): 86–7.
2. Cami J: Impactolatría; diagnóstico y tratamiento. Med Clin (Barc.) 1997; 109:515–524.

TARGET AUDIENCE:

General psychiatrists.

Poster 8 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

ADOLESCENT PERSONALITY STRENGTHS AND RISK FOR ADULT MENTAL HEALTH PROBLEMS

Elizabeth A. Bromley, M.D., M.A., *Resident in Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Box 84, New York, NY 10032*; Jeffrey G. Johnson, Ph.D.; Patricia Cohen, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize the utility of assessing personality strengths in adolescents, be able to incorporate this assessment into a clinical evaluation, and begin to consider the importance of personality strengths in treatment.

SUMMARY:

Objective: To investigate whether personality strengths during adolescence are associated with decreased risk for psychiatric disorders, educational or occupational problems, violent or criminal behaviors, and interpersonal difficulties during early adulthood.

Method: A representative community sample of 688 mothers from upstate New York and their offspring were interviewed from 1985 to 1986, at a mean offspring age of 16, and from 1991 to 1993, at a mean offspring age of 22.

Results: Youths with numerous personality strengths at mean age 16 were at decreased risk for psychiatric disorders, educational and occupational problems, interpersonal difficulties, and criminal behaviors at mean age 22. These associations remained significant after controlling for age, sex, socioeconomic status, verbal intelligence, pre-existing psychiatric disorders, and corresponding problems at mean age 16. Although youths with fewer personality strengths who experienced numerous stressful events were at elevated risk for psychiatric disorders during early adulthood, youths with a higher number of personality strengths at mean age 16 did not share this vulnerability.

Conclusions: Personality strengths during adolescence may contribute to decreased risk for a wide range of adverse outcomes during early adulthood. Systematic evaluation of character strengths may improve the clinical assessment of adolescents.

REFERENCES:

1. Klohnen EC, Vandewater EA, Young A: Negotiating the middle years: ego-resiliency and successful midlife adjustment in women. Psychology and Aging 1996; 11 (3): 431–442.
2. Resnick MD: Protective factors, resiliency and healthy youth development. Adolescent Medicine 2000; 11 (1): 157–165.

TARGET AUDIENCE:

Child/adolescent psychiatrists/psychologists; educators.

Poster 9 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

BLACK AND WHITE: DIFFERENCES IN RISKS FOR SUICIDALITY AMONG SUBSTANCE ABUSE PATIENTS

Joyce H. Chen, B.S., *Project Director, Program on Aging, Yale University School of Medicine, One Church Street, Seventh Floor, New Haven, CT 06511*; Peter Charpentier, M.P.H.; Holly G. Prigerson, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will become familiar with a newly developed scale to detect suicidality (the YES scale), and will be able to identify risk factors for suicidality in black and white substance abuse patients.

SUMMARY:

Objective: The Yale Evaluation of Suicidality (YES) scale is a new instrument recently developed to detect a wider range of suicidal thoughts and behaviors than those identified by previous suicide scales. Using this scale, we examine the differences between black and white substance abusers in risk factors for suicidality.

Method: Patients with a substance abuse/dependence diagnosis receiving treatment at Connecticut Mental Health Center and the West Haven Veterans Affairs CT Healthcare System are participants in an ongoing suicide study. Data on recent and past life events, quality of life, chronic conditions, social support, health service utilization, addictions, and psychiatric evaluation were obtained.

Results: To date, 116 subjects (62 white, 54 black) have been interviewed. Preliminary analyses indicate that the YES has a high degree of internal consistency amongst whites (alpha=.91) and blacks (alpha=.86). Significant associations between the YES scores and past and planned suicide attempts suggest the validity of the YES criterion in both whites (past attempts: OR=2.70 (0.23–0.60)[4444]; planned: OR=2.94 (0.21–0.57)[4444]) and blacks (past attempts: OR=1.82 (0.44–0.76)[444]); planned: OR=1.82 (0.40–0.77)[444]. Of 116 subjects, 36 did not endorse any suicidality. Thus, risk factor analyses were conducted only on those patients who endorsed any suicidality (N=80). Significant (p<.05) risks for sui-

cidality (YES scores) and suicide attempts (past and present) among whites were age and work limitation. A lack of social support and poor social functioning was a risk for blacks. Hopelessness and indirect self-destructive behavior were risk factors common to both groups.

Conclusion: The YES scale's high internal consistency and criterion validity amongst both blacks and whites suggest that it is well-suited for clinician use in suicidality detection. Different suicidality risk factors were found for blacks and whites, and our study extends prior work indicating that hopelessness is a risk factor for suicidality regardless of race (Fawcett et al. 1987, Beck et al. 1985).

REFERENCES:

1. Fawcett J, Scheftner W, Clark D, Hedeker D, et al: Clinical predictors of suicide in patients with major affective disorders: a controlled prospective study. Am J Psychiatry 1987; 144: 35–40.
2. Beck AT, Steer RA, Kovacs M, Garrison B: Hopelessness and eventual suicide: a 10-year prospective study of patients hospitalized with suicidal ideation. Am J Psychiatry 1985; 142: 559–563.

TARGET AUDIENCE:

Psychiatrists, physicians, researchers.

Poster 10 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

TREATMENT-RESISTANT DEPRESSION: HEALTH USE AND COSTS FOR FAMILY MEMBERS

Eli Lilly and Company

Patricia K. Corey-Lisle, Ph.D., R.N., *Senior Health Outcomes Scientist, Global Economic Affairs, Eli Lilly and Company, One Lilly Corporate Center, DC-1834, Indianapolis, IN 46285*; Roxanna Faripour, Ph.D.; Rae Starr, M.Phil.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate increased knowledge of the nature of the economic burden extending to family members of patients with treatment-resistant depressions.

SUMMARY:

Background: While increased economic burden associated with TRD patients has been documented economic burden of TRD family members has not been assessed. The more severe and chronic the depression, the greater the psychopathology and illness in family members. It is therefore hypothesized that higher health care costs may be found in TRD family members.

Methods: This retrospective analysis used data from a managed care organization (n = 3.5m). Depressed beneficiaries (N_{DEP} = 65,000) were classified as TRD-likely (N_{TRD} = 6,387) or TRD-unlikely by a treatment pattern algorithm. Utilization and costs were compared between family members of TRD-likely and TRD-unlikely patients.

Results: Prevalence of psychiatric disorders did not differ between family members of TRD-likely (N = 10,000) and TRD-unlikely patients (N = 97,000). TRD families averaged 1.2 more outpatient visits than the average MDD-only families ($p<0.05$). TRD families also had greater average total health care costs ($2,474 versus $2,095), total pharmacy costs ($763 versus $395), and greater pharmacy costs for antidepressants ($270 versus $97). All the differences were statistically significant ($p < 0.05$).

Conclusions: Family members of TRD-likely patients are higher and more costly utilizers of pharmacy services. These findings support the possibility that there is increased economic burden associated with health care costs for family members of TRD-likely patients.

REFERENCES:

1. Corey-Lisle PK, Marynchenko M, Bimbaum H, Greenberg P, Claxton A: Identification of claims data "signature" and economic consequences for treatment-resistant depression. Journal of Clinical Psychiatry, in press.
2. Pincus HA, Pettit AR: The societal costs of chronic major depression. Journal of Clinical Psychiatry 2001; 62:(suppl 6), 5–9.

TARGET AUDIENCE:

Psychiatrists.

Poster 11 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

CONTINUITY OF ANTIPSYCHOTICS IN TRANSITION FROM HOSPITAL TO OUTPATIENT CARE

Valerica D. Ene-Stroescu, M.D., *Resident Department of Psychiatry, University of Chicago, 100 Forest Place, #P-50, Oak Park, IL 60301*; Daniel J. Luchins, M.D., *Professor of Psychiatry, and Chief of Public Services, University of Chicago Hospitals, 5841 South Maryland Avenue, MC-3077, Chicago, IL 60637-1470*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize the importance of continuity of anti-

psychotic medication in outpatient setting and identify factors involved in noncompliance with following appointments.

SUMMARY:

Objectives: To examine the continuity of antipsychotics in patients discharged from hospitals to outpatient care methods: 89 patients were followed for three consecutive visits. We examined physicians' prescribing patterns and whether changes in medication affected adherence to appointment. We also examined whether drug type affected linkage to outpatient or adherence to appointments.

Results: 53 patients were discharged on typical 33 on atypicals, 37 on decanoate, and 52 on oral preparations. At the third visit 14 were on typicals, 19 on atypicals, 17 on decanoate, and 21 on orals of the 28 patients not linked, 15 were on typicals and 12 on atypicals, 19 on orals and 9 on decanoate. Three patients of 13 who had a switch between typical and atypicals dropped out compared with 20 of 48 who did not have a switch. Six of 12 patients who had a switch between oral and decanoate dropped out compared with 15 of 47 who did not have a switch.

Conclusions: Patients discharged on atypicals vs. typical have higher chances to stay on atypicals. Linkage to outpatient was not influenced by the type of antipsychotic or by the route of administration drug class or route switch did not influence dropout rates.

REFERENCES:

1. Malan RD, Luchins DJ, Filhiner CG, et al: Discontinuity of outpatient antipsychotic pharmacotherapy risperidone maintenance after hospitalization. J Pharm Tech 2001; 110: 90–94.
2. Oleson M, Mechanic D, Hansell S, et al: Predicting medication noncompliance after hospital discharge among patients with schizophrenia. Psychiatric services 2000; 51(2): 216–222.

TARGET AUDIENCE:

Community mental health centers.

Poster 12 **Thursday, October 10**
4:00 p.m.-5:30 p.m.

MEASURING GENERALIZATION IN INDEPENDENT LIVING SKILLS TRAINING

National Institute on Disability and Rehabilitation Research

Catana E. Brown, Ph.D., *Associate Professor, Occupational Therapy Education, University of Kansas Medical Center, 3901 Rainbow Boulevard, 3033 Robinson Building, Kansas City, KS 66160*; Edna Hamera, Ph.D.; Melisa Rempfer, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) describe issues in measuring outcomes of skills training interventions, and (2) assess generalization of learning in skills training programs.

SUMMARY:

When skills training is used as an intervention for individuals with severe mental illness, it is hoped that the skills acquired will be applied in the individual's everyday life; however, relatively few studies include outcomes related to generalization. This poster presents measures developed for a grocery shopping skills training program conceptualized as outcomes of knowledge, performance, generalization to real life, and generalization to another environment. These measures include (1) the Test of Grocery Shopping Knowledge (a paper and pencil test), (2) the Test of Grocery Shopping Skills (a performance-based test of skill acquisition administered in the natural environment of a grocery store), (3) the Test of Grocery Shopping Application (an observation measure of the participant's real life grocery shopping), and (4) the Test of Drug Store Shopping Skills (same as #2 but in a drug store). Psychometric properties of the instruments will be presented. The challenges of developing measures that are administered in natural settings and real-life situations will be described. Finally, we will explain how these measures are being used in an outcomes study of a grocery shopping skills training intervention.

REFERENCES:

1. Dilk MN, Bond GR: Meta-analytic evaluation of skills training research for individuals with severe mental illness. Journal of Consulting and Clinical Psychology 1996; 64: 1337–1346.
2. Hamera E, Brown CE: Developing a context-based performance measure for persons with schizophrenia: the Test of Grocery Shopping Skills 2000; 54: 20–25.

TARGET AUDIENCE:

Clinicians and researchers interested in skills training.

Poster 13 **Thursday, October 10**
4:00 p.m.-5:30 p.m.

EMOTION DYSREGULATION IN TRICHOTILLOMANIA

Marla Wax Deibler, M.A., *National Institutes of Mental Health, 10 Center Drive, Building 10, Room 3-D-41, Bethesda, MD 20892*

EDUCATIONAL OBJECTIVES:

At the conclusion of this poster session, participants should have a greater understanding of the personality traits and patterns associated with trichotillomania. The participant should also be better equipped to diagnose and treat the disorder effectively.

SUMMARY:

Although currently classified as an impulse-control disorder, it has been suggested that trichotillomania (TTM) may be more closely related to OCD. Although there have been investigations of TTM in terms of pathological personality disturbance as quantified by Axis II diagnoses, there has been no study of nonpathological personality characteristics of individuals with TTM. Close examination of the personalities of these patients may prove crucial in gaining a more comprehensive understanding of these patients, conceptualizing their illness, and generating more effective treatments. A total of 55 individuals with TTM and 49 healthy controls were asked to complete self-report measures and a psychiatric diagnostic interview (SCID-I). In an analysis of NEO-PI-R factors, neuroticism emerged as the sole discriminating factor between groups $F(1, 102) = 47.8$ ($p<0.000$), with TTM neuroticism scores significantly higher than those of NCs. In an analysis of NEO-PI-R facets and depression ratings, depression was the most discriminating variable between groups $F(1, 98) = 54.76$ ($p < 0.000$) followed by self-consciousness $F(2, 97) = 31.87$ ($p < 0.000$), compliance $F(3, 96) = 23.26$ ($p < 0.000$), and straightforwardness $F(4, 95) = 19.03$ ($p < 0.000$). Although not emerging as a significantly discriminating variable, impulsiveness scores were significantly elevated in TTM subjects. The findings suggest that there are personality characteristics that best differentiate TTM subjects from non-psychiatric controls. Further, these results suggest that the most significant differences lie in the intensity, internalization of, and ability to control emotional experience.

REFERENCES:

1. Soriano, JL, O'Sullivan RL, Baer L, Phillips KA, McNally RJ, Jenike M: Trichotillomania and self-esteem: a survey of 62 female hair pullers. J Clin Psychiatry 1996; 57: 77–82.
2. Stemberger RM, Thomas AM, Mansueto CS, Carter JG: Personal toll of trichotillomania: behavioral and interpersonal sequelae. J Anxiety Disorders 2000; 14: 97–104.

TARGET AUDIENCE:

Mental health professionals.

Poster 14 **Thursday, October 10**
4:00 p.m.-5:30 p.m.

ATYPICAL ANTIPSYCHOTIC UTILIZATION AND OUTCOMES IN A STATE HOSPITAL SYSTEM

Steven J. Fiorello, R.Ph., M.S., *Pharmacy Director, Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services, Building 32, Pouch A, Harrisburg, PA 17105-1300*; Robert H. Davis, M.D., *Associate Medical Director, Department of Public Welfare, Pennsylvania Office of Mental Health and Substance Abuse Services, Building 32, Harrisburg, PA 17105*; Pamela S. Smith, Pharm.D.; Jon Vlasnik, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) recognize the metabolic parameters that may be affected with various atypical antipsychotics and the impact of such in the management of patients with schizophrenia. (2) understand the implications for combination antipsychotic therapy and strategies that may be implemented in an institutional setting to address add-on therapies.

SUMMARY:

Schizophrenia affects only about 1% of the U.S. population, yet it is reportedly responsible for 2.5% of all health care expenditures. A retrospective evaluation of patient medical charts was conducted to determine utilization patterns of atypical antipsychotics for patients with schizophrenia in a state hospital system. Data were analyzed to determine the effects of these agents on patient weight, serum glucose, and lipid parameters. The study population comprised 756 patients (30% of total population) who were receiving antipsychotic medication in eight state mental hospitals. Of these patients, 56.1% were receiving monotherapy, and 43.9% of patients were receiving combination antipsychotic therapy. Patients receiving monotherapy with olanzapine and clozapine experienced the highest average weight gain, 11.9 and 9.2 pounds, respectively. Serum glucose changes during therapy were analyzed and included those patients with a concurrent diagnosis of diabetes mellitus. Of the 82 patients (10.8%) with diabetes mellitus, 39.1% were started on antidiabetic regimens after initiation of antipsychotic therapy, indicating new onset or worsening diabetes. Lipid panel data indicated that triglycerides are not adequately controlled, with average triglycerides of 171 mg/dL. Based on this evaluation, additional strategies to manage metabolic parameters as well as symptoms of schizophrenia are being implemented throughout the state hospital system.

REFERENCES:

1. Levine J, Chengappa KNR, Patel A, Vagnucci A, John V, Brar JS, Chalasani L, Parepally H, Ganguli R: Obesity and medical illnesses in psychiatric patients admitted to a long-term psychiatric facility. Journal of Psychiatric Practice 2001;7:432–439.
2. Mir S, Taylor D: Atypical antipsychotics and hyperglycemia. Int Clin Psychopharmacol 2001;16(2):63–73.

TARGET AUDIENCE:

Physicians, pharmacists, nurses in psychiatric practice (institutional).

Poster 15 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

CHALLENGES IN TRAINING UKRAINIAN PSYCHIATRISTS TO USE A *DSM-IV*-BASED INSTRUMENT

Zinoviy A. Gutkovich, M.D., *Assistant Professor, Department of Psychiatry, State University of New York at Stony Brook, Health Science Center, Room 020, Stony Brook, NY 11794*; Charles Webb, Ph.D.; Johan M. Havenaar, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize challenges related to the task of training psychiatrists from the former Soviet Union to use a DSM-IV-based instrument.

SUMMARY:

In collaboration with WHO's World Mental Health Survey of mental illness around the world, we trained 15 Ukrainian psychiatrists to use the Structured Clinical Interview for DSM-IV (SCID-IV). The training program lasted for five days, and included didactic, role-playing, training videos, and practice interviews. We assessed the expert-trainee concordance of SCID diagnoses. The psychiatrists were broken into groups of seven and eight on Day 3 of the training; one trainee conducted the interview while the others observed and diagnosed a total of 11 interviews per group. The same 11 subjects were interviewed in both groups. The rate of agreement was 93.2% (95% Confidence Interval: 85.4–100%) for affective disorders, 87.8% (95% CI: 80.7–94.9%) for substance use disorders, and 84.9% (95% CI: 78.7–91.0%) for anxiety disorders. There were multiple challenges in training Ukrainian psychiatrists to use the DSM based SCID. These challenges included cultural differences (American vs. Ukrainian) with respect to the classification of problem drinkers and less severe cases of mental illness, and nosological differences (DSM-IV vs. ICD-10) such as using specific diagnostic criteria and a multiaxial system.

REFERENCES:

1. Thompson JW, Pincus H: A crosswalk from DSM-III-R to ICD-9-CM. Am J Psychiatry 1989; 146: 1315–1319.
2. Gureje O, Mavreas V, Vazquez-Barquero JL, Janca A: Problems related to alcohol use: a cross-cultural prospective. Culture, Medicine & Psychiatry 1997; 21(2): 199–211.

TARGET AUDIENCE:

Specialists in clinical diagnosis, psychiatric epidemiology and cross-cultural psychiatry.

Poster 16 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

ETHNIC DISPARITIES IN MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES IN THE HOMELESS POPULATION

Fatima Imara, B.S., *Department of Psychiatry, University of Southern California, Keck School of Medicine, 2020 Zonal Avenue, IRD Building #110, Los Angeles, CA 90033*; Aaron Kaufman, M.D., *Intern, Department of Psychiatry, University of Southern California, Keck School of Medicine, 2020 Zonal Avenue, IRD Building #110, Los Angeles, CA 90033*; Bradley D. Stein, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) recognize that mental illness and substance abuse are significant problems for the homeless. (2) understand that race may be a factor associated with the probability of treatment utilization in the homeless. (3) understand that insurance status and homelessness may be factors associated with the probability of treatment utilization in the homeless.

SUMMARY:

High rates of mental illness and substance abuse have been documented in America's homeless, yet the treatment needs of many homeless have gone unmet. Disparities exist in the use of mental health and substance abuse services. Racial and ethnic minorities are overrepresented in the homeless, and disparities in service use in these groups may be associated with unmet need. An examination of the disparities in use has yet to be performed at a national level.

The effect of race and ethnicity on utilization of mental health, alcohol, and drug treatment services by the homeless was studied.

Bivariate and multivariate analysis of mental health and substance abuse service use in the homeless was performed using data compiled by the U.S. Census Bureau.

We found that African-American homeless were less likely to use mental health and alcohol abuse services than Caucasian homeless. Clinical need (i.e., symptoms of mental illness and significant substance abuse history) and insurance predicted higher probability of service use. ''Literal homelessness'' predicted a lower probability of use.

Our findings suggest racial and ethnic disparities in the use of treatment services that need to be addressed to improve mental health and substance abuse services for the homeless.

REFERENCES:

1. Koegal P: Utilization of mental health and substance abuse services among homeless adults in Los Angeles. Medical Care 1999; 37: 306–317.
2. Kushel M: Factors associated with the health care utilization of homeless persons. JAMA 2001; 285: 200–206.

TARGET AUDIENCE:

Physicians, nurses, all mental health professionals, homeless assistance providers, public.

Poster 17 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

RISPERIDONE AND OLANZAPINE USE WITHIN A BEHAVIORAL HEALTH ORGANIZATION

Janssen Pharmaceutica and Research Foundation

Michael T. Johnsrud, M.D., *Research Associate, Center for Pharmaco-Economics Studies, University of Texas at Austin, 2409 University Avenue, Room 3210-E, Austin, TX 78712*; M. Lynn Crismon, Pharm.D., *Professor of Psychiatric Pharmacy, College of Pharmacy, University of Texas, University of Texas MC-A-1930, Austin, TX 78712*; Ann Thompson, B.S.N., M.B.A.; Amy Grogg, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the economic impact of newly-started risperidone or olanzapine patients on total mental health related costs within a behavioral health organization.

SUMMARY:

Objective: To compare the economic impact of newly-started risperidone and olanzapine patients on total mental health-related expenditures within a behavioral health organization.

Methods: Texas Medicaid and indigent schizophrenia patients initiated on risperidone or olanzapine between November 1999 and April 2000 were included in a retrospective, intent-to-treat database analysis of pharmacy and mental health service records from a behavioral health organization. Patient claims data were collected for a period of one year post-initiation on the atypical antipsychotic agent.

Results: There was no difference ($p>0.05$) between the risperidone (n=120) and olanzapine (n=143) cohorts with respect to mean age and distributions in gender, ethnicity, or schizoaffective patients. Risperidone patients had significantly lower ($p<0.001$) post-initiation antipsychotic agent expenditures ($1,763, sd=$1,193) versus olanzapine patients ($2,582, sd=$2,055). Risperidone patients had lower, but not statistically significant, mental health medical expenditures ($p=0.792$) compared with olanzapine patients ($4,714, sd=$10,047 versus $5,077, sd=$11,915, respectively) as well as lower ($p=0.393$) total (agent plus medical) mental health care costs, compared with olanzapine ($6,477, sd=$10,090 versus $7,659, sd=$11,976, respectively).

Conclusion: While no difference was found with regard to total post-initiation mental health-related expenditures, risperidone use provides a positive economic impact on total pharmacy costs, when compared with olanzapine, within a behavioral health organization.

REFERENCES:

1. Revicki DA: Pharmacoeconomic studies of atypical antipsychotic drugs for the treatment of schizophrenia. Schizoph Res 1999; 35(Suppl): S100–109.
2. Hanson MA: Pharmacoeconomics of schizophrenia in the 21st century. J Clin Psychiatry 1999. 60(Supp11): 26–30.

TARGET AUDIENCE:

Behavioral health organization Administrators and medical directors.

Poster 18 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

HOW DO YOU DEMONSTRATE THAT A THERAPIST IS COMPETENT?

John Manring, M.D., *Department of Psychiatry, State University of New York, Upstate Medical University at Syracuse, 750 East Adams Street, Syracuse, NY 13210*; Bernard D. Beitman, M.D.; Mantosh J. Dewan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the available methods for evaluating clinical work; be able to construct a portfolio for assessing competence in psychotherapy.

SUMMARY:

For many decades, psychotherapy has been the most widely taught and practiced therapeutic modality in mental health. However, there is still no accepted method of certifying the competence of practitioners. Recently, governmental and training oversight committees have pressured programs to demonstrate the competence of their trainees, e.g., the psychiatry residency review committee has charged psychiatry programs to demonstrate competence of trainees in five areas of psychotherapy, leading to two main problems: what to measure and how to measure it. What specific skills are essential for competence in each of the five listed psychotherapies? Are these skills both necessary and also sufficient for effective psychotherapy, or are additional skills required?

We compare two lists of general skills for psychotherapy, one from the perspective of specific "schools" of psychotherapy and one from a more eclectic "integrative" approach. Further, we defined competence as falling midway on a continuum from "novice" to "expert." Next, 13 methods for measuring competence from the ACGME "toolbox" are evaluated for their applicability to psychotherapy. Finally, we propose a "portfolio" that includes tests of knowledge and either recordings or direct observation of therapy sessions in which specific techniques are demonstrated as a practical method of assessing competence in psychotherapy.

REFERENCES:

1. Beitman B, Yue D: Learning Psychotherapy. New York, WW Norton & Company, 1999
2. ACGME Outcome Project: Toolbox of Assessment Methods, Version 1.1, September, 2000.

TARGET AUDIENCE:

Psychiatrists, psychologists, social workers.

Poster 19 **Thursday, October 10**
4:00 p.m.-5:30 p.m.

MANAGED CARE RATES AND PROFESSIONAL INCOME: 1995–2002

Mantosh J. Dewan, M.D., *Professor and Chair, Department of Psychiatry, State University of New York, Upstate Medical University at Syracuse, 750 East Adams Street, Syracuse, NY 13210*; John Manring, M.D., *Department of Psychiatry, State University of New York, Upstate Medical University at Syracuse, 750 East Adams Street, Syracuse, NY 13210*; Quentin Phung, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should appreciate the changes in managed care reimbursement from 1995 to 2001; know the mean income of psychiatrists, psychologists, and social workers over this period; discuss the possible impact of reimbursement rates on practice patterns and income.

SUMMARY:

There is much speculation but little firm data on how managed care organizations' (MCOs) rates correlate with income of mental health practitioners (psychiatrists, psychologists, and social workers) over the past few years.

Method: We collected fee schedules for five MCOs and Medicare for 1995–96, 1998–99, and 2001–02. Together they owned 48% of the market share in 1995 (56% in 2001) and covered 60 million lives in 1995 (124 million in 2001). Medicare covered 37 and 39 million lives, respectively. Mean income between 1995 and 2000 for psychiatrists, psychologists, and social workers was obtained from yearly surveys.

Results: All codes (initial evaluation, hourly psychotherapy, medication management) for all three disciplines saw a 7% to 26% decrease in reimbursement from 1995 to 1998. However, between 1998 and 2001, all codes increased-except initial evaluations by social workers, which remained the same. Initial evaluations by psychologists rose the most, by 55% ($73 to $113). From 1995 to 2001, psychiatrists gained by 2% to 33%, psychologists lost 17% for a psychotherapy hour ($86–$71) and social work rates dropped 9% to 20%.

Psychiatrists' gross income dropped 4.5% between 1995 ($170,000) and 1997 ($162,000) and rose 3% between 1997–1999 ($167,000); psychologists dropped 15% ($87,000–$75,000) and rose 12% ($75,000–$84,000) respectively. Social work incomes held steady, at $35,000 in 1995 and $36,499 in 1999. Academic psychiatrists and psychologists gained 2% to 3% each year.

REFERENCES:

1. Farber L, Murray D: A slip in net worth. Medical Economics 2001;5(21).
2. Dewan M: Are psychiatrists cost effective? An analysis of integrated versus split treatment. American Journal of Psychiatry 1999;156:324–326.

TARGET AUDIENCE:

Psychiatrists, psychologists, and social workers.

Poster 20 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

REHABILITATION OF FORENSIC PATIENTS IN A CIVIL PSYCHIATRIC HOSPITAL

Joselito B. Morales, M.D., *Forensic Program Medical Director, Department of Medical Affairs, Eastern State Hospital, 4601 Ironbound Road, Williamsburg, VA 23187*; Karen M. Marsh-Williams, *OTR/L, Rehabilitation Services Director, Eastern State Hospital, 107 Wilderness Lane, Williamsburg, VA 23188*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the demographic and clinical differences between the forensic population and the general psychiatric population at this civil state psychiatric hospital in Virginia in order to address the treatment and rehabilitation needs of the forensic patients.

SUMMARY:

Goal: To determine the demographic and clinical differences between the forensic and the general psychiatric population at this civil state psychiatric hospital in order to better address the treatment and rehabilitation needs of the forensic patients.

Method: A new forensic program has been started at this 500-bed civil state psychiatric hospital in Williamsburg, Virginia. The hospital already has a psychosocial rehabilitation program. A cross-sectional comparison of the following was done: Axis I, II, and III diagnoses; sex, age, GAF, prior admission history, and length of stay.

Results: Of the 49 forensic patients, 36 were males. There is a preponderance of substance abuse/dependence and personality disorder among the forensic population. The GAF is much higher for the forensic population (58.78 vs. 37.34), as well as the prior admission history (8.00 vs. 6.78), and length of stay (1,159 vs. 1,032). The age and number of medical problems are similar.

Conclusion: There are clear demographic and clinical differences between the forensic and the general civil psychiatric populations at this civil state psychiatric hospital. This, therefore, necessitates adjustments in the existing program structure and rehabilitation focus for the forensic population.

REFERENCES:

1. Linhorst DM, Turner MA: Treatment of forensic patients: an expanding role for public psychiatric hospitals. Health and Social Work 1999; 24: 18–26.
2. Wettstein RM (ed): Treatment of Offenders With Mental Disorders. Guilford Press, 1998.

TARGET AUDIENCE:

Psychiatrists, nurses, psychologists, social workers, rehabilitation therapists.

Poster 21 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

IMPROVED QUALITY OF LIFE IN SCHIZOPHRENIA WITH LONG ACTING INTRAMUSCULAR RISPERIDONE

Janssen Pharmaceutica and Research Foundation

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

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participant should be able to understand the impact of schizophrenia on health-related quality of life (HRQoL), and the implication of treatment with long-acting risperidone injection on HRQoL, in comparison with placebo treatment and to general, age-corrected, U.S. health norms.

SUMMARY:

Objective: To measure the impact of treatment with 25 mg and 50 mg risperidone long-acting injection on health-related quality of life (HRQoL) in patients with schizophrenia, and to compare results with age-corrected U.S. population norms. The novel every other week injection of risperidone is the first long-acting formulation for an atypical antipsychotic.

Methods: HRQoL was measured using the SF-36 scale alongside a 12-week, double-blind, randomized, placebo controlled study. Ratings were collected at baseline and end of the study. SF 36 domain include physical functioning (PF), role-physical (RP), bodily pain (BP), general health (GH), vitality (VT), social functioning (SF), role-emotional (RE), and mental health (MH).

Results: Baseline demographics and clinical data were comparable for all groups. Baseline SF-36 domain scores were significantly lower ($p<0.01$) than norms data in all groups except for RP. The treatment groups (Risperdal 25 mg or 50 mg IM every two weeks for 12 weeks) improved toward the norms data, with no significant differences on all eight domains in the 25mg group, and on four domains in the 50 mg group (BP, VT, RE, MH).

Conclusion: Patients treated with risperidone 25 and 50 mg for 12 weeks experienced significant improvement in their HRQoL. The patients' scores moved to normal levels at Week 12 on all domains in the 25 mg group.

Supported by a grant from Janssen Pharmaceutica.

REFERENCES:

1. Kane J, Eerdekens M, Keith S: Efficacy and safety of a novel long-acting risperidone formulation. Presented at the 40th ACNP Annual Meeting, December 9–13, 2001, Waikoloa, Hawaii.
2. Ware JE, Sherbourne CD: The MOS 36-item short-form health survey (SF-36). I. conceptual framework and item selection. Medical Care 1992; 30:473–483.

TARGET AUDIENCE:

Psychiatrists, other physicians, nurses, pharmacists, psychologists & social workers.

Poster 22 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

ELEVATED APOPTOSIS MARKER BCL-2 IN THE CEREBRAL SPINAL FLUID OF PATIENTS WITH SCHIZOPHRENIA

Mental Illness, Research Education and Clinical Center of the Veterans Administration

Henry A. Nasrallah, M.D., *Professor of Psychiatry and Neurology, Department of Mental Health Services, University of Mississippi Medical Center, 1500 East Woodrow Wilson Drive, Jackson, MS 39216*; Meng-Yang Zhu, M.D., Ph.D.; David L. Garver, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that the loss of brain tissue on MRI scans in schizophrenia may be due to accelerated apoptosis, or programmed neuronal death, rather than neurodegenerative necrosis.

SUMMARY:

Introduction: There is now substantial evidence for brain tissue loss in schizophrenia (such as reduced cortical volume and enlarged cerebral ventricles (both at the onset of the illness (neurodevelopmental) and progressively after recurring psychotic relapses (assumed to be neurodegenerative). The mechanism of neuronal loss remains unknown, but the lack of gliosis in post-mortem brain studies in schizophrenia suggests a non-inflammatory process. We postulated that psychosis in schizophrenia may be associated with an acceleration of programmed cell death (apoptosis), and that apoptosis markers should be elevated in schizophrenic patients.

Methods: We measured the CSF concentration of the proto-oncogene bcl-2, which is involved in the regulation of cell death, in 40 consenting subjects with schizophrenia in acute relapse (who were neuroleptic-free for > 10 days) as well as in four consenting healthy volunteers. The bcl-2 was measured using ELISA assay.

Results: The mean CSF bcl-2 in the controls was 2.73 $\pm$ 1.54 μ/mL (95% CI = 0.273 – 6.187). 14/40 (35%) of the schizophrenia sample had CSF bcl-2 levels in excess of the 95% CI of the controls and none of the schizophrenia patients had CSF bcl-2 levels below the 95% CI of controls. The 14 patients with very high bcl-2 levels had an earlier mean age of first hospitalization than the patients whose bcl-2 was within the controls CI (23.1 $\pm$ 7.4 vs 28.1 $\pm$ 6.8 years; $p = 0.056$).

Discussion: This is the first report of elevation of the apoptosis marker bcl-2 in the CSF in a subgroup of schizophrenia patients. These findings point to the possibility that apoptosis is more likely than necrosis to be the underlying mechanism for the brain tissue loss observed in schizophrenia during a psychotic episode. The relationship to early onset of illness is intriguing and may indicate that the neurodevelopment neurobiology of the brain in schizophrenia may be associated with the apoptotic mechanisms that may be triggered or accelerated during acute psychosis. Other possible implications will be discussed.

Supported in part by the VA and VISN 16 MIRECC.

REFERENCES:

1. Nasrallah HA, Tolbert HA: Neurobiology and neuroplasticity in schizophrenia. Archieves of Annual Psychiatry 1997; 54:913–914.
2. Jarskog LF, etal: Cortical bcl-2 protein expression and apoptotic regulation in schizophrenia. Biological Psychiatry 2000; 48:641–650.

Poster 23 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

MENTAL HEALTH CARE SYSTEMS AND HEALTH SERVICE USE

Eli Lilly and Company

Nicole Nitz, M.S., *Senior Health Outcomes Scientist, Lilly Research Laboratories, Eli Lilly and Company, Lilly Corporate Center, DC-1758, Indianapolis, IN 46285*; Madhav Namjoshi, Ph.D., *Health Outcomes Scientist, Lilly Research Laboratories, Eli Lilly and Company, Lilly Corporate Center, DC-1758, Indianapolis, IN 46285*; Martin Dossenbach, M.D.; Istvan Bitter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to describe some differences in this study of mental health services use by region and by characteristics of the mental health care system.

SUMMARY:

Objectives: WHO-defined mental health care system characteristics and inpatient and outpatient service use

were examined for outpatients with schizophrenia in 27 countries.

Methods: IC Schizophrenia Outpatient Health Outcomes (IC SOHO) study is a three-year observational study in Latin America, Central/Eastern Europe, Middle East, North Africa, and Asia/Pacific regions (n=7,648). Service use was for six-months prior to initiating/changing antipsychotics at discretion of treating psychiatrists.

Results: Globally, 31% had been hospitalized; 97% visited psychiatrists. Day-hospital use differed by region ($p<0.0001$, range Middle East/Africa=4%, Latin America=27%). Hospital admission and length of stay were associated with having a list of essential therapeutic drugs, a national mental health system, community-based care, and a specified mental health budget ($p<0.05$). Outpatient visits were associated with having a list of essential therapeutic drugs and a national mental health system ($p<0.05$).

Conclusion: Health services use may differ by structure of mental health systems; longitudinal analyses may help describe this association.

REFERENCES:

1. World Health Organization: Atlas: Mental Health Resources in the World 2001. Geneva, 2001; http://www.who.int/Smental_health_Publication/Pages_2001/Pubs_Atlas/final/En.pdf.
2. Desjarlais R, Eisenberg L, Good B. Kleinman A: World Mental Health: Problems and Priorities in Low-Income Countries. Oxford, Oxford University Press, 1995.

Poster 24 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

FOUR-YEAR OUTCOMES OF OLANZAPINE AND PSYCHOSOCIAL TREATMENT

Eli Lilly and Company

Douglas L. Noordsy, M.D., *West Central Community Support Services, and Associate Professor, Department of Psychiatry, Dartmouth Medical Center, 1555 Elm Street, Manchester, NH 03101*; Christopher O'Keefe, M.A., *Director of Clinical Research, Mental Health Center of Greater Manchester, 1555 Elm Street, Manchester, NH 03101*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize long-term outcomes associated with olanzapine treatment in a CMHC setting and identify theories of interactions between second-generation antipsychotics and psychosocial rehabilitation.

SUMMARY:

Objective: This study's goals are to evaluate the three- to four-year outcomes of the decision to switch to olanzapine treatment in a CMHC setting. Interactions between medication and case management/rehabilitation are also explored.

Method: Previous work presented outcomes of 104 patients switching to olanzapine and 49 remaining on conventional antipsychotics, combined with case management and psychosocial rehabilitation. After 12 months, the olanzapine group demonstrated significant improvement compared with baseline across measures of symptoms and functioning. The olanzapine group demonstrated greater improvement in hospitalization and competitive employment; however, absolute values just surpassed the reference group at 12 months. Therefore, the same measures, with some additional scales, were repeated after 36–48 months to evaluate whether treatment with a second-generation antipsychotic results in greater response to long-term rehabilitation treatment.

Results: The results will examine patient outcomes 36–48 months post-baseline. Information on long-term effects and tolerability of olanzapine will be presented. There will be a focus on employment, functional outcomes, and service utilization data.

Conclusions: This poster will draw conclusions about the long-term outcomes associated with use of a second-generation antipsychotic in combination with case management and rehabilitation services in a CMHC setting. This project was funded by a grant from Lilly Research Laboratories.

REFERENCES:

1. Noordsy DL, OKeefe CD, Mueser KT, Xie H: Six-month outcomes for patients who switched to olanzapine treatment. Psychiatric Services 2001; 52(4): 501–508.
2. Noordsy DL, O'Keefe CD: Effectiveness of combining atypical antipsychotics and psychosocial rehabilitation in a community mental health setting. J Clin Psychiatry 1999; 60 (suppl 19): 47–51.

TARGET AUDIENCE:

Community mental health providers.

Poster 25 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

A NEW CHALLENGE ABOUT PATIENT INFORMATION IN FRANCE: IS ELECTRONIC MEDICAL RECORD OR ELECTRONIC PATIENT RECORD A SOLUTION?

Veronique A. Lovejoy-Olivier, M.D., *Department of Psychiatry, Centre Hospital Paul Guiraud, 54 Avenue de*

la Republique, Villejuif, France 94806; Isabelle Teillet, M.D., *Department of Psychiatry, Centre Hospital Paul Guiraud, 54 Avenue de la Republique, Villejuif, France 94806*; Denis H. Chino, M.D.; Marie-Christinet Velut-Chino, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this session, attendants should be able to understand the forthcoming changes in medical and nurse practices due to new patient rights in France to access their individual medical records.

SUMMARY:

In France, where our practice takes place, only recently (March 2001) by law, patients' rights to be informed about as well as to handle their own medical records, has begun. The major understatement of this law is to make most medical records directly available to one person. We will discuss the implications of collection of future records as growing consumer health lobbies and the growing democratic needs of our society face these challenges, especially in health care.

We would like to demonstrate in this poster the methods we conceived to join in is today and tomorrow's digital audio-visual, easy-compressed, easy-transferable individual data to patient's personal EMR or EPR, bringing each one to be the active and long-lasting core of their medical data recollection.

REFERENCES:

1. National Electronic Health Records Taskforce: A health information action plan for Australia. Includes a newsroom, outline of projects and information www.health.gov.au/healthonline/nehrt.htm
2. Loi 2002-303 du 04 Mars 2002 relative aux droits des malades et à la qualité du système de santé http://www.legifrance.gouv.fr/html/frame✂lois✂reglt.htm.

TARGET AUDIENCE:

Physicians and nurses.

Poster 26 **Thursday, October 10**
4:00 p.m.-5:30 p.m.

HISTORY OF ABUSE AND MAJOR DEPRESSIVE DISORDER INCREASE INPATIENT HEALTH CARE UTILIZATION

Aetna Quality Care Research Fund

Jeffrey M. Levine, M.D., *Chair, Department of Psychiatry, Bronx-Lebanon Hospital Center, 1276 Fulton Avenue, 5th Floor, Bronx, NY 10456*; Karen Brown, M.D.; David Fiellin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate increased understanding of the psychiatric factors that influence medical/surgical health care utilization.

SUMMARY:

The purpose of this study was to examine psychiatric factors that may lead to repetitive inpatient medical/surgical health care utilization. In an academic primary care clinic, we performed a cross-sectional analysis of a cohort of current adult outpatients who had at least one medical or surgical inpatient admission in the past year and at least two admissions within two years. Patients participated in a multi-faceted psychosocial assessment that included demographic data, reading level, psychiatric syndromes (PRIME-MD), functional status (SF-36), and history of physical/sexual abuse. A total of 22 of 77 patients (28.6%) met criteria for current MDD. Despite similar overall calculated inpatient costs over the past year (mean $23,556 vs. $16,483, p>.2, N.S.), those with MDD had been hospitalized more often (mean 3.5 vs 2.0 times, p=.01). Patients with MDD had comparable physical functioning as measured on the SF-36, but more bodily pain, poorer self-reported general health, poorer role and social functioning, and lower mental health and vitality ($p \leq .02$ for all). Patients with MDD reported more lifetime physical or emotional abuse (68% vs. 33%, p=.006) and greater occurrence of physical violence within the past year (32% vs. 7%, p=.01). Depressed patients with a lifetime history of abuse (N=15) showed particularly elevated hospitalization rates over the past year (mean 3.8 hospitalizations, p=.001). A history of physical violence may mediate higher medical utilization rates found previously in depressed medical outpatients. Further study of the synergistic effects of victimization and depression on repetitive inpatient medical/surgical care is warranted.

REFERENCES:

1. McCauley J, et al: Clinical characteristics of women with history of childhood abuse. JAMA 1997; 277:1362.
2. Simon G, et al: Health care costs associated with depressive and anxiety disorders in priamry care. American Journal of Psychiatry 1995; 152:325.

TARGET AUDIENCE:

Consult psychiatrists, primary care physicians, health care administrators.

Poster 27 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

SECLUSION AND RESTRAINT INVERSELY ASSOCIATED WITH ASSAULTS AGAINST STAFF

Ramanbhai C. Patel, M.D., *Director, Adult Psychiatry Services, Bronx-Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10456*; Jeffrey M. Levine, M.D., *Chair, Department of Psychiatry, Bronx-Lebanon Hospital Center, 1276 Fulton Avenue, 5th Floor, Bronx, NY 10456*; Ali Khadivi, Ph.D.; Angela Rennalls-Atkinson, M.S.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize dangers of patient assaultiveness as a possible consequence of efforts to minimize seclusion and restraint.

SUMMARY:

We undertook a performance improvement project to reduce the use of seclusion and restraint on our adult psychiatry acute inpatient service. The site is a large inner-city community hospital inpatient psychiatry service where patients are poor, overwhelmingly insured through Medicaid or Medicare with little managed care penetration, suffering predominantly from severe and persistent mental illness and dual diagnosis disorders, 60% male, 80% involuntarily admitted, with median patient age approximately 40 years. The intervention was compatible with Joint Commission (JCAHO) mandates and included staff education, addition of history of inpatient violence to admission forms, continuous nursing monitoring to minimize duration of episodes of seclusion/restraint, post-episode staff and patient debriefing, and senior nursing and physician review of each episode. Results showed a decrease in total episodes of seclusion and restraint in the 12 months pre- and post-intervention from 310 (160 seclusions, 150 restraints) to 148 (53 seclusions, 95 restraints), a reduction of 52%. Over this time, numbers of admissions (1,766 vs. 1,602) and total patient days (27,726 vs. 24,030) were not significantly changed. However, episodes of assault on staff by patients increased from 31 (0.11 per 100 patient days) in the pre-intervention period to 83 (.35 per 100 patient days) after the intervention (RR=3.18). We conclude that efforts to decrease seclusion and restraint may be accompanied by increased risk of harm to psychiatric staff, and intensive safety monitoring and staff training should accompany all such efforts.

REFERENCES:

1. El Din S, Reza A: Risk factors and correlates of violence among acutely ill psychiatric patients. Psychiatric Services 2001; 52:75.
2. Lam JN, et al: The relationship between patients' gender and violence leading to staff injuries. Psychiatric Services 2000; 51:1167.

TARGET AUDIENCE:

Inpatient psychiatrists, nurse managers, administrators.

Poster 28 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

DETERMINANTS OF QUALITY OF LIFE AMONG PERSONS WITH MENTAL ILLNESS AND DIABETES

Leticia T. Postrado, Ph.D., *Data Manager, Department of Psychiatry, University of Maryland at Baltimore, 685 West Baltimore, MSTF, Room 300, Baltimore, MD 21201*; Janine C. Delahanty, M.A., *Data Analyst, Department of Psychiatry, University of Maryland at Baltimore, 685 West Baltimore, MSTF, Room 300, Baltimore, MD 21201*

EDUCATIONAL OBJECTIVES:

At the end of the session, participants will acquire knowledge on factors that are linked with general life satisfaction among persons with diabetes who have severe mental illness (SMI) and who do not have SMI.

SUMMARY:

Objective: The ultimate goal of health interventions is to improve patients' quality of life. Knowledge of modifiable factors that influence people's well being can be helpful in attaining the goal. This paper compares the determinants of quality of life of persons with SMI and diabetes, and persons without SMI who have diabetes.

Methods: This paper utilizes data of an ongoing study (n = 231) that aims to compare persons with schizophrenia with persons with MA, and to non-SMIs who suffer from diabetes on diabetes-specific health behaviors, outcomes and quality of diabetes care. Our study focuses on the quality of life of the three groups and the determinants of their quality of life. The Lehman's QOLI was used to measure general life satisfaction or quality of life.

Results: Persons with major affective disorder (MA) have the lowest Life Satisfaction scores; those with no SMI have the highest. Persons with schizophrenia have higher scores than the MA group, but lower than the non-SMI group. Results of stepwise multiple regression analyses revealed that the determinants of quality of life differ among the three groups. Among persons who have schizophrenia and diabetes, non-Caucasian race, being ever married, higher self-rated physical health, and lower perceived severity of illness are significantly associated

with greater life satisfaction. Among persons who have MA and diabetes, the determinants of greater satisfaction in life are higher self-rated emotional health and less perceived barriers to action. Among non-SMI persons who have diabetes, greater satisfaction in life is associated with male gender and higher self-rated emotional health.

Conclusion: Determinants of quality of life differ by diagnoses. Utilizing such information in designing interventions for the appropriate group of patients may be more likely to be successful.

REFERENCES:

1. Lehman AF, Ward NC, Linn LS: Chronic mental patients: the quality of life issue. American Journal of Psychiatry 1982; 139:10.
2. Brown GC, Brown MM, Sharma S, et al: Quality of life associated with diabetes mellitus in an adult population. Journal of Diabetes Complications 2000; 1: 18–24.

TARGET AUDIENCE:

Mental health care providers.

Poster 29 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

REDUCING WARD VIOLENCE BY WORKING WITH OFFENDERS WHO HAVE MENTAL DISORDERS

Merrill R. Rotter, M.D., *Associate Professor and Director, Division of Law and Psychiatry, Albert Einstein College of Medicine, and Bronx Psychiatric Center, 1500 Waters Place, Bronx, NY 10461*; Stacey Tanenbaum, M.D., *Chief Resident, Department of Psychiatry, Montefiore Medical Center, 1500 Waters Place, Bronx, NY 10461*; Michael F. Steinbacher, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand an effective approach to reducing inpatient ward incidents by targeting incarceration-adaptive beliefs and behaviors among mentally ill offenders.

SUMMARY:

Introduction: A significant number of individuals in the mental health system have histories of criminal incarceration. Behaviors and beliefs adaptive in correctional settings may present increased risk of conflict or injury to staff or patients. In this study, we present the results of a cognitive/behavioral group treatment (SPECTRM) for mentally ill offenders in a civil hospital targeted at decreasing at-risk behaviors.

Methods: Incident data from a male inpatient admissions ward at a state psychiatric facility were compared for two seven-month periods in 1997 and 1998, respectively. Mentally ill offenders in the 1998 cohort received the SPECTRM intervention. Demographic and diagnostic data were gathered for the two cohorts. A subset of each group received risk assessment ratings on the HCR-20 and PCL-R.

Results: SPECTRM intervention was associated with a 28% overall decrease in incident frequency and a 40% reduction in violent incidents from 1997 to 1998. There were no significant differences in age, diagnosis, ethnicity, history of violence, or risk assessment ratings.

Conclusions: Treatment targeting jail and prison adaptive beliefs and behaviors reduces untoward and dangerous incidents on psychiatric wards that include patients with histories of incarceration.

REFERENCES:

1. Rotter MR, Steinbacher M: The clinical impact of doing time: mental illness and incarceration, in Forensic Mental Health: Working with Offenders with Mental Illness. Edited by Landsburg G, Smiley A. Kingston, NJ, Civic Research Institute, 2001.
2. Beran, NL, Hotz, AM: The behavior of mentally disordered criminals in civil mental hospitals: Hospital and Community Psychiatry 35, 585–589.

TARGET AUDIENCE:

General psychiatry.

Poster 30 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

PERSONALITY DISORDERS IN PRISON: AREN'T THEY ALL ANTISOCIAL?

Merrill R. Rotter, M.D., *Associate Professor and Director, Division of Law and Psychiatry, Albert Einstein College of Medicine, and Bronx Psychiatric Center, 1500 Waters Place, Bronx, NY 10461*; Bruce Way, Ph.D., *Director of Evaluation and Research, Central New York, Box 300, Marcy, NY 13403*; Hal Smith; Michael F. Steinbacher, M.A.

EDUCATIONAL OBJECTIVES:

At this session, the participant should be able to understand the difficulties in assessing character pathology among mentally disordered offenders.

SUMMARY:

The provision of mental health services in the correctional system is challenging at best for various clinical, administrative, and structural reasons. Among the complicating factors is the assessment and management of character pathology, which either confounds the treat-

ment of the more "serious" mental illnesses (e.g., Axis I disorders) and/or presents itself as the primary focus for intervention. In this poster, we review the prevalence of personality disorders on the prison mental health services caseload in New York State. We compare inpatient and outpatient rates among the various disorders documented in the prison system as well as look at these rates within the context of the rates of personality disorder in the state mental health system, generally. Finally, the impact of personality disorder on clinical service utilization is explored.

REFERENCES:

1. Rotter MR, Steinbacher M: The clinical impact of doing time: mental illness and incarceration, in Forensic Mental Health: Working With Offenders with Mental Illness. Edited by Landsburg G, Smiley A. Kingston, NJ, Civic Research Institute, 2001.
2. Cote G, Hodgins S: Co-Occurring mental disorders among criminal offenders. Bulletin of the American Academy of Psychiatry and the Law 1990; 18: 271–281.

TARGET AUDIENCE:

General psychiatry.

Poster 31 **Thursday, October 10**
4:00 p.m.-5:30 p.m.

NOVEL ASSESSMENT OF PSYCHIATRY RESIDENTS: STRATEGIC MANAGEMENT SIMULATIONS

Usha G. Satish, Ph.D., *Associate Professor, Department of Psychiatry, State University of New York Medical University, 750 East Adams Street, Syracuse, NY 13210*; Sigfried Streufert, Ph.D., *Professor Emeritus, Department of Psychiatry, State University of New York Medical University, 750 East Adams Street, Syracuse, NY 13210*; John Manring, M.D.; Mantosh J. Dewan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand novel ways of assessing resident competencies; focus on underlying decision making process in addition to "content" focused teaching; enhance critical thinking.

SUMMARY:

Introduction: The Strategic Management Simulations (SMS) has been used to assess and train decision-making skills in professionals (including skills required by physicians). While most teaching modules are "content" based, this effort integrates the "process" elements of thinking into the curriculum.

Method: The present research employs SMS simulations to assess competencies in 25 psychiatric residents. Skills required for integrative decision making are assessed including, flexibility, strategy, and breadth of approach. Test scores on PRITE and Columbia psychotherapy exams were also obtained. In addition, attending faculty familiar with the residents' work evaluated each resident on a rating scale. Simulation performance on multiple measures was compared with faculty ratings, PRITE, and Columbia Psychotherapy scores.

Results: Correlation coefficients ranging from .60 to .80 were obtained between SMS measures and faculty ratings.

Conclusion: Several simulation measures correlated higher with faculty ratings than PRITE and Columbia Psychotherapy scores. In contrast to assessment on the two standard tests, however, simulation performance values (which are highly stable over time) can be obtained at any time (e.g., immediately after entry into a residency program) and reflect specific different components of resident competency. Obtained information about the resident's competencies can be used for focused feedback and training to enhance subsequent performance.

REFERENCES:

1. Satish U, Streufert S, Barach P. Assessing and improving medical competency: Using strategic management simulations. Simulation and Gaming 2001; 156–164.
2. Satish U, Streufert S, Marshall R, Smith S, Powers S, Gorman P, Krummel T: Strategic management simulations is a novel way to measure resident competencies. The American Journal of Surgery 2001; 181: 557–561.

TARGET AUDIENCE:

Psychiatrists, educators, and psychologists.

Poster 32 **Thursday, October 10**
4:00 p.m.-5:30 p.m.

ECONOMICS OF PERSISTENCE WITH INITIALLY PRESCRIBED ANTIPSYCHOTICS IN OLDER PSYCHOTIC PATIENTS AND IN PATIENTS WITH BIPOLAR DISORDER

AstraZeneca Pharmaceuticals

W. Robert Simons, M.D., *President, Global Health Economics and Outcomes, 515 Short Hills Road, Short Hills, NJ 07078*; Richard E. White, M.D.; Elaine Yu, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that quetiapine has a higher level of therapy persistence than other antipsychotic agents, which translates into substantial health care cost savings.

SUMMARY:

Objectives: To evaluate persistency with antipsychotic monotherapies and whether improved persistency yields cost savings.

Methods: Claims data were used to identify 220 quetiapine patients initiated on monotherapy. Matched patients were randomized to three comparators: haloperidol, risperidone, and olanzapine. Endpoints were duration on monotherapy and whether costs decreased with greater duration on monotherapy.

Results: Quetiapine-treated patients aged 45 to 64 remained on treatment for 284 vs 261 days for risperidone (P=0.71), vs 144 for haloperidol (P<0.01), and vs 147 for olanzapine (P<0.01). Savings for this group were $665.34/year/patient vs haloperidol, $95.05 vs risperidone, and $651.08 vs olanzapine. In the >65 group, patients persisted with quetiapine for 278 days vs 201 for risperidone (P=0.05), 260 vs 68 for haloperidol (P<0.01), and 258 vs 192 for olanzapine (P=0.16). Savings were $912.46/year/patient for quetiapine vs haloperidol, $365.93 vs risperidone, and $313.66 vs olanzapine. Annual health care costs were reduced by $4.75/day ($P$<0.01) for each additional day of persistence. Median persistencies for bipolar patients were 225 days for quetiapine, compared with 98 for haloperidol (P<0.01), 154 for risperidone (P<0.01), and 158 for olanzapine (P<0.01), yielding cost savings of $722.63, $403.99, and $438.13.

Conclusions: Quetiapine had the highest level of therapy persistence, yielding healthcare cost savings.

REFERENCES:

1. Mauskopf JA, David K, et al: Annual health outcomes and treatment costs for schizophrenia populations. J Clin Psychiatry 1999; 60(Suppl 19): 14-9; discussion 20-2.
2. Lindstrom E, Bingefors K: Patient compliance with drug therapy in schizophrenia. Economic and clinical issues. Pharmacoeconomics 2000; 18(2): 106–24.

TARGET AUDIENCE:

Professional.

Poster 33 **Thursday, October 10**
4:00 p.m.-5:30 p.m.

INCREASED RISK OF ACCIDENTS AND INJURIES FOR PATIENTS WITH ADHD

Eli Lilly and Company

Calvin Sumner, M.D., *Clinical Research Physician, Neuroscience Medical Affairs, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285*; Andrine R. Swensen, Ph.D.; Ami J. Claxton, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to better understand the severity of attention-deficit/hyperactivity disorder, and to consider ADHD patients as a group to target with suicide prevention programs.

SUMMARY:

Objective: Two symptoms of ADHD, hyperactivity and poor impulse control, may increase risk of injury for patients with this disorder. A preponderance of research conducted to date has focused on the association between ADHD and accidental injury. The purpose of this study was to evaluate the risk of the spectrum of intentional injuries, from poisonings to suicides, for ADHD patients.

Methods: Between January 1, 1991, and May 31, 2000, patients with a diagnosis of ADHD (n = 55,760) were retrospectively identified from a U.S. managed care database. Age, gender-, and index-year-matched controls (n = 167,280) were randomly selected. Key outcome measures were intentional injury (e.g., poisoning), suicide attempts, and completed suicides. Multivariate analyses were used.

Results: ADHD patients were 2.5 times more likely to suffer from an intentional injury (95%CI: 2.1–2.8). Additionally, ADHD patients were 2.9 times more likely to attempt suicide (95% CI: 2.4–3.5); this remained statistically significant after adjusting for depression and substance abuse. ADHD patients were three times more likely to complete suicide; however, this was not statistically significant due to small numbers and inadequate power (95% CI: 0.75–12).

Conclusion: ADHD can have serious consequences and may be an important disorder to target with suicide prevention efforts.

REFERENCES:

1. Farmer JE, Peterson L: Injury risk factors in children with attention deficit hyperactivity disorder. Health Psychol 1995; 14:325–331.
2. DiScala C, Lescohier I, Barthel M, Li GH: Injuries to children with attention deficit hyperactivity disorder. Pediatrics 1998; 102:1415–1421.

TARGET AUDIENCE:

Health care professionals who are interested in the assessment and treatment of attention-deficit/hyperactivity disorder.

Poster 34 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

CHARACTERISTICS OF ANTI-HEPATITIS C POSITIVE OPIATE ADDICTS IN AN INNER CITY

Hla Tun, M.D., M.P.H., *Addiction Psychiatry Fellow, Department of Psychiatry, Bronx-Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10456*; John B. Osei-Tutu, M.D., *Director, Chemical Dependence Service, Department of Psychiatry, Bronx-Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10456*; Ali Khadivi, Ph.D.; Andreas Evdokas, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will be able to recognize the significant correlates of hepatitis C among methadone-treated, inner-city opiate addicts, and its impact on illicit drug use behaviors during treatment period.

SUMMARY:

Studies suggest that the prevalence of anti-hepatitis C (anti-HCV) varies among different patient populations. This project examines the prevalence, clinical characteristics, substance use behaviors, comorbid psychiatric disorders, and other medical variables in an inner-city methadone maintenance population. A retrospective review was conducted on 112 adult admissions to Bronx-Lebanon MMTP from January 2000 to March 2001, who remained in treatment for at least one year. 62.5% were positive for anti-HCV. The prevalence of anti-HCV tended to increase with age, and was significantly associated with intravenous drug use, earlier onset of heroin use, longer duration of heroin and cocaine use, and comorbid hepatitis B and HIV. Anti-HCV positive subjects showed a significant increase in serum aminotransferases levels and a higher rate of positive benzodiazepine use in urine toxicology reports. Additionally, these patients had significantly less reduction in overall illicit drug use. These findings suggest that anti-HCV status may be associated with differential impact on the effectiveness of methadone maintenance treatment, and implications for treatment in this population are discussed.

REFERENCES:

1. Fingerhood MI, Jasinski DR, Sullivan JT: Prevalence of hepatitis C in a chemically dependent population. Arch Intern Med 1993; 153: 2025–2030.
2. Garfein RS, Doherty MC, Monterroso ER, Thomas DL, Nelson KE, Vlahov D: Prevalence and incidence of hepatitis C virus infection among young adults injection drug users. J AIDS and Human Reteovirology 1998; 18 (Suppl 1): S11–S19.

TARGET AUDIENCE:

Psychiatrists, social workers, and trainees.

Poster 35 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

MOVIE CLIPS: THE POWERFUL TOOLS FOR THE COMMUNITY MENTAL HEALTH EDUCATION ON STIGMA

Fuat Ulus, M.D., *Presque Isle Psychiatric Associates, Inc., 1330 West 26th Street, Erie, PA 16508*; Eda Ulus, B.S., *Instructor, Texas Technical Institute, 3201 West Loop 289, #34, Lubbock, TX 79407*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to review the research relevant to regional and global strategies in educating the given community where the stigma compromises the mental health services.

SUMMARY:

This poster study reviews the contemporary educational methods and formats in the service of promoting public awareness among people where the stigma of mental illness interferes with the services provided for patients. The study also examines the commercial movies and their application to educate the public about mental health in different community settings, including but not limited to the business circles, schools, and higher education centers, law enforcement agencies, courts, prisons, and congregations. The public has developed and maintains bias toward the mentally ill and mental health treatment for decades, in part because of sensationalized movies such as One Flew Over the Cuckoo's Nest (seventies), Dressed to Kill (eighties), and The Silence of the Lambs (nineties). The public also watches movies where the clinicians as well as the treatment are presented in a positive manner. Unlike the popular public belief, out of over 1,200 movies produced by Hollywood between 1906 and 2000, there have been more than 700 films where compassionate mental health providers were depicted.

Handouts listing those movies and clips will be shared with the participants and the strategies regarding the public education through the application of this powerful tool will be discussed with interested clinicians and educators.

REFERENCES:

1. Stereotype Threat and Severe Mental Illness, Chicago Consortium for Stigma Research (CCSR), Patrick Corrigan, PsyD, May 24, 2002, Website: www.stigmaresearch.org.

2. Davidson S, Judd F, Jolley D, et al: The general health states of people with mental illness. Australasian Psychiatry 2000; 8:1, Website: www.sane.org.au.

TARGET AUDIENCE:

Psychiatrists, psychologists, social workers, educators, advocates, teachers, and clergy.

Poster 36 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

CO-PRESCRIBING IMPROVES ANTIDEPRESSANT TREATMENT ADEQUACY RATES

Eli Lilly and Company

Jeffrey B. Weilburg, M.D., *Depression Clinical and Research Program, Department of Psychiatry, Massachusetts General Hospital, 55 Fruit Street, Boston, MA 02114*; Kathleen M. O'Leary, B.A., *Data Analyst, Depression Clinical and Research Program, Department of Psychiatry, Massachusetts General Hospital, 50 Staniford Street, 4th Floor, Boston, MA 02114*; Randall S. Stafford, M.D., Ph.D.; James B. Meigs, M.D.; Paul Pirraglia, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the impact of PCP-psychiatrist collaboration on antidepressant prescribing.

SUMMARY:

Background: Antidepressants (ADs) produce optimal outcomes when provided at adequate dose and duration, yet AD treatment is often inadequate. Improving treatment adequacy is an important health policy goal. To date, most effective improvement efforts have used structured prospective programs.

Methods: Retrospective analysis of pharmacy claims made by 1,754 patients in a managed care plan with a PCP at our academic medical center between 1996 and 2000. No depression management program was operating during this time. Treatment adequacy was defined as any period of average dose equivalent to fluoxetine ≥ 20 mg/day for ≥ 90 continuous days. We evaluated the independent impact of prescriber type on treatment adequacy using logistic regression.

Results: Patients prescribed ADs solely by PCPs had an adequacy rate = 26%. Patients prescribed ADs by both psychiatrists and PCPs had an adequacy rate = 61% ($p < .0001$). The increased adequacy of such co-prescribing was confirmed in our regression analysis (OR 3.7 95%CI 2.2–6.2 vs. PCP only).

Conclusions: Co-prescribing conducted under "usual care" conditions, absent a structured QI program, significantly improved adequacy rates. Exploration of factors involved, which may have included effective communication between PCPs and psychiatrists and judicious selection of referrals, may inform future care improvement efforts.

REFERENCES:

1. Goldman LS, Nielsen NH, Champion HC: Awareness, diagnosis, and treatment of depression. J Gen Intern Med 1999;14:569–80.
2. Katon W, Von Korff M, Lin E, et al: Stepped collaborative care for primary care patients with persistent symptoms of depression: a randomized trial. Arch Gen Psychiatry 1999;56:1109–15.

TARGET AUDIENCE:

Psychiatrists and clinicians.

Poster 37 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

SAFETY TRAINING AND VIOLENCE PREVENTION FOR MENTAL HEALTH PROFESSIONALS

Robert L. Weisman, D.O., *Assistant Professor of Psychiatry, Strong Ties Community Support Program, University of Rochester, and Co-Director, Project Link, 1650 Elmwood Avenue, Rochester, NY 14620*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to recognize the core concepts of a comprehensive safety training curriculum for multidisciplinary mental health professionals.

SUMMARY:

Prevention of violence is an important challenge for those who train and supervise mental health workers. Such prevention and training requires time, effort, funding and administrative support. Through the experiences and training provided to Project Link, a mental health outreach program in urban upstate New York and recipient of the 1999 American Psychiatric Association's Gold Award, a Safety and Violence Education (SAVE) curriculum was developed. Utilizing the SAVE training, various mental health and health care professionals have been trained.

The aims of this training program include the following: improved access to care for difficult-to-treat mentally ill patients as well as training key violence prevention concepts in order to improve job safety, satisfaction, and staff retention for multidisciplinary mental health

staff. Seven key concepts contained in the acronym OBSERVE, are reviewed in detail prior to and following each agency's training.

Results taken from satisfaction surveys using a 1–10 scale of seven SAVE program trainings in the community were analyzed and will be presented for review.

The poster will also describe the creation of an interactive CD ROM-based training tool for safety and violence prevention and refresher training with competency review.

REFERENCES:

1. Weisman RL, Lamberti JS: Brief report: violence prevention and safety training for case management services. Community Mental Health Journal 2002;38:339–348.
2. Monahan J: Mental disorders and violent behavior: perceptions and evidence. American Psychologist 1992;47:511–521.

TARGET AUDIENCE:

The intended audience includes mental health professionals and administration.

Poster 38 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

COMORBIDITY PATTERNS AND CORRELATES IN ROUTINE PSYCHIATRIC PRACTICES

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EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate knowledge of the patterns of Axis I comorbidity in routine psychiatric practice and resulting patterns of disability and treatment.

SUMMARY:

Objective: To present data on patterns of Axis I comorbidity in a representative sample of routine psychiatric practice in the U.S. and the relationship of comorbidity status to specific clinical correlates, patterns of disability, and provision of psychopharmacologic and psychotherapeutic treatments.

Methods: The data were gathered from a sample of 1,843 psychiatrists participating in the American Psychiatric Association Practice Research Network's 1999 Study of Psychiatric Patients and Treatments. Data were analyzed to determine the prevalence of Axis I comorbidity rates and the relationship to functional status and treatments.

Results: The most prevelant comorbidity pairing in the sample was depression and anxiety disorders (11.2%). Odds ratios indicated a significantly increased likelihood of substance use disorders given a diagnosis of schizophrenia (1.83, 95% C.I. = 1.31–2.55). Specific Axis I comorbid diagnosis pairings were associated with differential rates of disability and psychiatric treatment utilization. For example, those with substance use disorders were significantly less likely to receive psychotherapy if they had comorbid schizophrenia.

Conclusions: Comorbid Axis I disorders have a relatively high prevalence in routine psychiatric practice, with significant implications for patient functioning and treatment. Knowledge of the relationships between comorbid Axis I disorders and functional and treatment characteristics is important for planning effective treatment interventions and research strategies.

REFERENCES:

1. Regier DA, Farmer ME, Rae DS, Locke BZ, Kieth SJ, Judd LL, Goodwin FK: Comorbidity of mental disorders with alcohol and other drug abuse: results from Epidemiologic Catchment Area (ECA) study. JAMA 1990; 264:2511–2518.
2. Kessler RC: Epidemiology of psychiatric comorbidity, in Textbook in Psychiatric Epidemiology, Edited by Tsuang MT, Tohen M, Zahner GEP, New York, John Wiley & Sons, 1995, pp 179–197.

TARGET AUDIENCE:

Clinicians and health services researchers.

Poster 39 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

ANTIPSYCHOTIC-INDUCED TYPE 2 DIABETES: EVIDENCE FROM A LARGE HEALTH PLAN DATABASE

AstraZeneca Pharmaceuticals

Elaine Yu, Pharm.D., *Associate Director, Health Economic Outcomes Research, Central Nervous System, AstraZeneca Pharmaceuticals, 1800 Concord Pike, Wilmington, DE 19850*; Frank Gianfrancesco, M.D., *President, HECON Associates, Inc., 9833 Whetstone Drive, Montgomery Village, MD 20886*; Richard E. White, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the association of antipsychotic treatment with type 2 diabetes and realize that preliminary reports have increasingly implicated olanzapine as causing or exacerbating type 2 diabetes, while few have implicated quetiapine and risperidone.

SUMMARY:

Objective: To evaluate the association of antipsychotic treatment with type 2 diabetes.

Methods: Claims data for patients with psychosis within a health plan of nearly 2 million patients were analyzed using statistical models. Frequencies of newly treated type 2 diabetes in patients untreated with antipsychotics and among patients treated with quetiapine, risperidone, olanzapine, and conventional antipsychotics were compared.

Results: Based on exposure measured in months of antipsychotic treatment, quetiapine and risperidone patients had estimated odds of receiving treatment for type 2 diabetes that were lower than those of patients untreated with antipsychotics (not statistically significant). Patients treated with conventional antipsychotics had estimated odds that were virtually equivalent to those of patients untreated with antipsychotics. Olanzapine alone had odds that were significantly greater than those of patients untreated with antipsychotics ($P<0.05$). Odds ratios based on eight months of prescreening for preexisting type 2 diabetes and assuming 12 months of antipsychotic treatment were the following: quetiapine=0.953 (95% CI, 0.408–2.227); risperidone=0.652 (95% CI, 0.306–1.393); olanzapine=1.426 (95% CI, 1.049–1.945); and conventional antipsychotics=1.024 (95% CI, 0.669–1.564).

Conclusions: Case reports have increasingly implicated olanzapine as causing or exacerbating type 2 diabetes, while few have implicated quetiapine and risperidone. This study supports these findings.

REFERENCES:

1. Buse JB: Metabolic side effects of antipsychotics: focus on hyperglycemia and diabetes. J Clin Psychiatry 2002; 63 Suppl 4: 37–41.
2. Sernyak MJ, Leslie DJ, et al: Association of diabetes mellitus with use of atypical neuroleptics in the treatment of schizophrenia. Am J Psychiatry 159(4): 561–6.

TARGET AUDIENCE:

Professional.

Poster 40 **Thursday, October 10**
4:00 p.m.-5:30 p.m.

TREATMENT OF THE NOT-GUILTY-BY-REASON-OF-INSANITY POPULATION

Joseph Battaglia, M.D., *Clinical Director, Bronx Psychiatric Center, and Assistant Clinical Professor of Psychiatry, Albert Einstein College of Medicine, 1500 Waters Place, Bronx, NY 10461*; Daniel J. Smuckler, M.D., *Department of Psychiatry, Albert Einstein College of Medicine, and Bronx Psychiatric Center, 1500 Waters Place, Bronx, NY 10461*; Madeleine S. Abrams, C.S.W.; Jeffery Lucey, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will understand the efficacy of the multi-modal treatment of this special population at Bronx Psychiatric Center.

SUMMARY:

Civil state psychiatric facilities in New York State are responsible for treating patients found not guilty by reason of insanity (NGRI) following stabilization in a forensic hospital. This phase of treatment is critical as it determines the extent to which these offenders will be reintegrated into society. Few studies have addressed the impact of intensive long-term treatment on the level of functioning of these individuals. We will review the current model for the treatment and reintegration of the NGRI population at Bronx Psychiatric Center. All of the patients studied have spent a minimum of one year on the inpatient training unit. The model includes offerings in individual therapy, psychopharmacologic thereapy, family therapy, group therapy, vocational planning, MICA treatment, life-skills training, and forensic consultation. The rationale for the model will be reviewed. The poster will include results of a pilot study investigating clinical outcomes using social/vocational functioning scales. Reports from patient and family satisfaction surveys will examine reconnection to family and community networks.

REFERENCES:

1. Luettgen J, Chrapko WE, Reddon JR: Preventing violent re-offending in not criminally responsible patients. An evaluation of a continuity of treatment program.
2. Lindquist P, Svifworth J: Evidencey-based rehabilitation in forensic psychiatry Per Lindquist, Jeremy Svifworth British Journal of Psychiatry 2000;320–323.

TARGET AUDIENCE:

Clinicians working with seriously mentally ill, forensic patients.

Poster 41 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

TRANSFERRING VIOLENT PSYCHIATRIC PATIENTS TO FORENSIC SERVICES

Scott I. Bienenfeld, M.D., *Department of Psychiatry, Bronx Psychiatric Center, 1500 Waters Place, Bronx, NY 10014*; Ali Khadivi, Ph.D., *Associate Director of Psychology, Department of Psychiatry, Bronx-Lebanon Hospital, 1276 Fulton Avenue, 6th Floor, Bronx, NY 10456*; Merrill R. Rotter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will learn about the characteristics and dynamic factors presented by violent psychiatric patients requiring transfer to forensic hospital settings.

SUMMARY:

Under New York State law, article 57, psychiatric patients whose behavior is determined as unmanageable in a civil state hospital can be transferred to a forensic hospital. This study will examine the demographic and clinical variables of 28 violent psychiatric patients who required such transfer initiations between 2000 and 2001. Detailed information was obtained for each patient from the office of mental health and from the various state hospitals, which initiated transfer requests. In addition to basic diagnostic and demographic information, the following variables will be examined: extensive past psychiatric history, criminal history, history of incarceration, history of violence during hospitalization, pattern and type of violence, type of incidents occurring prior to the transfer request, medications, treatment compliance, medication therapeutic levels, and treatment strategies that were utilized. Finally, a comparison will be made between patients who were accepted for transfer and those patients who were denied transfer to forensic settings. The results of the study will be discussed in terms of its implication on the management of violent psychiatric patients in institutions. Participants will learn about the characteristics and dynamic factors presented by violent psychiatric patients requiring transfer to forensic hospital settings.

REFERENCES:

1. Tardiff K: Assessment and management of violent patients. 2nd Edition. Washington D.C., American Psychiatric Press, 1996.
2. Beck JC: The therapist's legal duty when the patient may be violent. Psychiatric Clin North Amer 1988; 11:665–679.

TARGET AUDIENCE:

General psychiatrists, forensic psychiatrists, forensic psychologists, and hospital administrators.

Poster 42 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

CHARACTERISTICS OF MENTALLY ILL CHEMICALLY ABUSING PATIENTS WHO GET REHOSPITALIZED

Ali Khadivi, Ph.D., *Associate Director of sychology, Department of Psychiatry, Bronx-Lebanon Hospital, 1276 Fulton Avenue, 6th Floor, Bronx, NY 10456*; Andreas Evdokas, Ph.D., *Department of Psychiatry, Bronx-Lebanon Hospital, 1276 Fulton Avenue, 6th Floor, Bronx, NY 10456*; Karl D. Dormesy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will learn about factors associated with re-hospitalization in a MICA patient population.

SUMMARY:

Literature has shown that nonadherence to treatment, substance abuse, and past hospitalizations are associated with re-hospitalization in mentally ill patients. However, little is known about these factors in Mentally III Chemically Abusing (MICA) patients. This study examines the demographic and clinical variables of MICA patients in outpatient treatment who get re-hospitalized. All patients (n=111) attending an inner-city adult MICA day treatment program are prospectively being followed for 12 months. A preliminary analysis at eight months indicates that 45 patients (40.5%) were re-hospitalized at least once. These patients are characterized as follows: 75% female, 50% African American, and 33% Latino, with an average age of 47.5. Seventy-five percent of them live with family or in a residential facility. All patients have had previous hospitalizations with a mean number of 5.6. 83.3% have at least one major medical diagnosis and 60% are noncompliant with medication. More than half have a history of sexual abuse. With regard to dangerousness, 33% have a history of suicide attempts, and 50% have a history of assault. The data for 12 months will be presented and a comparison will be made between MICA patients who get re-hospitalized and those who do not, and treatment implications will be discussed.

REFERENCES:

1. Sanguineti VR, Samuel SE, Schwartz SL, Robeson MR: Retrospective study of 2,200 involuntary psychiatric admissions and readmission. Am J Psych 1996; 153: 392–396.
2. Swett C: Symptom severity and number of previous psychiatric admissions as predictors of readmission. Psychiatric Services 1995; 46: 482–485.

TARGET AUDIENCE:

Community psychiatrists, clinical psychologist, and mental health professionals.

Poster 43 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

CLINICAL CHARACTERISTICS AND RESOURCE USE IN LATE-LIFE MENTAL ILLNESS

Martha Sajatovic, M.D., *Associate Professor of Psychiatry, Cleveland VA Medical Center, 345 Timberidge Trail, Gates Mills, OH 44040-9319*; Susan J. Hatters Friedman, M.D., *Resident, Department of Psychiatry, University Hospitals of Cleveland, 11100 Euclid Avenue, Cleveland, OH 44106*; Raymond C. Bingham, Ph.D.; Josephine L. Sabharwal, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will gain familiarity with outcomes of late-life serious mental illness.

SUMMARY:

This retrospective, electronic record review study evaluated clinical characteristics and hospital-based resource use among older adults with bipolar disorder (BPD), schizophrenia/schizoaffective (SZ/SA) disorder, depression, and dementia discharged from an inpatient geropsychiatric unit. There were 137 patients, mean age 73.5 years, with SZ/SA (N=35), BPD(N=21), major depression (N=32) or dementia (N=49). Women were significantly overrepresented among individuals with SZ/SA compared with older adults with BPD, depression, and dementia (p=.034). Among older adults with BPD, and in contrast to what might be expected in younger populations, anticonvulsant medications were predominantly utilized as mood stabilizers, with only rare use of lithium. Anticonvulsants were also utilized extensively in late-life SZ/SA (62.5% of cases) and dementia (54.9% of cases). While there were a greater proportion of older adults with bipolar disorder who abused substances (19%) compared with older adults from other diagnostic groups, this difference was not statistically significant. Individuals with SZ/SA disorder were the youngest group, while individuals with dementia were the oldest group (p<.001). It is possible that fewer individuals with serious chronic psychiatric disorders survive to their eighth and ninth decades due to increased morbidity and mortality associated with psychiatric illness. Additional studies are needed on outcomes of serious chronic psychiatric illness in late life to help us plan and provide optimal care environments for these older adult populations.

REFERENCES:

1. Bartels SJ, Foresten B, Miles KM, Joyce T: Mental health service use by elderly patients with bipolar disorder and unipolar major depression. Am J Geriatr Psychiatry 2000; 8(2): 160–166.
2. Palmer BW, Heaton SC, Jeste DV: Older patients with schizophrenia: Challenge in the coming decades. Psychiatric Services 1999; 50(9): 1178–1183.

TARGET AUDIENCE:

Psychiatrists, nurses, social workers.

Poster 44 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

MANAGED CARE'S DECREASING LENGTH OF STAY INCREASES READMISSIONS FOR PATIENTS WITH MAJOR DEPRESSIVE DISORDER

Roberto A. Figueroa, M.D., *Resident, Western Psychiatric Institute and Clinic, University of Pittsburgh Medical Center, 3811 O'Hara Street, Pittsburgh, PA 15213*; Jeffrey Harman, Ph.D.; John Engberg, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should have a better understanding of the impact that managed care has on the length of stay for inpatient treatment of major depression and how this affects the readmission rate.

SUMMARY:

Objective: To analyze the impact of length of stay on readmission rates for inpatient treatment of major depression and compare the magnitude of this impact between managed care and fee-for-service payers.

Methods: We use a secondary data set that contained information about patients' characteristics, diagnosis, length of stay, and the insurance type on all the hospital discharges that occurred in Pennsylvania during 1997 and 1998.

We rely on an econometric technique, instrumental variables, to estimate the impact of length of stay on rate of readmission for approximately 40,000 discharges with primary diagnosis of major depression.

Results: Inpatient treatment for major depression is significantly shorter when the primary payer is a health maintenance organization (HMO). On patients covered by HMOs, shorter length of stay was associated with higher readmission rates. Decreasing the length of stay by a third (i.e. from six to four days) would increase the readmission rate by 18% (i.e. from 0.168 to 0.205). This association was not found in patients covered by fee for service.

Conclusion: Decreasing length of stay for the inpatient treatment of major depression by HMOs may result in an increased rate of readmissions. Instrumental variables can be useful tools to address problems of sample selection in health services research.

REFERENCES:

1. Lyons JS: Predicting readmission to the psychiatric hospital in a managed care environment: implications for quality indicators. American Journal of Psychiatry 1997; 154(3): 337–40.
2. Wickizer TM, Lessler D: Do treatment restrictions imposed by utilization management increase the likelihood of readmission for psychiatric patients? Med Care 1998; 36(6): p. 844–50.

Poster 45 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

COMORBIDITIES AND COSTS OF ADULT PATIENTS WITH ADHD

Eli Lilly and Company

Maureen J. Lage, Ph.D., *Research Scientist, Healthmetrics Outcomes Research, 64 East Shore Avenue, Groton Long Point, CT 06340*; Andrine R. Swensen, Ph.D.; Kristina Secnik, Ph.D.

EDUCATIONAL OBJECTIVES:

To understand the comorbidities, medical and productivity costs in adults diagnosed with ADHD.

SUMMARY:

Objective: Examine the prevalence of comorbities as well as costs for adults diagnosed with attention-deficit hyperactivity disorder (ADHD).

Methods: Individuals diagnosed with ADHD between 1997–1999 were retrospectively identified from a database that captures inpatient, outpatient, and prescription drug services from approximately 45 large employers. The ADHD cohort (N=607) was matched to the non-ADHD (N=1214) cohort at a 1:2 ratio based upon age, gender and metropolitan statistical area. Variables of interest included co-morbidities and medical costs. Time missed from work due to absenteeism, short-term disability or worker compensation was also examined for a small sub-sample (N=87) of the population.

Results: Adults diagnosed with ADHD were significantly more likely to have a comorbid diagnosis of anxiety ($p<0.0001$), bipolar disorder ($p<0.0001$), depression ($p<0.0001$), drug/alcohol abuse ($p<0.0001$), enuresis ($p=00003$), asthma ($p=0.0020$), or irritable bowel syndrome ($p=0.0008$) compared to the control group. Adults diagnosed with ADHD had significantly higher outpatient costs ($p<0.0001$), prescription drug costs ($p<0.0001$), and total medical costs ($p<0.0001$) compared with the non-ADHD cohort. Employees diagnosed with ADHD were significantly more likely to be "unofficially" absent from work ($p<0.0001$).

Conclusions: Results demonstrate that adults with ADHD have a higher prevalence of comorbidities, higher medical costs, and more absences than other individuals.

REFERENCES:

1. Birnbaum HG, Cremieux PY, Greenberg PE, et al: Using health care claims data for outcomes research and pharmacoeconomic analyses. Pharmacoeconomics 1999; 16:1–8.
2. Ramsey S, Summers KH, Leong SA, et al: Productivity and medical costs of diabetes in a large employer population. Diabetes Care 2002; 25:23–29.

Poster 46 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

THE COST OF ANXIETY DISORDER TO EMPLOYERS: A CASE-CONTROL STUDY

Eli Lilly and Company

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EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be educated, using a retrospective, case-control methodology, about the medical and productivity costs for individuals who have been diagnosed with anxiety.

SUMMARY:

Objective: The purpose of this retrospective, case-control study is to examine the medical and productivity costs for individuals who have been diagnosed with anxiety.

Methods: This study uses an employer database that collected medical, absenteeism, short-term disability, and worker compensation records during 1999 from six major employers. Patient diagnosed with anxiety disorder (based on ICD-9 codes of 300.0, 300.00, 300.01, 300.02 or 300.21) (N=601) were matched at a 1:2 ratio to patients not diagnosed with anxiety disorder (N=1202) based upon age, sex, and metropolitan statistical area. Chi-square and t-statistics were used to compare the anxiety population with the control group.

Results: Employees diagnosed with anxiety disorder are significantly more likely to have additional diagnoses, use more medical and psychiatric services, and are more likely to be hospitalized or visit the emergency room compared with the control group. Furthermore, employees diagnosed with anxiety disorder have significantly higher medical costs ($5,447 vs. $2,344; p<0.0001), productivity costs ($2,366 vs. $1,438; p<0.0001) and total costs ($7,813 vs. $3,782; p<0.0001) compared with the control group.

Conclusion: Results indicate employed individuals diagnosed with anxiety disorder have significantly higher medical and productivity costs. Further examination of costs attributed to anxiety disorder and those resulting from comorbidities is warranted.

REFERENCES:

1. Dupont RL, Rice DP, Miller LS, Shiraki SS, Rowland CR, HJ Harwood: Economic Costs of Anxiety Disorders. Anxiety 1996; 2: 167–172.
2. Greenberg PE, Sisitsky MA, Kessler RC, Finkelstein SN, Berndt ER, Davidson JRT, Ballenger JC, AJ Fyer: The Economic Burden of Anxiety Disorders in the 1990s. Journal of Clinical Psychiatry 60;7:427–435.

Poster 47 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

PROLACTIN LEVELS IN CHILDREN AFTER LONG-TERM TREATMENT WITH RISPERIDONE

Janssen Pharmaceutica and Research Foundation

Robert L. Findling, M.D., *Professor of Pediatrics and Adolescent Health, and Director, Division of Child and Adolescent Psychiatry, University of Cleveland Medical Center, 11100 Euclid Avenue, Cleveland, OH 44106-5080*; Vivek Kusumakar, M.D.; Denis Daneman

EDUCATIONAL OBJECTIVES:

At the end of the presentation, the participant will be able to describe the temporal effects on prolactin levels, the rate of prolactin-related side effects, and the safety and tolerability profile of short- and long-term risperidone treatment in children and adolescents.

SUMMARY:

Objective: To explore the effect of long-term risperidone use on prolactin levels in children 5 to 15 years of age.

Methods: Five clinical double-blind and open-label trial databases involving 709 children were analyzed. The primary analysis population (PAP) consisted of 592 children (83% boys; 80% Caucasian; 73% were Tanner Stage 1) with pre-dose and at least one post-dose prolactin observation at/or after Week 4. Exploratory analysis was conducted at different risperidone treatment timepoints: 550 children with seven weeks, 499 with three months, 441 with six months, and 358 with 12 months, of risperidone treatment.

Results: Mean prolactin levels at baseline (pre-dose) were 7.8 (SD=7.2; range: 2.0–76.5) ng/ml, and rose to 29.4 ng/ml (SD=16.5) during Weeks 4 to 7. Thereafter, mean levels decreased and within 12 months returned to within normal limits (mean 16.1 ng/ml, SD=13.2). Prolactin levels below 30 ng/mL were observed in 89% of children and 6% of children had possible prolactin-related side effects. No correlation between prolactin levels and prolactin-related side effects was found.

Conclusion: Despite transient, modest increases in prolactin levels becoming evident after four weeks of risperidone therapy, mean prolactin levels returned to within normal limits within 12 months with no serious sequelae noted.

REFERENCES:

1. Wiedemann, G, Jonetz-Mentzil: Establishment of reference ranges for prolactin in neonates, infants, children and adolescents. Eur J Clin CHem CLin Biochem 1993; 31(7).
2. Wudarsky M, Nicolson R, et al: Elevated prolactin in pediatric patients on typical and atypical antipsychotics. J of Child and Adol Psychopharm 1999; 9(4).

TARGET AUDIENCE:

Pediatric, psychiatrists.

Poster 48 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

RISPERIDONE FOR BEHAVIORAL DISTURBANCES IN ADULTS WITH MENTAL RETARDATION

Janssen Pharmaceutica and Research Foundation

Carlo A. Gagiano, *Westdene Research Center, P.O. Box, Danh of South Africa 9310*; Liliane Thorpe, M.D.; Stephen G. Read, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participant will be able to discuss the efficacy and safety of risperidone for managing behavioral disturbances in adults with borderline mental functioning or mild to moderate mental retardation.

SUMMARY:

Objective: To evaluate the long-term safety and efficacy of risperidone in treating disruptive behavior disor-

ders in adults with mild, moderate, or borderline mental retardation.

Method: In a one-year, international, multicenter, open-label, follow-on trial, patients who had participated in a previous four-week, double-blind, placebo-controlled study were given flexible-dose risperidone at 1 to 4 mg/day.

Results: Of the 58 patients included in the follow-on trial, 32 were treated for a full year. Overall mean modal risperidone dose was 1.81 mg/day. Based on the total score of the Aberrant Behavior Checklist, BPI, and CGI, behavior improved significantly within the first weeks and was sustained throughout the one-year study. Adverse events were reported by 52 patients; somnolence (n = 24) was the most common adverse event. The level of EPS was low; no significant changes were noted in ESRS scores. Risperidone did not affect attention or verbal memory. There was a mean weight increase of 3.8 kg at end point. No clinically relevant changes were observed in laboratory results, vital signs, or ECG parameters.

Conclusions: Risperidone was well tolerated and maintained improvement in disruptive behavior disorders in adults with borderline intellectual functioning or mental retardation.

REFERENCES:

1. McDougle CJ, Holmes JP, Carlson DC, Pelton GH, Cohen DJ, Price LH: A double-blind, placebo-controlled study of risperidone in adults with autistic disorder and other pervasive developmental disorders. Arch Gen Psychiatry 1998;55:633–41.
2. Khan BU: Brief report: risperidone for severely disturbed behavior and tardive dyskinesia in developmentally disabled adults. J Autism Dev Disord 1997;27:479–89.

TARGET AUDIENCE:

Psychiatrists.

Poster 49 **Thursday, October 10**
4:00 p.m.-5:30 p.m.

THE EFFECTS OF ANTIPSYCHOTIC PARTIAL COMPLIANCE ON RESOURCE UTILIZATION IN A SCHIZOPHRENIA AND BIPOLAR DISORDER POPULATION

Janssen Pharmaceutica and Research Foundation

Krishnan Ramaswamy, Ph.D., *Associate Director, Central Nervous System Outcomes Research, Janssen Pharmaceutica and Research Foundation, 1125 Trenton Harbourton Road, Titusville, NJ 08560*; Amy Grogg, Pharm.D.; Michael Eaddy, Ph.D., Pharm.D.; Robert Mauch, Jr., Ph.D., Pharm.D.; Susan Maue, Ph.D., B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to view data showing that compliant patients were more likely to receive atypical antipsychotics.

SUMMARY:

Background: Even with the advent of new treatment modalities, patients continue to be only partially compliant and this lowers the effectiveness of treating schizophrenia and bipolar disorders (Lindstrom and Bingefors, 2000). The purpose of this study was to examine the effects of partial compliance on medical resource utilization.

Methods: Patients receiving antipsychotics and diagnosed as having schizophrenia or bipolar disorders in a large southeastern Medicaid program were placed into three mutually exclusive cohorts based on their level of compliance. Compliance was measured by the continuous, multiple-interval-medications-available methodology. Patients were deemed partially compliant if compliance was less than 80%, compliant if compliance was 80% to 125%, and overly compliant if compliance was greater than 125%. Medical charges were log transformed and modeled as a function of compliance controlling for background covariates. Logistic regression was used to model the probability of specific types of utilization and the probability of medication switch/augmentation.

Results: A total of 7,864 patients were used in this analysis. Of these, 2,655 patients were classified as partially compliant, 5,065 as compliant, and 144 patients as overly compliant. After controlling for background covariates, partially compliant patients were 49% ($p<0.01$) more likely to have an inpatient hospitalization, and incurred 55% ($p < 0.01$) higher inpatient charges when compared to compliant patients. Partially compliant patients were 20% ($p<0.01$) less likely to be receiving atypical antipsychotics, and 64% ($p<0.01$) more likely to switch or augment when compared with compliant patients. Overly compliant patients were 69% ($p<0.01$) less likely to switch or augment when compared to compliant patients.

Conclusion: Partially compliant patients incurred higher inpatient charges and were more likely to have an inpatient hospitalization when compared with compliant patients. Compliant patients were more likely to receive atypical antipsychotics.

Source of Funding: Janssen Pharmaceutica, Inc.

REFERENCES:

1. Janssen Pharmaceutica, 1125 Trenton-Harbourton Rd., Titusville, NJ 08560-0200
2. Applied Health Outcomes, Two Urban Centre, 4890 W. Kennedy Blvd., Suite 760 Tampa, FL 33609

Poster 50 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

THE EFFECTS OF ATYPICAL AND ORAL CONVENTIONAL ANTIPSYCHOTICS ON THE COMPLIANCE OF MENTAL HEALTH PATIENTS

Janssen Pharmaceutica and Research Foundation

Krishnan Ramaswamy, Ph.D., *Associate Director, Central Nervous System Outcomes Research, Janssen Pharmaceutica and Research Foundation, 1125 Trenton Harbourton Road, Titusville, NJ 08560*; Amy Grogg, Pharm. D., Michael Eaddy, Ph.D., Pharm.D.; Robert Mauch, Jr., Ph.D., Pharm.D.; Susan Maue, Ph.D., B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to determine that patients taking atypical antipsychotics are more compliant than patients taking conventional antipsychotics.

SUMMARY:

Background: Various factors are associated with mental health medication partial compliance. The purpose of this study was to assess compliance rates in patients prescribed atypical and oral conventional antipsychotics.

Methods: All patients receiving antipsychotics in a large southeastern Medicaid program were placed into two mutually exclusive drug-type cohorts based on the presence of their first antipsychotic prescription between July 1, 1999, and February 28, 2000. Patients were deemed partially compliant if compliance, measured by the continuous, multiple-interval-medications-available methodology, was less than 80% and compliant if compliance was greater or equal to 80%. Logistic regression was used to model the probability of being compliant, controlling for severity, switching/augmenting rates, and other patient covariates. Subanalyses were conducted on patients identified as having schizophrenia or bipolar disorders, assuming more liberal treatment patterns.

Results: There were 23,316 patients that met all inclusion and exclusion criteria, of which 3,995 (17.1%) were diagnosed as having bipolar disorders and 3,869 (16.5%) patients with schizophrenia. The majority of patients (58.5%) were taking oral conventional antipsychotics followed by atypical (39.8%) and conventional depot (1.7%) antipsychotics. Over all analyses, patients taking atypical antipsychotics were more compliant than patients taking oral conventional antipsychotics (Table 1).

Table 1. Odds of Compliance verses Oral Conventional Antipsychotics

	Odds Ratio	95% Odds Ratio
Overall	1.91	1.121 to 1.266
Schizophrenia/Bipolar Disorders	1.107	1.000 to 1.226
Schizophrenia Only	1.221	1.050 to 1.396

Conclusion: Patients taking atypical antipsychotics are more compliant than patients taking conventional antipsychotics.

Source of Funding: Janssen Pharmaceutica, Inc.

REFERENCES:

1. Janssen Pharmaceutica, 1125 Trenton-Harbourton Rd., Titusville, NJ 08560-0200
2. Applied Health Outcomes, Two Urban Centre, 4890 W. Kennedy Blvd., Suite 760 Tampa, FL 33609

Poster 51 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

ANTIPSYCHOTICS AND INDEPENDENT LIVING IN CONDITIONALLY RELEASED FORENSIC PATIENTS

Janssen Pharmaceutica and Research Foundation

Ashley King Berman, Ph.D., *California Forensic Assessment Project, 110 Gough Street, Suite 203-A, San Francisco, CA 94102*; Kay Sadik, Ph.D., Pharm.D.; Amy Grogg, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to evaluate the success of risperidone, olanzapine, and conventional neuroleptics in sustaining the independent living status of formerly incarcerated psychotic patients.

SUMMARY:

Objective: To compare differences in outcomes in conditionally released prisoners prescribed risperidone, olanzapine, or conventional neuroleptics.

Method: In a retrospective chart review, we included patients with schizophrenia, schizoaffective disorder, or psychosis NOS who had committed a violent crime and had been prescribed a conventional neuroleptic, risperidone, or olanzapine for one year. Logistic regression models were used to determine differences between groups.

Results: Data from 144 conventional neuroleptic, 69 risperidone, and 48 olanzapine patients were reviewed. Except for housing status, no statistically significantly different outcome variables were found. Approximately 31% risperidone, 26% conventional neuroleptic, and 13% olanzapine patients achieved independent living status. When controlling for use of anticholinergics and number of prior hospitalizations, more risperidone patients achieved independent living than did olanzapine patients (P = .006). When controlling for diagnosis, mood stabilizers/anticholinergics, and prior hospitalizations/arrests, fewer olanzapine patients achieved independent living status than did conventional neuroleptic

patients (P = .03). Risperidone and conventional neuroleptic patients did not significantly differ.

Conclusions: Violent offenders receiving risperidone who are conditionally released from prison are more likely than those given olanzapine to achieve independent living status.

Importance: Therapies to sustain independent living are economically favored for violent, forensic patients.

REFERENCES:

1. Buscema CA, Abbasi QA, Barry DJ, et al: An algorithm for the treatment of schizophrenia in the correctional setting: the Forensic Algorithm Project. J Clin Psychiatry 2000;61:767–83.
2. Pinals DA, Buckley PF: Novel antipsychotic agents and their implications for forensic psychiatry. J Am Acad Psychiatry Law 1999;27(1):7–22 Review.

TARGET AUDIENCE:

Psychiatrists.

Poster 52 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

INPATIENT CHART ABSTRACTION STUDY OF ATYPICAL ANTIPSYCHOTIC RESOURCES AND COSTS

Janssen Pharmaceutica and Research Foundation

Kathleen Degen, M.D., *Medical Director, Behavioral Health Center Outpatient Department, and Director of Research, Middlesex Hospital, 28 Crescent Street, Middletown, CT 06457*; Deidre Neighbors; William Irish; Rebecca Lopez

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to distinguish the antipsychotic drug cost differences and other medication and resource utilization patterns associated with risperidone, olanzapine, and quetiapine when used as treatments for patients with schizophrenia during a stay at an acute mental health inpatient facility.

SUMMARY:

Objectives: To compare the average total daily study drug costs of risperidone (n=120), olanzapine (n=153), and quetiapine (n=54) as treatment for schizophrenia/schizoaffective disorder during inpatient hospitalization.

Methods: Retrospective data on inpatient drug utilization was collected on 327 patients at three acute inpatient mental health facilities through 60 days following initiation of study drug. A propensity scoring method, modified for three treatment groups, was used to adjust for treatment selection bias. Adjustments were made for factors that predicted treatment selection for all study drugs, including age, gender, race, and facility.

Results: The average daily study drug cost was $4.35 less for risperidone than for olanzapine (95% CI, −$5.84 to −$2.86), and $1.41 less for risperidone than for quetiapine (95% CI, −$3.89 to $0.81). No statistically significant between-group differences were observed in length of stay. Average daily dose for patients on study drug at time of discharge was 4.85 mg (SD, 2.29) for risperidone, 14.22 mg (5.44) for olanzapine, and 368.64 mg (230.52) for quetiapine.

Conclusions: The daily inpatient study drug cost of risperidone was lower than that of olanzapine (statistically significant) and of quetiapine (not statistically significant).

Importance: Pharmacotherapeutic choices must be considered carefully in light of rising hospitalization costs.

REFERENCES:

1. Procyshyn RM, Zervaj S: Drug utilization patterns and outcomes associated with in-hospital treatment with risperidone or olanzapine. Clin Ther 1998;20:1203–1217.
2. D'Agostino RB: Propensity score methods for bias reduction in the comparison of a treatment to a nonrandomized control group. Stat Med 1998;17:2265–2281.

TARGET AUDIENCE:

Psychiatrists, health economists.

Poster 53 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

THE MOTHERS' PROJECT FOR HOMELESS MOTHERS WITH MENTAL ILLNESS

Substance Abuse and Mental Health Services Administration

Patricia L. Hanrahan, Ph.D., *Associate Professor of Psychiatry, University of Chicago, 5841 South Maryland Avenue, MC-3077, Chicago, IL 60637*; Marion L. McCoy, Ph.D., *Director of Research, Thresholds, 4101 North Ravenswood Avenue, Chicago, IL 60613*; M. A. Zeitz, M.Ed.; L. Cloninger, Ph.D.; Jerry Dincin, Ph.D.; Thomas A. Simpatico, M.D.; Daniel J. Luchins, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should (1) recognize the need for services for homeless mothers with mental illness, (2) understand the components of an exemplary service model for this population,

and (3) recognize the potential for decreasing homelessness among mothers with mental illness.

SUMMARY:

Purpose: The Mothers' Project serves homeless mothers with mental illness and their children. The purpose of this naturalistic study is to describe the characteristics of the homeless mothers enrolled in the Mothers' Project and to follow up on their progress in the program.

Design and Measures: This retrospective, pre and post study used chart reviews of all 24 mothers who were identified as having a history of being homeless, and who were enrolled in the Mothers' Project from 5/13/96 to 1/31/2002. The main outcome concerned the extent to which homelessness decreased between intake, six months, and 12 months.

Intervention: Intensive case management and a problem solving approach to psychosocial rehabilitation are at the core of the intervention. In addition to case management, mental health services included psychiatric diagnosis, medication monitoring, and participation in the Mothers' Project.

Results: Among the 19 mothers who continued in the program, all were housed either independently or in supportive housing after 12 months, $p < .001$. The majority of the children in their care at intake remained with them after a year, 77% (N = 27).

Conclusion: Overall, the Mothers' Project appeared to benefit both homeless mothers with mental illness and their children.

REFERENCES:

1. Zeitz MA: The Mothers' Project: a clinical case management system. Psychiatric Rehabilitation Journal 1995; 19(1):55–63.
2. Dincon J, Zeitz M: Helping mentally ill mothers. Hospital & Community Psychiatry 1992; 44(11): 1106–1107.

TARGET AUDIENCE:

Social workers, psychiatrists, psychologists.

Poster 54 **Thursday, October 10**
4:00 p.m.-5:30 p.m.

COMMUNITY TREATMENT FOR PREVIOUS OFFENDERS WITH MENTAL ILLNESSES

David L. Roberts, M.A., *Executive Director, Center for Public Mental Health Services and Policy Research, University of Chicago, 220 Elizabeth Street, #A-24, Chapel Hill, NC 27514*; Patricia L. Hanrahan, Ph.D., *Associate Professor of Psychiatry, University of Chicago, 5841 South Maryland Avenue, MC-3077, Chicago, IL 60637*; Marion L. McCoy, Ph.D.; Daniel J. Luchins, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize factors that contribute to hospital and jail recidivism among people with mental illnesses; describe services that have been developed to serve individuals with mental illnesses who are recidivistic; describe how these factors interact and reinforce one another in perpetuating recidivism.

SUMMARY:

Purpose: This study examined the extent to which factors that have been found to affect recidivism among persons who are ex-offenders and have mental illnesses were present in one cohort of clients in an ACT jail linkage program in Chicago. These factors include homelessness, poverty, trauma, substance use, and limited linkage between criminal justice and mental health systems.

Methods: This is a qualitative study of the first cohort of 24 persons identified by the jail linkage project since 1997. It uses archival treatment and criminal justice data as well as an analysis of 24 semi-structured interviews with the entire cohort of clients. Both experiences before jail, and the clients' views on the linkage project were addressed in the interview. The study also includes a description of the jail linkage program.

Results: Results of the analysis suggest that it is possible to successfully identify, engage, and retain in treatment clients who struggle with the full range of factors that usually lead to recidivism.

Conclusion: Given the high numbers of persons with mental illness who are incarcerated, this model program should be expanded and replicated.

REFERENCES:

1. Gold Award. Helping Mentally Ill People Break the Cycle of Jail and Homelessness: The Thresholds, State, County Collaborative Jail Linkage Project, Chicago, Psychiatric Services 2001;52:1380–1382.
2. Watson A, Hanrahan P, Luchins D, Lurigio A: Paths to jail among mentally ill persons: service needs and service characteristics. Psychiatric Annals 2001; 31:421–429.

TARGET AUDIENCE:

Community treatment providers and administrators.

Poster 55 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

THE *PARAPRAXIS* NEWSLETTER: A CREATIVE COMMUNICATION TOOL FOR RESIDENTS

Teri L. Wolf, M.D., *Resident, Department of Psychiatry, University of Michigan Medical Center, 1500 East Medical Center Drive, Ann Arbor, MI 48105*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the usefulness of newsletters and magazines in residency training programs as a forum to discuss professional issues and as a creative outlet to further generate discussion about psychiatric attitudes, decisions, and practices.

SUMMARY:

Psychiatrists must strive for excellent communication and collaboration in their practices, not only to coordinate treatments with other physicians and therapists, but also to maintain close ties with colleagues, to keep abreast of current medical issues, to discuss ethical considerations, and to consider how current events and other relationships in the world at large may impact our patients. Residency is an ideal time to practice these communication skills, as the resident's sense of professional identity grows along with the recognition of increasing complexities in the field. One often overlooked communication tool is the residency newsletter. The Parapraxis is a seasonal publication for residents, faculty, and friends of the department of psychiatry at the University of Michigan. Produced by residents, it is both a forum for discussion of professional issues, and a creative outlet to foster further discussion and ideas about the world around us, and the events that shape our attitudes and decisions as caregivers. Through opinion pages, essays, editorials, and artistic submissions, the Parapraxis aims to address the ideas in our professional community, while helping residents practice communication and collaboration skills in a personally and professionally satisfying manner.

REFERENCES:

1. Hepworth J: Creating collaborative environments for clinical care and training: from cacophony to symphony and jazz. Clinics in Family Practice, 2001; 3(1); 63–75.
2. Riba MB, Balon R: Psychopharmacology and Psychotherapy: A Collaborative Approach. American Psychiatric Press, Inc. Washington DC, 1999, pp 279–306.

TARGET AUDIENCE:

Residents, clinicians in psychiatry and psychology, training directors, educators.

Poster 56 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

MANAGED CARE ORGANIZATIONS CAN HELP IDENTIFY POTENTIAL RESEARCH RECRUITS

Duane J. DiFranco, M.D., *Clinical Instructor, Department of Psychiatry, University of Michigan, 2500 Green Road, Suite 700, Ann Arbor, MI 48105*; Marcia Valeustech, M.D.; John F. Greden, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize that managed behavioral health care organizations can help identify potential research recruits in a manner compatible with the administrative functioning of the MBHO.

SUMMARY:

Introduction: Excellence in psychiatric treatment depends on excellence in psychiatric research. Recruiting subjects for research is often very difficult. Managed care may have a further negative impact on psychiatric research, yet many managed behavioral health care organizations (MBHOs) collect clinical data from enrollees at the time of authorization. We demonstrate that these data can be used to identify potential research recruits, which may assist investigators by lowering familiar recruitment barriers.

Study Design: The structured screening instrument in use at our institution's MBHO was changed using a modified Delphi technique to incorporate and integrate the opinion of experts. The instrument collects clinical data and assesses interviewees' willingness to have an investigator contact them to discuss departmental research opportunities. We present data on 153 interviews.

Results: Modified interviews took 13% longer than standard interviews. The instrument was able to identify interviewees who were medication- and alcohol-free and those who had likely depression, hazardous drinking, illicit drug use, and current prescription drug use. Overall, 60% of interviewees agreed to be contacted by an investigator. Only hazardous drinkers and pregnant women were significantly less likely to agree to be contacted. The mean age of those who agreed to be contacted was 33; the mean age of those who declined was 40 ($p<.01$).

Conclusions: MBHOs can help identify potential research recruits with little negative impact. Most enrollees who access behavioral health care through an MBHO

are willing to be contacted by an investigator. Data collected by MBHOs can help characterize interviewees across important clinical domains.

REFERENCES:

1. McKee M: The impact of managed care on clinical research. Pharmacoeconomics 1998; 14(1):19–25.
2. Ross S: Barriers to participation in randomized controlled trials: a systematic review. J Clin Epidemiol 1999; 52:1143–1156.

TARGET AUDIENCE:

Administrators over research infrastructure; clinical investigators.

Poster 57 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

BIPOLAR DEPRESSION: DILEMMA WITH ANTIDEPRESSANT USE

Anoop Karippot, M.D., *Fellow, Department of Child and Adolescent Psychiatry, University of Louisville, 69 Highwood Place, Louisville, KY 40206*

EDUCATIONAL OBJECTIVES:

Participants will learn the use of antidepressants and their potential side effects on maintenance therapy in bipolar patients.

SUMMARY:

Antidepressants administered to bipolar subjects may induce manias, mixed states, or rapid cycling. Usually discontinuation of the offending agent results in rapid resolution. More recently we have noted that long-term use of antidepressants may induce chronic dysphoria and an irritable state. A case series is presented in which six type-I bipolar subjects receiving antidepressants continuously for several years developed chronic dysphoria. A triad of dysphoric mood, irritability and middle insomnia that is frequently associated with occupational dysfunction can occur in some bipolar patients receiving antidepressants for at least three years. Typically initial treatments with antidepressants for the index episode were effective. Over time, depressive symptoms returned and would transiently improve with dose increase or change of agents. Ultimately, the dysphoria and associated symptoms became chronic and resulted in dysfunction. Discontinuation of antidepressants was associated with a slow and gradual improvement in these symptoms over the ensuing year. Concomitant mood stabilizer did not appear to alter this pattern. Additional studies are required to investigate safety of long term use of antidepressants in bipolar illness.

REFERENCES:

1. Ghaerni NS; Boiman E: "Diagnosing bipolar disorder and the effects of antidepressants: a naturalistic study. J Clin Psych 2000; 61: 804–808.
2. Kupfer D, Carpenter L: Possible role of antidepressants in precipitating mania and hypomania in recurrent depression. Am J Psych 1998; 145: 303–308.

Poster 58 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

VALPROATE-ASSOCIATED PANCREATITIS IN A TEN-YEAR-OLD CHILD: A PSYCHIATRY CONSULTATION/ LIAISON EXPERIENCE

Anoop Karippot, M.D., *Fellow, Department of Child and Adolescent Psychiatry, University of Louisville, 69 Highwood Place, Louisville, KY 40206*

EDUCATIONAL OBJECTIVES:

Participants will learn about acute pancreatitis associated with valproic acid treatment, morbidity and mortality and methods to prevent such complications.

SUMMARY:

Background: Pancreatitis is usually considered a rare side effect of valproate. We describe a case of acute pancreatitis in a child patient with use of valproate in a psychiatric consultation liaison setting.

The development of acute pancreatitis in a 10-year-old boy being treated with divalproic acid for bipolar disorder and aggressiveness. A brief discussion of other previously reported complication with valproic acid is included. The morbidity and mortality associated with the psychopharmacological agent and its potential harm and methods to avoid such complications are discussed.

The challenges of dealing with this issue in a consultation-liaison setting are discussed.

REFERENCES:

1. Fecik SF, Stoner SC: Recurrent acute pancreatitis associated with valproic acid use for mood stabilization 19(5); Journal of Clinical Psychopharmacology. 1999; 483–484.
2. Batalden PB, Van Dyne BJ: Pancreatitis associated with valproic acid therapy. Pediatrics 64: 520–522.

Poster 59 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

FREQUENT VISITORS TO A CRISIS CENTER

Flinn Foundation

Cynthia L. Arfken, Ph.D., *Assistant Professor of Psychiatry and Behavioral Neurosciences, Addiction Research*

Institute, Wayne State University School of Medicine, 2761 East Jefferson Avenue, Detroit, MI 48207; Lori Zeman, Ph.D., *Interim Chief Operating Officer, Clinical Affairs, Psychiatry and Behavioral Medicine Professionals, Wayne State University, 2751 East Jefferson, Suite 500, Detroit, MI 48207*; Alireza Amirsadri, M.D.; Edward Mischel, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify risk factors for frequent visitors to crisis centers and discuss possible interventions to ameliorate the burden they pose on the health care system.

SUMMARY:

Targeting interventions to people who disproportionately use health care resources is an attractive option for limiting costs. The screening and crisis center in one major city was experiencing an increase in frequent visitors, straining both staff and space. We found, using a case-control study with follow-up at health care facilities, that independent risk factors for frequent visits were being homeless, hospitalized in past year, needing medication, and not naming a person who knows them well. The frequent visitors were also more likely to have visited emergency medicine departments, crisis residential and outpatient clinics in the past year. Their median health care charge for the one year was $19,500 or almost six times the median charge for the group who had infrequent visits to the screening and crisis center. These results suggest that people who frequently utilize the screening and crisis center have basic social needs defying traditional short-term crisis interventions. Addressing their disproportionate use of all health care resources will require additional integration of systems. We are currently conducting a study that will investigate the utility and satisfaction with brief visits and medication reviews in the screening and crisis center as a possible intervention.

REFERENCES:

1. Breslow RE, Erickson BJ, Cavanaugh KC: The psychiatric emergency service: where we've been and where we're going. Psychiatric Quarterly 2000; 71: 101–121.
2. Ellison JM, Blum N, Barsky AJ: Repeat visitors in the psychiatric emergency service: a critical review of the data. Hospital and Community Psychiatry 1986; 37: 37–41.

TARGET AUDIENCE:

Emergency psychiatrists, administrators, policy.

Poster 60 **Thursday, October 10**
4:00 p.m.-5:30 p.m.

COST AND CLINICAL OUTCOMES OF RISPERIDONE VERSUS OLANZAPINE IN SCHIZOPHRENIA

Janssen Pharmaceutica and Research Foundation

Dennis Meletiche, Pharm.D., *Manager, Outcomes Research, Janssen Pharmaceutica and Research Foundation, 1125 Trenton Harbourton Road, Titusville, NJ 08560*; Marcia Rupnow, Ph.D.; Montserrat Vera-Llonch, M.D.; Thomas Delea, M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, recognize that patient compliance with therapy can be enhanced and total monthly costs of care reduced when risperidone, rather than olanzapine, is used in the treatment of chronic schizophrenia or schizoaffective disorder.

SUMMARY:

Objective: To estimate clinical outcomes and associated costs of care of treatment with risperidone versus olanzapine in patients with chronic schizophrenia or schizoaffective disorder up to one year following therapy initiation.

Methods: A Markov model was developed to estimate the number of patients who experience side effects (i.e., EPS, prolactin-related disorders, weight gain, and diabetes) of antipsychotic therapies, relapse of psychiatric symptoms, as well as therapy discontinuation following these events at one year. Associated costs of care were also calculated. Model estimates were based on findings from a randomized, controlled, clinical trial of risperidone and olanzapine and other published and unpublished sources.

Results: The expected number of patients remaining on initial therapy at one year was higher for risperidone (76% versus 45% for olanzapine); the expected number of months on therapy was lower for olanzapine (8.0 versus 10.5 for risperidone). Therapy discontinuation was primarily driven by patients experiencing changes in body weight exceeding 5 kg since therapy initiation. Expected mean total costs of care per month on therapy were 8% higher for olanzapine ($2,198 versus $2,033 for risperidone).

Conclusions: Therapy discontinuation at one year was lower for risperidone than for olanzapine. Expected monthly costs of care were also lower for risperidone than olanzapine.

REFERENCES:

1. Knapp M: Schizophrenia costs and treatment cost-effectiveness. Acta Psychiatr Scand Suppl 2000;102(407)15–18

2. Foster RH, Goa KL: Risperidone: a pharmacoeconomic review of its use in schizophrenia. Pharmacoeconomics 1998;14:97–133.

TARGET AUDIENCE:

Psychiatrists.

Poster 61 **Thursday, October 10 4:00 p.m.-5:30 p.m.**

THE PENNSYLVANIA STATE HOSPITAL SECLUSION AND RESTRAINT REDUCTION PROGRAM

Steven J. Karp, D.O., *Medical Director, Deputy Secretary's Office for Mental Health and Substance Abuse Services, Pennsylvania Department of Public Welfare, P.O. Box 2675, Room 502, Harrisburg, PA 17105-2675*; Robert H. Davis, Jr., M.D., *Associate Medical Director, Deputy Secretary's Office for Mental Health and Substance Abuse Services, Pennsylvania Department of Public Welfare, Beechmont Building, First Floor, Harrisburg, PA 17110*; Charles Curie, M.S.W.; Gregory M. Smith, M.S.W.

EDUCATIONAL OBJECTIVES:

1. Seclusion and restraint present significant risk to patient and staff no longer representing a best practice.
2. Seclusion and restraint usage can be dramatically reduced resulting in positive outcomes for patients and staff.
3. Seclusion and restraint reduction leads to less patient injuries, less staff injuries, and less use of PRN medications.

SUMMARY:

The Commonwealth of Pennsylvania's Office of Mental Health and Substance Abuse Services (OMHSAS) identified seclusion and restraint as practices that are associated with significant risk to the patient and to the staff in the State hospitals. No longer considered acceptable or compatible with best practice, alternatives to the use of these restrictive interventions were encouraged. Strict guidelines for the use of seclusion and restraint were developed to assure patient safety and to assure that neither would be used unless all reasonable alternatives had been exhausted. Additionally, the guidelines required the attending physician to perform an on-site assessment of the patient concurrent with the use of these restrictive measures in order to assure that the patient was not being physically compromised and to assure that alternative measures were being continuously pursued. Prior to the issuance of the guidelines, the incidence and duration of episodes of seclusion and restraint were used as benchmark measures of performance among the State hospitals. This identification of seclusion and restraint as high-risk interventions and the encouraged use of alternatives caused a decline in the incident and duration of seclusion and restraint from the initiation of the process in 1997. With adoption of the guidelines in January of 1999, the rate of decline accelerated.

Since 1997, combined incidents of seclusion and restraint have been reduced by 74%, while hours of use have decreased by 96%. Disabling staff injuries have decreased as much as 67% in the hospital using the least seclusion and restraint, with an overall decrease of 0.12/1000 patient-days to 0.10/1000 patient-days since 1997. Patient assault-related injuries have not increased, remaining at about 1.5/1000 patient days. There has been no compensatory increase in the use of "as needed" medication. Heightened staff awareness, training in crisis intervention techniques, identification of risk factors, increased use of atypical antipsychotic medication, and programming tailored to the identified patient needs are all factors that have contributed to this endeavor.

REFERENCES:

1. Meehan T, Vermeer C, Windsor C: Patient's Perception of seclusion: a qualitative investigation. J Adv Nurs 31(2):370–7, 2000.
2. Goetz R, et al.: Reducing the Use of Seclusion and Restraint: Part II, National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council. Alexandria, VA, 2001.

POSTER SESSION 2

Posters 62–121

Poster 62 **Friday, October 12 10:30 a.m.-12 noon**

DELIRIUM IN ELDERLY PATIENTS UNDERGOING CARDIAC SURGERY: A PROPOSAL FOR A CLINICAL SUSPICION INDEX

Bogdan P. Sasaran, M.D., *Assistant Professor of Psychiatry, State University of New York, Stony Brook University Hospital, and Assistant Professor of Psychiatry, Mt. Sinai Medical School, Elmhurst Hospital Center, SUNY T-10, Suite 020, Stony Brook, NY 11794-1101*; Shereen A. Morse, M.D., *Resident, Department of Psychiatry, State University of New York, Stony Brook University Hospital, SUNY T-10, Suite 020, Stony Brook, NY 11794-1101*; Luminita E. Sasaran, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have knowledge of principal preoperative risk factors that can delineate those at highest risk to develop delirium after sugery.

SUMMARY:

Introduction: Delirium has been reported to occur in up to 70% of the elderly undergoing cardiac surgery, being associated with increased mortality. Although old age is the principal risk factor predictive of cognitive impairment, a newly developed clinical suspicion index based on other preoperative risk factors may help in delineating the higher-risk patient.

Method: A systematic literature review identified the preoperative risk factors used in our index. The index was then applied in a case-control study of persons (N=17; 70 years and older), who underwent open-heart surgery.

Results: 35.3% (n=6) of the patients developed delirium within four weeks postoperatively, of which 50% (three patients) died during the hospitalization. 64.7% (n=11) had more than one risk factor of which 45.4% (n=5) were delirious, versus 35.3% (n=6) who had only one risk factor and one case of delirium. Duration of hypertension, evidence of cerebrovascular disease, cardiac disease with left ventricular dysfunction, and systolic hypotension were the identified preoperative major criteria in our index.

Conclusion: Having more than one preoperative risk factor greatly increases the risk of developing delirium (OR=4.1) when assessed with the proposed suspicion index which can be applied as a preoperative screening tool in this special population.

REFERENCES:

1. Murkin JM, Newman SP, Stump DA, et al: Statement of consensus on assessment of neurobehavioral outcomes after cardiac surgery. Ann Thorac Surg 1995; 59:1289–95.
2. Selnes OA, Goldsborough MA, Borowicz LM, et al: Determinants of cognitive change after coronary artery bypass surgery a multifactorial problem. Ann Thorac Surg 1999; 67:1669-76.

TARGET AUDIENCE:

Consultation-liaison, geriatric, and general psychiatrists, nurse practitioners.

Poster 63 **Friday, October 11 10:30 a.m.-12 noon**

INCREASING RETURN RATE BY A POST-INTAKE DEBRIEFING OF PATIENT EXPECTATIONS

Katherine A. Kaiser, M.S., *Department of Psychiatry, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, D-3 East, Baltimore, MD 21224*; Gerard Gallucci, M.D., J.D., *Medical Director of Community Psychiatry, Johns Hopkins Bayview Medical Center, and Southeastern Consulting, Inc., 4940 Eastern Avenue, D-2 East, Baltimore, MD 21224*; Karen L. Kaufman, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the value of increased patient participation in the treatment process. The participant should be able to engage the patient in a dialogue about the patient's expectations and assist the patient in reframing these expectations toward informed treatment choices.

SUMMARY:

Objective: This study was conducted to learn if a "debriefing" session about patient expectations would increase the rate of return for treatment. A brief post-intake session, specifically addressing a patient's expectations of treatment, was added at the conclusion of the usual intake format and compared with a control condition of the usual intake format.

Method: All patients were adults who had called for an intake at Johns Hopkins Bayview's Outpatient Community Psychiatry Program in Baltimore City. Patients were randomly assigned to the usual intake format condition (N = 30) or to the expectations "debriefing" condition (N = 30). The "debriefing" intervention consisted of three questions immediately following intake designed to engage the patient in a dialogue about expectations of treatment. The outcome variables reviewed were, patients who expressed a desire to return but "dropped out" and patients who returned for at least one appointment.

Results: Of the patients, 83% who received the "debriefing" session returned for at least one appointment, compared with 57% who received only the usual intake format.

Conclusions: Community outpatient clinics can increase the rate of return and moreover increase patient participation in treatment by engaging in a dialogue about the patient's expectations *after* the intake.

REFERENCES:

1. Hardin SI, Subich LM, Holvey JM: Expectancies for counseling in relation to premature termination. Journal of Counseling Psychology 1988;35(1):37–40.
2. Lowe RH: Responding to "No-Shows": some effects of follow-up method on community mental health center attendance patterns. Journal of Counseling and Clinical Psychology 1982;50(4):602–603.

Poster 64 **Friday, October 11 10:30 a.m.-12 noon**

PREVALENCE OF HEPATITIS B AND HEPATITIS C AMONG HEROIN ADDICTS

Chandresh Shah, M.D., *Assistant Chief of Psychiatry, Los Angeles VA Outpatient Clinic, and Clinical Associate Professor of Psychiatry, University of Southern California, 351 East Temple Street, Los Angeles, CA 90012*; Kathryn Lacon, R.N., M.N., *Los Angeles VA Outpatient Clinic, 351 East Temple Street, Los Angeles, CA 90012*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the high prevalence of hepatitis among heroin addicts.

SUMMARY:

Infection with hepatitis C virus (HCV) has often been called the "silent epidemic." Hepatitis C is one of the leading causes of chronic liver disease, fibrosis, cirrhosis, and hepatocellular carcinoma. Approximately 1.8% of Americans are seropositive for HCV. The 1999 "VA HCV Screening" revealed that 8% to 10% of veterans receiving medical care at the VA are seropositive. Injection drug use is highly associated with HCV infection. We wanted to study the prevalence of HCV infection among heroin addicts in a methadone maintenance treatment program (MMTP). Patients were enrolled into the program for a minimum of 90 days and were recommended for laboratory tests. Out of 153 patients, 136 had completed testing. There were 134 male patients who were 55.07 (SD=10.05) years old, and two female patients who were 47.26 (SD=18.61) years old. The male patients received 46 (SD=2.83) mg/day of methadone, and the female patients received 34 (SD=5.66) mg/day of methadone. 95.59% of these patients were seropositive for HCV. Similarly testing for hepatitis B virus (HBV) showed that only 14.71% of the patients were seronegative; the rest were in various stages of infection, from acute hepatitis to being a carrier of HBV. This high prevalence of this hidden viral infection poses a challenge to the MMTP. The gravity of sequelae of this viral infection demands that all heroin addicts receive prompt screening, adequate counseling, and appropriate consultation. This is important because MMTP is the only point of contact for medical care for most of the heroin addicts.

REFERENCES:

1. McCarthy JJ, Flynn N: Hepatitis C in methadone maintenance patients: prevalence and public policy implications. J Addict Dis 2001; 20(1):19–31.
2. Carter H, Robinson G, et al: Prevalence of hepatitis B and C in a methadone clinic population: implications for hepatitis B vaccination. N Z Med J 2001;114(1136):324–326.

TARGET AUDIENCE:

Addiction psychiatrists, nurses, primary care providers.

Poster 65 **Friday, October 11 10:30 a.m.-12 noon**

CHANGING TRENDS IN FORENSIC PSYCHIATRIC CARE IN CANADA

Michael D. Teehan, M.D., *Associate Professor, Department of Psychiatry, Dalhousie University, Queen Elizabeth II Health Sciences Centre, Halifax, NS, Canada B3H-2E2*; Scott Theriault, M.D., *Associate Professor, Department of Psychiatry, Dalhousie University, East Coast Forensic Hospital, 88 Gloria McCluskey, Halifax, NS, Canada B3B-2B8*

EDUCATIONAL OBJECTIVES:

To alert clinicians, administrators, and government policy makers to a trend of increasing diversion of patients with mental illness into either prison or forensic psychiatric systems. Putative reasons for these trends are explored.

SUMMARY:

Data from the provincial forensic psychiatric services over the past 10 years in Nova Scotia, Canada, show a clear and alarming increase in the number of patients entering the forensic psychiatric system. In this province of 908,000 people, the number of patients under the jurisdiction of the Criminal Code Review Board, NCR, (not criminally responsible by reason of mental disorder) has increased from 37 in 1992 to 98 in 2002. This trend is mirrored in Ontario, and is reported also in the U.K. Reports from the Canadian prison system report much higher rates of mental illness among inmates, than in the general population. Data from the U.S. correctional systems are also supportive of a concentration of severely mentally ill people in prison populations.

Because of these trends, there has been significant resource allocation to forensic services, in terms of beds, staffing levels, and the development and implementation of community-based treatments. The trends have also brought about significant changes in the functioning of the Criminal Code Review Board, which is charged with supervision of patients found not criminally responsible by reason of mental disorder.

A number of hypotheses are explored that may account for this trend. These include recent legislative changes in Canada, difficulties with access to general psychiatry systems, deinstitutionalization, and the diversion of resources to forensic services. Implications of

this trend for patients and their families, psychiatric systems of care, and society are discussed.

The target audience is government policy makers, administrators of psychiatric services, advocacy groups forensic psychiatric service administrators.

REFERENCES:

1. Arboleda-Florez et al: The effects of changes in the law concerning mentally disordered offenders: The Alberta Experience with Bill C-30. Can J Psychiatry; 1995; 40: 225–233.
2. Gray JE, et al: Mental Health Law in Canada. Canadian Mental Health Law and Policy 2000; (11): 328–339.

Poster 66 **Friday, October 11 10:30 a.m.-12 noon**

PREVALENCE OF DIAGNOSED CORONARY HEART DISEASES IN PERSONS WITH BIPOLAR OR SCHIZOPHRENIC DISORDERS

Eli Lilly and Company

Christine Eickhoff, M.S., *Research Associate, Department of Outcomes Research, Eli Lilly and Company, One Lilly Corporate Center, DC-4025, Indianapolis, IN 46285*; Haya Ascher-Svanum, Ph.D., *Research Scientist, Outcomes Research, Eli Lilly and Company, One Lilly Corporate Center, DC-4025, Indianapolis, IN 46285*; Patrick McCollam, Pharm.D.; John S. Kennedy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the audience will be able to identify the proportion of patients with a bipolar or schizophrenic disorder who are diagnosed with coronary heart diseases for which the prescription of QTc-prolonging drugs may be contraindicated.

SUMMARY:

Background: Some medications are linked to drug-induced cardiac arrhythmias or prolongation of the QTc interval, and are contraindicated for individuals with various coronary heart diseases (''contraindicated-CHD''). This retrospective database analysis evaluated the prevalence of contraindicated-CHD among individuals with a bipolar or schizophrenic disorder.

Methods: An administrative claims database from a large managed care organization was used to identify 4,870 individuals with a bipolar (N=3,153) or schizophrenic disorder (N=1,717) in 1999, and to determine the prevalence of diagnosed contraindicated-CHD. CHD conditions included acute/chronic myocardial infarction, acute ischemic heart disease, conduction disorders, cardiac arrhythmias, heart failure, angina pectoris, and other chronic ischemic heart diseases.

Results: Contraindicated-CHD conditions were diagnosed in 13.3% of patients (12.8% of patients with a bipolar disorder, 14.1% of patients with a schizophrenic disorder). The most common conditions were cardiac arrhythmias (5.5%) and heart failure (4.2%). The prevalence of contraindicated-CHD was significantly higher among older (age>65) and male patients.

Conclusions: About one in ten individuals in this sample was diagnosed with contraindicated-CHD. Special attention should be given prior to prescribing QTc-prolonging medications that are contraindicated for patients with these conditions.

REFERENCES:

1. Glassman AH, Bigger JT: Antipsychotic drugs: prolonged QTc interval, torsade de pointes, and sudden death. Am J Psychiatry 2001; 158: 1774–1782.
2. Buckley NA, Sanders P: Cardiovascular adverse effects of antipsychotic drugs. Drug Safety 2000; 23(3): 215–228.

TARGET AUDIENCE:

Prescribing physicians.

Poster 67 **Friday, October 11 10:30 a.m.-12 noon**

SWITCHING MIDDLETOWN STATE HOSPITAL FROM BRAND NAME TO GENERIC CLOZAPINE

Parukutty M. Krishnan, M.D., *Clinical Director, Department of Psychiatry, Middletown Psychiatric Center, 122 Dorothea Dix Drive, Middletown, NY 10940-6198*; William Fiero, R.Ph; Stephen M. Goldfinger, M.D.

EDUCATIONAL OBJECTIVES:

The learner will be able to describe the interchangeability of brand and generic clozapine and recognize potential economic factor in moves to generic drugs.

SUMMARY:

In 1997, generic clozapine was first introduced and was approved by the Food and Drug Administration (FDA) as pharmaceutically and therapeutically equivalent to the branded product, meeting specifications for identity, strength, quality, purity, and potency. As of April 2002, nationally, generic substitution rates for clozapine had exceeded 50%. In January 2001, there were 43 patients at Middletown State Hospital taking Clozaril brand clozapine. The Drug Monitoring/Therapeutics Committee became interested in the potential cost savings and potential clinical implications that would result

if patients were switched from brand to generic CZP. All Clozaril patients were switched to generic clozapine during February 2000. Physicians and unit staff worked with the pharmacy in writing orders and carefully observing clients' behavioral changes and tolerability of the product. Clozapine blood levels and BPRS scores were obtained on all patients before the switch. By February 28, 2000, all 43 clients were taking generic clozapine. Two patients showed some signs of irritability, which resolved by increasing bclozapine by 50 mg. No cases of decompensation were observed. The switch has been generally accepted by patients and clinicians.

The differences in the mean BPRS scores, dosages, and blood levels of the pre- and post-generic data were not significantly different. After conversion to generic clozapine, for the period February 2000-February 2001, our cost had decreased to $145,747, resulting in a savings of $67,805 or 31.8%.

Substitution of generic medications for branded products may be one of the only areas where significant savings can be achieved with minimal risk to the patient.

REFERENCES:

1. Sajbel TA, Carter GW, Wiley RB: Converting patients from brand-name clozapine to generic clozapine, The Annals of Pharmacotherapy 2001;(35).
2. Goldfinger SM, Silver MA, Henderson D, Bolton S, Sheth N, Mittleberg E, Hepner A, Karukin M: Interchangeability of brand and generic clozapine. Poster session APA 2001; May 13-18, 2001; Philadelphia, PA Abstract NR698 and at NIMH 41st Annual New Clinical Drug Evaluation Unit Meeting May 28-31, 2001, Phoenix, Arizona.

TARGET AUDIENCE:

Dept. of Psychiatry.

Poster 68 **Friday, October 11**
10:30 a.m.-12 noon

TREATMENT RESPONSE OF OPIUM SMOKING AMONG REFUGEES TO METHADONE MAINTENANCE

Muhammad W. Azeem, M.D., *Psychiatry Fellow, Harvard Medical School, Children's Hospital of Boston, 1320 North Union Avenue, Fergus Falls, MN 56537*; Gregory A. Carlson, B.A., *Director, Hennepin Faculty Associates, Addiction Medicine Program, Hennepin County Medical Center, 914 South 8th Street, Suite D-131, Minneapolis, MN 55404*; Chomehanh Soudaly, L.P.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and understand the trends of opium use, psychiatric comorbidity, and methadone maintenance effectiveness among opium-dependent Hmong refugees.

SUMMARY:

Objective: To examine the outcome of methadone maintenance in opium-dependent Hmong refugees.

Methods: Medical records were searched for Hmong patients in methadone treatment between January 1995 and September 1997. Patients progress was assessed over nine months.

Results: 44 Hmong patients were found. Data were available on 40 patients, mean age 47.7 years, 33 males/7 females, 93% married, 27% employed, mean opium pipes smoked/day 105. At admission, 100% met the DSM-IV criteria for opium dependence, 75% for major depressive disorder, and 68% for PTSD. Average urine samples were 27/patient over nine months with only 4/27 positive for opiates, mostly in the first three months of treatment. The Addiction Severity Index composite score improved from 3.9 at admission to 2.1 at nine months ($p < .01$) with subscales of employment/support status changing from 4.4 to 1.5 ($p < .01$), drug use from 8.9 to 4.6 ($p < .01$), family/social relationships from 4.5 to 1.7 ($p < .01$), and psychiatric status from 6.2 to 4.5 ($p < .01$). Using outcome criteria modified from Drug Abuse Research Project, 70% were highly successful.

Conclusions: These findings suggest that opium-dependent Hmong patients can show marked improvement while in a methadone maintenance program. Prospective controlled studies are warranted.

REFERENCES:

1. Westermeyer J, Lyfong T, Westermeyer M, Neider J: Opium addiction among Indochinese refugees in the United States: characteristics of addicts and their opium use. Am J of Drug & Alcohol Abuse 1991; 17:267–277.
2. Farre M, Mas A, Torrens M, Moreno V, Cami J: Retention rate and illicit opioid use during methadone maitenance interventions: a meta-analysis. Drug and Alcohol Dependence 2002; 65:283–290.

TARGET AUDIENCE:

Psychiatrists, psychologists, social workers, nurses.

Poster 69 **Friday, October 11**
10:30 a.m.-12 noon

STIMULANT EFFECTIVENESS IN WELL CONTROLLED VERSUS POORLY CONTROLLED PEDIATRIC EPILEPSY

Muhammad W. Azeem, M.D., *Psychiatry Fellow, Harvard Medical School, Children's Hospital of Boston,*

1320 North Union Avenue, Fergus Falls, MN 56537; Joseph M. González-Heydrich, M.D., *Assistant Professor of Psychiatry, Harvard Medical School, Children's Hospital of Boston, 300 Longwood Avenue, Fegan 8, Boston, MA 02115*; David R. Damaso, M.D.; Blaise Bourgeois, M.D.; Joseph Biederman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the effectiveness and tolerability of stimulants in children and adolescents with epilepsy and recognize the comorbid psychiatric diagnosis in this population.

SUMMARY:

Objective: Compare effectiveness and tolerability of methylphenidate and amphetamine between pediatric epilepsy patients who had been seizure free (SzFree) for six months and those who were not (NotSzFree).

Methods: Medical records were examined for baseline and treatment visits of patients <18 years with epilepsy receiving methylphenidate or amphetamine between 11/98–10/01.

Results: A total of 21 patients (mean age 10.6 ± 4.2years, 67% male) were identified. SzFree and NotSzFree were 48% and 43%, respectively, with 9% unknown. Methylphenidate (average dose 0.6 ± 0.3mg/kg/day) was used in 10 patients, amphetamine (average dose 0.4 ± 0.3mg/kg/day) in 15, and both in four. Diagnoses include attention-deficit/hyperactivity disorder (SzFree 100% versus NotSzFree 67%, p=0.05) and intermittent explosive disorder (SzFree 10% versus NotSzFree 89%, p<0.05). Responder rates to either stimulant were SzFree 60% and NotSzFree 33% (p=ns). Discontinuation rates due to adverse events were 20% for SzFree and 67% for NotSzFree (p<0.05). Seizure frequency increased for two NotSzFree patients and no SzFree patients. 70% of discontinuations were due to agitation.

Conclusions: Patients with well-controlled epilepsy had lower rates of stimulant discontinuation due to adverse effects and trend towards higher response to stimulants than patients with poorly controlled epilepsy. These findings could be due to difference in diagnosis rates among SzFree and NotSzFree group. Controlled studies are warranted.

REFERENCES:

1. Feldman H, Crumrine P, Handen BL, Alvin R, Teodori J: Methylphenidate in children with seizures and attention-deficit disorder. American Journal of Diseases of Children 1989; 143:1081–1086.
2. Gross-Tsur V, Manor O, Van der Meere J, Joseph A, Shalev RS: Epilepsy and attention deficit hyperactivity disorder: is methylphenidate safe and effective? Journal of Pediatrics 1997; 130:40–44.

TARGET AUDIENCE:

Psychiatrists, residents, child psychiatrists, neurologists.

Poster 70 **Friday, October 11**
10:30 a.m.-12 noon

SMOKING IN PSYCHIATRIC UNITS

Sadiq H. Al-Samarrai, M.D., *Chief Resident, Department of Psychiatry, Cooper Hospital, 401 Haddon Avenue, E&R Building 356, Camden, NJ 08103*; Thomas S. Newmark, M.D., *Chief, Department of Psychiatry, Cooper Hospital, 401 Haddon Avenue, E&R Building, #356, Camden, NJ 08103*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will have useful skills to help the mentally ill patient quit smoking and how education will help to achieve this goal.

SUMMARY:

Smoking is a major contributing factor to health problems in mentally ill patients because they smoke more than the general population. It leads to increased metabolism of psychotropic medications that cause higher cost management. We studied 31 voluntary and involuntary psychiatric units through telephone contact. The nurses on the units were asked to elaborate on the following questions: (1) Are they a smoking or nonsmoking facility? (2) For smoking units, we asked about how many times a day are the patients allowed to smoke? (3) Is there a designated area for the patients to smoke? (4) For nonsmoking units, we asked how was the nonsmoking policy enforced and what difficulties they faced managing it? The study showed that 84% of the units allowed their patients to smoke cigarettes outside the unit with an average of 5.16 times a day. Sixteen percent of the units had a successful nonsmoking policy. These units had smoking privileges in the past but as they gained practical skills for handling the patients with nicotine dependence they changed to the nonsmoking policy. The objective of this poster is to study smoking policies in psychiatric units and to learn if smoke-free psychiatric units are feasible.

REFERENCES:

1. Glynn SH, Sussman S: Why patients smoke. Hospital and Community Psychiatry 1990; 41:1027.
2. Lyon E: A review of the effects of nicotine on schizophrenia and antipsychotic medications. Psychiatric Services 1999; 50(10):1346–1350.

TARGET AUDIENCE:

Psychiatrists, residents, students, nurses, therapists and social workers.

Poster 71 **Friday, October 11 10:30 a.m.-12 noon**

AN OPEN-LABEL COMMUNITY-ASSESSMENT TRIAL OF ADDERALL XR IN PEDIATRIC ADHD

Shire US Inc.

Paul J. Ambrosini, M.D., *Department of Psychiatry, MCP Hahnemann, 3200 Henry Avenue, Philadelphia, PA 19129*; David Mays, Pharm.D., *Director, Medical Information, Shire Pharmaceutical, 1901 Research Boulevard, Suite 500, Rockville, MD 20850*; Frank A. Lopez, M.D.; M. Alex Michaels, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the acute tolerability and effectiveness of Adderali XR in the treatment of ADHD in the community practice setting.

SUMMARY:

Objective: This study has been conducted to evaluate the tolerability and effectiveness of Adderall XR in the treatment of pediatric ADHD in the community practice setting.

Method: A prospective, open-label, seven-week study conducted at 378 sites. A total of 2,968 children (mean age 9.5 years) with a DSM-IV diagnosis of ADHD and currently taking stable doses of immediate-release Adderall® or any methylphenidate formulation were enrolled. Efficacy was assessed by the Conners' Global Index Scale-Parent version (CGIS-P) eight- and 12-hours after a single AM dose and by the Clinical Global impression Scale (CGI).

Results: There was a statistically significant improvement from baseline in the mean CGIS-P scores at week 7 (12-hour baseline = 11.7, week 7 = 7.4; mean change = −4.3 [N=2529, STD=8.1], $p<0.0001$). CGI improvement scores revealed 60.1% of subjects were much improved or very much improved. The most frequently reported drug-related or possibly related AEs for Adderall XR were insomnia (5.7% of subjects reporting), anorexia (4.6%), and headache (4.3%).

Conclusion: Children with ADHD, well controlled on stimulant therapy, showed significant improvement in symptoms after switching to treatment with Adderall XR. The medication was well tolerated. Adderall XR appears to be a safe and efficacious once-daily treatment for pediatric ADHD.

Supported by Shire Pharmaceutical Development Inc.

REFERENCES:

1. McCracken J, Biederman J, Greenhill L, et al: Analog classroom assessment of SLI381 for the treatment of ADHD. Poster presentation at the 47th Annual Meeting of the American Academy of Child and Adolescent Psychiatry, New York, NY: October 26, 2000.
2. Biederman J, Lopez F, Boellner S, et al: A randomized, double-blind, placebo-controlled, parallel-group study of SLI381 in children with attention deficit hyperactivity disorder. Pediatrics 2002; in press.

TARGET AUDIENCE:

Clinicians treating pediatric ADHD.

Poster 72 **Friday, October 11 10:30 a.m.-12 noon**

NEUROLEPTIC DISCONTINUATION IN DUAL DIAGNOSIS PATIENTS

AstraZeneca Pharmaceuticals

E. Sherwood Brown, M.D., Ph.D., *Assistant Professor, Department of Psychiatry, University of Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, MC 8849, Dallas, TX 75390-9070*; Vicki A. Nejtfk, Ph.D.; Dana C. Perantie, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should realize that discontinuation of neuroleptics and addition of quetiapine may be associated with improvement in psychiatric symptoms and reduction in stimulant cravings in patients with psychiatric illness.

SUMMARY:

Objective: To examine the effect of neuroleptic discontinuation or substitution of an atypical antipsychotic on psychiatric symptoms and stimulant use in patients with mental illness.

Methods: Patients with cocaine/amphetamine abuse receiving chronic neuroleptic therapy were randomized to continue or discontinue neuroleptic. Patients in discontinuation group were tapered off neuroleptic and given the atypical antipsychotic quetiapine. A total of 29 patients were enrolled, including 15 with bipolar disorder, four with schizophrenia, seven with schizoaffective disorder, and three with major depressive disorder and cocaine/amphetamine-related disorders receiving neuroleptics (mean 331mg/d chlorpromazine equivalents).

Results: Patients included 19 men/10 women (mean age=37±8 years). Twenty-four patients returned for at least one follow-up and were used in the analysis. In

discontinuation group, eight patients were given quetiapine (394mg/d mean exit dose) for psychotic symptoms, while four non-psychotic patients received no antipsychotic. Significant decreases ($P<0.05$) in discontinuation group (n=12) compared with continuation group (n=12) were seen in the Cocaine Craving Questionnaire (CCQ). In discontinuation subgroup receiving quetiapine (n=8), significant reductions ($P<0.05$) compared with continuation group were observed in CCQ, BPRS, and HRSD.

Conclusions: This pilot study suggests discontinuation of neuroleptics and addition of quetiapine is associated with improvement in psychiatric symptoms and reduction in stimulant cravings. Larger controlled trials are needed.

REFERENCES:

1. Brown ES, et al.: Drug abuse and bipolar disorder: comorbidity or misdiagnosis. J Affect Disord 2001; 65:105–115.
2. Tiffany ST, et al.: The development of a cocaine craving questionnaire. Drug Alcohol Depend 1993; 34:19–28.

TARGET AUDIENCE:

Psychiatrists.

Poster 73 **Friday, October 11 10:30 a.m.-12 noon**

MEDICAL COMORBIDITIES AND PSYCHIATRIC EMERGENCY ADMISSIONS OF OLDER ADULTS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the prevalence of medical comorbidities in older adults receiving emergency admission for a psychiatric disorder.

SUMMARY:

Objectives: Medical comorbidities are important considerations in the evaluation and treatment of psychiatric disorders in older adults. However, previous research has largely been restricted to outpatient samples and has not examined medical comorbidities in older adults treated in emergency settings. This investigation assessed the prevalence of medical comorbidities associated with psychiatric emergency admissions of older adults.

Method: Analysis of Medicare claims data for the primary diagnosis of a psychiatric disorder and associated medical comorbidities among adults aged 65 years and older who received emergency hospitalization in 2000.

Results: 110,043 psychiatric emergency admissions were reported among older adults in the U.S. in 2000, with an average of 2.4 medical comorbidities (N= 264,845) reported per admission. Dementia, mood disorders, and schizophrenia and other psychotic disorders were significantly more prevalent emergency admission diagnoses of older adults (44.4%, 24.4%, 21.0%, respectively) than were substance-related, anxiety, and medication-induced disorders (7.7%, 2.0%, 0.4%, respectively). Circulatory, endocrine, and metabolic disorders were the most prevalent medical comorbidities across all admitting psychiatric diagnoses (35.7%, 11.0%, 10.8%, respectively). The prevalence of endocrine, musculoskeletal, and overdose-related comorbidities was increased among patients admitted with mood disorders and an elevated rate of circulatory comorbidities was reported among patients with anxiety disorders.

Conclusions: These results indicate that medical comorbidities occur frequently among older adults receiving emergency hospitalization, with their prevalence varying between different psychiatric diagnoses.

REFERENCES:

1. Currier GW, Allen MH: Emergency psychiatry: physical and chemical restraint in the psychiatric emergency service. Psychiatric Serv 2000;51:717–719.
2. Tueth JM, Zuberi: Life-threatening psychiatric emergencies in the elderly: overview. J Geriatr Psychiatry Neurol 1999;12:60–66.

TARGET AUDIENCE:

Psychiatrists, nonpsychiatric physicians, nurses, psychologists.

Poster 74 **Friday, October 11 10:30 a.m.-12 noon**

PSYCHIATRIC MORBIDITY AFTER A BIG FLOOD IN A KOREAN RURAL AREA

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Korea 110-744; Joon-Young Lee, *Clinical Instructor, Department of Psychiatry, Seoul National University College of Medicine, 28 Yongun-Dong, Chongno-Gu, Seoul, South Korea 110-744*; Jang K. Kim, M.D.

SUMMARY:

Objectives: Firstly, to investigate the incidence, prevalence, and factors associated with the severity of the posttraumatic stress disorder after a flood, and secondly, to observe the clinical features and natural course of the disorder after a flood.

Methods: One and a half months after a big flood in a rural area, Yonchon county, we applied structured questionnaires and clinical interviews on 140 subjects who visited the emergency mobile mental health service complaining of emotional distress, which developed after experiencing the flood. Each structured questionnaire was composed of the Impact of Event Scale(IES), Beck Depression Index(BDI), Spielbergs, and State-Trait Anxiety Index(STAI). Psychiatrists conducted clinical interview using Post-traumatic Stress Disorder Interview(PTSD-I). Two and a half years after the flood, we applied the same structured questionnaire to these victims, and the completion rate was 64.7%.

Results: (1) 140 residents who were 1.63% of all flood victims visited the emergency mobile psychiatric service complaining of emotional distress, which developed after experiencing the flood. The rate of visit varied widely from 0.17% to 21.73%. (2) Of the 140 residents, 66 (46.4%) victims were given the diagnosis of posttraumatic stress disorder(PTSD). Of the 90 residents who were followed up 2.5 years after the flood, 28(31.1%) were still above the threshold of high clinical concern based on the IES. (3) Status of coping at the point of the first interview was the risk factor for developing PTSD, and old age and low educational level were the risk factors for developing delayed-onset PTSD. (4) Symptom group of increased arousal marked higher score than the symptom groups of re-experiencing, avoidance, and numbness. (5) While intrusive symptoms were more prominent than the avoidance symptoms at the first interview, avoidance symptoms were more prominent at the second interview, 2.5 years later. (6) Depressive and anxiety symptoms were highly prevalent, and they persisted more than 2.5 years.

Conclusion: After a flood, a considerable proportion of victims suffered from PTSD: emotional distress and socio-occupational dysfunction were more prevalent than expected. These findings suggest that we should develop plans for continuing mental health service after natural disasters.

REFERENCES:

1. Cardena E, Spiegel D: Dissociative reactions to the San Francisco Bay Area earthquake of 1989. AJP 1993;150(3):474–478.
2. Madakasira S, OBrien KF: Acute posttraumatic disorder in victims of a natural disaster. J Nervous Ment Dis 1987;175(5):286 290.

Poster 75 **Friday, October 11**
10:30 a.m.-12 noon

INCREASING RATES OF HOMICIDE-SUICIDE IN OLDER PERSONS

Retirement Research Foundation

Donna Cohen, Ph.D., *Professor, Department of Aging and Mental Health, University of South Florida, 13301 Bruce B. Downs Boulevard, Tampa, FL 33612*; Carl Eisdorfer, M.D., Ph.D., *Professor and Chair, Department of Psychiatry, University of Miami, 1695 N.W. 9th Avenue, Suite 3100, Miami, FL 33101*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the implications of increasing homicide-suicide rates for evaluating risk in younger and older individuals as well as developing approaches to prevention.

SUMMARY:

Objective: The purpose of this study was to determine the annual incidence of homicide-suicide (HS) from 1997–2001 in Florida and to compare rates by age.

Methods: All new cases of HS were ascertained from the files of all 24 Florida medical examiner districts for each of five years from 1997–2001. Annual HS rates were calculated, age-adjusted by year, for total HS cases per 100,000 total population, per 100,000 persons 55 years and older, and per 100,000 persons 54 years and younger.

Results: A total of 292 HSs were identified in Florida over the five-year period, with 40% in the older population. Eighty-five percent of older HSs were spousal/consortial compared with 50% in the younger group. The annual incidence rates from 1997 through 2001 for the total population in Florida were 0.40, 0.36, 0.36, 0.40, and 0.60 per 100,000. The annual incidence rates for the population 55 years and older were 0.48, 0.43, 0.43, 0.50, and 1.07 per 100,000, consistently higher than the annual incidence rates for the population 54 years and younger: 0.36, 0.32, 0.32, 0.36, and 0.42, and substantially higher than previous reports in literature.

Conclusion: This is the first statewide study of HS rate trends. The results replicate our 1998 AJP paper showing higher annual incidence rates in the older age group as well as the prominent role of men as perpetrators. The increasing HS rate in the older age group emphasizes the importance of better detection and preventive intervention.

REFERENCES:

1. Cohen D, Llorente M, Eisdorfer C: Homicide-suicide in older persons. Am J Psychiatry 1998; 155: 390–396.
2. Marzuk PM, Tardiff K, Hirsch CS: The epidemiology of murder-suicide. JAMA 1992; 267: 3179–3183.

TARGET AUDIENCE:

Researchers, practitioners, law enforcement, and administrators.

Poster 76 **Friday, October 11 10:30 a.m.-12 noon**

MURDER-SUICIDE INVOLVING CHILDREN 16 YEARS OLD AND YOUNGER: A FIVE-YEAR STUDY

Donna Cohen, Ph.D., *Professor, Department of Aging and Mental Health, University of South Florida, 13301 Bruce B. Downs Boulevard, Tampa, FL 33612*; Carl Eisdorfer, M.D., Ph.D., *Professor and Chair, Department of Psychiatry, University of Miami, 1695 N.W. 9th Avenue, Suite 3100, Miami, FL 33101*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the antecedent factors for children 16 years and younger who are at risk for being killed by parents in a homicide-suicide and apply the knowledge towards intervention and prevention.

SUMMARY:

Objective: To identify the prevalence and characteristics of homicide-suicides (HSs) in Florida, involving children 16 years and younger.

Method: This was a descriptive epidemiological study based on reviews of Florida medical examiner files from 1997–2001. All completed HSs, where one or more children were killed by an adult, as well as attempted HSs involving children the same age, were tabulated. Main outcome measures were the number of HSs as well as sociodemographic and antecedent variables.

Results: A total of 42 children and 12 adults were killed in 32 HSs; six children and one adult were killed in 12 attempted HSs, but 15 children and four adults survived. Fifty-five percent of adults, usually a parent, who killed a child(ren) and then committed suicide, were men. When an adult killed one or more children and another adult, usually the mother, the perpetrator was always male.

Conclusions: Ten children were killed annually in an HS in Florida, 12% of annual homicide deaths of children 16 and younger. The percentage of female perpetrators was higher than other HS subtypes. Although mothers only killed children, fathers also killed wives/girlfriends, and other adult family members. Research should focus on clarifying risk factors in HSs involving children to better understand and prevent these tragedies. Clinicians should also screen children for risk when parents are depressed, separating, and having custody disputes.

REFERENCES:

1. Cohen D, Llorente M, Eisdorfer C: Homicide-suicide in older persons. Am J Psychiatry 1998;155:390–396.
2. Byard RM, Knight D, James RA, Gilbert J: Murder-suicides involving children. AM J Forensic Med Pathol 1999:20(4);323–327.

TARGET AUDIENCE:

Researchers, practitioners, law enforcement, and administrators.

Poster 77 **Friday, October 11 10:30 a.m.-12 noon**

ZIPRASIDONE IN PATIENTS WITH MENTAL RETARDATION AND MALADAPTIVE BEHAVIORS

Pfizer Inc.

Seth A. Cohen, M.D., *Private Practice, 1315 First Avenue, North, Seattle, WA 98109-3105*; Brian Fitzgerald, Ph.D.; Anthony Okos, M.D.; Shirin Khan

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participant should be able to discuss the reported use of ziprasidone in a population with mental retardation and maladaptive behaviors and the antipsychotic's effects on behavioral measures, weight, and lipid profile.

SUMMARY:

Background: Atypical antipsychotics effectively reduce maladaptive behavior in individuals with mental retardation, yet bring significant weight gain and metabolic anomalies. Ziprasidone, a weight-neutral antipsychotic for patients with schizophrenia or schizoaffective disorder, has not been studied in a population with mental retardation and maladaptive behaviors.

Method: Forty patients with mental retardation and maladaptive behaviors, who had gained excessive weight or were inadequately responsive to other agents, were switched to ziprasidone. Weight, total cholesterol, HDL, LDL, triglycerides, glucose, and frequency of maladaptive behavior were recorded at baseline and after six months of ziprasidone treatment.

Results: Ziprasidone treatment was associated with a weight loss of 8.1 pounds ($P \leq 0.05$), as well as a signifi-

cant reduction in total cholesterol and triglycerides. The monthly frequency of maladaptive behavior remained unchanged or improved in 72% of the patients.

Conclusion: Ziprasidone effectively reduces the frequency of maladaptive behavior in a patient group with mental retardation while improving weight and lipid profile.

REFERENCES:

1. McIntyre RS, McCann SM, Kennedy SH: Antipsychotic metabolic effects: weight gain, diabetes mellitus and lipid abnormalities. Can J Psychiatr 2001;46:273–281.
2. McDougle CJ, Holmes JP, Carlson DC, et al: A double-blind, placebo-controlled study of risperidone in adults with autistic disorder and other pervasive developmental disorders. Arch Gen Psychiatry 1998;55:633–641.

TARGET AUDIENCE:

Psychiatrists, psychiatric nurses.

Poster 78 **Friday, October 11 10:30 a.m.-12 noon**

EFFECT OF MEMANTINE ON COSTS ASSOCIATED WITH ADVANCED ALZHEIMER'S DISEASE

Forest Laboratories, Inc.

Rahul Dhanda, Ph.D., *Assistant Director of Biostatistics, Forest Laboratories, Inc., 909 Third Avenue, New York, NY 10022*; Anders Wimo, M.D., Ph.D.; Bengt Winblad, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand the effect of memantine on the caregiver burden and costs of advanced Alzheimer's disease.

SUMMARY:

Currently, there are no approved treatments for advanced AD, which is associated with large demands on caregiver time and high rates of institutionalization (two major components of the substantial economic burden of the disease). We assessed the pharmacoeconomic effects of treatment with memantine, an NMDA-receptor antagonist that has shown efficacy for AD.

During a 28-week, double-blind, placebo-controlled study in 252 patients with advanced AD, the primary outcomes of resource utilization, residential status, and costs were assessed. Resource use and residential status were tracked using the Resource Utilization in Dementia (RUD) questionnaire, and an average unit cost was assigned to each relevant resource utilization variable.

According to multivariate analyses of the treated-per-protocol population (N=166), memantine treatment was associated with a significant reduction in average monthly caregiver time compared with placebo (−51.5 hours; p=0.02). The incidence of institutionalization at endpoint was also significantly lower in the memantine group (p=0.04). These reductions in resource utilization were associated with average cost reductions of $824/month (p=0.03) for caregivers and $1,234/month (p=0.01) for society. There was also a trend toward lower direct non-medical costs among patients on memantine (between-group difference of $431/month).

Thus, memantine treatment in advanced AD appears to significantly reduce costs relative to placebo.

REFERENCES:

1. Ernst RL, Hay JW: The US economic and social costs of Alzheimer's disease revisited. Am J Public Health 1994; 8: 1261–1264.
2. Wimo A, Wetterholm AL, Mastey V, Winblad B: Evaluation of the health care resource utilisation and caregiver time in anti-dementia drug trials—a quantitative battery, in Health Economics of Dementia. Edited by Wimo A, Jonsson B, Karlsson G, Winblad B. J Wiley & Sons, London, 1998, pp 465–499.

TARGET AUDIENCE:

Geriatric psychiatrists.

Poster 79 **Friday, October 11 10:30 a.m.-12 noon**

REACTIONS TO THE WORLD TRADE CENTER DISASTER IN NEW YORK CITY AREA PATIENTS WITH BIPOLAR DISORDER

Carrie J. Endick, C.S.W., *Professional Associate in Psychiatry, New York Presbyterian Hospital, Weill Medical Center, 525 East 68th Street, Box 140, New York, NY 10021*; Joseph F. Goldberg, M.D., *Assistant Professor of Psychiatry, New York Presbyterian Hospital, Weill Medical Center, 525 East 68th Street, Box 140, New York, NY 10021*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be informed about the psychological reactions and clinical-psychopathologic features of bipolar patients in the New York city area.

SUMMARY:

Background: The role of stress in exacerbating bipolar disorder remains controversial. We evaluated reactions

to the 9/11 catastrophe in an existing, well characterized NYC bipolar cohort.

Method: We assessed 31 NYC DSM-IV bipolar patients, with and without prior PTSD, for PTSD or affective symptom exacerbations, substance abuse, and clinical status in the two to four month aftermath of 9/11.

Results: (1) Almost half of subjects directly witnessed or lost friends in the World Trade Center (WTC) collapse. (2) Over two-thirds had increases from baseline in guilt, somatization, anger, and alcohol/drug use. (3) Global symptom severity worsened significantly from one month pre 9/11@ p<01.4. Features of PTSD (22%) and of increased alcohol use (66%) were evident mainly in those with pre-existing symptoms. (5) Those with (versus without) increased alcohol use had greater levels of mania, anger, social anxiety, and concentration impairment (p>.05).

Conclusions: A majority of NYC bipolar patients had some intensification of affective and/or anxiety features after 9/11. Psychopathologic features among NYC bipolar patients in the 9/11 aftermath, particularly involving alcohol and post-traumatic anxiety, were most likely to arise in those with previous substance abuse or PTSD.

REFERENCES:

1. Terr L, Bloch D, Michael B, Shi H, Reinhardt J, Metayer S: Children's thinking in the wake of Challenger. American Journal of Psychiatry 1997; 154:6.
2. Maes M, Mylle J, Delmeire L, Altamura C: Psychiatric morbidity and comorbidity following accidental man-made traumatic events: incidence and risk Factors. Eur Arch of Psych and Clin Neur 2000; 250(3):56–62.

Poster 80 **Friday, October 11**
10:30 a.m.-12 noon

REDUCTION BY OLANZAPINE OF OCCUPATIONAL DISRUPTIVENESS AMONG CAREGIVERS OF PATIENTS WITH ALZHEIMER'S DEMENTIA

Eli Lilly and Company

Peter D. Feldman, Ph.D., *Senior Scientific Communications Associated, Lilly Research Laboratories, Eli Lilly and Company, One Lilly Corporate Research Center, Indianapolis, IN 46285*; John S. Kennedy, M.D., *Clinical Research Physician, Department of Outcomes Research Eli Lilly and Company, One Lilly Corporate Center, DC-4025, Indianapolis, IN 46285*; Carrie A. Young, M.S.; Alan F. Breier, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the attendee should be able (1) to understand the use of Occupational Disruptiveness scores in the Neuropsychiatric Inventory Scale, and (2) to identify the psychobehavioral disturbances of Alzheimer's patients that respond well to treatment with olanzapine, thereby reducing caregiver's levels of distress.

SUMMARY:

Neuropsychiatric disturbances in patients with dementia can impact caregivers and affect overall patient management.

This *a priori*-defined analysis investigates changes in caregiver distress, as measured by Occupational Disruptiveness scores associated with each individual dimension of the Neuropsychiatric Inventory Nursing Home Version (NPI/NH) rating scale. Elderly nursing home patients with Alzheimer's dementia were randomized to either placebo or fixed dose olanzapine (Olz: 5, 10, or 15 mg/d) for six weeks of double-blind therapy. Successful completers entered an 18-week, open-label extension, during which they received flexible-dose Olz (5–15 mg/d). After the acute phase, reductions were seen in distress ratings reported by caregivers of patients receiving low-dose (5-mg) Olz. Significant reductions occurred relative to placebo in the NPI/NH Occupational Disruptiveness Psychosis Total (sum of Hallucinations and Delusions scores) and Core Total (sum of Hallucinations, Delusions, and Agitation scores) scores, and in the Delusions and Irritability dimensions. Results with higher doses (10, 15 mg) were largely nonsignificant compared with placebo. However, patients entering the extension improved significantly further on the occupational disruptiveness total, psychosis total, and core total, and in the agitation, delusions, disinhibition, and irritability dimensions.

These results indicate that olanzapine may significantly reduce occupational disruptiveness for caregivers of dementia patients with neuropsychiatric disturbances.

REFERENCES:

1. Street JS, Clark WS, Gannon KS, Cummings JL, Bymaster FP, Tamura RN, Mitan SJ, Kadam DL, Sanger TM, Feldman PD, Tollefson GD, Breier A: Olanzapine treatment of psychotic and behavioral symptoms in patients with Alzheimer's disease in nursing care facilities: a double-blind, randomized trial. Arch Gen Psychiatry 2000; 57:968–976.
2. Wood SA, Cummings JL, Barclay T, Hsu MA, Allahyar M, Schnelle JF: Assessing the impact of neuropsychiatric symptoms on distress in professional caregivers. Aging Ment Health 1999; 3:241–245.

Poster 81 **Friday, October 11 10:30 a.m.-12 noon**

FOLLOW-UP RATES OF DUAL DIAGNOSIS PATIENTS AFTER EMERGENCY ROOM TREATMENT

Timothy W. Fong, M.D., *Addiction Psychiatry Fellow, University of California at Los Angeles, Neuropsychiatric Institute, 61301/2 Saturn Street, Los Angeles, CA 90035*; John W. Tsuang, M.D.; Andrew P. Ho, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that dual-diagnosis patients have a low rate of follow-up to mental health appointments and substance abuse referrals after they are discharged from a psychiatric ER.

SUMMARY:

Dual-diagnosis patients (those with co-occurrence of severe mental illness and substance use disorders) are often brought to the psychiatric emergency room for evaluation and treatment, but it is unclear to what degree they comply with treatment recommendations. In general, dual-diagnosis patients are difficult to treat because of their noncompliance with follow-up care from the inpatient setting. This is a study designed to determine the follow-up rate of discharged patients from the psychiatric emergency room to mental health appointments, mental health referrals, and substance abuse referrals. We reviewed six months of psychiatric emergency room evaluations, collecting data on all dually diagnosed patients. Starting two weeks after discharge, we attempted to contact each patient and interview them regarding what they had done with their aftercare plans. Close to 50% of the dually diagnosed patients contacted attended a mental health referral or appointment. Only 20% of the dually diagnosed patients given a substance abuse referral actually showed up. More intensive effort is therefore required to engage this vulnerable population into treatment.

REFERENCES:

1. Klinkenberg WD: Predictors of receipt of aftercare and recidivism among persons with severe mental illness: a review. Psychiatric Services 1996; 47:487–496.
2. Bogenschutz MP, Siegfried SL: Factors affecting engagement of dual-diagnosis patients in outpatient treatment. Psychiatric Services 1998; 49:1350–1352.

TARGET AUDIENCE:

Psychiatrists, psychologists, social workers, nurses and other professionals who work with dual-diagnosis patients.

Poster 82 **Friday, October 11 10:30 a.m.-12 noon**

AN OPEN-LABEL EXTENSION STUDY OF MEMANTINE IN ADVANCED ALZHEIMER'S DISEASE

Forest Laboratories, Inc.

Heikki Hakkarainen, M.D., *Medical Director, Forest Laboratories, Inc., 909 Third Avenue, New York, NY 10022*; Barry J. Reisberg, M.D.; Frederick A. Schmitt, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the long-term efficacy, safety, and tolerability of memantine in the treatment of advanced Alzheimer's dementia.

SUMMARY:

Changes in glutamatergic activity appear to play a pathophysiologic role in Alzheimer's disease (AD). Therefore, agents that antagonize the excitotoxic effects of glutamate, such as the moderate affinity NMDA-receptor antagonist memantine, hold promise for AD treatment. To assess the long-term safety and efficacy of memantine, we conducted a 24-week, open-label extension study.

We previously conducted a 28-week, double-blind, placebo-controlled study of memantine in 252 advanced AD patients. At endpoint, patients randomized to memantine exhibited significantly less functional and cognitive decline ($p<0.05$) than placebo controls, as measured by the ADCS-ADL, FAST, and SIB, respectively. In the present study, 175 patients who completed the double-blind study were given open-label memantine treatment for an additional 24 weeks. Efficacy parameters included the CIBIC-Plus, ADCS-ADL, FAST, and SIB.

Following open-label treatment, the results observed for each of the efficacy measures demonstrated that patients who switched to memantine from placebo improved relative to the projected rate of continued decline. In addition, there were no clinically important differences in adverse events between patients switched to memantine or maintained on memantine during the extension phase, suggesting that maintenance memantine therapy was well tolerated.

These results support the use of memantine in long-term treatment of patients with advanced AD.

REFERENCES:

1. Parsons CG, Danysz W, Quack G: Memantine is a clinically well tolerated N-methyl-D-aspartate (NMDA) receptor antagonist—a review of preclinical data. Neuropharmacology 1999; 38: 735–767.

2. Jain KK: Evaluation of memantine for neuroprotection in dementia. Expert Opin Investig Drugs 2000; 9(6): 1397–406.

TARGET AUDIENCE:

Geriatric psychiatrists.

Poster 83 **Friday, October 11 10:30 a.m.-12 noon**

A PLACEBO-CONTROLLED STUDY OF MEMANTINE IN ADVANCED ALZHEIMER'S DISEASE

Forest Laboratories, Inc.

Heikki Hakkarainen, M.D., *Medical Director, Forest Laboratories, Inc., 909 Third Avenue, New York, NY 10022*; Barry J. Reisberg, M.D.; Albrecht Stoeffler, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the efficacy, safety, and tolerability of memantine in the treatment of advanced Alzheimer's dementia.

SUMMARY:

Preclinical studies show that agents that block the pathological stimulation of the NMDA receptor protect against glutamate-mediated neurotoxicity. Therefore, memantine, a moderate affinity NMDA-receptor antagonist, may be efficacious for the treatment of AD. Accordingly, we conducted a double-blind, placebo-controlled trial of memantine in AD patients.

Patients with advanced AD (GDS stage 5 or 6, FAST 6a, and MMSE scores 3–14), were randomized to receive 28 weeks of either memantine 20 mg/day (n=126) or placebo (n=126). The mean MMSE score at baseline was 7.9. Efficacy measures included the ADCS-ADL, CIBIC-Plus, SIB, and FAST.

At endpoint, the ADCS-ADL showed significantly less deterioration in memantine-treated patients compared with placebo (−2.49 compared with −5.86; p= 0.003). For the CIBIC-Plus, a significant benefit was also observed in favor of memantine (p=0.025). Additionally, evaluation of cognition using the SIB and FAST demonstrated significant benefits in favor of memantine (p<0.01). Memantine treatment was safe and well tolerated.

These results indicate that memantine is a safe and efficacious treatment for the functional, global, and cognitive deficits of advanced AD. Such interventions warrant further investigation in AD and related disorders, as they may provide important new treatment options.

REFERENCES:

1. Parsons CG, Danysz W, Quack G: Memantine is a clinically well tolerated N-methyl-D-aspartate (NMDA) receptor antagonist—a review of preclinical data. Neuropharmacology 1999; 38: 735–767.
2. Jain KK: Evaluation of memantine for neuroprotection in dementia. Expert Opin Investig Drugs 2000; 9(6):1397–406.

TARGET AUDIENCE:

Geriatric psychiatrists.

Poster 84 **Friday, October 11 10:30 a.m.-12 noon**

LOW DOSE TEMAZEPAM: EARLY COMPARATIVE STUDIES

C. David Matthews, R.Ph., *Department of Psychiatry, Brownsville Medical Center, 2517 Garrett Road, Harlingen, TX 78552*; Stephen M. Goldfinger, M.D., *Professor and Vice Chair, Departmment of Psychiatry, Downstate Medical Center, 450 Clarkson Avenue, Brooklyn, NY 11203*

EDUCATIONAL OBJECTIVES:

The learner will be able to describe benzodiazepine hypnotics and dose-related effects, and to recognize characteristics of an "ideal" hypnotic.

SUMMARY:

Approximately 35% of the adult U.S. population suffers from insomnia; 50% of them consider it a serious problem. Insomnia complaints may involve difficulty falling asleep, maintaining uninterrupted sleep, and early morning awakenings. Medications used for insomnia include barbiturates, benzodiazepine hypnotics, nonbenzodiazepines (Omega-1 receptor agonists), and OTC agents, including antihistamines.

The ideal hypnotic agent would have a rapid onset of action, a sufficiently sustained action to facilitate sleep throughout the night, and no residual action causing sedation or memory loss during waking hours. The existence of inactive metabolites is important in having a sedative hypnotic that has a "clean profile". This ideal agent is not metabolized through the cytochrome P 450 system, minimizing the possibility of drug-drug interactions. It would allow fixed dosing, with no necessity to reduce the optimal dose for elderly patients.

No single agent available today meets all the above criteria for an "ideal" hypnotic. Choice of medication must reflect the above properties, coupled with the history of prior treatment responses, general efficacy, side effect profiles and considerations of routes of metabolism. Medication choice is often a function of drug half

life; a shorter half life means shorter uninterrupted sleep, a longer half life, daytime sedation. Long-standing clinical practice is to use the lowest possible dosage of hypnotics for the briefest time, since both attenuation of effect and potential for abuse remain concerns.

Temazepam, a medium half life benzodiazepine, has been compared with flurazepam and triazolam for efficacy and side-effects. Sedation with flurazepam was the least intense, with triazolam associated with significant deficits in information recall at 24 hours. The presence of active metabolites with an extremely long half life (50 hours) further limits the usefulness of flurazepam, since metabolites accumulate with repeated dosing and can lead to serious daytime sedation. Further, the triazolam dose used (0.25 mg) was higher than currently recommended.

Temazepam has traditionally been prescribed at what may may be considered higher then necessary doses as well (15-30 mg. in most studies.) In a comparison study of Temazepam at dosages of 7.5, 15, and 30 mg, there was a linear relationship between total sleep time, latency to persistent sleep, and dose. However, there may be no clinical significance to these differences. Thus, a 75% decrease in dose (30 to 7.5 mg) was associated with a difference of only 18.7 minutes in total sleep time and 8.3 minutes in latency to sleep.

Temazepam has no active metabolites, may be used at the same dosage in elderly populations and younger adults, has no accumulation upon repeat dosing, and has no active metabolites.

Further evaluation of the comparative efficacy and tolerability of low (7.5mg) dose Temazepam versus zaleplon and zolpidem are needed. This minimal dosing strategy mey provide a safe and effective alternative to other hypnotic medication strategies.

REFERENCES:

1. Greenblatt DJ, Harmatz JS, et al: Pharmacokineticdeterminants of dynamic differences among the benzodiazepine hypnotics. ArchGen Psych 1989; 46:326–332.
2. Roehrs T, Vogel G, et al: Dose effects of Temazepam in transient insomnia. Drug Res 1990; 40m(II) 8, 859–863.

Poster 85 **Friday, October 11**
10:30 a.m.-12 noon

EFFICACY AND SAFETY OF ATOMOXETINE IN CHILDHOOD ADHD WITH AND WITHOUT COMORBID OPPOSITIONAL DEFIANT DISORDER

Eli Lilly and Company

Stuart L. Kaplan, M.D., *Professor of Psychiatry and Pediatrics, and Director, Division of Child and Adolescent Psychiatry, Penn State College of Medicine, H-073, Hershey, PA 63104*; Joan Busner, Ph.D.; John H. Heiligenstein, M.D.; Douglas K. Kelsey, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to determine the potential utility of atomoxetine in treating ADHD symptoms in children with and without comorbid ODD and to determine the safety profile of atomoxetine in ADHD children with and without comorbid ODD.

SUMMARY:

Objective: Compare the safety and efficacy of atomoxetine, a highly specific, presynaptic inhibitor of the norepinephrine transporter protein vs. placebo in pediatric ADHD with and without comorbid ODD.

Methods: A total of 253 children (mean age = 9.8, SD=1.6) were enrolled in two identical, multi-site, double-blind, randomized, placebo-controlled trials for a nine-week, acute treatment phase with atomoxetine, or placebo. Patients met DSM-IV ADHD criteria and ODD was diagnosed with DICA-IV-Parent. ADHD severity was assessed weekly with the ADHD-RS-IV-Parent: Inv and CGI. Clinical response was defined as ≥25% reduction in ADHD RS Total scores from baseline to endpoint.

Results: 39% of the patients were diagnosed with comorbid ODD. The ADHD RS, and CGI scores from baseline to endpoint were markedly improved in the atomoxetine treatment group compared with placebo, with no significant difference attributable to the presence or absence of comorbid ODD. A significantly higher percentage of atomoxetine patients with and without ODD achieved a clinical response compared with placebo (all p values ≤0.007). Atomoxetine was well tolerated with discontinuation rates less than 6% for both groups.

Conclusion: Atomoxetine appears to be safe and efficacious for the management of pediatric ADHD without regard to comorbid ODD.

REFERENCES:

1. Swanson JM, et al: Clinical relevance of the primary findings of the MTA: success rates based on severity of ADHD and ODD symptoms at the end of treatment. J Child & Adolesc Psychiatry 2001; 40(2):168–179.
2. Kuhne M, et al: Impact of comorbid oppositional or conduct problems on attention-deficit hyperactivity disorder. J Child & Adolesc Psychiatry 1997; 36(12):1715–1725.

TARGET AUDIENCE:

Health care professionals interested in treatment of ADHD/ODD.

Poster 86 **Friday, October 11 10:30 a.m.-12 noon**

EFFICACY OF ATOMOXETINE IN CHILDREN AND ADOLESCENTS WITH ADHD

Eli Lilly and Company

Jill Gonzales, B.S., *Scientific Communications Consulted Neuroscience Medical Affairs, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285;* Douglas K. Kelsey, M.D., Ph.D.; Albert J. Allen, M.D., Ph.D.; David Michelson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that atomoxetine is an effective treatment option for both the hyperactive and inattentive symptoms of ADHD in children and adolescents.

SUMMARY:

Objective: Two recently completed clinical trials assessed efficacy of atomoxetine in children and adolescents with ADHD.

Methods: Patients enrolled in six- to eight-week, double-blind, placebo-controlled trials received either atomoxetine or placebo. ADHD symptoms were assessed by change from baseline-to-endpoint total ADHD RS scores. Similar analyses for the ADHD RS inattentive and hyperactive/impulsive subscales, CGI-S, and CPRS-R-ADHD Index were examined.

Results: A total of 296 children (6 to 11 years of age, 179 atomoxetine, 117 placebo) and 120 adolescents (12 to 18 years of age, 71 atomoxetine, 49 placebo), participated. Children and adolescents receiving atomoxetine reported significant reduction in ADHD RS total scores compared with placebo ($p < .001$, $p = .009$, respectively). Similar results were observed for the inattentive ($p < .001$, $p = .012$, respectively), and hyperactive/impulsive ($p < .001$, $p = .024$, respectively), ADHD RS subscales, CGI-S ($p < .001$, $p = .002$, respectively), and CPRS-R ADHD Index ($p < .001$, $p < .001$, respectively) for children and adolescents treated with atomoxetine compared with placebo. No significant differences were found between children or adolescents for either treatment.

Conclusions: These studies suggest that atomoxetine is effective for treating children and adolescents with ADHD and is an alternative to more traditional interventions.

REFERENCES:

1. Spencer T, Biederman J, Heiligenstein J, Wilens T, Faries D, Prince J, Faraone SV, Rea J, Witcher J, Zervas S: An open-label, dose-ranging study of atomoxetine in children with attention deficit hyperactivity disorder. J Child Adolesc Psychopharmacol 2001; 11:251–265.
2. Michelson D, Faries D, Wernicke J, Kelsey D, Kendrick K, Sallee FR, Spencer T, et al: Atomoxetine in the treatment of children and adolescents with attention-deficit/hyperactivity disorder: a randomized, placebo-controlled, dose-response study. Pediatrics 2001; 108:e83.

TARGET AUDIENCE:

Health care professionals who are interested in the assessment and treatment of attention-deficit/hyperactivity disorder.

Poster 87 **Friday, October 11 10:30 a.m.-12 noon**

PREVALENCE OF TYPE II DIABETES AMONG OUTPATIENTS ON ANTIPSYCHOTIC DRUGS

J. Steven Lamberti, M.D., *Associate Professor of Psychiatry, Strong Ties, University of Rochester, and Director of Project Link, 240 Hampton Way, Penfield, NY 14526-1531*; John F. Crilly, M.P.H., *Department of Psychiatry, University of Rochester, 300 Crittenden Boulevard, Rochester, NY 14642*; Kumar Maharaj, R.Ph.; David Olson, Ph.D., R.Ph.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to recognize the prevalence of diabetes among patients receiving antipsychotic drugs, and to better understand the possible risk factors.

SUMMARY:

Purpose: Recent studies have suggested that treatment with antipsychotic medications is a risk factor for development of type II diabetes. The purpose of this study is to examine the point prevalence of diabetes among outpatients with schizophrenia and schizoaffective disorder receiving antipsychotic medications.

Methodology: A retrospective chart review was conducted on 409 patients receiving antipsychotic medications at Strong Ties Community Support Program, a clinic of the University of Rochester Department of Psychiatry.

Results: Mean age of patients was 42.2 years, and 57.2% were male. Patients were 60.9% Caucasian, 32.3% African American, 5.1% Hispanic, and 1.7% other. At the time of review, 29.1% received clozapine, 25.2% received olanzapine, 20.8% received risperidone, 13.2% received quetiapine, 7.1% received fluphenazine decanoate, and 4.6% received haloperidol decanoate. Average lifetime duration of antipsychotic drug expo-

sure averaged 13.6 years per patient. Sixteen percent had a known family history of diabetes. Overall prevalence of diabetes was 12.2%.

Conclusion: Prevalence of type II diabetes among patients with schizophrenia and schizoaffective disorder receiving antipsychotic medications is significantly higher than that reported in the general population. A prospective study is currently underway to monitor fasting blood glucose and cholesterol and triglyceride levels over time in this study population.

REFERENCES:

1. Herderson, DC, Cagliero, E, Gray C, et al: Cozapine, diabetes mellitus, weight gain, and lipid abnormalities: A five-year naturalistic study. Am J Psychiatry 2000; 157 (6) 975–81.
2. Lindenmeyer JP, Nathan AM, Smith RC: Hyperglycemia associated with the use of atypical antipsychotics. J Clin Psychiatry 2001; 62 Suppl. 23:30–8.

TARGET AUDIENCE:

Psychiatrists, nurses, and pharmacists.

Poster 88 **Friday, October 11 10:30 a.m.-12 noon**

ECONOMIC IMPACT OF ANTIPSYCHOTIC-ASSOCIATED DIABETES AMONG MEDICAID PATIENTS

Hong Li, Ph.D., *Associate Director, Global Outcomes Research, Bristol-Myers Squibb Pharmaceutical Research Institute, 5 Research Parkway, Department 753, Wallingford, CT 06492*; Allan Z. Safferman, M.D., *Director, Drug Safety, Bristol-Myers Squibb Pharmaceutical Research Institute, 5 Research Parkway, Department 753, Wallingford, CT 06492*; Patricia Hines, A.S.; Taro Iwamoto, Ph.D.

EDUCATIONAL OBJECTIVES:

Understand the potential economic impacts of new onset diabetes among schizophrenic patients taking certain atypical antipsychotic medications.

SUMMARY:

Objective: Diabetes has been associated with use of certain atypical antipsychotics. Economic impact of diabetes management among adult schizophrenic California Medicaid patients between October 1997 and June 2000 was assessed through a retrospective cohort study.

Method: The study population was derived from the full Medi-Cal claims database. Entry criteria included: (1) primary diagnosis of schizophrenia followed by a single agent prescription for either clozapine, olanzapine, or risperidone: (2) continuous eligibility through two years of follow up. Comparisions of total physician costs per patient per month (PMPM) were conducted according to antipsychotic agent and diabetes status. Analyses were adjusted for age, gender, and race-ethnicity.

Results: Among 3,186 patients, 427 (13.4%) incident diabetes cases were reported, comprised of 115 (27%) clozapine, 180 (42%) olanzapine, and 132 (31%) risperidone patients. The adjusted total physician costs PMPM was significantly greater ($p<0.001$) for diabetic (D) versus non-diabetic (ND) patients: D=$1,458, ND=$942 among clozapine patients; D=$2,419, ND=$1,403 among olanzapine patients; and D=$2.219, ND=$1,235 among risperidone patients.

Conclusion: In addition to clinical concerns over the apparent association between certain atypical antipsychotic use and diabetes, the current study highlights the need to consider the economic impact of diabetes management in these patients.

REFERENCES:

1. Buse JB: Metabolic side effects of antipsychotics: focus on hyperglycemia and diabetes. J Clin Psychiatry 2002;63 (suppl 4): 37–41.
2. Sernyak MJ, Leslie DL, Alarcon RD, Losconczy MF, Rosenheck R: Association of diabetes mellitus with use of atypical neuroleptics in the treatment of schizophrenia. Am J Psychiatry 2002;159:561–66.

TARGET AUDIENCE:

Psychiatrists, pharmacy/medical director.

Poster 89 **Friday, October 11 10:30 a.m.-12 noon**

VENLAFAXINE XR IN SOCIAL ANXIETY DISORDER

Wyeth Pharmaceuticals

Richard M. Mangano, Ph.D., *Senior Director, Central Nervous System Clinical Research, Wyeth Pharmaceuticals, 500 Arcola Road, Collegeville, PA 19426*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the anxiolytic efficacy of venlafaxine XR in the treatment of generalized social anxiety disorder.

SUMMARY:

The objective of this pooled data analysis was to determine the anxiolytic efficacy of venlafaxine XR (VEN XR) in generalized social anxiety disorder (SAD).

Data from two multicenter, double-blind, placebo-controlled, parallel-group studies of outpatients with

generalized SAD were pooled for efficacy analysis (last-observation-carried-forward). Both studies had a one-week placebo lead-in period preceding the 12-week randomized, flexible-dose study of VEN XR (75–225 mg/day; n=259) or placebo (n=273), followed by an optional two-week taper period. The primary efficacy variable was the Liebowitz Social Anxiety Scale (LSAS) total score.

The pooled analysis indicated that VEN XR was significantly better than placebo in Weeks 3–12 (P=0.007, Week 3; $P \leq 0.001$, Weeks 4–12), based on LSAS total scores. Significant efficacy of VEN XR over placebo as early as Week 3 was also demonstrated by using the LSAS subscales of performance, social interaction, avoidance factors, and some fear factors (eg, public speaking). Likewise, early separation of efficacy favoring active treatment over placebo was noted on the fear, avoidance, and physiologic factors of the Social Phobia Inventory (SPIN), a secondary efficacy variable used in this study.

VEN XR is significantly more effective than placebo in the short-term treatment of generalized SAD.

REFERENCES:

1. Hackett D: Venlafaxine XR in the treatment of anxiety. Acta Psychiatr Scand 2000; 102:30–35.
2. Lépine J-P, Pélissolo A: Why take social anxiety disorder seriously? Depress Anxiety 2000; 11:87–92.

TARGET AUDIENCE:

Psychiatrists.

Poster 90 **Friday, October 11 10:30 a.m.-12 noon**

TRICHOTILLOMANIA TREATMENT MEDICATION EFFECTIVENESS AND PREDICTORS OF OUTCOME

Shani H. Osbourne, B.A., *Department of Psychiatry, Yale University, 100 York Street, Suite 2-H, New Haven, CT 06511*; C. Neil Epperson, M.D.; Suzanne Wasylink, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the role of baseline anxiety and depressive symptoms in the treatment of trichotillomania with antidepressant medications; become more informed about the relative efficacy of fluvoxamine and desipramine in the treatment of trichotillomania.

SUMMARY:

Objective: Enthusiastic support for the hypothesis that serotonin reuptake inhibitors (SRIs) are more effective in the treatment of trichotillomania (TM) than noradrenergic antidepressants had been dampened by recent reports of their limited and/or short lived efficacy. In an attempt to confirm the preferential efficacy of SRIs in the treatment of TM, the authors conducted a controlled study comparing the *selective* SRI fluvoxamine (FVX) versus the predominantly noradrenergic agent desipramine (DMI).

Methods: Thirty-two psychotropic medication-free female and one male meeting DSM-IV criteria for TM of at least moderate severity (based on the Psychiatric Institute Trichotillomania Scale (PITS) were enrolled in this ongoing 12-week outpatient double-blind study. Medication was titrated to final mean FVX and DMI doses of 197 mg/d and 221 mg/d, respectively. Severity of TM, depression, and anxiety were assessed biweekly.

Results: Repeated measures analysis of variance (ANOVA) revealed no significant medication group by time interaction (p = .54) with respect to total PITS scores (main outcome variable). Regardless of medication group assignment, treatment responders were found to have significantly lower baseline anxiety (p = .01) and depression scores (p = .02) as assessed using standard rating scales.

Conclusions: Although cautious interpretation is warranted given the preliminary nature of these findings, this study does not support the hypothesis that FVX is more efficacious than DMI in the treatment of TM. However, these results are consistent with the general opinion that comorbid depressive and anxiety symptoms, which are common in TM, can impede acute as well as long-term treatment response.

REFERENCES:

1. Swedo SE, et al: A double-blind comparison of clomipramine and desipramine in the treatment of trichotillomania (hair pulling). NEJM 1989; 321:497–501.
2. Diefenbach GJ, et al: Trichotillomania: a challenge to research and practice. Clin Psychology Rev 2000; 20:289–309.

TARGET AUDIENCE:

Psychiatrists involved in the pharmacologic treatment of individuals with trichotillomania.

Poster 91 **Friday, October 11 10:30 a.m.-12 noon**

EFFICACY AND TOLERABILITY OF ESCITALOPRAM IN THE TREATMENT OF ANXIETY DISORDERS

Forest Laboratories, Inc.

Mark H. Pollack, M.D., *Associate Professor of Psychiatry, Massachusetts General Hospital, 15 Parkman*

Street, WACC-815, Boston, MA 02114; Anjana Bose, Ph.D.; Hongjie Zheng, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the efficacy and tolerability of escitalopram in the treatment of anxiety disorders.

SUMMARY:

Introduction: Given the prevalence and morbidity associated with the anxiety disorders, there is a pressing need for the development of effective and well-tolerated agents for their treatment. In trials of depressed patients, escitalopram reduced anxiety symptoms associated with depression; it also demonstrated anxiolytic properties in a number of animal models of anxiety.

Objective: Three double-blind, placebo-controlled, phase III studies were conducted to determine the efficacy and safety of escitalopram in patients with panic disorder (PD), generalized anxiety disorder (GAD), and social anxiety disorder (SAD), respectively.

Methods: After a placebo run-in period, outpatients with a DSM-IV diagnosis of either PD, GAD, or SAD were randomized to double-blind treatment (8–12 weeks) with placebo or escitalopram. Primary efficacy parameters were panic attack frequency, HAMA total score, and LSAS total score, respectively.

Results: In all three studies, escitalopram demonstrated significantly greater improvement than placebo at endpoint for the primary efficacy parameter. Escitalopram patients also had significantly greater improvement than placebo patients on secondary efficacy parameters including CGI, quality of life, and other study-specific measures as panic and agoraphobia (PD), HAMA psychic anxiety (GAD), and LSAS avoidance and fear/anxiety (SAD). Escitalopram was well tolerated with adverse events generally in the mild to moderate range.

Conclusion: Escitalopram is effective and well tolerated in the treatment of PD, GAD, and SAD.

REFERENCES:

1. Stein DJ, Stahl S: Serotonin and anxiety: current models. Int Clin Psychopharmacol 2000;15 Suppl 2:S1–6.
2. Lydiard RB: Effects of escitalopram on anxiety symptoms in depression. NR Abstract 525 Presented at the 154th Annual Meeting of the American Psychiatric Association, May 2001, New Orleans.

TARGET AUDIENCE:

Practicing psychiatrists.

Poster 92

Friday, October 11
10:30 a.m.-12 noon

MIRTAZAPINE FOR THE TREATMENT OF DEMENTIA-ASSOCIATED BEHAVIORAL PROBLEMS

Organon Inc.

William E. Reichman, M.D., *Vice Dean, Robert Wood Johnson School of Medicine and Dentistry, University of New Jersey, 185 South Orange Avenue, Newark, NJ 07103*; Julie Coleman, R.N., B.S.N., *Department of Psychiatry, Robert Wood Johnson School of Medicine and Dentistry, University of New Jersey, 675 Hoes Lane, Piscataway, NJ 08854*; Peter M. Aupperle, M.D.; Lee Hyer, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be familiar with the pharmacologic options available for the treatment of dementia-associated behavior.

SUMMARY:

Objective: To demonstrate that mirtazapine is safe and effective for the treatment of non-psychotic behavioral symptoms in dementia.

Methods: This is an ongoing open-label trial of mirtazapine over a 12-week period in 30 patients with dementia and significant behavioral disturbances as established by using threshold cutoff scores for inclusion on the BEHAVE-AD and Neuropsychiatric Inventory (NPI). These scales are also the primary efficacy measures. Outcome data, vital signs and adverse events are recorded at each monthly visit. Subjects are started on 15 mg/day of mirtazapine; if greater efficacy is desired, the daily dose can be increased by 15 mg per week until a maximum tolerated dose of 45 mg/day is achieved.

Results: This study is ongoing; preliminary results are presented here. The mean NPI score decreased by 11 points and the mean BEHAVE-AD score decreased by 5.3 points from baseline to study endpoint (reductions of 32% and 49% respectively). Reductions in anxiety, depression, and irritability are particularly notable. The mean dose of mirtazapine was 40 mg/d in these patients. The only adverse event reported so far was increased insomnia, in one participant. No other adverse events were observed.

Conclusions: This interim report demonstrates that mirtazapine appears effective and well-tolerated for the treatment of non-psychotic behavioral disturbances.

REFERENCES:

1. Katz IR, Jeste DV, Mintzer JE, et al: Comparison of risperidone and placebo for psychosis and behavioral disturbances associated with dementia: a randomized,

double-blind trial. J Clin Psychiatry 1999;60:107–115.
2. Sultzer D, Gray KF, Gunay I, et al: A double-blind comparison of trazodone and haloperidol for treatment of agitation in patients with dementia. Am J Geriatr Psychiatry 1997;5(1):60–69.

TARGET AUDIENCE:

Psychiatrists, mental health clinicians.

Poster 93 **Friday, October 11 10:30 a.m.-12 noon**

DOSING AND EFFECTIVENESS OF QUETIAPINE IN TREATING CHILDREN AND ADOLESCENTS

AstraZeneca Pharmaceuticals

J. Philip Reimherr, M.D., *Psychiatric Group of the North Shore, 30 Boston Street, Lynn, MA 01904*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that quetiapine is safe and effective in treating children and adolescents with diagnoses of affective disorders.

SUMMARY:

Objective: To evaluate the dosing and effectiveness of quetiapine in the treatment of children and adolescents who were significantly ill with affective disorders.

Methods: A retrospective chart review was conducted of quetiapine-treated children and adolescents diagnosed with affective disorders accompanied by psychotic symptoms. Effectiveness was assessed using the Clinical Global Impressions (CGI) Scale. Tolerability was assessed using the Abnormal Involuntary Movement Scale (AIMS) and adverse event reports.

Results: A total of 43 patients were enrolled (mean age=13±3 years [±SD; range: 6–18 years]). Most patients had at least two diagnoses, and the most common were: ADHD, 34 (79%); bipolar II disorder, 28 (65%); posttraumatic stress disorder, 12 (27.9%); mood disorder, four (9.3%); bipolar disorder, four (9.3%); and major depression, two (4.7%). The average quetiapine dose was 307±189 mg/d (median: 275 mg/d; range: 50–800 mg/d). Of patients maintained on quetiapine (mean: 12.5±10.3 months), 39 of 41 (95%) had markedly decreased CGI scores. The mean change in CGI score was −1.3±0.6 (median: −1; range: −3–0). AIMS scores for all patients were negative. The most common adverse event was fatigue, but it generally disappeared within a week after quetiapine initiation.

Conclusions: Quetiapine was safe and effective in treating children and adolescents with affective disorders.

REFERENCES:

1. Coyle JT: Childhood mood disorders: unmet needs but important opportunities. Biol Psychiatry 2001;49:959.
2. McConville BJ, Arvanitis LA, Thyrum PT, et al: Pharmacokinetics, tolerability, and clinical effectiveness of quetiapine fumarate: an open-label trial in adolescents with psychotic disorders. J Clin Psychiatry 2000;61:252–260.

TARGET AUDIENCE:

Professional.

Poster 94 **Friday, October 11 10:30 a.m.-12 noon**

LONG-TERM SAFETY OF ATOMOXETINE IN CHILDREN AND ADOLESCENTS WITH ADHD

Eli Lilly and Company

Kory Schuh, Ph.D., *Scientific Communications Associate, Neuroscience Medical Affairs, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285*; J.F. Wernicke, M.D., Ph.D.; C. Kratochyil, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) understand the 12-month safety profile of atomoxetine in children and adolescents, and (2) recognize atomoxetine as a treatment option for ADHD for both children and adolescents.

SUMMARY:

Objective: This study assesses 12-month safety and tolerability data of atomoxetine in children and adolescents with ADHD.

Methods: Patients met DSM-IV criteria for ADHD and completed a 10-week, open-label, dose-titration trial to establish efficacy, followed by a one-year extension study.

Results: A total of 258 children (7 to 11 years) and 67 adolescents (12 to 17 years), received at least one atomoxetine dose, and 112 (43%) and 30 (45%) were treated for at least one year. Atomoxetine was well tolerated; only nine children (3.5%) and two adolescents (3.0%) discontinued due to an adverse event. A slight increase in mean diastolic blood pressure (DBP) and pulse (HR) was observed for both children (DBP = 3.64 mm Hg; HR = 4.28 BPM) and adolescents (DBP = 3.43 mm Hg; HR = 2.58 BPM). Mean weight and height

increased in children (2.17 kg, 4.01 cm) and in adolescents (4.35 kg, 5.81 cm). Effects on ECG parameters were consistent with an increased heart rate for both subgroups. No evidence of a drug related QTc prolongation was observed.

Conclusions: Atomoxetine was well tolerated and long-term therapy mean weight increased for both subgroups. These results support the use of atomoxetine for treating children and adolescents with ADHD.

REFERENCES:

1. Spencer T, Biederman J, Heiligenstein J, Wilens T, Faries D, Prince J, Faraone SV, Rea J, Witcher J, Zervas S: An open-label, dose-ranging study of atomoxetine in children with attention deficit hyperactivity disorder. J Child Adolesc Psychopharmacol 2001; 11:251–265.
2. Michelson D, Faries D, Wernicke J, Kelsey D, Kendrick K, Sallee FR, Spencer T, et al.: Atomoxetine in the treatment of children and adolescents with attention-deficit/hyperactivity disorder: a randomized, placebo-controlled, dose-response study. Pediatrics 2001; 108:e83.

TARGET AUDIENCE:

Health care professionals who are interested in the assessment and treatment of attention-deficit/hyperactivity disorder.

Poster 95 **Friday, October 11**
10:30 a.m.-12 noon

MEDICATION MAINTENANCE IN OCD

Scott Soloway, M.D., *Department of Psychiatry, New York University School of Medicine, 33 Gold Street, #612, New York, NY 10038*; Eric D. Peselow, M.D., *Department of Psychiatry, New York University School of Medicine, 33 Gold Street, #612, New York, NY 10038*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the efficacy of maintenance medication in the long-term treatment of OCD.

SUMMARY:

Objective: The utility of medication in the acute treatment of OCD has been well established. Less well known is the role of maintenance treatment for OCD. The purpose of this presentation is to evaluate the efficacy of long-term treatment for OCD.

Method: We evaluated 73 patients with OCD treated in our clinic for nine years, from June 9, 1993, to January 2002). These patients were treated acutely on an open basis for eight to 12 weeks. They were evaluated with a Y-BOCS scale on entry into our clinic and following eight to 12 weeks of treatment. All patients who responded (defined as a 33% decrease in Y-BOC score and a final Y-BOC of 15 or less) were then followed on their acute medication until one of two outcomes-termination well (remained well until the end of our analysis or dropped out well, or decided to D/C medication or stop medication due to side effects), or relapse defined as a return of original symptoms and a decision to change the maintenance medication.

Results: A total of 28 of the 73 patients (38.4%) who initially responded relapsed over a subsequent five-year period. The probability of remaining stable was 90% at one year, 79% at two years, 67% at three years, 55% at four years, and 48% at five years. The higher the Y-BOCS score at 12 weeks and the presence of comorbidity predicted a faster relapse. The patient who received CBT and the patient who could be maintained on single drug had a better prophylactic course.

Conclusion: Implications of these findings will be discussed.

REFERENCES:

1. Montgomery SA: Long-term management of obsessive-compulsive disorder. International Clinical Psychopharmacology 1996; 11(Suppl)23–29.
2. Mundo E, Boreggi SR, Pirolo R et al: Long-term pharmacotherapy of obsessive-compulsive disorder. A double-blind controlled study. Journal of Clinical Psychopharmacology, 1997; 17:4–10.

TARGET AUDIENCE:

Psychiatrists and psychologists.

Poster 96 **Friday, October 11**
10:30 a.m.-12 noon

SELECTIVE EMOTIONAL NUMBING IN MALE AND FEMALE BOSNIAN REFUGEES WITH PTSD

Bristol-Myers Squibb Company

Aida Spahic-Mihajlovic, M.D., *Psychiatrist, Alexian Brothers Medical Center, Elk Grove Village, 2160 South First Avenue, Maywood, IL 60153*; John W. Crayton, M.D.; Edward J. Neafsey, Ph.D.

EDUCATIONAL OBJECTIVES:

After this poster the participant, should understand that in PTSD emotional numbing may affect positive aspects of experience much more so than negative ones.

SUMMARY:

Emotional numbing is a prominent symptom of PTSD. To gain further understanding of numbing, groups of

adult male and female Bosnian refugees with and without a diagnosis of PTSD were studied using Lang's Looking at Pictures test (n=10–11/group). In this test subjects view a series of 21 pictures taken from the International Affective Picture Set and, after each picture, rate it for its valence (pleasant-unpleasant) and arousal (high-low) using the Self-Assessment Manikin (SAM), a cartoon figure rating scale. All subjects also were characterized using Foa's PTSD symptom scale (PTSDSS) and the Hamilton Rating Scale for Depression. PTSD subjects had significantly and substantially higher scores on both symptom scales than did control subjects, and, in addition, female PTSD subjects had higher PTSDSS scores than male PTSD subjects. All subjects (male and female, control and PTSD) had relatively normal valence ratings, but in both male and female PTSD subjects picture arousal ratings were abnormal. In particular, in contrast to controls and normals, PTSD subjects gave pleasant pictures low arousal ratings. This suggests that the emotional numbing in PTSD is not global but rather is selectively or primarily directed at pleasant or positive aspects of experience.

REFERENCES:

1. Lang PJ, Greenwald MK, Bradley MM, Hamm AO: Looking at pictures: affective, facial, visceral, and behavioral reactions. Psychophysiology 1993; 30:261–273.
2. Litz BT, Orsillo SM, Kaloupek D, Weathers F: Emotional processing in posttraumatic stress disorder. J Abnormal Psychology 2000; 109:26–39.

TARGET AUDIENCE:

Those interested in posttraumatic stress disorder.

Poster 97 **Friday, October 11 10:30 a.m.-12 noon**

ESCITALOPRAM IN THE TREATMENT OF PANIC DISORDER

Forest Laboratories, Inc.

Ivan Gergel, M.D., *Medical Department, Forest Laboratories, Inc., 909 Third Avenue, New York, NY 10022*; Stephen M. Stahl, M.D., Ph.D.; Dayong Li, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the efficacy and tolerability of escitalopram in the treatment of panic disorder.

SUMMARY:

Background: Escitalopram, the single isomer responsible for the serotonin reuptake inhibition produced by the racemic SSRI citalopram, has been shown to be effective in reducing anxiety symptoms in patients with major depression, social anxiety disorder, and generalized anxiety disorder.

Objective: This randomized, double-blind, placebo-controlled, multicenter trial evaluated escitalopram in male and female patients (aged 18–80) with DSM-IV-defined panic disorder with or without agoraphobia.

Method: A total of 237 patients received double-blind treatment with escitalopram or placebo. Outcome measures included the Modified Sheehan Panic and Anticipatory Anxiety Scale, the Panic and Agoraphobia Scale, the Hamilton Anxiety Scale, Clinical Global Impressions Scale, Patient Global Evaluation, and Quality of Life Questionnaire.

Results: On the basis of these efficacy measures, escitalopram in comparison to placebo significantly reduced panic attack frequency and severity, anticipatory anxiety, and phobic avoidance, and significantly improved overall clinical status and quality of life. Escitalopram treatment was tolerated as well as placebo, with a 6% rate of discontinuation for adverse events.

Conclusion: The results of this study suggest that escitalopram is efficacious and well tolerated in the treatment of panic disorder.

REFERENCES:

1. Wade AG, Lepola U, Koponen HJ, Pedersen V, Pedersen T: The effect of citalopram in panic disorder. Br J Psychiatry 1997;170:549–53.
2. Hyttel J, Bogeso KP, Perregaard J, Sanchez C: The pharmacological effect of citalopram residues in the (S)-(+)-enantiomer. J Neural Transm Gen Sect 1992;88:157–60.

TARGET AUDIENCE:

Practicing psychiatrists.

Poster 98 **Friday, October 11 10:30 a.m.-12 noon**

A RANDOMIZED, PLACEBO-CONTROLLED TRIAL OF ONCE-DAILY ADMINISTRATION OF ATOMOXETINE: A NEW TREATMENT FOR ADHD IN CHILDREN AND ADOLESCENTS

Eli Lilly and Company

Calvin Sumner, M.D., *Clinical Research Physician, Neuroscience Medical Affairs, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285*; David Michelson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand atomoxetine's mechanism

of action and its efficacy and potential as a therapy for ADHD, and understand some of the pharmacologic mechanisms that could account for persistence of effect despite declining plasma drug levels.

SUMMARY:

Objective: Stimulants are currently the most widely used therapies for ADHD. We assessed the safety and efficacy of atomoxetine, a non-stimulant drug being studied as an ADHD treatment in children and adults, which has previously been assessed only using twice-daily administration.

Methods: Atomoxetine was studied in a six-week, double-blind, placebo-controlled, parallel design in children and adolescents with weight-adjusted, once-daily administration each morning. Outcomes were assessed with investigator, parent, and teacher reports using an intent-to-treat analysis.

Results: Atomoxetine (N = 86) was superior to placebo (N = 84) as assessed by investigator, parent, and teacher reports, with a 0.71 effect size for the primary outcome measure. Data from a parent diary suggested that drug-specific effects were sustained into the evening. Discontinuations due to adverse events were low for both groups (atomoxetine 2.3%, placebo 1.2%).

Conclusion: Atomoxetine is a promising therapy for children and adolescents. Once-daily administration of atomoxetine is effective and appears to be safe and well tolerated. The treatment effect size is similar to that observed with twice-daily therapy, and evidence suggests that drug-specific effects are maintained throughout the day. These data also indicate that efficacy with atomoxetine may be associated with regulatory changes that persist beyond the drug's plasma half-life.

REFERENCES:

1. Spencer T, Biederman J, Heiligenstein J, Wilens T, Faries D, Prince J, Faraone SV, Rea J, Witcher J, Zervas S: An open-label, dose-ranging study of atomoxetine in children with attention deficit hyperactivity disorder. J Child Adolesc Psychopharmacol 2001; 11:251–265.
2. Michelson D, Faries D, Wernicke J, Kelsey D, Kendrick K, Sallee FR, Spencer T, et al.: Atomoxetine in the treatment of children and adolescents with attention-deficit/hyperactivity disorder: a randomized, placebo-controlled, dose-response study. Pediatrics 2001; 108:e83.

TARGET AUDIENCE:

Health care professionals who are interested in the assessment and treatment of attention-deficit/hyperactivity disorder.

Poster 99 **Friday, October 11**
10:30 a.m.-12 noon

ANTIDEPRESSANT ADHERENCE: ATTITUDES AND FEELINGS ABOUT TAKING MEDICINE

Eli Lilly and Company
Marijo B. Tamburrino, M.D., *Department of Psychiatry, Medical College of Ohio, RHC-3120 Glendale, Toledo, OH 43614*; Denis Lynch, Ph.D., *Department of Family Medicine, Medical College of Ohio, 1015 Garden Lake, Toledo, OH 43614*; Rollin Nagel, Ph.D.; Laura Burlen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) recognize the importance of patient education in enhancing adherence to antidepressant medication, and (2) identify attitudes that may predict lower adherence to antidepressant medication.

SUMMARY:

Objective: The purpose of this study was to increase understanding of antidepressant adherence among family practice outpatients.

Methods: Participants came from a family practice clinic, were at least 18 years old and on antidepressant medication for at least one month. Instruments: Beck Depression Inventory, Interpersonal Support Evaluation List, Medication Adherence Rating Scale, Health Belief Inventory, and a Demographic Questionnaire.

Results: Study instruments were completed by 61 subjects (mean age: 46 years; 41 females and 20 males.) Taking their medication "all of the time" was reported by 73% of the subjects and they were compared with the five patients who indicated taking their antidepressant medication "some of the time." Patients who did not take their medication consistently were more likely to have stopped taking the medication because of how they felt after taking the medicine ($p<.008$) and to report being careless about taking their medication ($p<.001$). Subjects who did not adhere thought their medication was less helpful ($p<.03$), that it would be more difficult to take their medication as prescribed by their doctor ($p<.05$), were more likely to be unmarried ($p<.04$), and to report greater dissatisfaction with their doctor ($p<.04$). There were no differences in level of depression between these groups.

Conclusion: Patients' self-reported level of adherence was high. Improved patient education and enhanced patient satisfaction may increase adherence.

REFERENCES:

1. Kayton W, Von Korff M, Lin E, et al: Stepped collaborative care for primary care patients with persistent

symptoms of depression. Archives of General Psychiatry 199; 56(12):1109–1115.
2. Choo PW, Rand CS, Invi TS, et al: Validation of patient reports, automated pharmacy records, and pill counts with electronic monitoring of adherence to antihypertensive therapy. MedicalCare 1999;37(9): 846–857.

Supported by a $10,000 unrestricted educational grant from Eli Lilly.

Poster 100 **Friday, October 11 10:30 a.m.-12 noon**

MIRTAZAPINE VERSUS FLUOXETINE: EFFECTS ON SLEEP IN MAJOR DEPRESSIVE DISORDER PATIENTS WITH INSOMNIA

Organon Inc.

Andrew Winokur, M.D., Ph.D., *Professor, Department of Psychiatry, University of Connecticut Health Center, 10 Talcott Notch Road, Third Floor, Farmington, CT 06030-6415*; Keith A. Gary, Ph.D.; Nicholas A. DeMartinis III, M.D.; Daniel P. McNally, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) demonstrate diffential effects of mirtazapine and fluoxetine on objective measures of sleep and (2) recognize mirtazapine as an effective treatment in the subpopulation of MDD patients with complaints of insomnia.

SUMMARY:

Sleep complaints are common in patients with major depressive disorder (MDD). Both MDD and antidepressant drugs characteristically alter objective sleep measures. This study compares the effects of mirtazapine and fluoxetine on sleep continuity measures in MDD patients with insomnia. Patients (n=19) received initial baseline PSG evaluation over two consecutive nights. Subjects were randomly assigned to either fluoxetine (20–40 mg) or mirtazapine (15–45 mg) treatment for an eight-week, double-blind, treatment trial. Single night PSGs were conducted at weeks 1, 2, and 8, with depression ratings assessed at baseline and weeks 1,2,3,4,6, and 8. Statistical analyses was performed by repeated measures ANOVA followed by Dunnet's post hoc analyses. Patients receiving mirtazapine (n=8) had significant improvement in objective sleep continuity measures at eight weeks. Improvement in total sleep time and sleep efficiency were significant after only two weeks of mirtazapine treatment. No significant changes in sleep continuity measures were observed in the fluoxetine group (n=11). Both groups improved clinically in mood and subjective sleep measures from baseline, with no differences between groups. These data demonstrate the differential effects of mirtazapine and fluoxetine, with significant improvement in favor of mirtazapine, on objective sleep parameters in MDD patients with insomnia.

REFERENCES:

1. Winokur A, Satea M, Hayes J, Bayles-Dazet W, MacDonald M, Gary K: Acute effects of mirtazapine on sleep continuity and sleep architecture in depressed patients; a pilot study. Biol Psych 2000; 48:75–78.
2. Winokur A, Gary KA, Rodner S, Rae-Red C, Fernando AT, Szuba MP: Depression, sleep physiology and antidepressant drugs. Depress Anxiety 2001;14:19–28.

TARGET AUDIENCE:

Mental health providers.

Poster 101 **Friday, October 11 10:30 a.m.-12 noon**

GAD IN CHILDREN AND ADOLESCENTS TREATED WITH VENLAFAXINE XR

Wyeth Pharmaceuticals

Paul P. Yeung, M.D., M.P.H., *Director, Clinical Research, Wyeth Pharmaceuticals, 500 Arcola Road, Collegeville, PA 19426*; Arifulla Khan, M.D.; Nadia R. Kunz, Pharm.D.; Leslie W. Lamm, M.B.A.; Elizabeth Nicolacopoulus, B.S.N.; Lisa Jenkins, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to recognize that venlafaxine XR may be effective and well tolerated in treating children and adolescents with generalized anxiety disorder.

SUMMARY:

Background: Venlafaxine XR is an effective treatment for adults with GAD but no data are available in pediatric patients.

Methods: Results from two eight-week, multicenter, placebo-controlled, double-blind, flexible-dose studies in 175 children (6–11 years old) and 145 adolescents (12–17 years old) randomly assigned to receive venlafaxine XR (dose by weight; n=157) or placebo (n=163) were combined. The primary efficacy variable was the Columbia KIDDIE-SADS GAD total score for nine delineated items; primary endpoint was the final on-therapy evaluation. Secondary efficacy variables were the C-KIDDIE-SADS GAD total and the individual Severity and Impairment scores, total scores for PARS, HAM-

A, and the SCARED Parent and Child Forms, and CGI Severity and Improvement scores.

Results: Venlafaxine-treated patients had an adjusted mean decrease of 17.4 points on the primary efficacy variable v. 12.7 for the placebo group ($p<0.001$). Secondary measure results were similar. Defining response as a score <3 on the CGI Improvement scale, 69% of venlafaxine patients responded v. 48% in the placebo group ($p<0.001$). The most common (≥5% and incidence 2X placebo) AEs were asthenia, anorexia, pain, and somnolence.

Conclusion: Venlafaxine XR is an effective, well-tolerated treatment in children and adolescents with GAD.

REFERENCES:

1. Allgulander C, Hackett D, Salinas E: Venlafaxine extended release (ER) in the treatment of generalized anxiety disorder: twenty-four-week, placebo-controlled dose-ranging study. British Journal of Psychiatry 2001; 179:15–22.
2. Gelenberg AJ, Lydiard RB, Rudolph RL, Aguiar L, Haskins JT, Salinas E: Efficacy of venlafaxine extended-release capsules in nondepressed outpatients with generalized anxiety disorder: a six-month randomized controlled trial. JAMA 2000; 283(23):3082–8.

TARGET AUDIENCE:

Child and adolescent psychiatrists; general psychiatrists who treat children or adolescents.

Poster 102 **Friday, October 11 10:30 a.m.-12 noon**

RELAPSES OF PTSD AND DEPRESSION AFTER ANTIDEPRESSANT DISCONTINUATION IN REFUGEES

Amer Smajkic, M.D., *Resident, Department of Psychiatry, University of Illinois at Chicago, 912 South Wood Street, MC-913, Chicago, IL 60612*; Stevan M. Weine, M.D., *Department of Psychiatry, University of Illinois at Chicago, 1601 West Taylor Street, Room 423-S, Chicago, IL 60612*; Zvezdana Djuric-Bijedic, M.D.; Ivan Pavkovic, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the listeners should be familiar with the relapse of PTSD and depression in refugee trauma.

SUMMARY:

Relapses of PTSD and Depression after antidepressant discontinuation in Refugees

Objective: To describe PTSD and depression relapses and treatment behavior after antidepressant discontinuation in a population of treated traumatized refugees from Bosnia-Herzegovina.

Subjects: Subjects were the 42 Bosnian refugees being treated in our clinical program who had discontinued antidepressants over a two-year period. Standardized assessments were done prior to and after discontinuation.

Results: After discontinuation, 18 (43%) relapsed with PTSD and 24 (57%) did not. Comparing these groups, we found significant differences in PTSD severity, BDI severity, subjective rating of worsening, sleep, and psychotherapy. There were 13 (31%) antidepressant restarters and 29 (69%) non-restarters. The relapsers, restarters showed the highest figures in PTSD severity, BDI severity, subjective rating of worsening, and sleep. The relapsers and non-restarters had moderate symptom levels, but lower subjective appraisals of distress, and were the highest utilizers of psychotherapy.

Conclusion: When treated traumatized refugees discontinue SSRIs, a subset continues to have a relapse of PTSD with depressive symptoms, indicating chronicity. Further services-based research is necessary to develop means of addressing those who have or may relapse after antidepressant discontinuation, giving more attention to this group of important public health concern.

REFERENCES:

1. Smaskic A: Sertraline, Paroxetine, and Venlafaxine in Refugee PTSD with Depression.
2. Weine S: Clinical Assessments and Trauma Testimonies of Newly Resetled Bosnian Refugees.

TARGET AUDIENCE:

Psychiatrists, psychologists, social workers, medical students.

Poster 103 **Friday, October 11 10:30 a.m.-12 noon**

OBSTETRIC COMPLICATIONS AND SERVICES UTILIZATION IN MENTALLY ILL WOMEN

Roberto A. Figueroa, M.D., *Resident, Western Psychiatric Institute and Clinic, University of Pittsburgh Medical Center, 3811 O'Hara Street, Pittsburgh, PA 15213*; Sarah Scholle, Ph.D.; Marijane Krohn, Ph.D.; Eydie L. Moses-Kolko, M.D.; Jeffrey Harman, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should have a better understanding of the incidence of obstetric complications in women with severe psychiatric disorders compared with the general population.

SUMMARY:

Objective: To compare the incidence of obstetric complications and services between severely mentally ill women and the general population.

Methods: We used Pennsylvania hospital discharge data for 1997 and 1998 to identify women with a major mental illness, drugs- and alcohol-related diagnosis, or dual diagnosis prior to a delivery admission or during the delivery hospitalization. We used multivariate regression methods to estimate the effects of psychiatric disorders on obstetric complications, length of stay, and total charges controlling for age, ethnicity, region, and payer.

Results: Women with psychiatric admissions prior to delivery were more likely to have an obstetric complication than controls, and this was statistically significant for women with a psychiatric disorder only ($p=0.002$), a primary drugs and alcohol problem ($p<0.001$), or a dual diagnosis ($p=0.036$). Women with a current diagnosis of primary psychiatric disorder had higher incidence of c-sections ($p=0.056$), longer length of stay ($p=0.05$), and higher total charges ($p=0.073$).

Conclusion: Maternal psychiatric illness is associated with greater risk of obstetric complications and more expensive delivery care.

REFERENCES:

1. Bennedsen BE, et al: Obstetric complications in women with schizophrenia. Schizophrenia Research 2001; 47(2–3):167–75.
2. Perkin MR, et al: The effects of anxiety and depression during pregnancy on obstetric complications. British Journal of Obstetrics & Gynaecology 1993; 100(7):629–34.

TARGET AUDIENCE:

Psychiatrists, health services researchers.

Poster 104 **Friday, October 11**
10:30 a.m.-12 noon

BORDERLINE PERSONALITY DISORDER AND PERPLEXITY IN TREATMENT

Zakaria Siddiqui, M.D., *Resident, Department of Psychiatry, Creighton University, 7319 Wirt Circle, #21, Omaha, NE 68134*; Surender P. Punia, M.D.; Matthew K. Egbert, M.D.

REFERENCES:

1. Rocca P, Marchiaro L, Cocuzza E, Bogetto F: Treatment of borderline personality disorder with risperidone. J Clin Psychiatry 2002;63(3):241–4.
2. Chiesa M, Fonagyp, Holmes J, Drahorad C, Harrison-Hall: Health service use costs by personality disorder following specialist and nonspecialist treatment: a comparative study. J Personal Disord 2002;16(2): 160–73.

Poster 105 **Friday, October 11**
10:30 a.m.-12 noon

SELF-PERCEIVED PSYCHOTROPIC MEDICATION EFFICACY IN COMORBID TOURETTE'S SYNDROME AND OCD

Veronica Holland LaSalle, B.A., *Intramural Research Training Award Fellow, Laboratory of Clinical Science, Obsessive-Compulsive Disorders, National Institute of Mental Health, 10 Center Drive, MSC-1234, Room 3D-41, Bethesda, MD 20892-1264*; Jersino Jean-Mary, B.A., *Intramural Research Training Award Fellow, Laboratory of Clinical Services, Obsessive-Compulsive Disorders, National Institute of Mental Health, 10 Center Drive, MSC-1234, Room 3D-41, Bethesda, MD 20892-1264*; Marla Wax Deibler, M.A.; Mark J. Smith, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the ways in which various psychotropic medications impact obsessive-compulsive symptoms and tics among patients with obsessive compulsive disorder and Tourette's syndrome.

SUMMARY:

Background: Approved psychopharmacological treatments for Tourette's syndrome (TS) and obsessive compulsive disorder (OCD) are vastly different (e.g., neuroleptics for TS, SSRIs for OCD), yet TS and OCD are heavily comorbid. It is unclear whether the same psychotropics are efficacious for both types of symptoms in a given patient. Spontaneous patient preferences may indicate whether the actions of psychotropic substances are substance specific, symptom specific, or patient specific.

Methods: Individuals with both TS and OCD completed self-report questionnaires on effects of nonprescription, prescription, and recreational drugs, on their tics and obsessive-compulsive symptoms. For each substance, participants could respond "never tried," "no effect," "improved symptoms," or "aggravated symptoms." Improvement rates (difference in percentage of symptom improvement minus worsening) were calculated, with >30% indicating a favorable result.

Results: Most patients reported no differences in self-perceived efficacy of substances on the two types of symptoms. Serotonin antidepressants, however, were more effective on obsessive-compulsive symptoms,

whereas marijuana and neuroleptics were more effective on tics.

Conclusion: Results suggest similar profiles of psychotropic substance sensitivity for the two types of symptoms with clear differences for a few substances. Findings suggest different neurochemical bases of tics and obsessive-compulsive symptoms for patients with comorbid TS and OCD.

REFERENCES:

1. Keuthen NJ, O'Sullivan RL, Sprich-Buckminster S. Trichotillomania: current issues in conceptualization and treatment. Psychother Psychosom 1998;67(4–5):202–13.
2. Osbourne SH, Epperson CN, Wasylink S. Trichotillomanina treatment: medication effectiveness and predictors of outcome. APA Annual Meeting 2002, NR402.

TARGET AUDIENCE:

Clinicians seeing OCD and TS patients.

Poster 106 **Friday, October 11 10:30 a.m.-12 noon**

MOTOR LEARNING AND CORTICAL EXCITABILITY IN PATIENTS WITH TOURETTE'S SYNDROME VERSUS CONTROLS

Jersino Jean-Mary, B.A., *Intramural Research Training Award Fellow, Laboratory of Clinical Services, Obsessive-Compulsive Disorders, National Institute of Mental Health, 10 Center Drive, MSC-1234, Room 3D-41, Bethesda, MD 20892-1264*; Mark J. Smith, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to have a general knowledge of the TMS procedure with respect to measuring motor cortex excitability in controls and Tourette's patients.

SUMMARY:

Objective: Evaluate baseline trancranial magnetic stimulation (TMS) motor cortex excitability and the effects of a motor learning task in controls and Tourette's patients with OCD.

Background: Studies show increased motor cortex excitability in Tourette's and OCD patients, but none concerning patients with both. Cortical excitability is measured using response amplitudes of single TMS pulses in resting and contracted muscles and by the paired-pulse technique. Amplitudes increase after motor learning, but in OCD patients there is a ceiling effect. Primary Tourette's patients with OCD should produce similar electrophysiological results to patients with OCD alone.

Design/Methods: Single-pulse amplitudes in patients and controls using fixed values (90% to 130%) of resting and active motor thresholds before and after a sequenced serial reaction time test (SRTT). Paired-pulse TMS was also compared.

Results: Patients showed higher amplitudes than controls in both resting and active conditions, but no difference in paired-pulse amplitudes. There was no difference in amplitudes after SRTT in patients contrary to controls.

Conclusion: Increased resting and active amplitudes in Tourette's patients with OCD and a ceiling effect after motor learning confirms previous studies. These anomalies indicate that pathological changes in the motor cortex in Tourette's syndrome may be similar to those in OCD.

REFERENCES:

1. Boylan LS, Sackeim HA: Magnetoelectric brain stimulation in the assessment of brain physiology and pathophysiology. Clin Neurophysiol 2000;111(3):504–12.
2. Pascual-Leone A, Nguyet D, Cohen LG, Brasil-Neto JP, Cammarota A, Hallett M: Modulation of muscle responses evoked by transcranial magnetic stimulation during the acquisition of new fine motor skills. J Neurophysiol 1995;74(3):1037–45.

Poster 107 **Friday, October 11 10:30 a.m.-12 noon**

EFFICACY OF PSYCHOTROPIC SUBSTANCES IN INDIVIDUALS WITH TRICHOTILLOMANIA

Marc M. Solomon, B.A., *Laboratory of Clinical Services, National Institute of Mental Health, 31059 Woodstream Drive, Farmington Hills, MI 48334*; Jersino Jean-Mary, B.A., *Intramural Research Training Award Fellow, Laboratory of Clinical Services, Obsessive-Compulsive Disorders, National Institute of Mental Health, 10 Center Drive, MSC-1234, Room 3D–4I, Bethesda, MD 20892-1264*; Mark J. Smith, M.D., Ph.D.; Marla Wax Deibler, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that although trichotillomania is considered to be an obsessive-compulsive (OC) spectrum disorder, effective treatment avenues for the condition, evidenced by our self-reported study on substance preferences, most likely differ from those of the other OC disorders

SUMMARY:

A number of studies have reported efficacy of psychotrophic drugs in trichotillomania (TTM), but there are no proven pharmacological treatments. Some people consider TTM to be an OCD spectrum disorder; therefore, one would expect that effective psychopharmacological treatments for OCD would be similarly effective in TTM. Individuals with self-identified TTM were asked to complete a self-reported questionnaire on the effects of various psychotropic substances on TTM symptoms, including prescription and recreational drugs, hormones, herbals, and others. For each substance, subjects could respond "never tried," "no effect," "improved symptoms," or "aggravated symptoms." Effectiveness rates (defined in this study as the difference between the percentage of subjects whose condition was improved and the percentage of subjects whose condition was exacerbated) were calculated. A similar questionnaire was given to OCD patients concerning OCD symptoms. Preliminary results indicate effectiveness rates greater than 30% symptom abatement when TTM subjects took tranquilizers, neuroleptics, buspirone, serotonin antidepressants, non-serotonin antidepressants, and Saint John's Wort, whereas for OCD patient symptom reduction resulted from serotonin antidepressants, tranquilizers, marijuana, and alcohol. These findings suggest differences in pharmacological response between OCD and TTM as well as a strong anxiety component in TTM.

REFERENCES:

1. O'Sullivan RL, Mansueto CS, Lerner EA, Miguel EC: Characterization of trichotillomania. A phenomenological model with clinical relevance to obsessive-compulsive spectrum disorders. Psychiatr Clin North Am 2000;23(3):587–604.
2. Stephenson PS: Eyelash pulling: a rare symptom of anxiety. Clinical Pediatrics 1974;13, 147–9.

Poster 108 **Friday, October 11**
10:30 a.m.-12 noon

RISPERIDONE EFFECTS ON SLEEP-WAKE CYCLE DISTURBANCES IN DEMENTIA

Janssen Pharmaceutica and Research Foundation

Susanne Schwalen, *Janssen-Cilag Pharmaceutica, Raiffe Senstrabe 8, Neuss, Germany D-41470*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to appreciate the improvements in sleep-wake cycle disturbances that may occur with the use of risperidone treatment in patients with behavioral and psychological symptoms of dementia.

SUMMARY:

Objective: To evaluate whether risperidone has effects on sleep-wake cycle disturbance in addition to its effects on behavioral and psychological symptoms of dementia (BPSD).

Methods: A postmarketing surveillance trial included 4,499 patients (mean age 81 years, 71% female) with BPSD. At baseline and Week 8 of risperidone treatment, physicians used a five-point scale (0=no problem to 4=very severe) to rate the sleep-wake cycle and other symptoms.

Results: Risperidone (mean dose of 1.6 mg/day) was well tolerated; the dropout rate was 7.6%, 2.6% attributable to adverse events. At baseline, among patients who had any symptoms of sleep-wake cycle disturbance, mean symptom severity score was moderate to severe (2.3 ± 0.9). After eight weeks of treatment with risperidone, mean symptom severity score significantly improved ($P<0.001$) to mild (1.0 ± 0.8). Sleep-wake cycle improvement was observed in 74% of patients, compared with deterioration in only 2%.

Conclusions: Risperidone was effective and well tolerated and helped restore the sleep-wake cycle disturbances observed in patients with BPSD, possibly attributable to its mild D_2-antagonistic and potent 5-HT_{2A}-antagonistic properties. The dopamine-antagonistic property may positively influence the disturbed diurnal rhythm control mechanism and therefore the sleep-wake cycle. 5-HT_{2A}-antagonism promotes deep sleep.

REFERENCES:

1. Rainer MK, Masching AJ, Ertl MG, Kraxberger E, Hauschofer M: Effect of risperidone on behavioral and psychological symptoms and cognitive function in dementia. J Clin Psychiatry 2001;62:894–900.
2. Tune LE. Risperidone for the treatment of behavioral and psychological symptoms of dementia. J Clin Psychiatry 2001;62 Suppl 21:29–32.

TARGET AUDIENCE:

Psychiatrists, geriatricians.

Poster 109 **Friday, October 11**
10:30 a.m.-12 noon

RISPERIDONE IS EFFECTIVE IN TREATING BEHAVIORAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA

Janssen Pharmaceutica and Research Foundation

Susanne Schwalen, *Janssen-Cilag Pharmaceutica, Raiffe Senstrabe 8, Neuss, Germany D-41470*; Alexander Kurz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to appreciate the improvements in behavioral and psychological symptoms as well as the improvement in sleep-wake cycle disturbances that occur with the use of risperidone treatment in elderly patients with dementia.

SUMMARY:

Objective: To assess the efficacy and safety of risperidone in elderly patients with behavioral and psychological symptoms of dementia (BPSD).

Methods: In this open-label, prospective, multicenter survey, 4,499 patients received risperidone (mean dose 1.6 ± 1.1 mg/day). Symptoms of delusions, aggression, social withdrawal, mistrust, and agitation/restlessness were assessed at baseline and Weeks 2, 3, and 8. Physicians rated patients' sleep-wake cycle disturbances at baseline and after eight weeks. Symptoms were rated on a five-point scale (0 = absent to 4 = severe).

Results: Delusions, aggression, social withdrawal, mistrust, and agitation/restlessness decreased in 60%, 79%, 71%, 78%, and 81% of patients, respectively. Mean baseline symptom scores (range 1.5–2.5) decreased by 0.5–0.8 at end point (P = 0.001). Among patients with moderate to severe sleep-wake cycle disturbances (2.3±0.9) at baseline, mean symptom-severity score significantly improved to mild after eight weeks (1.±0.8; P<0.001). Sleep-wake cycle disturbance improvement occurred in 74% of patients, whereas deterioration occurred in 2%. Risperidone was well tolerated.

Conclusions: Risperidone is well tolerated and effective in treating delusions, aggression, social withdrawal, mistrust, and agitation/restlessness in patients with BPSD. Risperidone improved sleep-wake cycle disturbances, most probably attributable to its mild D2 and potent 5-HT2A receptor antagonistic properties.

REFERENCES:

1. Rainer MK, Masching AJ, Ertl MG, Kraxberger E, Hauschofer M: Effect of risperidone on behavioral and psychological symptoms and cognitive function in dementia. J Clin Psychiatry 2001;62:894–900.
2. Tune LE: Risperidone for the treatment of behavioral and psychological symptoms of dementia. J Clin Psychiatry 2001;62 Suppl 21:29–32.

TARGET AUDIENCE:

Psychiatrists, geriatricians.

Poster 110 **Friday, October 11**
10:30 a.m.-12 noon

GENDER DIFFERENCES IN THE PATTERN OF DRUG ABUSE AMONG ADOLESCENTS

Jackeline S. Giusti, M.D., *Department of Psychiatry, Mayo Foundation, Mayo Clinic at Rochester, 427 4th Street, S.W., A-4, Rochester; MN 55902*; Sandra Scivoletto, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have increased awareness of characteristics of adolescents presenting for substance-use problems in an urban outpatient treatment setting.

SUMMARY:

Although prevalence of drug abuse is similar between adolescent genders, males are more often referred to treatment. Characterization of differences in drug abuse among genders is important for development of more specific treatment and prevention programs.

Objectives: To compare pattern of drug using between genders in adolescents.

Methods: A total of 124 drug abusers aged from 10 to 17 years (mean=15.4), formed the basis of this study. Adolescents were interviewed based on K-SADS for diagnosis of drug use and comorbities. Variables studied included age, gender, diagnosis of substance abuse/dependence, drugs consumed, illegal behavior, court problems, school grade, and age of drug-abuse onset. Multivariate analyses were performed to determine which significant different factors, were independently associated with gender differences.

Results: Ratio male:female was 4:1, but pattern of substance use was similar between genders. Court problems were observed in 49 (48%) males versus five (22%) females (p=0.07). Illegal behavior was similar between genders. Scholar delay was present in 87 (88%) males and 12 (60%) females (p<0.01). All these data were independently significant. No difference was found for the other variables.

Conclusion: Consequences of drug abuse (court problems and scholar delay) are much more evident among males, which could explain the higher prevalence of males in specialized treatment sets. However, females consumed the same amount of drugs and engaged in as much illegal behavior as males.

REFERENCES:

1. NIDA Epidemiologic trends in drug abuse—International Epidemiology work group on drug abuse—June 1999. National Institutes oh Health—Division Epidemiology and Prevention Research, National institute on Drug Abuse.
2. Dupre D, Miller N, Gold M, Rospenda K: Initiation and progression of alcohol, marijuana, and cocaine use among adolescent abusers. The American Journal on Addictions 1995; 4:43–48.

TARGET AUDIENCE:

Health professionals who work with children and adolescents.

Poster 111 **Friday, October 11 10:30 a.m.-12 noon**

RISPERIDONE VERSUS HALOPERIDOL AUGMENTATION IN SSRI REFRACTORY OCD: CLINICAL AND COGNITIVE EFFECTS

Janssen Pharmaceutica and Research Foundation

Xiaohua Li, M.D., Ph.D., *Department of Psychiatry and Behavioral Neurobiology, University of Alabama at Birmingham, 1700 7th Avenue South, Birmingham, AL 35294*; Warren T. Jackson, Ph.D.; Roberta May, M.A., C.C.R.C.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will recognize the clinical benefits that may be attained with adjunctive therapy with an atypical antipsychotic such as risperidone in patients whose response remains inadequate with SSRI monotherapy.

SUMMARY:

Objective: Vivid thoughts of deviant violence or aberrant sexual behavior occur in about 30% of patients with obsessive-compulsive disorder (OCD) and often resist treatment with SSRIs. Data suggest adjunctive treatment with atypical antipsychotics, for example, risperidone, is beneficial. We compared risperidone, haloperidol, and placebo in OCD patients on stable doses of SSRI, with residual severe symptoms including horrific thoughts.

Methods: This double-blind, crossover study assessed psychiatric symptoms and cognitive tasks using the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS), HAM-D scale, Symptom Check List-90-Revised self-report questionnaire, and neuropsychologic tests (including Emotional Stroop task).

Results: Fourteen patients were enrolled; 10 completed the study Risperidone improved obsessive symptoms (Y-BOCS 69.3% of baseline, compulsion 84.3%, and total score 76.4%). Respective changes with placebo were 107%, 90.6%, and 98.5%. Risperidone reduced depressive (HAM-D) symptoms (77.0% of baseline) and BPRS (49.5%) scores. Haloperidol showed similar effects on some symptoms but was less well tolerated. Three of 10 patients discontinued early on haloperidol phase and the remainder reported more side effects than with risperidone. Risperidone did not change the emotional reaction time compared with placebo.

Conclusions: Results suggest that risperidone is a promising adjunctive treatment for OCD patients with severe obsessions, including horrific thought.

REFERENCES:

1. Jenike MA, Rauch SL: Management the patient with treatment resistant obsessive-compulsive disorder: Current strategies. Arch Gen Psychiatry 1994;55:11–17.
2. McDonough M, Kennedy N: Pharmacological management of obsessive-compulsive disorder: a review for clinicians. Harv Rev Psychiatry 2002; 10:127–137.

TARGET AUDIENCE:

Psychiatrists.

Poster 112 **Friday, October 11 10:30 a.m.-12 noon**

CULTURAL VARIATIONS IN CANCER PAIN EXPRESSION

Christopher K. Wood, M.D., *Resident, Department of Psychiatry, University of Hawaii, 31356 Lusitana Street, Fourth Floor, Honolulu, HI 96816*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the differences in cancer pain expression among various ethnic groups. Ascertain which biopsychosocial factors contribute towards differences in cancer pain expression. Understand the need to monitor cancer pain and appreciate patients culture in the expression of pain.

SUMMARY:

The treatment of cancer pain is a major challenge in health care today. A person's cultural identity often impacts how pain is perceived, and subsequently, which treatment modalities will be most beneficial. In Hawaii where multiculturalism is the norm, there may exist differences in cancer pain expression among Hawaii's varied ethnic groups. The purpose of this study is to determine whether there are, indeed, cultural variations in cancer pain expression and to discuss the clinical implications of the findings should affirmative results be obtained.

The design of this project will be by retrospective chart review of 425 cancer inpatients in five ethnic groups (Caucasian, Chinese, Filipino, Japanese, and Native Hawaiian) diagnosed with stage-IV bone metastasis from 1999 through 2001. Abstracted from the chart will be ethnicity, other basic demographic variables, diagnostic information (medical and psychiatric), medications, and pain ratings as recorded on the FACES pain scale. Data will be managed and analyzed using SPSS. Cross-ethnic comparisons of pain expression and treatment will be made using ANOVA and regression.

Findings from this research will allow us to further develop theories and hypotheses about cancer pain expression and treatment differences among ethnic groups in Hawaii. Findings from this study and subsequent

research will allow caregivers to increase their awareness about ways that different ethnic groups express pain, and ultimately, lead to more appropriate ways to measure and treat pain.

REFERENCES:

1. Zborowski M: Cultural components of the response to pain. J Soc Issues 1952; 8:16–30.
2. Jucrez G: Influence of culture on cancer for management in Hispanic patients. Cancer Practice 1998; 262–269.

TARGET AUDIENCE:

Psychiatrists, physicians, and nursing staff who work with cancer patients.

Poster 113 **Friday, October 11 10:30 a.m.-12 noon**

ANTIDEPRESSANT USE AND DECLINE IN THE SUICIDE RATE IN THE U.S.: 1990–1999

Dale A. D'Mello, M.D., *Associate Professor, Department of Psychiatry, Michigan State University, Saint Lawrence Hospital, 1210 West Saginaw, Lansing, MI 48915*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should appreciate that trends reflecting increased recognition and treatment of depression in the community parallel an apparent decline in suicide rates

SUMMARY:

In the latter half of the 20th century the suicide rate in the U.S. declined dramatically, but remained relatively stable. Explanations of changes in rates of suicide are complex. Societal, environmental, and cultural factors all play a role. Advances in the recognition and treatment of psychiatric disorders may be equally relevant.

Objective: The purpose of this study was to examine the rates of suicide in the last decade of the 20th century, following the advent of safer antidepressants.

Method: The author compared the available data regarding suicide deaths retrieved from national mortality statistics with information on the changing trends of antidepressant prescription.

Results: Between 1990 and 1999 the suicide rate in the U.S. declined steadily from 12.4 to 10.7 deaths/100,000 population. This was true for all age cohorts, both genders, and diverse ethnic groups. The magnitude of the decline was modest, but unidirectional. During the same time period, prescriptions for antidepressants doubled.

Conclusions: The modest, but steady decline in the suicide rate may reflect the growing impact of enhanced recognition and treatment of psychiatric illness on the preservation of life, and on the quality of life for patients and their loved ones.

REFERENCES:

1. Pincus HA, Tanielian TL, Marcus SC, Olfson M, Zarin DA, Thompson J, Magno Zito J: Prescribing trends in psychotropic medications. JAMA 1998;279:526–531.
2. Hoyert DL, Arias E, Smith BL, Murphy SL, Kochaneck KD: Deaths: final data for 1999. National Vital Statistics Report. 2001;49(8). National Center for Health Statistics. DHHS Publication Number (PHS) 2001–1120.

TARGET AUDIENCE:

Psychiatrists, psychologists, social workers, nurses.

Poster 114 **Friday, October 11 10:30 a.m.-12 noon**

A PRAGMATIC AND CONVENIENT APPROACH FOR THE MANAGEMENT OF ACUTE AGITATION: RESULTS FROM A SERIES OF CLINICAL STUDIES

Janssen Pharmaceutica and Research Foundation

George M. Simpson, M.D., *Interim Chair, Department of Psychiatry, Los Angeles County and University of Southern California Medical Center, 2020 Zonal Avenue, IRD Room 204 POC, Los Angeles, CA 90033*; Georges Gharabawi, M.D.; Jacqueline D. Morein

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participant will appreciate the urgent need for coherent practice patterns for the delivery of psychiatric emergency care for acutely agitated patients and will be familiar with the beneficial role of orally administered risperidone plus lorazepam treatment in patients with acute psychotic agitation.

SUMMARY:

Background: There is an urgent need to establish psychiatric emergency care practice patterns for acutely agitated patients that balance patient rights, safety, and good standards of care. Previous practice has focused on rapid tranquilization, typically achieved through administration of immediate release intramuscular (IR-IM) preparations of antipsychotics and benzodiazepines. While these medications rapidly control symptoms through their sedative effects, they are invasive and carry risks for patients and hospital staff.

Methods: A recent naturalistic study of 60 patients compared the efficacy, safety, and tolerability of oral psychotropics (risperidone and lorazepam) with the IR-IM standard (haloperidol and lorazepam). A follow-up study was performed on 162 acutely psychotic patients randomized to oral 2 mg risperidone liquid/2 mg lorazepam or IR-IM intervention (5 mg haloperidol/2 mg lorazepam), evaluated for 24 hours

Results: Both treatment groups improved, with no significant between-group differences. In the follow-up study, score reductions on a five-item measure of psychotic agitation and an aggression scale were significant and equivalent in the 2 groups.

Conclusion: Our findings are consistent with a recent consensus guideline based on a survey of 50 psychiatric emergency department experts that indicated the preference of clinicians and patients to use oral psychotropics over IR-IM preparations whenever possible.

REFERENCES:

1. Feifel D. Rationale and guidelines for the inpatient treatment of acute psychosis. J Clin Psychiatry 2000;61 (Suppl 14): 27–32.
2. Hillard JR. Emergency treatment of acute psychosis. J Clin Psychiatry 1998;59 (Suppl 1):57–60.

TARGET AUDIENCE:

Emergency room psychiatrists.

Poster 115 **Friday, October 11**
10:30 a.m.-12 noon

RISPERIDONE IN REFRACTORY OCD: POSITRON EMISSION TOMOGRAPHY IMAGING

Janssen Pharmaceutica and Research Foundation

Eric Hollander, M.D., *380 Orienta Avenue, Mamaroneck, NY 10543*; Monte Buchsbaum, M.D., Stefano Pallanti, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize changes in brain metabolic patterns that occur in patients with obsessive-compulsive disorder treatment with risperidone.

SUMMARY:

Objective: To evaluate the efficacy of risperidone in patients with obsessive-compulsive disorder (OCD) not responsive to selective serotonin reuptake inhibitors (SSRIs) and image associated patterns of metabolic change in the brain.

Method: In a double-blind, parallel-group trial, patients received risperidone or placebo. Positron emission tomography and magnetic resonance imaging scans were obtained at baseline and 8 weeks.

Results: Fifteen of 16 patients completed the study. Risperidone was associated with significant increases in relative metabolic rate in the striatum, cingulate gyrus, and prefrontal cortex, especially in the orbital region. Four of 9 risperidone patients showed clinical improvement (CGI score of 1 or 2 at eight weeks); none of the six placebo patients showed improvement. Clinical response was more likely in risperidone-treated patients with low relative metabolic rates in the striatum and high relative metabolic rates in the anterior cingulate gyrus. These results are consistent with a fronto-striatial circuit change related to both dopaminergic and serotonergic systems and the presence of psychopharmacologic subtypes within OCD.

Conclusions: Risperidone normalizes brain metabolic patterns in OCD patients not responsive to SSRIs. Patients with low relative metabolic rates in the striatum and high metabolic rates in the cingulated gyrus at baseline were more likely to respond.

REFERENCES:

1. Jacobsen FM: Risperidone in the treatment of affective illness and obsessive-compulsive disorder. J Clin Psychiatry 1995;56:423–429.
2. Hollander E, Bienstock CA, Koran LM, et al: Refractory obsessive-compulsive disorder: state of the art treatment. J Clin Psychiatry 2002;63 (Suppl 6): 20–29.

TARGET AUDIENCE:

Psychiatrists, neurologists.

Poster 116 **Friday, October 11**
10:30 a.m.-12 noon

MEDICAID COSTS OF DEMENTIA PATIENTS INITIATING ATYPICAL ANTIPSYCHOTICS

Janssen Pharmaceutica and Research Foundation

Ann K. Thompson, M.B.A., B.S.N., *Assistant Director, Regional Outcomes Research, Janssen Pharmaceutica and Research Foundation, Park Center, Suite 530, 2400 Dallas Parkway, Plano, TX 75093*; Anne Damiano, Sc.D., M.S.; Amy Grogg, Pharm.D.; Jesse Malkin, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, evaluate the relative California Medicaid costs associated with receiving risperidone or olanzapine among elderly patients with dementia who are naïve to atypical antipsychotics.

SUMMARY:

Objective: Medicaid claims from California were used to evaluate the association between atypical antipsychotic therapies and payer costs among elderly patients (> 66years) with dementia.

Methods: Patients were included in the study if they received risperidone (n=519) or olanzapine (n=255) in the first half of 1998 and had not received any atypical antipsychotics the year prior. The primary outcome was the change in total payer costs from one year prior to one year after study therapy initiation. Secondary outcomes included differences in mental health inpatient, outpatient, and medication costs. Each outcome was modeled (median regression with bootstrapping) as a function of study therapy (risperidone or olanzapine), demographics, mental health comorbidities, any long term care stays, prior inpatient stays, and prior duration of conventional therapy.

Results: After controlling for all other variables, the increase in total costs was significantly greater for olanzapine relative to risperidone with an adjusted median difference between treatments of $1,045 (p=0.032). Similarly, increases in mental health medication costs were significantly greater for olanzapine relative to risperidone ($803; p<0.001).

Conclusion: Among Medicaid dementia patients initiating atypical antipsychotic therapy, olanzapine was associated with greater increases in overall and medication costs relative to risperidone.

REFERENCES:

1. Martin BC, Ricci JF, Kotzan JA, Lang K, Menzin J: The net cost of Alzheimer disease and related dementia: a population-based study of Georgia Medicaid recipients. Alzheimer Dis Assoc Disord 2000; 14(3):151–9.
2. Bhana N, Spencer CM: Risperidone: a review of its use in the management of the behavioural and psychological symptoms of dementia. Drugs Aging 2000; 16(6):451–71.

TARGET AUDIENCE:

Psychiatrists, health economists.

Poster 117 **Friday, October 11**
10:30 a.m.-12 noon

TOLERABILITY AND SAFETY ISSUES IN A CLINICAL TRIAL UTILIZING THE ATYPICAL ANTIPSYCHOTIC RISPERIDONE IN TREATMENT-RESISTANT GAD PATIENTS

Janssen Pharmaceutica and Research Foundation

Olga Brawman-Mintzer, M.D., *Department of Psychiatry, Medical University of South Carolina, 5900 Core Road, Suite 203, Charleston, SC 29406-6076*; Wenle Zhao, Ph.D.; Rebecca Knapp, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to evaluate risperidone's safety and tolerability in the treatment of generalized anxiety disorder.

SUMMARY:

Objective: To assess risperidone's tolerability and safety of in non-depressed patients with treatment-resistant DSM-IV generalized anxiety disorder (GAD).

Methods: A 6-week, double-blind, placebo-controlled trial evaluating the efficacy and safety of risperidone augmentation in 40 non-depressed, treatment-resistant DSM-IV GAD patients. Since the study is still blinded, the clinical characteristics, compliance, completion rates, and adverse events of the first 30 study subjects are reported.

Results: The first 30 patients (80% females, mean age 49.13 years) were evaluated. At baseline, the mean duration of GAD symptoms was 21.9 years and mean total Hamilton Anxiety score was 21.2 (SD=3.29). The mean dose of study medication at week-5 was 1.2 mg (SD=0.36) daily. (90%) of study subjects received prior psychotropic medications, and all received current anxiolytic medications (60% received SSRIs/SNRI, 50% received benzodiazepines, and 20% received hypnotics). Treatment compliance was high (97%) and 77% completed the study. Non-tolerance of minimal dosing (n=2), and adverse events (n=3) have resulted in early treatment discontinuation. No extrapyramidal side effects or tardive dyskinesia were observed. No weight change (170 lbs [SD=35.16] at baseline vs. 173.5 lbs [SD=35.11] at endpoint) was observed.

Conclusion: Treatment-resistant GAD subjects potentially represent a distinct population that can easily adhere to and tolerate risperidone therapy.

REFERENCES:

1. Brawman-Mintzer O: Pharmacological treatment of generalized anxiety disorder. Psychiatric Clinics of North America. 2001; 119–139.
2. Pollack MH, Zaninelli R, Goddard A, et al: Paroxetine in the treatment of generalized anxiety disorder: results of a placebo-controlled, flexible dosage trial. J Clin Psychiatry 2001;62:350–357.

TARGET AUDIENCE:

Psychiatrists.

Poster 118 **Friday, October 11 10:30 a.m.-12 noon**

ORAL RISPERIDONE IN THE MANAGEMENT OF ACUTE AGITATED BEHAVIOR

Janssen Pharmaceutica and Research Foundation

Belynda D. Veser, M.D., *Clinical Instructor of Psychiatry, Medical University of South Carolina, 2016 Wappoo Drive, Charleston, SC 29412*; Frederick Veser, M.D.; Joseph Zealburg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, understand that the treatment of agitated behavior in emergency settings can be achieved more quickly and effectively when standard benzodiazepine therapy is augmented with risperidone.

SUMMARY:

Objective: To compare the efficacy of oral risperidone with oral haloperidol or placebo (all given as adjunctive therapy to IM lorazepam) in the management of agitated behavior in an emergency setting.

Methods: Efficacy measures: Positive and Negative Syndrome Scale (PANSS) total scores and PANSS-derived positive and aggression subscale scores. Efficacy was evaluated at baseline, 30 minutes, and 90 minutes.

Results: The mean age of the 31 patients was 39±11 years: 77% were men, and 53% black. Histories included schizophrenia, depression, alcoholism, bipolar disorder, anxiety, and dementia. All groups improved significantly 90 minutes after treatment compared to baseline as measured by the PANSS aggression subscale scores and the PANSS total scores ($p<0.05$). Patients treated with oral risperidone, but not with haloperidol or placebo, improved significantly from baseline at 30 minutes. This improvement was consistently observed on the PANSS total score ($p=0.009$) and the aggression subscale scores ($p=0.013$).

Conclusion: Only patients randomized to treatment with risperidone/lorazepam demonstrated a statistically significant improvement of their agitation 30 minutes following drug administration. Additionally, these results suggest that a benzodiazepine alone is inadequate treatment for agitation.

REFERENCES:

1. Cumel GW, Simpson GM: Risperidone liquid concentrate and oral lorazepam versus intramuscular haloperidol and intramuscular lorazepam for treatment of psychotic agitation. J Clin Psychiatry 2001;62:153–157.
2. Binder RL, McNeil DE. Contemporary practices in managing acutely violent patients in 20 psychiatric emergency rooms. Psychiatr Serv 1999;50:1553–1554.

TARGET AUDIENCE:

Emergency room psychiatrists.

Poster 119 **Friday, October 11 10:30 a.m.-12 noon**

RISPERIDONE IN TREATING AGITATION AND PSYCHOSIS ASSOCIATED WITH DEMENTIA

Janssen Pharmaceutica and Research Foundation

Grant N. Ko, M.D., *Senior Director, Central Nervous System and Analgesia, Janssen Pharmaceutica and Research Foundation*; Alistair Burns, M.D.; Fred Grossman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the beneficial effects of low-dose risperidone treatment in elderly patients with dementia.

SUMMARY:

Objective: To analyze the efficacy of risperidone in elderly patients with dementia found in three double-blind, 12-week trials.

Methods: Pooled analysis was performed on the change from baseline to study endpoint and change over time in efficacy scores obtained from the Cohen Mansfield Agitation Inventory (CMAI), the Behavioral Pathology in Alzheimer's Disease (BEHAVE-AD), and the Clinical Global Impression of Change (CGI-C) and CGI severity.

Results: Data from 722 risperidone-treated (median modal dose 1.0 mg/day) and 428 placebo-treated patients were analyzed. The mean change in CMAI at end point was significantly greater for risperidone versus placebo for both total score (−11.8 versus −6.4, respectively; $P < .001$) and total aggression subscale score (−5.0 versus −1.8, respectively; $P < .001$). The observed mean change from baseline to end point in BEHAVE-AD total score was significantly greater for risperidone versus placebo (−6.1 and −3.6, respectively; $P < .001$), which was also observed for the psychotic symptoms subscale (−2.1 and −1.2, respectively; $P = .003$). Significantly greater improvements were also observed in overall CGI-S and CGI-C among those treated with resperidone versus placebo.

Conclusion: Low dose risperidone is highly effective in treating behavioral and psychological symptoms in patients with dementia.

REFERENCES:

1. Rainer MK, Masching AJ, Ertl MG, Kraxberger E, Hauschofer M: Effect of risperidone on behavioral and psychological symptoms and cognitive function in dementia. J Clin Psychiatry 2001;62:894–900.
2. Tune LE: Risperidone for the treatment of behavioral and psychological symptoms of dementia. J Clin Psychiatry 2001;62 Suppl 21:29–32.

TARGET AUDIENCE:

Geriatric psychiatrists.

Poster 120 **Friday, October 11 10:30 a.m.-12 noon**

PTSD AND MOTOR VEHICLE ACCIDENTS

Issar Siddiqui, M.D., *Physician, Emergency Unit, Hamad General Hospital, P.O. Box 3050, Doha, Qatar*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and demonstrate-PTSD and its relation to motor accidents.

SUMMARY:

Objective: Posttraumatic stress disorder (PTSD) is a frequent consequence of motor vehicle accidents, but is rarely brought into the biopsychosocial treatment formulation of these patients. Current data regarding these patients with PTSD is insufficient.

Method: 48 randomly selected survivors of motor vehicle accidents were interviewed while hospitalized. In the ward, inpatients were screened for PTSD, depressive, and dissociative symptoms, for prior trauma, for pre-event and current level of functioning. Patient demographic and injury characteristics were also recorded. Percentages of these patients exhibiting the classical features were calculated.

Results: Of the 48 inpatients, 56% screened positive for high levels of symptomatic distress and impairment in their level of current functioning. They qualified for the full criteria after six months of follow-up. Degree of injury, female gender, and prior social and economic variables were directly proportional for future PTSD.

Conclusions: PTSD should be kept in mind in the complete biopsychosocial evaluation of any trauma patients. Screening tests should be developed for at-risk patients so that they be diagnosed and treated early.

REFERENCES:

1. Kwekkeboom KL, Seng JS: Recognizing and responding to post-traumatic stress disorder in people with cancer. Oncol Nurs Forum 2002; 29(4):643–50
2. Klein E, Koren D, Arnon I, Lavie P: No evidence of sleep disturbance in post-traumatic stress disorder: a polysomnographic study in injured victims of traffic accidents. Isr J Psychiatry Relat Sci 2002;39(1):3–10

TARGET AUDIENCE:

Physicians.

Poster 121 **Friday, October 11 10:30 p.m.-12 noon**

MEDICAID COSTS OF SCHIZOPHRENIA PATIENTS INITIATING ATYPICAL ANTIPSYCHOTICS

Ann K. Thompson, M.B.A., B.S.N., *Assistant Director, Regional Outcomes Research, Janssen Pharmaceutica and Research Foundation, Park Center, Suite 530, 2400 Dallas Parkway, Plano, TX 75093*; Amy Grogg, Pharm.D.; Anne Damiano, Sc.D., M.S.; Jesse Malkin, Ph.D.; Kay Sadik, Ph.D., Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the relative California Medicaid costs associated with receiving risperidone, olanzapine, or quetrapine among patients with schizophrenia who are naive to atypical antipsychotics.

SUMMARY:

Objective: Evaluate the association between alternative atypical antipsychotic therapies and California Medicaid costs among non-elderly schizophrenia patients.

Methods: Patients were included in the study if they received risperidone, olanzapine, or quetrapine (study therapy) in the first half of 1998 and had not received any atypical antipsychotics the year prior. Two subgroups were analyzed: (1) those with prior conventional antipsychotic use (n=5.054) and (2) those with no prior conventional use (n=2.492). The primary outcome was change in total costs from one year prior to one year after study therapy initiation. Secondary outcomes included differences in mental health inpatient, outpatient, and medication costs. Each outcome was modeled (median regression with bootstrapping) as a function of study therapy, demographics, mental health comorbidities, and prior inpatient stays.

Results: The total cost increase was significantly greater for olanzapine relative to risperidone in subgroup 1 with an adjusted median difference between treatments of \$555 ($p<0.001$). Total cost differences were largely explained by significant ($p\leq0.001$) differences in mental health medication costs between olanzapine and risperidone. \$648 in subgroup 1 and \$419 in subgroup 2.

Conclusion: Among Medicaid schizophrenia patients initiating atypical antipsychotic therapy, olanzapine was associated with greater increases in overall and medication costs relative to risperidone.

REFERENCES:

1. McCombs JS, Nichol MB, Simmel GL, Shi J, Smith RR: Use patterns for antipsychotic medications in medicaid patients with schizophrenia. J Clin Psychiatry 1999;60 Suppl 19:5–11; discussion 12–3
2. Martin BC, Miller LS. Expenditures for treating schizophrenia: a population-based study of Georgia Medicaid recipients. Schizophr Bull 1998;24(3).

TARGET AUDIENCE:

Psychiatrists.

POSTER SESSION 3

Posters 122–180

Poster 122 **Friday, October 11**
4:00 p.m.-5:30 p.m.

TESTOSTERONE GEL SUPPLEMENTATION IN TREATMENT-REFRACTORY DEPRESSED MEN

Unimed Pharmaceuticals, Inc.

Harrison G. Pope, Jr., M.D., *Professor of Psychiatry, Harvard Medical School, McLean Hospital, 115 Mill Street, Belmont, MA 02478*; Gen Kanayama, M.D., Ph.D.; Geoffrey H. Cohane, B.A.; Arthur J. Siegel, M.D.; James I. Hudson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) recognize the high prevalence of frank or borderline hypogonadism in depressed men refractory to conventional antidepressants, (2) consider routinely obtaining testosterone levels in middle-aged and older depressed men, (3) be aware of preliminary findings suggesting that testosterone replacement may offer psychiatric benefits for such individuals.

SUMMARY:

Psychiatrists frequently see middle-aged men with depression refractory to standard antidepressant treatment. We screened 56 such men, and found that 24 (43.6%) displayed frank or borderline hypogonadism, with morning total testosterone levels ≤350 ng/dl (normal range in our laboratory 270–1070 ng/dl). We entered 23 of these men into a randomized trial of testosterone transdermal gel, added to each subject's existing antidepressant medications. One subject responded to an initial one-week, single-blind placebo washout; 12 were subsequently randomized to testosterone gel and 10 to placebo gel for eight weeks. Subjects in the two treatment groups were closely matched on baseline demographic and psychiatric measures. Subjects randomized to testosterone gel improved significantly more than subjects on placebo on the Hamilton Rating Scale for Depression ($p < 0.001$) and the Clinical Global Impression-Severity Scale ($p = 0.035$), though not on the Beck Depression Inventory ($p = 0.15$). One subject assigned to testosterone reported increased difficulty with urination, suggesting an exacerbation of benign prostatic hyperplasia; no other subject reported adverse events apparently attributable to testosterone. These preliminary findings suggest that frank or borderline hypogonadism is surprisingly common in treatment-refractory middle-aged men. Psychiatrists should consider routinely obtaining testosterone levels in such patients, since some such men may benefit from testosterone replacement.

REFERENCES:

1. Pope HG Jr, Cohane GH, Kanayama G, Siegel A, Hudson JI: Testosterone gel supplementation in treatment-refractory depressed men: a randomized placebo-controlled trial, submitted publication.
2. Seidman SN, Rabkin J: Testosterone replacement therapy for hypogonadal men with SSRI-refractory depression. J Affective Disord 1998; 48:157–161.

TARGET AUDIENCE:

Clinicians who treat middle-aged or older men with depression.

Poster 123 **Friday, October 11**
4:00 p.m.-5:30 p.m.

PATIENT AND RATER EDUCATION ABOUT EXPECTATIONS IN CLINICAL TRIALS: AN APPROACH TO REDUCING PLACEBO RESPONSE RATES IN DEPRESSION AND GAD TRIALS

Daniel L. Zimbroff, M.D., *Medical Director, Pacific Clinical Research, 1317 West Foot Hill Boulevard, Suite 200, Upland, CA 91786*; Shlomo Brook, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to reduce placebo response rates in depression and generalized anxiety disorder trials.

SUMMARY:

Methods: The Patient and Rater Education of Expectations in Clinical Trials (PREECT), a two-component approach, has been developed for psychopharmacology clinical trials. PREECT emphasizes the development of a research alliance between the investigating physician and the study subject, rather than the traditional therapeutic alliance. PREECT also includes careful training of study-site staff about the potential harmful impact of supportive and encouraging remarks to the subject during study participation. Placebo response and signal detection data from two double-blind, randomized psychopharmacology clinical trials were examined.

Results: In trial one, the PREECT site had the lowest placebo-response rate of the six sites that enrolled subjects. 3/19 (15.5%) placebo treated subjects had sustained 50% HAM-D response, defined as a 50% Ham-D response for ≥2 weeks. The range of sustained placebo response rates for the non-PREECT sites ranged from 25% to 44.4%. The Day 35 endpoint mean difference between active treatment and placebo was −3.07 points on the HAM-D at the PREECT site, and −2.57 points at Day 42. The Day 42 endpoint difference ranged between +1.91 and −8.00 point (SD 6–9 points) at the other five sites. In trial two, the PREECT site had a 55-point LSAS difference between the SSRI test agent group and placebo. Drug-placebo differences ranged from 63.3 to −8.1 at the other sites with comparable numbers of subjects.

Conclusions: Preliminary evidence from two well-controlled psychopharmacology clinical trials indicate that the PREECT approach reduced the placebo-response rate and improved signal detection as compared with sites not using the PREECT approach. This may have important implications for psychotropic drug development, as high trial failure rates, primarily due to high placebo response rates, add time and cost to new drug development and potentially lead to the discontinuation of useful, innovative therapies from further development.

The authors thank Sanofi-Synthelabo Pharmaceuticals Inc and Solvay Pharmaceuticals for their cooperation in providing the placebo response data from the trial.

REFERENCES:

1. Khan A, Warner HA, Brown WA: Symptom reduction and suicide risk in patients treated with placebo in antidepressant clinical trials. An analysis of the Food and Drug Administration database. Arch Gen Psychiatry 2000;57:311–317.
2. Thase M: How should efficacy be evaluated in randomized clinical trials of treatments for depression. J Clin Psychiatry 1999;60(4):23–31.

Poster 124 **Friday, October 11**
4:00 p.m.-5:30 p.m.

DIABETES AND BODY MASS INDEX IN PATIENTS WITH BIPOLAR DISORDER RECEIVING VARIOUS ATYPICAL ANTIPSYCHOTICS

Rafael A. Torres, M.D., *Medical Director, VA Mental Health Outpatient Clinic, and Department of Psychiatry, University of Mississippi, 1500 East Woodrow Wilson Drive, Jackson, MS 39216*; Henry A. Nasrallah, M.D., *Professor of Psychiatry and Neurology, Department of Mental Health Services, University of Mississippi Medical Center, 1500 East Woodrow Wilson Drive, Jackson, MS 39216*; Candace L. Perry, B.S.; Erica Love, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that all first-line atypical antipsychotics are efficacious in the treatment of bipolar patients, but there are differences in the weight gain and diabetes rates among these antipsychotics.

SUMMARY:

Atypical antipsychotics are now widely used in the management of bipolar disorder, usually with a mood stabilizer but sometimes as monotherapy. Atypicals produce far less EPS, but metabolic side effects (obesity, diabetes, and dyslipidemia) are not uncommon. We conducted a study of the patterns of the use of atypical antipsychotics in a teaching VA medical center, and compared the body mass index (BMI) as well as the prevalence of diabetes in the bipolar population receiving various atypical antipsychotics.

Seventy-four bipolar patients receiving atypicals for at least six months were identified. Mean age was 51.8 years, 85% were male, and 73% Caucasian. The majority (77%) received their atypical antipsychotic once a day (qd) and 23% received their atypical b.i.d. or t.i.d. The atypical antipsychotics used were olanzapine (N=29, mean dose = 9.7 mg/day), quetiapine (N=27, mean dose = 138.9 mg/day), and risperidone (N=16, mean dose = 2.8 mg/day). None of the patients received a combination of two antipsychotics, but 62/74 (84%) received a mood stabilizer with the atypical antipsychotic and the rest (N= 12) were deemed stable on monotherapy of quetiapine of (N=5), risperidone (N=4), and olanzapine (N=3).

The mean BMI was highest in the olanzapine group (31.28 kg/m^2). Diabetes was present in 18.75% of the risperidone group (3/16), 18.52% of the olanzapine group (5/27), and 6.9% of the quetiapine group (2/29).

The results of this study indicate that bipolar patients can be stabilized on all the atypical antipsychotics (ziprasidone was not yet available at the time of the study), usually in combination with a mood stabilizer (lithium

or valproate). All the patients were overweight and the BMI was highest in the olanzapine group and lowest in the risperidone group but with no significant differences among the groups. Finally, diabetes prevalence was lowest in the quetiapine group and equally high in both the olanzapine and risperidone groups. The significance of the findings will be discussed in light of the emerging literature on the efficacy and safety of atypical antipsychotics in schizophrenia as well as in bipolar disorder.

REFERENCES:

1. McInTyre RS et al: Antipsychotic metabolic effects: weight gain, diabetes mellitus, and lipid abnormalities.
2. Allison DB et al: Antipsychotic-induced weight gain: a comprehensive research synthesis. Americal J Psychiatry 1999;156:1686–1696.

Poster 125 **Friday, October 11 4:00 p.m.-5:30 p.m.**

CHARACTERISTICS OF LARGE COHORT OF PATIENTS WITH BIPOLAR DISORDER

GlaxoSmithKline

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EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the demographic and clinical characteristics of a large cohort of patients with bipolar I disorder and to characterize the burden of this disorder on their lives.

SUMMARY:

Objective: To characterize a large cohort of bipolar I patients and to document the burden of this disorder on their lives.

Methods: Patients enrolled into the preliminary phase of two 18-month, randomized, placebo-controlled maintenance studies (GW605/GW606) were included. All were currently or recently symptomatic and had a DSM-IV diagnosis of bipolar disorder. Patients provided interview-based information on demographic characteristics and clinical history.

Results: The median age of the 1,305 patients who were analyzed was 41.8 years, 58% were women, and 90% were white. The mean age at onset was 23 years, and the mean duration of illness was 20 years. Positive family history for bipolar or any affective illness was present in 28% and 35%, respectively. Sixty-six percent had previously been hospitalized for bipolar disorder, and 35% had attempted suicide. Previous depressive episodes outnumbered other types of mood episodes by a factor of at least 1.5. Baseline CGI, GAS, and SF-36 scores suggested more functional impairment and a lower quality of life in those patients currently or recently depressed versus those manic.

Conclusion: These findings reinforce the chronicity and severity of bipolar disorder, especially bipolar depression. Improved intervention strategies are needed to decrease the burden of this debilitating illness.

REFERENCES:

1. Kupfer DJ, Frank E, Grochocinski VJ, et al.: Demographic and clinical characteristics of individuals in a bipolar disorder case registry. J Clin Psych 2002; 63(2):120–125.
2. Woods SW: The economic burden of bipolar disease. J Clin Psych 2000; 61(13):38–41.

TARGET AUDIENCE:

General psychiatrists, health outcomes researchers.

Poster 126 **Friday, October 11 4:00 p.m.-5:30 p.m.**

QUALITY OF LIFE IN BIPOLAR VERSUS UNIPOLAR DEPRESSION AND U.S. POPULATION NORMS

GlaxoSmithKline

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EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe quality of life for a clinical trial bipolar disorder population compared to a unipolar depression population and U.S. population norms.

SUMMARY:

Objective: To assess quality of life (QOL) in bipolar I patients compared with QOL in unipolar depression and in a general population in the United States (U.S. Norms).

Methods: Currently or recently symptomatic patients with bipolar I disorder were enrolled in two placebo-controlled, double-blind maintenance trials (GW605/GW606). Baseline SF-36 scores were compared with scores from a sample (n=2,474) of adults from a general U.S. population and with scores from a unipolar depressed population from the Medical Outcomes Study (n=502).

Results: Index-depressed patients had significantly lower QOL scores on all SF-36 subscales compared with U.S. National Norms ($p<0.001$) and compared with unipolar depressed patients on six subscales: physical role, general health, vitality, social functioning, emotional role, mental health ($p<0.001$). Index-manic patients had significantly lower QOL scores compared with US Norms on six subscales, excluding Vitality and Physical Functioning. Compared with unipolar depressed patients, manic bipolar patients had significantly higher ($p<0.001$) QOL scores on all subscales, except Emotional Role (similar in both populations) and Social Functioning (significantly lower in manic bipolar patients, $p<0.001$).

Conclusion: Patients with bipolar I disorder have significant psychosocial impairment, compromised functioning, and diminished QOL. The QOL in bipolar depressed patients is significantly lower than in unipolar depression.

REFERENCES:

1. Stewart AL, Greenfield S, Hays RD, et al.: Functional status and well-being of patients with chronic conditions. JAMA 1989; 262(7):907–913.
2. Ware JE, Snow KK, Kosinski M, Gandek B: SF-36 Health Survey: Manual and Interpretation Guide. Boston, Mass, The Health Institute, 1993.

TARGET AUDIENCE:

General psychiatrists, health outcomes researchers.

Poster 127 **Friday, October 11**
4:00 p.m.-5:30 p.m.

SAFETY META-ANALYSIS OF OLANZAPINE-FLUOXETINE COMBINATION VERSUS PLACEBO

Eli Lilly and Company

Donald P. Hay, M.D., *Clinical Research Physician, Neuroscience Medical Affairs, Eli Lilly and Company, One Lilly Corporate Center, DC-4025, Indianapolis, IN 46285*; Sanjay Dube, M.D.; Scott W. Andersen, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize and describe the acute safety profile of OFC compared with placebo.

SUMMARY:

Background: Recent evidence suggests that olanzapine-fluoxetine combination (OFC) has enhanced antidepressant qualities compared with monotherapies and is a promising treatment option for difficult-to-treat depressions. As an index of its tolerability, OFC's acute safety profile was examined against placebo.

Methods: Meta-analyses of safety measures were performed from two parallel, eight-week double-blind trials (n=148). Patients with psychotic depression were treated with OFC or placebo.

Results: Of events occurring in ≥10% of patients, significantly more OFC patients experienced somnolence (25%, 5%; p=0.001) and peripheral edema (10.4%, 0%; p=0.003). The proportion of patients with >10% increase in weight was significantly higher for OFC than placebo (6.7%, 0%; p=0.035). No other significant differences were seen between OFC treatment and placebo for adverse events (including weight gain), extrapyramidal symptoms, abnormal electrocardiograms, or categorical changes in vital signs or laboratory analytes.

Conclusion: Acute OFC treatment was associated with a higher incidence of somnolence, peripheral edema, and potentially significant weight gain compared with placebo. This profile is similar to those of OFC's component monotherapies, and provides evidence for the acute tolerability of this combination treatment.

REFERENCES:

1. Bhana N, Foster RH, Olney R, Plosker GL: Olanzapine: an updated review of its use in the management of schizophrenia. Drugs. 2001:61(1):111–161.
2. Beasley CM, Koke SC, Nilsson ME, Gonzales JS: Adverse event and treatment discontinuations in clinical trials of fluoxetine in major depressive disorder: updated meta-analysis. Clinical Therapeutics 2000:22(11):1319–1329.

TARGET AUDIENCE:

Psychiatrists.

Poster 128 **Friday, October 11**
4:00 p.m.-5:30 p.m.

OLANZAPINE-FLUOXETINE COMBINATION FOR PSYCHOTIC MAJOR DEPRESSION

Eli Lilly and Company

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize the benefits of olanzapine-fluoxetine combination (OFC) for treating psychotic major depression.

SUMMARY:

Background: Between 16% and 54% of MDD adults have psychotic features. Antipsychotic-antidepressant combinations have been shown more effective than monotherapies for reducing depressive symptoms.

Methods: Two parallel, eight-week, double-blind trials with an optional 48-week, open-label extension phase compared olanzapine-fluoxetine combination (OFC) with olanzapine or placebo in psychotic depression (n= 249). Efficacy was evaluated with the HAMD-24.

Results: Pooled data showed OFC achieved greater mean total score decrease (−18.3) than olanzapine (−14.4, p=0.072) and placebo (−11.4, p=0.001). The OFC response rate at endpoint (≥50% total score decrease) was significantly greater (56%) than that of olanzapine (36%) or placebo (30%). The OFC median time to response was significantly better (12 days) than placebo (20 days), and equal to olanzapine (12 days). In the extension phase, 71% of OFC responders maintained response. Significantly more OFC partial responders (≥25% total score decrease at two weeks) attained full endpoint response compared with olanzapine or placebo (64%, 35%, 32%).

Conclusion: OFC demonstrated greater improvement in depressive symptoms and greater rate of response than olanzapine or placebo. Approximately three-fourths of acute OFC responders maintained a long-term response.

REFERENCES:

1. Dubovsky SL: Challenges in conceptualizing psychotic mood disorders. Bull Menninger Clin 1994; 58:197–214.
2. Spiker DG, Weiss JC, Dealy RS, et al: The pharmacological treatment of delusional depression. Am J Psych 1985; 142(4):430–436.

TARGET AUDIENCE:

Psychiatrists.

Poster 129 **Friday, October 11**
4:00 p.m.-5:30 p.m.

SAFETY META-ANALYSIS OF OLANZAPINE-FLUOXETINE COMBINATION VERSUS FLUOXETINE

Eli Lilly and Company

Donald P. Hay, M.D., *Clinical Research Physician, Neuroscience Medical Affairs, Eli Lilly and Company, One Lilly Corporate Center, DC-4025, Indianapolis, IN 46285*; Sara Ann Corya, M.D.; Scott W. Andersen, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize the safety profile of OFC compared with fluoxetine.

SUMMARY:

Background: Studies suggest that OFC enhances antidepressant effects in treatment-resistant depression (TRD). We evaluated whether OFC yields adverse effects not associated with fluoxetine monotherapy.

Methods: Meta-analysis of safety data from four double-blind studies (n=688) was performed. OFC was compared with fluoxetine for TRD patients or for sexual dysfunction reported with fluoxetine. Adverse events, vital signs, electrocardiograms, laboratory analytes, extrapyramidal symptoms, and sexual dysfunction (ASEX scale; n=564) were analyzed.

Results: Of events occurring in ≥10% of OFC or fluoxetine patients, significantly more OFC patients experienced weight gain, somnolence, increased appetite, and asthenia, while significantly fewer OFC patients experienced headache, diarrhea, nausea, and insomnia. The proportion of patients with >10% weight gain was significantly higher for OFC than fluoxetine (16.3%, 0.4%). There were no significant categorical changes in laboratory analytes, ECG, heart rate, and EPS measures, or significant mean differences for ASEX between groups.

Conclusion: No unexpected changes were seen in adverse effects commonly reported with fluoxetine monotherapy, and the observed differences between OFC and fluoxetine are consistent with the olanzapine component. These results support the acute safety and tolerability of OFC.

REFERENCES:

1. Bhana N, Foster RH, Olney R, Plosker GL: Olanzapine: an updated review of its use in the management of schizophrenia. Drugs. 2001:61(1):111–161.
2. Beasley CM, Koke SC, Nilsson ME, Gonzales JS: Adverse event and treatment discontinuations in clinical trials of fluoxetine in major depressive disorder: an updated meta-analysis. Clinical Therapeutics 2000:22(11):1319–1329.

TARGET AUDIENCE:

Psychiatrists.

Poster 130 **Friday, October 11 4:00 p.m.-5:30 p.m.**

OPEN-LABEL DULOXETINE TREATMENT OF MAJOR DEPRESSION IN PATIENTS AGES 65 AND OLDER

Eli Lilly and Company

Madelaine M. Wohlreich, M.D., *Clinical Research Physician, Neuroscience Medical Affairs, Eli Lilly and Company, 5202 Potters Pike, Indianapolis, IN 46234*; John S. Kennedy, M.D.; Craig Mallinckrodt, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should recognize that these data suggest duloxetine to be a safe, well-tolerated, and effective treatment for MDD in patients aged ≥65.

SUMMARY:

This report examines duloxetine, a potent and balanced inhibitor of both serotonin and norepinephrine reuptake, in the treatment of MDD in patients aged ≥65. Data were obtained from a 52-week, open-label study in which patients with MDD (n=101, mean $HAMD_{17}$ baseline = 21.8) received duloxetine treatment (80 mg/d to 120 mg/d). Efficacy measures included $HAMD_{17}$ total score, Beck Depression Inventory-II (BDI-II), Patient Global Impression of Improvement (PGI-I), Clinical Global Impression of Severity (CGI-S), and the Sheehan Disability Scale (SDS). Mean changes in $HAMD_{17}$ total score at weeks 6, 28, and 52 were −13.0, −17.4, and −17.5 (all p<.001). Observed case response rates at 6, 28, and 52 weeks were 62.9%, 84.9% and 89.4%, respectively, while remission rates were 41.4%, 69.8% and 72.3%, respectively. Significant improvement (p<.001) in both clinician- (CGI-S) and patient-rated (PGI-I) measures of improvement were observed at week 1 and sustained throughout the study. Significant improvements (p<.001) were also seen in all assessed $HAMD_{17}$ subscales (core, anxiety, retardation, sleep, Maier), $HAMD_{17}$ items 1 and 3, BDI-II total score, and SDS subfactors (work, social, and family) at all scheduled assessment points (weeks 6, 28, and 52). The most frequently reported treatment-emergent adverse events were dizziness, nausea, constipation, and somnolence.

REFERENCES:

1. Detke MJ, Lu Y, Goldstein DJ, Hayes JR, Demitrack MA: Duloxetine, 60 mg once daily, for major depressive disorder: a randomized double-blind placebo-controlled trial. J Clin Psychiatry 2002; 63:308–315.
2. Bymaster FP, Dreshfield-Ahmad LJ, Threlkeld PG, Shaw JL, Thompson L, Nelson DL, Hemrick-Luecke SK, Wong DT: Comparative affinity of duloxetine and venlafaxine for serotonin and norepinephrine transporters in vitro, human serotonin receptor subtypes, and other neuronal receptors. Neuropsychopharmacology 2001; 25:871–880.

TARGET AUDIENCE:

Psychiatrists treating elderly patients with depression.

Poster 131 **Friday, October 11 4:00 p.m.-5:30 p.m.**

SAFETY AND TOLERABILITY OF THE ANTIDEPRESSANT DULOXETINE

Eli Lilly and Company

Madelaine M. Wohlreich, M.D., *Clinical Research Physician, Neuroscience Medical Affairs, Eli Lilly and Company, 5202 Potters Pike, Indianapolis, IN 46234*; Pierre Van Tran, M.D.; Michael J. Detke, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize the safety profile of duloxetine in the treatment of MDD. Specifically, duloxetine did not demonstrate any clinically significant effect on cardiovascular functioning and did not induce weight gain.

SUMMARY:

Objective: To examine safety and tolerability of duloxetine, a potent dual reuptake inhibitor of serotonin and norepinephrine, across multiple clinical trials.

Method: Data from seven double-blind trials were pooled for analyses (duloxetine at 40–120 mg/d n=1032, placebo n=723). Patients were treated for up to 12 weeks.

Results: Discontinuation due to adverse events was 14.6% and 5.0%, respectively, for the duloxetine and placebo groups. Treatment-emergent adverse events (incidence for duloxetine of ≥5.0% and twice the rate of placebo) were nausea, dry mouth, fatigue, dizziness, constipation, somnolence, decreased appetite, and sweating. The incidence of diastolic hypertension (elevated BP for three consecutive visits) for duloxetine was 0.3%. There were no clinically relevant effects on QTc interval or body weight. No significant differences existed between duloxetine and placebo in treatment-emergent abnormal laboratory values at endpoint. The difference in mean change in ASEX total score was not significantly different between duloxetine and placebo.

Conclusion: Duloxetine was demonstrated to be safe and well tolerated.

REFERENCES:

1. Bymaster FP, Dreshfield-Ahmad LJ, Threlkeld PG, Shaw JL, Thompson L, Nelson DL, Hemrick-Luecke

SK, Wong DT: Comparative affinity of duloxetine and venlafaxine for serotonin and norepinephrine transporters in vitro and in vivo, human serotonin receptor subtypes and other neuronal receptors. Neuropsychopharmacology 2001; 25:871–880.
2. Pitsikas N. Duloxetine. Curr Opin Investig Drugs 2000; 1:116–121.

TARGET AUDIENCE:

Psychiatrists.

Poster 132 **Friday, October 11 4:00 p.m.-5:30 p.m.**

DULOXETINE VERSUS PAROXETINE IN THE TREATMENT OF DEPRESSION

Eli Lilly and Company

Madelaine M. Wohlreich, M.D., *Clinical Research Physician, Neuroscience Medical Affairs, Eli Lilly and Company, 5202 Potters Pike, Indianapolis, IN 46234*; David J. Goldstein, M.D.; Yili Lu, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize that duloxetine, a potent dual reuptake inhibitor of serotonin and norepinephrine, is efficacious in the treatment of MDD.

SUMMARY:

Objective: To compare the efficacy of duloxetine (40 & 80 mg/d administered BID), a potent dual reuptake inhibitor of serotonin and norepinephrine, with the SSRI paroxetine (20 mg QD) and placebo in the treatment of MDD.

Method: In this eight-week, randomized, double-blind study, efficacy was evaluated using total $HAMD_{17}$ (primary), MADRS, CGI-S, PGI-I, HAMA, and VAS for pain. Safety and tolerability were also assessed.

Results: Duloxetine was superior to placebo in reduction of $HAMD_{17}$ total scores. Duloxetine 80 mg/d was statistically superior to placebo on most secondary efficacy measures and to paroxetine on $HAMD_{17}$ total score. The remission rate for duloxetine 80 mg/d was 50%, paroxetine 37%, and placebo 30%. Duloxetine 80 mg/d significantly reduced overall pain. Insomnia was the only adverse event reported significantly more frequently for duloxetine 80 mg/d than for paroxetine. There was no significant difference between duloxetine and placebo groups for hypertension.

Conclusions: Duloxetine, a dual reuptake inhibitor of both 5-HT and NE, may be more effective than paroxetine, an SSRI, for patients with MDD.

REFERENCES:

1. Bymaster FP, Dreshfield-Ahmad LJ, Threlkeld PG, Shaw JL, Thompson L, Nelson DL, Hemrick-Luecke SK, Wong DT: Comparative affinity of duloxetine and venlafaxine for serotonin and norepinephrine transporters in vitro and in vivo, human serotonin receptor subtypes and other neuronal receptors. Neuropsychopharmacology 2001; 25:871–880.
2. Pitsikas N: Duloxetine. Curr Opin Investig Drugs 2000; 1:116–121.

TARGET AUDIENCE:

Psychiatrists.

Poster 133 **Friday, October 11 4:00 p.m.-5:30 p.m.**

THE EFFICACY OF DULOXETINE 60MG QD FOR THE TREATMENT OF DEPRESSION

Eli Lilly and Company

Madelaine M. Wohlreich, M.D., *Clinical Research Physician, Neuroscience Medical Affairs, Eli Lilly and Company, 5202 Potters Pike, Indianapolis, IN 46234*; Michael J. Detke, M.D.; Yili Lu, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize that duloxetine 60 mg QD, a potent dual reuptake inhibitor of serotonin and norepinephrine, is efficacious, safe, and well tolerated in the treatment of both the emotional and painful physical symptoms associated with MDD.

SUMMARY:

Objective: To examine the antidepressant efficacy of duloxetine, a potent dual reuptake inhibitor of serotonin (5-HT) and norepinephrine (NE) at 60 mg QD in MDD patients.

Methods: Adult patients (n=245), meeting DSM-IV criteria for MDD, were randomly assigned to placebo or duloxetine 60 mg QD for a nine-week, double-blind treatment. The primary efficacy assessment was $HAMD_{17}$ total score. Physical symptoms were measured by the Somatic Symptom Inventory (SSI) and visual analog scales (VAS) for pain.

Results: Duloxetine was statistically significantly superior to placebo at Weeks 2 to 9 in reduction of $HAMD_{17}$ total score and resulted in an odds ratio for remission of 2.6 relative to placebo. Duloxetine resulted in a significant reduction in severity of overall pain compared to placebo. Duloxetine was well tolerated.

Conclusions: These results indicated that duloxetine 60 mg QD was safe and efficacious and that duloxetine

may be the treatment of choice for MDD patients with painful physical symptoms.

REFERENCES:

1. Bymaster FP, Dreshfield-Ahmad LJ, Threlkeld PG, Shaw JL, Thompson L, Nelson DL, Hemrick-Luecke SK, Wong DT: Comparative affinity of duloxetine and venlafaxine for serotonin and norepinephrine transporters in vitro and in vivo, human serotonin receptor subtypes and other neuronal receptors. Neuropsychopharmacology 2001; 25:871–880.
2. Pitsikas N. Duloxetine. Curr Opin Investig Drugs 2000; 1:116–121.

TARGET AUDIENCE:

Psychiatrists.

Poster 134 **Friday, October 11 4:00 p.m.-5:30 p.m.**

VALIDATION OF A TREATMENT ALGORITHM FOR TREATMENT-RESISTANT DEPRESSION

Eli Lilly and Company

Patricia K. Corey-Lisle, Ph.D., R.N., *Senior Health Outcomes Scientist, Global Economic Affairs, Eli Lilly and Company, One Lilly Corporate Center, DC-1834, Indianapolis, IN 46285*; Roxanna Farinpour, Ph.D.; Rae Starr, M. Phil.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize treatment pattern methodologies used in identifying TRD patients and limitations associated with retrospective study of this population.

SUMMARY:

Objective: TRD has been studied retrospectively by identifying patients through treatment pattern algorithms. TRD-likely patients were found to be higher and more costly health care services utilizers. This study attempted to replicate a previously developed algorithm and compare utilization and costs for TRD-likely and TRD-unlikely patients.

Methods: Data for members in a large managed care organization (n=2M) were evaluated. Depressed plan members (N_{DEP}=17,283) were classified as TRD-likely (N_{TRD}=1,561) or TRD-unlikely via the treatment-pattern algorithm. Resource utilization and costs were compared between groups for year 2000 data.

Results: In this plan, 9% of the depressed sample was classified as TRD-likely with average annual health care costs of $6061.63 for TRD-likely patients and $3686.95 for TRD-unlikely patients. The average number of health claims among TRD-likely patients was almost twice that of TRD-unlikely patients (69.89 vs. 35.83).

Conclusion: Findings confirm previous retrospective TRD studies, underscoring that the high costs are comparable across different health care plans. These findings highlight the need for effective therapies for this subset of depressed patients.

REFERENCES:

1. Corey-Lisle PK, Claxton H, Marynchenko M, Greenberg P: Treatment-resistant depression: analysis of claims data. The World Journal of Biological Psychiatry 2001; 2, (Suppl. 1), 183S.
2. Crown WH, Ling DCY, Finkelstein SN, Berndt ER, White AS: Health care utilization in patients with treatment-resistant depression. Poster Presentation at American Psychiatric Association, May, New Orleans, 2001.

TARGET AUDIENCE:

Psychiatrists.

Poster 135 **Friday, October 11 4:00 p.m.-5:30 p.m.**

THE ANTIDEPRESSANT DULOXETINE AND ANXIETY SYMPTOMS ASSOCIATED WITH DEPRESSION

Eli Lilly and Company

Stephen K. Brannan, M.D., *Clinical Research Physician, Neuroscience Medical Affairs, Eli Lilly and Company, One Lilly Corporate Center, DC-4025, Indianapolis, IN 46285*; David J. Goldstein, M.D.; Michael J. Detke, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize that duloxetine was efficacious in the treatment of both anxiety and depressive symptoms associated with MDD.

SUMMARY:

Objective: To examine the effect of duloxetine, a potent dual reuptake inhibitor of serotonin and norepinephrine, on anxiety symptoms in depressed patients. Anxiety occurs in about 60% of MDD patients.

Methods: Three double-blind studies in MDD evaluated effects on anxiety. Study 1 assessed duloxetine 120 mg/d (administered BID) and fluoxetine 20 mg/d. Study 2 assessed duloxetine 40 mg/d and 80 mg/d (administered BID) and paroxetine 20 mg/d. Study 3 assessed duloxetine at 60 mg/d. All studies used the 17-item HAMD. Studies 1 and 2 used the HAMA. The HAMD anxiety/somatization subfactor and anxiety psychic item (Item 10) and HAMA were evaluated.

Results: Duloxetine was significantly more effective for HAMD Item 10 and anxiety/somatization subfactor over placebo in all studies and over fluoxetine in Study 1. In Study 2, duloxetine (80 mg/d) was significantly more effective for anxiety/somatization subfactor over paroxetine, and duloxetine 80 mg/d significantly reduced HAMA total score compared with placebo.

Conclusion: Duloxetine effectively relieved anxiety in depressed patients, and the anxiolytic effect was greater for duloxetine than for SSRIs.

REFERENCES:

1. Bymaster FP, Dreshfield-Ahmad LJ, Threlkeld PG, Shaw JL, Thompson L, Nelson DL, Hemrick-Luecke SK, Wong DT: Comparative affinity of duloxetine and venlafaxine for serotonin and norepinephrine transporters in vitro and in vivo, human serotonin receptor subtypes and other neuronal receptors. Neuropsychopharmacology 2001; 25:871–880.
2. Stein MB, Kirk P, Prabhu V, Grott M, Terepa M: Mixed anxiety-depression in a primary-care clinic. J Affect Disord 1995; 34:79–84.

TARGET AUDIENCE:

Psychiatrists.

Poster 136 **Friday, October 11 4:00 p.m.-5:30 p.m.**

EFFECTS OF THE ANTIDEPRESSANT DULOXETINE ON SEXUAL FUNCTION

Eli Lilly and Company

Stephen K. Brannan, M.D., *Clinical Research Physician, Neuroscience Medical Affairs, Eli Lilly and Company, One Lilly Corporate Center, DC-4025, Indianapolis, IN 46285*; Michael J. Detke, M.D.; Pierre Van Tran, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize that duloxetine has little impact on female sexual functioning and the effect on males is similar to SSRIs.

SUMMARY:

Objective: To determine the effect of duloxetine, a potent inhibitor of serotonin and norepinephrine, on sexual function in depressed patients.

Method: Data were obtained from four double-blind trials (duloxetine at 40–120 mg/d n=444, placebo n=293, paroxetine n=154, and fluoxetine n=67). Sexual function was evaluated by the ASEX questionnaire and reported adverse events.

Results: ASEX total score mean changes did not differ among groups. However, the treatment-by-gender interaction approached significance (p=.089). On Question 4 (How easily can you reach an orgasm?), treatment-by-gender interaction was significant (p=.004). Differences between groups for females did not approach significance, but for males, duloxetine and paroxetine had significantly greater (worsening) mean changes than placebo. For adverse events, duloxetine-treated patients reported decreased libido (4.9% vs. 1.4%), abnormal ejaculation (7.0% vs. 1.6%), and impotence (6.2% vs. 0.5%) significantly more often than placebo-treated patients but reports were not significantly different from fluoxetine or paroxetine.

Conclusion: No differences between treatment groups were detected in female sexual function. Duloxetine and paroxetine delayed orgasm in males, which was numerically greater for paroxetine.

REFERENCES:

1. Bymaster FP, Dreshfield-Ahmad LJ, Threlkeld PG, Shaw JL, Thompson L, Nelson DL, Hemrick-Luecke SK, Wong DT: Comparative affinity of duloxetine and venlafaxine for serotonin and norepinephrine transporters in vitro and in vivo, human serotonin receptor subtypes and other neuronal receptors. Neuropsychopharmacology 2001; 25:871–880.
2. Pitsikas N: Duloxetine. Curr Opin Investig Drugs 2000; 1:116–121.

TARGET AUDIENCE:

Psychiatrists.

Poster 137 **Friday, October 11 4:00 p.m.-5:30 p.m.**

EVALUATION OF DULOXETINE IN THE TREATMENT OF DEPRESSION

Eli Lilly and Company

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize the evidence supporting the clinical efficacy of duloxetine, a potent dual reuptake inhibitor of serotonin and norepinephrine, in the treatment of MDD and how it compares to SSRIs.

SUMMARY:

Objective: To examine the efficacy of duloxetine, a potent reuptake inhibitor of serotonin and norepinephrine.

Method: Data from two eight-week, and one nine-week randomized, double-blind, studies of depressed outpatients utilizing duloxetine 40–120 mg/d were examined. Depression was measured by $HAMD_{17}$ total score (primary), MADRS, CGI, and PGI scales.

Results: In all studies, duloxetine (40–120 mg/d) was superior to placebo in change on $HAMD_{17}$ total score. In the first study, the remission rates were 43% (duloxetine 120 mg/d, given BID), 30% (fluoxetine 20 mg/d), and 27% (placebo). In the second study, duloxetine 80 mg/d (given BID) resulted in a significantly greater reduction in $HAMD_{17}$ total score compared with paroxetine. The remission rate for duloxetine 80 mg/d was 50% compared with 37% (paroxetine 20 mg/d), and 30% (placebo). In the third study, the odds ratio for remission for duloxetine (60 mg QD) was 2.6 relative to placebo.

Conclusion: These data demonstrated that duloxetine was efficacious in the treatment of depression.

REFERENCES:

1. Bymaster FP, Dreshfield-Ahmad LJ, Threlkeld PG, Shaw JL, Thompson L, Nelson DL, Hemrick-Luecke SK, Wong DT: Comparative affinity of duloxetine and venlafaxine for serotonin and norepinephrine transporters in vitro and in vivo, human serotonin receptor subtypes and other neuronal receptors. Neuropsychopharmacology 2001; 25:871–880.
2. Pitsikas N. Duloxetine. Curr Opin Investig Drugs 2000; 1:116–121.

TARGET AUDIENCE:

Psychiatrists.

Poster 138 **Friday, October 11 4:00 p.m.-5:30 p.m.**

OLANZAPINE IN THE TREATMENT OF BIPOLAR DEPRESSION

Eli Lilly and Company

John M. Plewes II, M.D., *Clinical Research Physician, Neuroscience Medical Affairs, Eli Lilly and Company, 15001 Senator Way, Indianapolis, IN 46032*; Mauricio Tohen, M.D., Ph.D.; Richard Risser, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the attendee should recognize the relative strengths and weaknesses of olanzapine and OFC in treating BPD.

SUMMARY:

Objective: Determine the efficacy and safety of olanzapine, and the combination of olanzapine+fluoxetine (OFC) compared with placebo in the treatment of bipolar depression (BPD).

Methods: BPD patients with baseline MADRS ≥20 were randomized for eight weeks of double-blind treatment with olanzapine (5–20 mg/d, n=370), OFC (n=86), or placebo (n=377).

Results: Starting at Week 1 and sustained throughout the study, olanzapine and OFC groups were superior to the placebo group. Endpoint mean MADRS change was significantly greater on olanzapine (−12.7) or OFC (−17.1) than on placebo (−9.4, p<.001). Improvement on OFC was significantly greater than on olanzapine alone (p=.002). Induction of mania (baseline YMRS < 15 and ≥ 15 anytime subsequently) did not differ between groups (olanzapine 5.7%, placebo 6.7%, OFC 6.4%). Common (>10%) and significant adverse events reported in the olanzapine group compared with placebo were somnolence, weight gain, increased appetite, and dry mouth, whereas headache and insomnia were more common and significant on placebo.

Conclusion: Olanzapine demonstrated superiority to placebo in the treatment BPD; OFC also showed superiority compared with placebo and to olanzapine.

REFERENCES:

1. Sachs GS, Koslow CS, Ghaemi SH: The treatment of bipolar depression. Bipolar Disord 2000; 2 (3 Pt 2):256–60.
2. Tohen M, Jacobs TG, Grundy SL, Banov MC, McElroy SL, Janicak PG, Zhang F, Toma V, Francis BJ, Sanger TM, Tollefson GD, Breier A: Efficacy of olanzapine in acute bipolar mania: a double-blind, placebo-controlled study. Arch Gen Psychiatry 2000; 57:841–849.

TARGET AUDIENCE:

Psychiatrists.

Poster 139 **Friday, October 11 4:00 p.m.-5:30 p.m.**

LONG-TERM OLANZAPINE-FLUOXETINE USE IN MAJOR DEPRESSIVE DISORDER: INTERIM DATA

Eli Lilly and Company

John M. Plewes II, M.D., *Clinical Research Physician, Neuroscience Medical Affairs, Eli Lilly and Company, 15001 Senator Way, Indianapolis, IN 46032*; Sara Ann Corya, M.D.; Scott W. Andersen, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusions of this presentation, the participant should recognize the long-term safety profile and effectiveness of an olanzapine-fluoxetine combination treatment for MDD.

SUMMARY:

Background: Olanzapine-fluoxetine combination (OFC) demonstrated treatment effects in treatment-resistant depression (TRD), reflecting elevated norepinephrine, dopamine, and serotonin levels in PFC. Long-term (76 weeks) safety and efficacy was investigated in MDD patients with or without TRD.

Method: Interim data were analyzed for 560 enrolled patients over 52 weeks of open-label OFC treatment. Safety was assessed via adverse events, laboratory analytes, vital signs, electrocardiography, and extrapyramidal symptom measures. MADRS was the primary efficacy measure.

Results: Somnolence, weight gain, dry mouth, increased appetite, and headache were most frequently reported. MADRS mean total scores decreased six points (31.6) (2 to 5 days), 17 points (eight weeks), and 18 points (52 weeks). For patients with physician-defined TRD, MADRS mean total scores decreased seven points (32.6) (two to five days), 15 points (eight weeks), and 17 points (52 weeks). Response and remission rates were high (63%, 55%) and relapse rate was low (12%).

Conclusions: The OFC safety profile was similar to that of component monotherapies, OFC showed rapid, sustained improvement in depressive symptoms in MDD patients, with or without TRD.

REFERENCES:

1. Bhana N, Foster RH, Olney R, Plosker GL: Olanzapine: an updated review of its use in the management of schizophrenia. Drugs 2001:61(1):111–161.
2. Beasley CM, Koke SC, Nilsson ME, Gonzales JS: Adverse event and treatment discontinuations in clinical trials of fluoxetine in major depressive disorder: An updated meta-analysis. Clinical Therapeutics 2000:22(11):1319–1329.

TARGET AUDIENCE:

Psychiatrists.

Poster 140 **Friday, October 11 4:00 p.m.-5:30 p.m.**

META-ANALYSIS OF OLANZAPINE-FLUOXETINE USE IN TREATMENT-RESISTANT DEPRESSION

Eli Lilly and Company

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize the effectiveness of an olanzapine-fluoxetine combination (OFC) in TRD patients.

SUMMARY:

Background: Up to 30% of MDD patients are resistant to conventional antidepressant treatment. Subsequent therapy may include augmentation with an antipsychotic to enhance treatment effect. The efficacy of olanzapine-fluoxetine combination (OFC) was compared with component monotherapies for TRD (retrospective SSRI failure and a prospective non-SSRI failure) patients.

Methods: A meta-analysis was performed on one eight-week, and one 12-week double-blind study. Subjects (n=797) with non-bipolar, TRD without psychotic features were randomized to OFC, or olanzapine or fluoxetine monotherapy MADRS was the primary efficacy measure.

Results: OFC patients achieved significantly greater improvement at Week 1 (−7.31) than olanzapine (−5.18, p=0.013) or fluoxetine (−5.26, p=0.004) patients and maintained the significant effect throughout eight weeks (−11.60; −7.55, p<0.001; −8.73, p<0.001). OFC patients had a significantly greater endpoint response rate than olanzapine (37.3%, 21.1%) and significantly greater endpoint remission rates than olanzapine or fluoxetine (24.9%, 13.1%, 15.2%).

Conclusion: OFC showed rapid improvement in depressive symptoms by Week 1 and sustained treatment effect throughout eight weeks. The combination demonstrated significant advantage over either component monotherapy, and represents a promising treatment strategy for TRD patients.

REFERENCES:

1. Amsterdam JD, Hornig-Rohan M: Treatment algorithms in treatment-resistant depression. Psychiatr Clin North Am 1996; 19:371–386
2. Robertson MM, Trimble MR: Major tranquilisers used as antidepressants. A review. J Affect Disord 1982; 4:173–193.

TARGET AUDIENCE:

Psychiatrists.

Poster 141 **Friday, October 11 4:00 p.m.-5:30 p.m.**

PHARMACOTHERAPY OF DEPRESSION IN WOMEN ACROSS THE REPRODUCTIVE CYCLE: FOCUS ON VENLAFAXINE

Wyeth Pharmaceuticals

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the readers/viewers of this poster will acquire rapid and comprehensive knowledge with respect to depression in women across the reproductive cycle.

SUMMARY:

The medical educational content of this poster will benefit mental health care providers, educators, and systems of care that treat women with depression. The large number of available antidepressants and the correspondingly large databases for each of these medications can be overwhelming. A distillation of the current medical database for antidepressant presented in an organized and concise poster format can assist health care providers and systems of care in knowledge acquisition, utilization, and organization. This poster reviews both evidence-based data and publications related to the use of venlafaxine in the female depressed patient. This poster distills and organizes the venlafaxine safety and efficacy database as it relates to depression in women.

Women constitute two-thirds of patients afflicted by depressive disorders. This gender difference begins around puberty and peaks through adulthood (i.e. ages 25–44 years). The recognition, accurate diagnosis, and pharmacotherapy of depressive disorders in women, is thus a major public health concern. Depression can occur in relationship to the premenstrual period, pregnancy period, postpartum period, and the perimenopause/menopause period. Antidepressant pharmacotherapy during these specific depressive phases in women may be optimized when the available medical information is distilled and organized into a single database. We have collected, distilled, and organized the available medical information that describes the use of venlafaxine in depressed women.

Methods: Relevant studies and published data were identified from systematic searches of electronic databases. Relevant data on file at Wyeth Pharmaceuticals was also searched. Databases searched included Medline, Embase, Biosis, and Wyeth product literature.

REFERENCES:

1. Einerson A, et al: Pregnancy outcomes following gestational exposure to venlafaxine: a multicenter prospective controlled study. Am J Psychiatry 2001; 158:1728–1730.
2. Ilet KF, et al: Distribution of venlafaxine and its 0-desmethyl metabolite in human milk and their effects in breastfed infants. Br J Pharmacol 2002; 53;1:17–22.

TARGET AUDIENCE:

Psychiatrists in clinical practice, psychiatric nurses, psychiatric pharmacists, health-system administrators.

Poster 142 **Friday, October 11**
4:00 p.m.-5:30 p.m.

OLANZAPINE VERSUS DIVALPROEX SODIUM FOR BIPOLAR MANIA IN RAPID CYCLERS

Eli Lilly and Company

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss relative findings for olanzapine and divalproex sodium in patients with rapid and non-rapid cycling bipolar disorder.

SUMMARY:

Objective: To compare olanzapine and divalproex for longer-term efficacy and safety in mania.

Method: This 47-week, randomized, double-blind study compared olanzapine (5–20 mg/day) with divalproex sodium (500–2500 mg/day) for bipolar manic or mixed episodes (N=251). Young-Mania Rating Scale (Y-MRS) ≥ 20 was required for inclusion, with scores ≤ 12 for remission and ≥ 15 for relapse.

Results: Over the 47-week trial, olanzapine-treated patients had better mean Y-MRS improvement ($p<0.01$) and shorter time to mania remission with 14 versus 62 days for olanzapine- and divalproex-treated groups, respectively ($p=0.047$). Symptomatic mania remission rates over the 47-week trial were 56.8% and 45.5% for olanzapine-divalproex-treated patients, respectively ($p=0.098$). Rates of subsequent relapse into mania or depression did not differ statistically between treatments: olanzapine (42.3%) and divalproex (56.5%) ($p=0.416$). Treatment-emergent adverse events and laboratory abnormalities more frequent with olanzapine ($p<.05$) were somnolence, dry mouth, increased appetite, weight gain, akathisia, and liver function test (increased ALT), and for divalproex ($p<.05$) were nausea, nervousness, manic reaction, rectal disorder, and decreased platelets. Mean weight increase (LOCF) was olanzapine 3.4 kg vs. divalproex 1.7 kg ($p=.045$).

Conclusions: Compared to divalproex-treated patients, olanzapine-treated patients had significantly greater mania improvement and faster time to remission.

REFERENCES:

1. Bowden CL, Calabrese JR, McElroy SL, Gyulai L, Wassef A, Petty F, Pope HG Jr, Chou JC, Keck PE Jr, Rhodes LJ, Swann AC, Hirschfeld RM, Wozniak PJ: A randomized, placebo-controlled 12-month trial of divalproex and lithium in treatment of outpatients with bipolar I disorder. Divalproex Maintenance Study Group. Arch Gen Psychiatry 2000; 57:481–9.
2. Tohen M, Jacobs TG, Grundy SL, McElroy SL, Banov MC, Janicak PG, Sanger T, Risser R, Zhang F, Toma V, Francis J, Tollefson GD, Breier A: Efficacy of olanzapine in acute bipolar mania: a double-blind, placebo-controlled study. The Olanzapine HGGW Study Group. Arch Gen Psychiatry 2000; 57:841–9.

TARGET AUDIENCE:

Psychiatrists treating patients with bipolar mania.

Poster 143 **Friday, October 11 4:00 p.m.-5:30 p.m.**

INDUCTION OF MANIC-LIKE SYMPTOMS IN PATIENTS WITH SCHIZOPHRENIA TREATED WITH OLANZAPINE, HALOPERIDOL, OR PLACEBO

Eli Lilly and Company

Patrick Toalson, R.Ph., *Medical Liaison, Neuroscience Medical Affairs, Eli Lilly and Company, 6116 Rosemont Court, Birmingham, AL 35242*; Robert W. Baker, M.D.; Jean-Pierre Lindenmayer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss olanzapine's impact on manic-like symptoms during treatment of schizophrenia.

SUMMARY:

Background: Published case reports describe manic-like symptoms during schizophrenia treatment with olanzapine and other agents. We explored the relationship of olanzapine to manic-like symptoms within the olanzapine schizophrenia clinical trial database.

Method: We analyzed three double-blind, randomized, six-week long trials evaluating olanzapine's efficacy versus haloperidol and/or placebo (N=2579). Potential treatment-emergent mania was identified based on (1) treatment-emergent adverse events, (2) categorical analyses comparing proportions of worsening during treatment on a mania-like cluster from the Positive and Negative Syndrome Scale (PANSS), and (3) mean change in mania-like cluster scores (LOCF).

Results: (1) Treatment-emergent manic-like adverse events: No significant difference between olanzapine and placebo or haloperidol for treatment-emergent manic reaction, agitation, or insomnia. (2) Categorical analysis: in every group studied, some patients had worsening on the mania-like cluster. In no comparison was the proportion of patients worsening numerically greater in an olanzapine group than placebo or haloperidol groups. (3) Mean change in mania-like cluster ratings: In no instance was mean change on olanzapine inferior to placebo or haloperidol.

Conclusion: Analyses do not support anecdotal reports that olanzapine provokes manic symptoms in schizophrenia but suggest manic-like symptoms may be part of the natural history of schizophrenia rather than medication adverse events.

REFERENCES:

1. Aubry JM, Simon AE, Bertschy G: Possible induction of mania and hypomania by olanzapine or risperidone: a critical review of reported cases. J Clin Psychiatry 2000; 61: 649–55.
2. Tohen M, Jacobs TG, Grundy SL, McElroy SL, Banov MC, Janicak PG, Sanger T, Risser R, Zhang F, Toma V, Francis J, Tollefson GD, Breier A: Efficacy of olanzapine in acute bipolar mania: a double-blind, placebo-controlled study. The Olanzapine HGGW Study Group. Arch Gen Psychiatry 2000; 57:841–9.

TARGET AUDIENCE:

Psychiatrists treating patients with schizophrenia.

Poster 144 **Friday, October 11 4:00 p.m.-5:30 p.m.**

VALIDATION OF A MANIC-LIKE SYMPTOM SCALE FROM THE POSITIVE AND NEGATIVE SYNDROME SCALE

Eli Lilly and Company

Patrick Toalson, R.Ph., *Medical Liaison, Neuroscience Medical Affairs, Eli Lilly and Company, 6116 Rosemont Court, Birmingham, AL 35242*; Jean-Pierre Lindenmayer, M.D.; Robert W. Baker, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to discuss steps used to develop and validate a mania-like factor from the Positive and Negative Syndrome scale, describe the items composing the new factor, and understand the utility of such a factor for clinical trials of schizophrenia.

SUMMARY:

Background: A mania-like factor was developed and validated from the Positive and Negative Syndrome Scale (PANSS).

Methods: Baseline PANSS data from six double-blind, randomized trials of olanzapine, three in schizophrenia (or schizoaffective disorder), and three in bipolar mania, were used in post-hoc analyses. Schizophrenia data were pooled and randomly split in half. Exploratory and confirmatory factor analyses were performed on the halves and separately on pooled bipolar data. Mania-like factor scores were correlated with Young-Mania Rating Scale (Y-MRS) scores in each bipolar study.

Results: Exploratory principle components analysis on the pooled schizophrenia database extracted the following five factors: cognitive, depressive, mania, and negative and positive factors. The mania-like factor loaded heavily on uncooperativeness, poor impulse control, excitement, and hostility. Results were similar in confirmatory schizophrenia and bipolar analyses. on Mania-like factor change from baseline correlated reasonably well (0.64–0.78) with Y-MRS in bipolar studies. At baseline, bipolar patients scored higher than schizophrenia patients on three of four PANSS mania items: poor impulse control, excitement, and hostility; the converse was true for most other items.

Conclusion: Factor analyses of the PANSS consistently uncovered a mania-like factor, which may be useful in examining manic symptoms in studies where adding a specific mania scale would be burdensome.

REFERENCES:

1. Kay SR, Opler LA, Lindenmayer JP: Reliability and validity of the Positive and Negative Syndrome Scale for Schizophrenia. Psychiatry Research 1988; 23:99–110.
2. Lindenmayer JP, Bernstein-Hyman R, Grochowski S. Five-factor model of schizophrenia: Initial validation. Journal of Nervous & Mental Disease 1994;182:631–638.

TARGET AUDIENCE:

Psychiatrists.

Poster 145 **Friday, October 11 4:00 p.m.-5:30 p.m.**

DYSPHORIC MANIA INDUCED BY HIGH-DOSE MIRTAZAPINE: A CASE FOR NOREPINEPHRINE SYNDROME?

Nadeem Bhanji, M.D., *Resident in Psychiatry, McGill University Health Centre, 1025 Pine Avenue, West, Montreal, QC, Canada H3A 1A1*; Howard C. Margolese, M.D., *Department of Psychiatry, McGill University Health Centre, 1025 Pine Avenue, West, Montreal, QC, Canada H3A 1A1*; Guy Chouinard, M.D., M.S.; Marie St. Laurent, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: diagnose manic symptoms induced by antidepressants such as mirtazapine, and recognize unusual features that can occur with mirtazapine-induced mania.

SUMMARY:

Background: The antidepressant mirtazapine antagonizes central presynaptic α_2-adrenergic auto and heteroreceptors resulting in increased central norepinephrine and serotonin activity. Histamine H_1 receptors are also antagonized as are postsynaptic serotonin 5-HT_2 and 5-HT_3 receptors, leading to primary serotonergic activity, mostly via 5-HT_{1A} receptors.

Method: Based on case report of a patient who developed mania with above-therapeutic recommended dosage of mirtazapine, we review the literature on the atypical nature of the manic symptoms.

Results: Eight subjects, including ours, were identified as having developed mirtazapine-induced mania with atypical features, consisting of dysphoria, irritability, insomnia, psychomotor agitation, and abnormal gait. Predisposing features identified in these subjects included presence of underlying brain dysfunction as well as certain SSRI-mirtazapine combinations.

Conclusion: Dysphoric mania with atypical features may be induced by mirtazapine in predisposed individuals, and thus argues for a common hypothesis such as "central norepinephrine hyperactivity" as a basis for the development of mania with mirtazapine.

REFERENCES:

1. Fawcett J, Barkin RL: Review of the results from clinical studies on the efficacy, safety and tolerability of mirtazapine for the treatment of patients with major depression. J Affect Disord 1998;51:267–85.
2. DeLeon, Furmage KM, Kalsounis J: Mirtazapine-induced mania in a case of poststroke depression. J Neuropsychiatry and Clin Neurosci. 1999;11:115–6.

TARGET AUDIENCE:

Psychiatrists, general practitioners; mood disorders specialists.

Poster 146 **Friday, October 11 4:00 p.m.-5:30 p.m.**

LAMOTRIGINE AUGMENTATION FOR TREATMENT-RESISTANT DEPRESSION

GlaxoSmithKline

Lowry A. Bushnell, M.D., *Clinical Assistant Professor, University of Utah Neuropsychiatric Institute, 501 Chipeta Way, Salt Lake City, UT 84108-1222*; Marilyn R.

Semenchuk, Pharm.D., *Central Nervous System Regional Medical Scientist, GlaxoSmithKline, 9030 North Silvermoon Way, Tucson, AZ 85743*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to state the role of lamotrigine augmentation for treatment-resistant depression.

SUMMARY:

Introduction: Previous studies have demonstrated improvement in mood, including depressive symptoms, in epilepsy and bipolar patients treated with lamotrigine. Little data are available demonstrating effectiveness of lamotrigine augmentation for treatment-resistant depression.

Methods: A retrospective chart review was completed on 52 mood disorder patients treated with lamotrigine augmentation following failed therapy (lack of effectiveness, development of tolerance, or adverse events) with multiple psychotherapeutic agents. Lamotrigine dosage was titrated as follows: 25 mg/day for two weeks, 50 mg/day for two weeks, 50 mg bid for one week, 100 mg bid for one week, then increased as necessary to best benefit.

Results: Twenty males and 32 females, average age 44 years (range 15–74), were studied. Fourty-three patients (83%) had recurrent moderate to severe depression, while the remainder were diagnosed with bipolar disorder. Lamotrigine augmentation was effective in all 52 patients. The average maintenance dose was 262 mg/day (range 50–400 mg/day). Three patients (5.8%) experienced adverse events; one reported nocturnal teeth grinding, which was treated with diazepam, and two patients experienced skin rash, which resolved upon lamotrigine discontinuation. Fourty-nine patients (94%) are still receiving lamotrigine.

Conclusion: This retrospective data analysis indicates that lamotrigine augmentation may be effective for both bipolar and unipolar treatment-resistant depression.

REFERENCES:

1. Edwards K, et al: Lamotrigine monotherapy improves depressive symptoms in epilepsy: a double-blind comparison with valproate. Epilepsy and Behavior 2001;2:28–36.
2. Calabrese J, et al: A double-blind, placebo-controlled study of lamotrigine monotherapy in outpatients with bipolar I depression. J Clin Psychiatry 1999;60:79–88.

TARGET AUDIENCE:

All mental health care professionals.

Poster 147 **Friday, October 11**
4:00 p.m.-5:30 p.m.

REMISSION FOLLOWING LONG-TERM ANTIDEPRESSANT TREATMENT WITH VENLAFAXINE

Wyeth Pharmaceuticals

Richard Entsuah, Ph.D., *Associate Director, Global Clinical Biostatistics Research, Wyeth Pharmaceuticals, 500 Arcola Road, Collegeville, PA 19426*; Nadia R. Kunz, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize the efficacy of venlafaxine/venlafaxine XR in the long-term maintenance of remission in outpatients with depression.

SUMMARY:

Purpose: To reanalyze data from two relapse/recurrence prevention trials evaluating remission maintenance with venlafaxine/venlafaxine XR (VEN/VEN XR) in depressed outpatients.

Methods: In both studies, open-label (OL) responders continued VEN/VEN XR or switched to placebo under double-blind (DB) conditions. Data from remitters at beginning of DB phase were analyzed. In recurrence prevention study, six-month OL VEN was followed by ≤12-month DB treatment; 495 patients entered and 286 completed OL phase, 258 OL completers achieved remission, 235 entered DB. In relapse prevention study, eight-week OL VEN XR was followed by ≤6-month DB; 490 patients entered and 401 completed OL, 318 satisfied criteria to enter DB, and 210 completers achieved remission.

Results: Study 1 included 173 (91 VEN, 82 placebo) remitters; remission remained significantly greater with VEN than placebo. At month 12, 67% of VEN patients vs 46% of placebo patients remained in remission ($P<0.01$). Study 2 included 210 (102 VEN XR, 108 placebo) remitters; remission remained significantly greater with VEN XR than with placebo. At month 6, 65% of VEN XR patients vs 37% of placebo patients remained in remission ($P<0.001$).

Conclusion: VEN/VEN XR is significantly better than placebo in maintaining remission over 6 or 12 months, demonstrating its efficacy in long-term therapy.

REFERENCES:

1. Thase ME, Entsuah AR, Rudolph RL: Remission rates during treatment with venlafaxine or selective serotonin reuptake inhibitors. Br J Psychiatry 2001; 178:234–241.
2. Smith D, Dempster C, Glanville J, et al: Efficacy and tolerability of venlafaxine compared with selective

serotonin reuptake inhibitors and other antidepressants: a meta-analysis. Br J Psychiatry 2002; 180:396–404.

TARGET AUDIENCE:

Psychiatrists who treat depression.

Poster 148 **Friday, October 11 4:00 p.m.-5:30 p.m.**

VENLAFAXINE AND SSRI REMISSION IN DEPRESSIVE EPISODES IN LESS THAN, MORE THAN, OR EQUAL TO 52 WEEKS

Wyeth Pharmaceuticals

Richard Entsuah, Ph.D., *Associate Director, Global Clinical Biostatistics Research, Wyeth Pharmaceuticals, 500 Arcola Road, Collegeville, PA 19426*; Jeffrey E. Kelsey, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to understand the relationship between remission and duration of depressive episode and the effect of early intervention.

SUMMARY:

Purpose: To determine if previously observed differential remission rates seen in comparisons of venlafaxine, SSRIs, and placebo occur in groups with both shorter (≤52 weeks) and longer (>52 weeks) durations of the depressive episode.

Methods: A total of 2,046 (of 2,117) patients (aged 18–83 years; mean HAM-D_{21} baseline scores 24–27) met the intent-to-treat criteria (began double-blind treatment, had at least one dose of study medication, and at least one HAM-D evaluation within three days of last dose). A total of 851 patients received venlafaxine (75–375 mg/day), 749 an SSRI [fluoxetine (20–80 mg/day), paroxetine (20–60 mg/day), or fluvoxamine (100–200 mg/day)], and 446 placebo. HAM-D remission (HAM-D_{17} score ≤ 7) rates were calculated on an LOCF basis. Between-group rate comparisons were carried out after eight weeks of treatment using the Fisher exact test ($P \leq 0.05$ considered) significant.

Results: Intervention before and including 52 weeks resulted in significantly ($p<0.025$) higher remission rates regardless of the treatment: venlafaxine (47% vs 38%), SSRI (38% vs 25%), and placebo (29% vs 19%). Venlafaxine was significantly more effective than SSRI intervention or placebo regardless of the duration.

Conclusions: Venlafaxine treatment results in higher remission rates than SSRIs regardless of the presenting depressive duration.

REFERENCES:

1. Riise T, Lund A: Prognostic factors in major depression: a long-term follow-up study of 323 patients. Journal of Affective Disorders 2001; 65(3):297–306.
2. Stassen HH, Angst J, Delini-Stula A: Severity at baseline and onset of improvement in depression. Meta-analysis of imipramine and moclobemide *versus* placebo. Eur Psychiatry 1994;9:129–136.

TARGET AUDIENCE:

Adult psychiatrists.

Poster 149 **Friday, October 11 4:00 p.m.-5:30 p.m.**

GEPIRONE EXTENDED RELEASE IN PATIENTS WITH ANXIOUS DEPRESSION

Organon Inc.

Maurizio Fava, M.D., *Director, Depression Clinical and Research Programs, Psychopharmacology Unit, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114*

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to discuss and evaluate (1) clinical evidence supporting the efficacy and tolerability of gepirone-ER in major depression and (2) clinical evidence supporting the efficacy of gepirone-ER for the short-term treatment of anxious major depressive disorder.

SUMMARY:

Study Purpose: To evaluate efficacy and tolerability of gepirone extended-release (ER) in patients with anxious major depressive disorder.

Method: This was an eight-week, double-blind, placebo-controlled study of gepirone-ER (20 mg to 80 mg/day). Eligible patients met DSM-IV criteria for major depression and had a baseline HAMD-17 total score ≥20. In this subgroup analysis, only patients who also met criteria for anxious depression (HAMD-17 anxiety/somatization factor score > 6) were included. Assessments were obtained at baseline and at Days 7, 14, 21, 28, 42, and 56.

Results: Gepirone-ER-treated patients (n=58) experienced a statistically significantly greater reduction from baseline in the HAMD-17 total score ($P < 0.05$) at Days 14, 21, 28, 42, and 56 versus placebo-treated patients (n=75). A significantly ($P < 0.05$) greater reduction in the mean HAMD-17 Item 12 (psychic anxiety) score was seen at each study visit for gepirone-ER. The mean change from baseline in the HAMD-17 anxiety/somatization factor score was significantly different ($P < 0.05$)

between groups at Days 14, 21, 28, 42, and 56 in favor of gepirone-ER.

Conclusion: Gepirone-ER was effective and well tolerated in patients with anxious depression.

REFERENCES:

1. Joffe RT, Bagby RM, Levitt A: Anxious and nonanxious depression. Am J Psychiatry 1993; 150:1257–1258.
2. Tollefson GD, Holman SL, Sayler ME, Potvin JH: Fluoxetine, placebo, and tricyclic antidepressants in major depression with and without anxious features. Journal of Clinical Psychiatry 1994; 55(2):50–9.

TARGET AUDIENCE:

Psychiatrists.

Poster 150 **Friday, October 11**
4:00 p.m.-5:30 p.m.

GEPIRONE EXTENDED RELEASE: NEW EVIDENCE FOR EFFICACY IN THE TREATMENT OF MAJOR DEPRESSIVE DISORDER

Organon Inc.

Alan D. Feiger, M.D., *President, Feiger Health Research Center, 3555 Lutheran Parkway, Suite 320, Wheat Ridge, CO 80033-6021*; Jon F. Heiser, M.D.; Ram K. Shrivastava, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to explain and consider (1) results from this clinical study supporting the efficacy of gepirone-ER for the short-term treatment of MDD, and (2) results from this clinical study supporting the safety and tolerability of gepirone-ER in patients with MDD.

SUMMARY:

Study Purpose: To assess the efficacy and tolerability of the 5-HT_{1A} agonist gepirone extended release (ER) in patients with major depressive disorder (MDD).

Method: Patients aged 18 to 70 years were eligible if they satisfied DSM-IV criteria for moderate-to-severe MDD and had a baseline HAMD-17 score ≥ 20. Patients were randomly assigned to placebo or gepirone-ER for 56 days. Gepirone-ER was initiated at 20 mg once daily, and increased to 40 mg at Day 4. After Day 7, the dose could be increased to 60 mg, and increased to 80 mg after Day 14. Thereafter, the dose was adjusted within the range of 40 mg to 80 mg daily. Efficacy was evaluated in the intent-to-treat (ITT) group using last-observation-carried-forward (LOCF).

Results: In 204 patients, the mean change from baseline in the HAMD-17 was significantly greater with gepirone-ER than placebo at Weeks 3 ($P = 0.013$) and 8 ($P = 0.018$). Significantly ($P \leq 0.05$) more patients on gepirone-ER than on placebo were HAMD-17 responders at Weeks 3 and 4 and HAMD-17 remitters at Weeks 6 and 8. Gepirone-ER did not cause weight gain, sedation, or sexual dysfunction and no serious adverse events occurred in gepirone-ER-treated patients.

Conclusion: Gepirone-ER is well tolerated and effective for short-term treatment of MDD.

REFERENCES:

1. Feiger AD: A double-blind comparison of gepirone extended release, imipramine, and placebo in the treatment of outpatient major depression. Psychopharmacol Bull 1996;32:659–665.
2. Wilcox CS, et al: A double-blind trial of low and high-dose ranges of gepirone-ER compared with placebo in the treatment of depressed outpatients. Psychopharmacol Bull 1996;32:335–342.

TARGET AUDIENCE:

Psychiatrists.

Poster 151 **Friday, October 11**
4:00 p.m.-5:30 p.m.

ESCITALOPRAM IS A WELL-TOLERATED SSRI

Forest Laboratories, Inc.

Ivan Gergel, M.D., *Medical Department, Forest Laboratories, Inc., 909 Third Avenue, New York, NY 10022*; Heikki Hakkarainen, M.D.; Gwen L. Zornberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should appreciate the safety and tolerability of escitalopram in the short-term treatment of depression.

SUMMARY:

Introduction: Escitalopram, the single isomer of citalopram, has been shown in several clinical trials to have antidepressant efficacy at a dose of 10 mg/day.

Objective: To assess the treatment-emergent adverse events associated with short-term escitalopram treatment.

Methods: A total of 715 depressed outpatients (male or female, aged 18–80 years) received acute treatment (up to eight weeks) with escitalopram (10–20 mg/day) in randomized, placebo-controlled, double-blind, multicenter studies. Spontaneously reported adverse events (AEs) were recorded at each study visit; vital

sign, ECG and laboratory value observations were taken at baseline and endpoint.

Results: Only one AE (nausea) occurred in escitalopram-treated patients at a greater rate than placebo, with an incidence exceeding 10%. Reports of somnolence and "activation" AEs (such as insomnia, agitation, and nervousness) were notably low. Overall, less than 6% of escitalopram-treated patients discontinued due to AEs. No clinically significant changes occurred in vital sign, ECG, or laboratory values. Two fixed-dose trials included an escitalopram 10 mg/day arm; in both trials, discontinuation due to AEs did not differ between escitalopram 10 mg/day and placebo.

Conclusion: In conclusion, escitalopram was safe and well tolerated at the doses used in these studies.

REFERENCES:

1. Montgomery SA, Loft H, Sanchez C, Reines EH, Papp M: Escitalopram (S-enantiomer of citalopram): clinical efficacy and onset of action predicted from a rat model. Pharmacol Toxicol 2001; 88: 282–286.
2. Muldoon C: The safety and tolerability of citalopram. Int Clin Psychopharmacol 1996;11 Suppl 1:35–40.

TARGET AUDIENCE:

Practicing psychiatrists.

Poster 152 **Friday, October 11**
4:00 p.m.-5:30 p.m.

EFFECT OF GEPIRONE EXTENDED RELEASE ON SEXUAL FUNCTION IN PATIENTS WITH MAJOR DEPRESSION

Organon Inc.

Michael Gibertini, Ph.D., *Clinical Development, Organon Inc., 375 Mount Pleasant Avenue, West Orange, NJ 07052*; Jonathan R.T. Davidson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to (1) explain clinical evidence indicating that gepirone-ER improves sexual function in patients with MDD, and (2) describe and assess the potential future clinical implications of changes in DISF-SR scores as observed with gepirone-ER in both females and males.

SUMMARY:

Study Purpose: To evaluate the effects of gepirone-ER vs. placebo on sexual functioning in outpatients with major depressive disorder (MDD).

Methods: This was an eight-week, randomized, double-blind, placebo-controlled, parallel-group study of gepirone-ER 20–80 mg/day. Patients were included in the analysis if they received a baseline and endpoint assessment of sexual function with the DISF-SR (Derogatis Inventory of Sexual Function-Self Report). Increases in the DISF-SR signify improvement in sexual functioning. Comparisons were performed with analysis of variance (ANOVA).

Results: Gepirone-ER (N=65) and placebo (N=73) groups were comparable at baseline. Mean baseline DISF-SR scores were 45.7 with gepirone-ER and 42.4 with placebo. A statistically significant difference was observed with gepirone-ER compared with placebo for mean change from baseline to endpoint on the DISF-SR total score (P=0.011). In females, the mean change from baseline in DISF-SR total score with gepirone-ER was 10.0 (N=46) vs. −1.5 for placebo (N=42)(P=0.043). In males, the mean increase in DISF-SR total scores with gepirone-ER was 11.1 (N=19) vs. 1.1 for placebo (N=31)(P=NS).

Conclusions: Gepirone-ER may have a positive effect on sexual function in patients with MDD.

REFERENCES:

1. Kennedy SH, Dickens SE, Elsfeld BS, et al: Sexual dysfunction before antidepressant therapy in major depression. J Affect Disorder 1999;56:201–208.
2. Derogatis LR: The Derogatis Interview for Sexual Functioning (DISP/DISF-SR): an introductory report. J Sex Mar Ther 1997:23;291–304.

TARGET AUDIENCE:

Psychiatrists.

Poster 153 **Friday, October 11**
4:00 p.m.-5:30 p.m.

TOPIRAMATE USE IN REFRACTORY BIPOLAR DISORDER

Ortho-McNeil Parmaceuticals, Inc.
Lawrence D. Ginsberg, M.D., *President and Chief Executive Officer, Red Oak Psychiatry Associates, 17115 Red Oak Drive, Suite 109, Houston, TX 77090-2607*

EDUCATIONAL OBJECTIVES:

At conclusion of this session, the participant should be able to discuss the effects of topiramate therapy on bipolar disorder symptomatology, CGI scores, body weight, and side effects.

SUMMARY:

Methods: Charts of outpatients with a DSM-IV diagnosis of bipolar disorder treated with adjunctive topiramate were reviewed retrospectively. Clinical assessments included Clinical Global Impression of Severity (CGI-S) and Improvement Scales (CGI-I). Data on

length of treatment, patient weight, and side effects were also analyzed.

Results: Two hundred sixty-eight patients were identified; of these 214 were treated with topiramate ≥1 month and served as the study population. Diagnoses included bipolar I (62%), bipolar II (27%) and bipolar NOS (11%). Topiramate treatment duration ranged from one to 25 months with a mean dose of 167±113 mg/day. Mean CGI-S at baseline was 4.4±0.8 and changed significantly by last visit (mean CGI-S: 3.7±0.9; P<0.001). Mean CGI-I at last visit was 3.1±0.8 (range: 1–5). Fifty-three percent of patients experienced mild improvement, with 21% much or very much improved based on CGI-I scores. Mean weight change from baseline was −7.5±20 lbs (P<0.05). The most common treatment-limiting adverse events were CNS-related symptoms, and none were serious. Data stratified by treatment duration revealed long-term effects as measured by CGI-S.

Conclusion: Many patients experience significant improvement in bipolar synmptoms with add-on topiramate therapy in clinical practice.

REFERENCES:

1. Chengappa KN, Rathore D, Levine J, Atzert R, Solai L, Parepally H, Levin H, Moffa N, Delaney J Brar JS: Topiramate as add-on treatment for patients with bipolar mania. Bipolar Disord 1999;1:42–53.
2. Marcotte D: Use of topiramate, a new anti-epileptic as a mood stabilizer. J Affect Disord 1998;50:245–251.

TARGET AUDIENCE:

Psychiatrists.

Poster 154 **Friday, October 11 4:00 p.m.-5:30 p.m.**

ESCITALOPRAM IN THE TREATMENT OF SEVERE DEPRESSION

Forest Laboratories, Inc.

Jack M. Gorman, M.D., *Professor and Vice Chair for Research, Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 32, New York, NY 10032*; Andrew Korotzer, Ph.D.; James Jin, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should appreciate the potential usefulness of escitalopram in the treatment of severe depression.

SUMMARY:

Introduction: Escitalopram is the single isomer responsible for the serotonin reuptake inhibition produced by the racemic antidepressant citalopram. SSRI antidepressants are not usually considered as first-line treatments for the most severely depressed patients. However, escitalopram is the most selective SSRI to date and represents an advance on the SSRI class.

Objective: To evaluate the efficacy of escitalopram in severely depressed patients.

Methods: Severely depressed (baseline MADRS>= 30) outpatients received eight weeks of double-blind treatment with escitalopram, citalopram, or placebo in three trials of similar design. The change from baseline to endpoint in MADRS was the primary efficacy variable for all three trials.

Results: In the pooled data set, both active treatments significantly improved depressive symptoms relative to placebo. However, escitalopram significantly separated from placebo at earlier time points than did citalopram. Furthermore, escitalopram was statistically significantly superior to citalopram at endpoint. Both escitalopram and citalopram were well tolerated.

Conclusion: These results suggest that escitalopram should be considered as a first-line agent in the treatment of severe major depression.

REFERENCES:

1. Hyttel J, Bogeso KP, Perregaard J, Sanchez C: The pharmacological effect of citalopram resides in the (S)-(+)-enantiomer. J Neural Transm Gen Sect 1992;88:157–60.
2. Roose SP, Glassman AH, Attia E, Woodring S: Comparative efficacy of selective serotonin reuptake inhibitors and tricyclics in the treatment of melancholia. Am J Psychiatry 1994;151(12):1735–9.

TARGET AUDIENCE:

Practicing psychiatrists.

Poster 155 **Friday, October 11 4:00 p.m.-5:30 p.m.**

SYMPTOMATIC RESPONSE TO LAMOTRIGINE MAINTENANCE IN BIPOLAR DISORDER

GlaxoSmithKline

Laszlo Gyulai, M.D., *Director, Bipolar Disorders Program, Department of Psychiatry, University of Pennsylvania, 3535 Market Street, #670, Philadelphia, PA 19104*; John M. Zajecka, M.D., *Assistant Professor of Psychiatry and Medical Director, Ambulatory Psychiatric Service, and Clinical Director, Woman's Board Depression Treatment and Research Center, Rush Presbyterian-St. Luke's Medical Center, 1725 West Harrison Street, #955, Chicago, IL 60612*; Brent Forrester, M.D.; Eleanora Gabriel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) use lamotrigine for the maintenance treatment of bipolar depression, (2) differentiate effects of lamotrigine and lithium on depressed and manic symptoms of bipolar disorder.

SUMMARY:

Background: Long-term treatment of bipolar depression is a difficult treatment challenge. Lamotrigine was shown to be effective in delaying affective *relapses.* Here we report the efficacy of lamotrigine monotherapy compared with placebo and lithium in maintaining low depressive and manic symptoms of patients with bipolar I disorder over 18 months.

Methods: Lamotrigine was initiated during an eight- to 16-week, open-label phase, while other psychotropic drugs were discontinued in currently or recently depressed bipolar I patients. Patients recovered in this phase were randomized to lamotrigine (fixed doses of 50mg, 200mg or 400mg daily), lithium (0.8 to 1.1mEq/L), or placebo for up to 18 months double-blind maintenance treatment. Symptom intensity ratings of depression (HAM-D), mood elevation (YMRS), and overall illness severity (CGI) were compared by repeated measures analysis.

Results: After recovery on open-label lamotrigine, the average and visit-wise increase in depression was less in the randomized lamotrigine group than in the placebo group (2.5 vs. 4.9 average HAM-D change, respectively; p=0.002) during the 18-month, double-blind treatment phase. Lamotrigine did not lead to worsening of mania symptoms, Lithium was superior to placebo in preventing the return of manic symptoms without worsening depressive symptoms in the visit-wise analysis ($p<0.05$).

Conclusions: (1) Lamotrigine provides a stronger *prevention* than placebo of the return of depressive symptoms and maintaining overall mood stability. (2) Lamotrigine and lithium appear to have distinct and potentially complementary effects on affective symptoms in bipolar I patients.

REFERENCES:

1. Bowden C, Ghaemi N, Gyulai L, et al: Lamotrigine delays mood episodes in recently depressed bipolar I patients. Poster presentation, American Psychiatric Association Annual Meeting, 2002.
2. Calabrese JR, Bowden CL, Sachs GS, et al: A double-blind, placebo-controlled study of lamotrigine monotherapy in outpatients with bipolar I depression. Lamictal 602 Study Group. Journal of Clinical Psychiatry 1999; 60(2):79–88.

TARGET AUDIENCE:

Psychiatrists, nurses, clinical specialists, clinical psychologists.

Poster 156 **Friday, October 11**
4:00 p.m.-5:30 p.m.

META-ANALYSIS OF CARDIAC SAFETY WITH ARIPIPRAZOLE

Bristol-Myers Squibb Company and Otsuka Pharmaceuticals

Darlene N. Jody, M.D., *Employee, Bristol-Myers Squibb Company, P.O. Box 4000, Princeton, NJ 08543-4000*; Anutosh R. Saha, Ph.D., *Director, Clinical Development, Otsuka-Maryland Research Institute, 2440 Research Boulevard, Rockville, MD 20850*; Robert Brunell, Ph.D.; Donald G. Archibald, M.Phil.; Taro Iwamoto, Ph.D.; Robert D. McQuade, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have learned that aripiprazole is not associated with QT_c prolongation.

SUMMARY:

Objective: A meta-analysis was done to assess the short- and long-term cardiac safety of aripiprazole, as measured by prolongation of the QT interval.

Methods: Short-term effects were based on five four- to six-week, double-blind, controlled studies in 1,648 patients, randomized to aripiprazole, placebo, or active control (haloperidol 10 mg/day or risperidone 6 mg/day). Long-term effects were based on a 52-week haloperidol-controlled study (n= 1294) and a 26-week open-label olanzapine-controlled study (n= 255). Data are presented as the mean change from baseline to study endpoint using a fractional exponent correction method.

Results: In the short-term studies, aripiprazole was comparable to placebo across all doses regardless of gender or race. Mean changes in QT_c with aripiprazole and placebo were −4.4 msec and −3.5 msec, respectively; changes with haloperidol and risperidone were −1.04 msec and +2.15 msec, respectively. In these studies, incidence at endpoint of a 30 msec increase in QT_c with aripiprazole was 4.3% compared with 5.5% for placebo; values for haloperidol and risperidone were 7.8% and 10.5%, respectively. In the long-term studies, aripiprazole was not associated with significant increases in QT_c.

Conclusion: Aripiprazole is not associated with QT_c prolongation following short- and long-term administration.

REFERENCES:

1. Gury C, Canceii O, Iaria P: Antipsychotic drugs and cardiovascular safety: current studies of prolonged QT interval and risk of ventricular arrhythmia. Encephale 2000;26(6):62–72.
2. Kikuchi T, Tottori K, Uwahodo Y, Hirose T, Miwa T, Oshiro Y, Morita S: 7-(4-[4-(2,3-Dichlorophenyl)-

1-piperazinyl]butyloxy)-3,4-dihydro-2(1H)-quinolinone (OPC-14597), a new putative antipsychotic drug with both presynaptic dopamine autoreceptor agonistic activity and postsynaptic D2 receptor antagonistic activity. J Pharmacol Exp Ther 1995;274(1):329–36.

TARGET AUDIENCE:

Psychiatrists and other clinicians who treat schizophrenia.

Poster 157 **Friday, October 11**
4:00 p.m.-5:30 p.m.

ESCITALOPRAM IS EFFICACIOUS AND WELL TOLERATED IN THE TREATMENT OF SOCIAL ANXIETY DISORDER

H. Lundbeck A/S

Siegfried Kasper, M.D., *Professor and Chair, Department of Psychiatry, University of Vienna, Währinger Gürtel 18–20, Wien, Austria A-1090*; Henrik Loft, M.S.C.; James R. Smith, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the potential usefulness of escitalopram in the treatment of social anxiety disorder.

SUMMARY:

Background: Escitalopram is a potent and highly selective SSRI, whose efficacy and safety in the treatment of MDD have recently been established.

Objective: This study compared the efficacy and safety of escitalopram with placebo in the treatment of social anxiety disorder (SAD).

Method: After a one-week, single-blind placebo period, outpatients (aged 18–65 years) with primary diagnosis of SAD (DSM-IV), who had an LSAS > or = 70 and a CGI-S > or = 4 at baseline, were randomized to 12 weeks of double-blind treatment with escitalopram (n=181) or placebo (n=177). Patients on escitalopram started at 10mg/day; if needed, the dose could be doubled after four, six, or eight weeks of treatment, so that the escitalopram-treated patients received 20mg/day.

Results: The primary efficacy variable, change in LSAS score from baseline to endpoint, showed a significant improvement for escitalopram relative to placebo. Secondary efficacy analyses also showed a significantly better therapeutic effect at endpoint for escitalopram relative to placebo on CGI-S, CGI-I, LSAS avoidance and fear/anxiety, and two of three items on the Sheehan Disability Scale (SDS). Escitalopram was well tolerated in this patient population.

Conclusion: This phase III study demonstrates that escitalopram 10–20mg/day is effective and well tolerated in the treatment of social anxiety disorder.

REFERENCES:

1. Baldwin D, Bobes J, Stein DJ, Scharwachter I, Faure M: Paroxetine in social phobia/social anxiety disorder. Randomized, double-blind, placebo-controlled study. Paroxetine Study Group. Br J Psychiatry 1999; 175: 120–6.
2. Van Ameringen M, Mancini C, Oakman JM, Farvolden P: Selective serotonin reuptake inhibitors in the treatment of social phobia: the emerging gold standard. CNS Drugs 1999; 11: 307–15.

TARGET AUDIENCE:

Practicing psychiatrists.

Poster 158 **Friday, October 11**
4:00 p.m.-5:30 p.m.

ESCITALOPRAM OFFERS EARLY SEPARATION FROM PLACEBO IN THE TREATMENT OF DEPRESSION

H. Lundbeck A/S

Stuart A. Montgomery, M.D., *Professor, Department of Psychiatry, Imperial College, P.O. Box 8751, London, United Kingdom W13 8PN*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the potential clinical benefits associated with the early separation of escitalopram treatment from placebo.

SUMMARY:

Background: Escitalopram has been proven safe and effective in the treatment of depression in recently completed phase III studies.

Objective: The efficacy of an antidepressant is evaluated on the basis of endpoint measurements and on the time at which efficacy first becomes measurable. This paper reports how escitalopram offered early separation relative to placebo in two randomized, double-blind, placebo-controlled, fixed-dose multicentre studies designed to evaluate the safety and efficacy of escitalopram in the treatment of depression.

Method: Outpatients with an ongoing major depressive episode (mean baseline MADRS score was approximately 29) were assigned to placebo, or 10 or 20 mg/day escitalopram and entered the eight week, double-blind treatment period following a one-week, single-blind placebo period. Severity of depressive symptomatology was evaluated using MADRS, CGI-S, and CGI I.

Results: In each of the studies, escitalopram gave rise to significant early differences from placebo: a significant improvement compared with placebo on the MADRS score was seen at Week 2 onwards and on the CGI-I at Week 1 onwards.

Conclusion: Escitalopram delivered a significant improvement in depressive symptoms from Week 1 onwards relative to placebo in these studies.

REFERENCES:

1. Montgomery SA, Loft H, Sanchez C, Reines EH, Papp M. Escitalopram (S-enantiomer of citalopram): clinical efficacy and onset of action predicted from a rat model. Pharmacol Toxicol 2001; 88: 282–286.
2. Stahl SM, Nierenberg AA, Gorman JM: Evidence of early onset of antidepressant effect in randomized controlled trials. J Clin Psychiatry 2001; 62 (suppl 4): 17–23.

TARGET AUDIENCE:

Practicing psychiatrists.

Poster 159 **Friday, October 11 4:00 p.m.-5:30 p.m.**

DIVALPROEX DELAYED RELEASE COMPARED TO DIVALPROEX EXTENDED RELEASE: PATIENT CONDITION, COMPLIANCE, AND PREFERENCE

Abbott Laboratories

Virginia Neal, Ph.D., *Research Psychologist, The Minirth Clinic, 2100 North Collins Boulevard, Suite 200, Richardson, TX 75080*; Franklin B. Minirth, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that preliminary data indicate switching 32 psychiatric patients from divalproex sodium delayed-release to divalproex sodium extended-release resulted in better compliance and improved condition, with more patients preferring the ER to the DR preparation.

SUMMARY:

This session will be of interest to physicians, nurses, and mental health professionals treating patients who have mood instability, seizures, or chronic migraine headaches. The poster displays the results of a chart review of 32 patients switched from the delayed-release divalproex preparation to the extended-release. Clinical condition before and after switching was assessed, level of compliance was determined, and their preference for each preparation was obtained. Summaries of the objectives, method, results, and conclusions are reviewed. Specifically, overall compliance improved by 8%; clinical condition improved by 50%; and 55% had fewer side effects. Sixteen patients of the 32 reviewed preference for the ER over the DR preparation; 10 patients stated no preference, and six patients did not respond to the question of preference. Sixteen patients out of 32 reviewed showed improvement in their symptoms on the ER preparation; 12 patients were unchanged clinically; and three patients were evaluated as worse following the switch. Two color charts graphically show patient preferences for ER over DR, and the change in the patients' clinical conditions following the switch.

REFERENCES:

1. Hilry D, Rodriguez G, Hales R: Treatment of comorbid bipolar disorder and epilepsy with valproate. The Journal of Neuropsychiatry and Clinical Neurosciences 2000; 12:283–285.
2. Luigi-Alberto P, Lupo L: Review: anti-epileptic drugs in the preventive treatment of migraine headache: a brief review. The Journal of Headache and Pain 2001; 2:13–19.

Poster 160 **Friday, October 11 4:00 p.m.-5:30 p.m.**

PHARMACOKINETICS AND SAFETY OF ARIPIPRAZOLE AND CONCOMITANT MOOD STABILIZERS

Bristol-Myers Squibb Company and Otsuka Pharmaceuticals

Lorraine Perkins, Pharm.D., *Medical Science Manager, Bristol-Myers Squibb Company, 30518 Whitney Drive, Castalc, CA 91384*; Leslie L. Citrome, M.D., M.P.H., *Clinical Professor of Psychiatry, New York University School of Medicine, and Director, Clinical Research and Evaluation, Nathan S. Kline Institute for Psychiatric Research, 140 Old Orangeburg Road, Orangeburg, NY 10962*; Richard Josassen, Ph.D.; Nigel M. Bark, M.D.; Karen S. Brown, M.S.; Suresh Mallikaarjun, Ph.D.; Daniel E. Salazar, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have a better understanding of the pharmacokinetics and safety of aripiprazole, given concurrently with lithium or divalproex sodium.

SUMMARY:

Objective: To assess the safety profile and pharmacokinetics of aripiprazole, an antipsychotic with a unique pharmacologic profile of dopamine D_2 partial agonism,

serotonin $5HT_{1A}$ partial agonism and $5HT_{2A}$ antagonism, when coadministered with lithium or divalproex sodium.

Methods: Two open-label, sequential treatment design studies were conducted in chronically institutionalized patients with schizophrenia or schizoaffective disorder requiring treatment with lithium (n=7) or divalproex sodium (n=6). Patients received aripiprazole 30 mg/day on Days 1–14 and aripiprazole with concomitant therapy on Days 15–36. Lithium was titrated from 900 mg until serum concentrations reached 1.0–1.4 mEq/L for ≥5 days. Divalproex sodium was titrated to 50–125 mg/L.

Results: Coadministration with lithium increased mean C_{max} and AUC values of aripiprazole by about 19% and 15%, respectively, while the apparent oral clearance decreased by 15%. There was no effect on the steady state pharmacokinetics of the active metabolite of aripiprazole. Coadministration with divalproex sodium decreased the AUC, C_{max}, and C_{min} of aripiprazole by 24%, 26%, and 22%, respectively, with minimal effects on the active metabolite.

Conclusion: Aripiprazole can be administered safely with therapeutic doses of lithium or divalproex sodium in patients with schizophrenia or schizoaffective disorder.

REFERENCES:

1. Dose M, Hellweg R, Yassouridis A, Theison M, Emrich HM: Combined treatment of schizophrenic psychoses with haloperidol and valproate. Pharmacopsychiatry 1998;31(4):122–5.
2. Kikuchi T, Tottori K, Uwahodo Y, Hirose T, Miwa T, Oshiro Y, Morita S: 7-(4-[4-(2,3-Dichlorophenyl)-1-piperazinyl]butyloxy)-3,4-dihydro-2(1H)-quinolinone (OPC-14597), a new putative antipsychotic drug with both presynaptic dopamine autoreceptor agonistic activity and postsynaptic D2 receptor antagonistic activity. J Pharmacol Exp Ther 1995;274(1):329–36.

TARGET AUDIENCE:

Psychiatrists and other clinicians who treat schizophrenia.

Poster 161 **Friday, October 11 4:00 p.m.-5:30 p.m.**

PATIENT RESPONSE IN DEPRESSION WITH OVEREATING AND OVERSLEEPING TO GEPIRONE EXTENDED RELEASE

Organon Inc.

Frederic M. Quitkin, M.D., *Director, Depression Evaluation Services, New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032*; Michael Gibertini, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to describe and evaluate clinical results indicating that gepirone-ER is an effective and well-tolerated antidepressant; and clinical data suggesting that gepirone-ER may be particularly effective for patients with chronic or recurrent MDD presenting with symptoms of overeating and/or oversleeping.

SUMMARY:

Study Purpose: To evaluate the efficacy of gepirone-ER, a 5-hydroxytryptamine receptor (1A) agonist, in patients with chronic or recurrent major depressive disorder (MDD) who present with symptoms of overeating and/or oversleeping.

Method: In an eight-week, double blind, placebo-controlled trial, outpatients with MDD of any subtype were included (N=204; HAMD-17 ≥ 20 at baseline; mean dose = 70.3 mg/day). For this analysis, a subset of patients with chronic or recurrent MDD who presented with overeating and/or oversleeping at baseline was defined as "probably atypical." Results were based on an intent-to-treat (ITT) and last-observation-carried-forward (LOCF) analysis.

Results: In the subset of patients defined as probable atypical, the change from baseline to endpoint was statistically significantly greater for gepirone-ER (N=60) than for placebo (N=51) for the mean total scores on the HAMD-17, MADRS, and HAMD-retardation factor ($P<0.05$).

Conclusion: These results suggest that gepirone-ER is effective in patients with MDD and may be particularly effective in patients with chronic or recurrent MDD presenting with overeating and/or oversleeping.

REFERENCES:

1. Kendler KS, Eavs LJ, Walters EE, Neale MC, Heath AC, Kesler RC: The identification and validation of distinct depressive syndromes in a population-based sample of female twins. Arch Gen Psychiatry 1996;53:391–399.
2. McGrath PJ, Stewart JW, Quitkin FM, et al: Gepirone treatment of atypical depression: preliminary evidence of serotonergic involvement. J Clin Psychopharmacol 1994; 14:347–352.

TARGET AUDIENCE:

Psychiatrists.

Poster 162 **Friday, October 11 4:00 p.m.-5:30 p.m.**

ESCITALOPRAM PREVENTS RELAPSE OF DEPRESSION EPISODES

Forest Laboratories, Inc.

Mark H. Rapaport, M.D., *Associate Professor of Psychiatry, University of California at San Diego, 8950 Villa*

La Jolla Drive, #2243, La Jolla, CA 92037-2315; Anjana Bose, Ph.D.; Hongjie Zheng, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that long-term continuation treatment with escitalopram effectively prevents relapse of major depression in patients who had responded to short-term treatment.

SUMMARY:

Introduction: The antidepressant efficacy of escitalopram at a dose as low as 10 mg/day is supported by several placebo-controlled trials of eight weeks duration.

Objective: The efficacy of long-term treatment with escitalopram in the prevention of depression relapse was evaluated.

Method: This multicenter trial was conducted as an extension study in depressed outpatients (male or female, 18–81 years old) having previously completed eight weeks of randomized, double-blind treatment with escitalopram, citalopram, or placebo. It consisted of an initial eight-week, open-label escitalopram treatment phase followed by a randomized, 36-week, double-blind, placebo-controlled, parallel-group phase. At the end of the open-label phase, responders (MADRS <= 12) were randomly assigned in a 2:1 ratio to escitalopram or placebo treatment. The primary efficacy variable was time to depression relapse (defined as MADRS score >= 22 or discontinuation due to an insufficient therapeutic response) from the start of the double-blind treatment phase.

Results: Time to depression relapse was significantly longer in escitalopram-treated patients (p=0.01), with the risk of relapse 44% lower in escitalopram-treated patients than in placebo-treated patients. Escitalopram-treated patients continued to exhibit low mean ratings of anxiety and depression symptoms during the double-blind phase, which were significantly lower than that of placebo treated patients.

Conclusion: Continuation treatment with escitalopram is effective in preventing relapse of depression.

REFERENCES:

1. Hochstrasser B, Isaksen PM, Koponen H, Lauritzen L, Mahner FA, Rouillon F, Wade AG, Andersen M, Pederson SF, Swart JC, Nil R: Prophylactic effect of citalopram in unipolar, recurrent depression: placebo-controlled study of maintenance therapy. Br J Psychiatry 2001;178:304–10.
2. Burke WJ: Fixed dose study of escitalopram in the treatment of depression. NR Abstract 518 Presented at the 154th Annual Meeting of the American Psychiatric Association, May 2001, New Orleans.

TARGET AUDIENCE:

Practicing psychiatrists.

Poster 163

Friday, October 11
4:00 p.m.-5:30 p.m.

MIRTAZAPINE ORALLY DISINTEGRATING TABLETS IN MATURE PATIENTS

Organon Inc.

Steven P. Roose, M.D., *Professor of Clinical Psychiatry, Columbia University College of Physicians and Surgeons, New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032-2603*; Peter J. Holland, M.D., *Director of Pediatric Studies, Summit Research Network, 7284 West Palmetto Park Road, #205, Boca Raton, FL 33433*; Howard A. Hassman, D.O.; Murray H. Rosenthal, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand (1) the design and methods of this clinical trial using mirtazapine orally disintegrating tablets in mature patients, and (2) the efficacy and safety of mirtazapine orally disintegrating tablets in actual clinical practice.

SUMMARY:

Objective: Assess effectiveness and safety of mirtazapine orally disintegrating tablets in patients at least 50 years old.

Methods: Six-week study in patients at least 50 years old with depression. Excluded if used a MAOI within 14 days or reside in nursing home. Mirtazapine orally disintegrating tablets started at 30 mg qhs, titration allowed (range 15–45 mg). Patient Ham-D-24 collected at baseline, Days 7–14, and Day 42. Physician CGI-Severity and Cumulative Illness Rating Scale-Geriatric evaluated at baseline. Effectiveness assessed by Ham-D change from baseline. Tolerability assessed through adverse events. Patient preference survey is completed.

Results: Sixty-three patients in intent-to-treat sample, 40 have completed study thus far. Mean baseline patient Ham-D-17 is 16.9. Mean change of –6.2 and –8.4 found at Days 7–14 and 42, respectively. Response rates 41.3% and 45.0% at Days 7–14 and 42 respectively. Anxiety/somatization and sleep disturbance factor scores also decreased. Eight patients discontinued due to adverse events. Preference survey includes several positive ratings.

Conclusions: Mirtazapine orally disintegrating tablets provide rapid reduction of depressive symptoms in mature patients that is sustained over six weeks of treatment. Starting at 30 mg, mirtazapine orally disintegrating tablets appear to be well tolerated. Information on effectiveness, tolerability, and patient preference is presented.

Funding Source(s): This research is supported by Organon Pharmaceuticals Inc.

REFERENCES:

1. De Boer T: The pharmacologic profile of mirtazapine. J Clin Psychiatry 1996; 57 (Suppl 4):19–25.
2. Holm KJ, Markham A: Mirtazapine: a review of its use in major depression. Drugs 1999; 57 (4):607–631.

TARGET AUDIENCE:

Psychiatrists, mental health clinicians.

Poster 164 **Friday, October 11 4:00 p.m.-5:30 p.m.**

EFFICACY AND TOLERABILITY OF ESCITALOPRAM IN PATIENTS INTOLERANT OF OTHER SSRIS

Forest Laboratories, Inc.

Murray H. Rosenthal, D.O., *Medical Director, Behavioral and Medical Research, Healthquest, 3625 Ruffin Road, Suite 100, San Diego, CA 92123-1841*; Gwen L. Zornberg, M.D.; Dayong Li, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that a patient unable to tolerate one SSRI may respond well to a trial with a different SSRI.

SUMMARY:

Introduction: Escitalopram is a new selective serotonin reuptake inhibitor (SSRI) that has shown antidepressant efficacy in several clinical trials at a dose of 10 mg/day. That dose has also shown to be well tolerated, with discontinuation rates due to adverse events not different from placebo.

Objective: To assess the tolerability of escitalopram among patients unable to tolerate another SSRI.

Methods: In this study, patients with major depressive disorder who had previously experienced at least two major depressive episodes were randomly assigned to eight weeks of open-label treatment with citalopram, fluoxetine, paroxetine, or sertraline. Patients unable to tolerate the assigned treatment were switched to treatment with escitalopram.

Results: A total of 46 patients who discontinued treatment from one of the SSRIs for adverse events were switched to eight weeks of open-label treatment with escitalopram. Of these, 39 (85%) were successfully switched to escitalopram treatment without the re-emergence of adverse events necessitating drug discontinuation. The incidence of any re-emergent adverse events associated with discontinuation with the first SSRI was low during escitalopram treatment. Depression symptoms improved during the course of escitalopram treatment.

Discussion: These results indicate that patients who are intolerant of other SSRIs can tolerate escitalopram treatment while experiencing an improvement in depressive symptomatology.

REFERENCES:

1. Thase ME, Feighner JP, Lydiard RB: Citalopram treatment of fluoxetine nonresponders. J Clin Psychiatry 2001;62:683–7.
2. Thase ME, Blomgren SL, Birkett MA, Apter JT, Tepner RG: Fluoxetine treatment of patients with major depressive disorder who failed initial treatment with sertraline. J Clin Psychiatry 1997;58:16–21.

TARGET AUDIENCE:

Practicing psychiatrists.

Poster 165 **Friday, October 11 4:00 p.m.-5:30 p.m.**

LAMOTRIGINE AND LITHIUM IN THE TREATMENT OF BIPOLAR I DISORDER

Melvin D. Shelton, M.D., Ph.D., *Assistant Professor, Case Western Reserve University Hospitals, 11400 Euclid Avenue, Suite 200, Cleveland, OH 44106*; Joseph R. Calabrese, M.D., *Director, Mood Disorders Program, Case Western Reserve University, 11400 Euclid Avenue, Suite 200, Cleveland, OH 44106-3986*; Charles L. Bowden, M.D.; Laszlo Gyulai, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant be familiar with new data regarding the efficacy of lithium and lamotrigine in the treatment of bipolar I disorder.

SUMMARY:

Objective: Two studies, prospectively designed for combined analysis, compared placebo, lithium, and lamotrigine for maintenance of bipolar I disorder (DSM-IV) in currently or recently depressed (GW605) or manic/hypomanic/mixed (GW606) episodes for < 18 months.

Methods: A total of 1,315 patients enrolled in the open label phases; 638 were stabilized and randomized to double-blind monotherapy with lamotrigine (n=280; 50–400mg/day fixed and flexible doses), lithium (n= 167; serum 0.8–1.1mEq), or placebo (n=191). Primary outcome was time from randomization to intervention for an emerging mood episode or all premature study dropouts, excluding those due to adverse events unrelated to bipolar illness. Tolerability was assessed using adverse events.

Results: Lamotrigine and lithium were superior to placebo for time to intervention for any mood episode ($p<0.001$ LTG vs. PBO; $p<0.001$ Li vs. PBO). Lamotrig-

ine was superior to placebo for time to intervention for a depressive episode (p=0.004 LTG vs. PBO, p=0.076 Li vs. PBO). Lithium was superior to placebo for time to intervention for a manic/hypomanic/mixed episode (p<0.001 Li vs. PBO; p=0.149 LTG vs. PBO). More diarrhea (19% vs. 7%, p<0.05) and tremor (14% vs. 4%, p<0.05) were reported by lithium-treated patients compared with lamotrigine.

Conclusions: Lamotrigine and lithium are complementary mood stabilizers. Lamotrigine was better tolerated than lithium.

REFERENCES:

1. Montgomery S, Akthar A, Bowden C, Calabrese J, Olajossy M: Lamotrigine demonstrates long-term stabilization in manic patients. World J Biological Psychiatry 2001; 2(S1):351S.
2. Behnke K, Soegaard J, Timotijevic L, Mehtonen O-P, Paska W: Lamotrigine: evidence for mood stabilization in bipolar I depression. World J Biological Psychiatry 2001; 2(S1):351–352S.

TARGET AUDIENCE:

Any practicing psychiatrist.

Poster 166 **Friday, October 11 4:00 p.m.-5:30 p.m.**

EFFECTS OF OLANZAPINE MONOTHERAPY AND OLANZAPINE IN COMBINATION WITH FLUOXETINE ON WORK FUNCTIONING IN PATIENTS WITH BIPOLAR DEPRESSION

Eli Lilly and Company

Lizheng Shi, Ph.D., *Senior Health Outcomes Research Scientist, Lilly Research Laboratories, Eli Lilly and Company, Lilly Corporate Center, DC-1758, Indianapolis, IN 46285*; Madhav Namjoshi, Ph.D., *Health Outcomes Research Scientist, Lilly Research Laboratories, Eli Lilly and Company, Lilly Corporate Center, DC-1758, Indianapolis, IN 46285*; Xiaomin Yu, Ph.D.; Robert W. Baker, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the attendee should be able to recognize the benefits in the work functional outcomes associated with olanzapine plus fluoxetine treatment for patients with bipolar depression.

SUMMARY:

Objective: To determine the benefits in work functioning associated with olanzapine (Olz) monotherapy and combination of olanzapine plus fluoxetine (OFC) compared with placebo (PBO) in a pooled sample from two double-blind, randomized controlled trials.

Method: Patients with DSM-IV bipolar depression (baseline MADRS rating ≥ 20) were randomized to olanzapine (5–20 mg/day; n=370), OFC (olanzapine: 6 mg or 12 mg/day plus fluoxetine: 25 or 50 mg/day; n=86), or placebo (n=377) for eight weeks. Work functioning outcomes were assessed by patient-reported work status and functional level at baseline and Week 8. The patients with work status as employee, students, house worker, and volunteers were classified as "work group." The work functional level was transformed to a work functional score.

Results: No difference in the proportion of "work group" patients by therapy was found at Week 8. From baseline to Week 8, OFC increased the percentage of patients who improved at least one grade in the work functional level [PBO: 9.9%; Olz: 9.9%; OFC: 18.3% (p-OFC-Olz=.062; p-OFC-PBO=.061). OFC-treated patients were associated with significantly greater improvement in the work functional score [PBO: 0.08; Olz: 0.15; OFC: 0.41 (p-OFC-PBO=.03; p-OFC-Olz=.09)].

Conclusions: Compared with placebo, OFC improved work functioning in patients with bipolar depression.

REFERENCES:

1. Shi L, Namjoshi MA, Zhang F, Gandhi G, Edgell ET, Tohen F, and Breier A: Olanzapine versus haloperidol: a prospective comparison of clinical and work status outcomes in bipolar disorder. Bipolar Disorders 2001: 3 suppl: 58.
2. Tohen M, Risser R, Baker RW, Evans AR, Tollefson GD, Breier A: Olanzapine in the treatment of bipolar depression. New Research Poster, American Psychiatric Association 155th Annual Meeting, May 22 2002, Philadelphia, PA.

Poster 167 **Friday, October 11 4:00 p.m.-5:30 p.m.**

COMPLIANCE IN BIPOLAR ILLNESS

Katharine Stratigos, B.S., M.S., *Department of Psychiatry, New York University School of Medicine, 166 Second Avenue, Apt. 8-E, New York, NY 10003*; Eric D. Peselow, M.D., *Department of Psychiatry, New York University School of Medicine, 33 Gold Street, #612, New York, NY 10038*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand the reasons why bipolar patients discontinue medication.

SUMMARY:

Objective: The utility of medication in the prophylaxis of bipolar illness has been well established. However, lithium has many burdensome side effects, including the long-term problem of renal toxicity. As a result of this, many patients discontinue their psychotropic medication. Since the consequences of noncompliance can be very devastating, the purpose of this paper is examine a variety of characteristics that may be predictive of noncompliance.

Method: We evaluated 101 patients with bipolar illness who were stabilized on medication for six to 48 months who subsequently dropped out of treatment, discontinuing their medication. These patients were examined with respect to demographic characteristics, clinical symptoms, personality traits, and attitudes toward their illness and the taking of medication (the latter via a survey following discontinuation). These patients were matched against a cohort of 131 patients who continued on maintenance medication and were examined with the same variables.

Results: The patients who dropped out of treatment tended to have more of a belief that they were well and no longer needed medication compared with the control group. They also felt more stigmatized by the illness and the need for medication. Patients who dropped out of treatment tended to have been ill for shorter periods of time and to have had fewer lifetime affective episodes. Patients who dropped out of treatment had slightly higher cluster B personality traits than the control group.

Conclusion: Implications of these findings (interpersonal chaos, family disruption, financial crises) and the reversal of noncompliance through experience with the illness and education will be discussed.

REFERENCES:

1. Jamison KR, Akiskol HS: Medication compliance in patients with bipolar disorders. Psychiatric Clinics of North America 1983; 6:175–192.
2. Connelly CE, Davenport YB, Nurnberge JI: Adherence to treatment regimes in a lithium carbonate clinic. Archives of General Psychiatry 1982; 39:585–588.

TARGET AUDIENCE:

Psychiatrists and psychologists.

Poster 168 **Friday, October 11 4:00 p.m.-5:30 p.m.**

OLANZAPINE COMBINED WITH LITHIUM OR VALPROATE FOR RELAPSE PREVENTION OF BIPOLAR DISORDER: AN 18-MONTH STUDY

Eli Lilly and Company

Mauricio Tohen, M.D., Ph.D., *Medical Advisor and Research Fellow, Lilly Research Laboratories, Eli Lilly and Company, One Lilly Corporate Center, DC-1758, Indianapolis, IN 46285*; K.N. Roy Chengappa, M.D.; Trisha Suppes, M.D.; Robert W. Baker, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the attendee should be able to determine the benefit of the use of olanzapine in augmentation therapy for mood stabilization in bipolar I disorder.

SUMMARY:

Objective: To determine whether olanzapine cotherapy reduces symptomatic relapse among bipolar patients treated with lithium or valproate.

Methods: Following six weeks of acute therapy, patients remitting on olanzapine combined with lithium or valproate were randomized to olanzapine (5–20 mg/day, n=30) or placebo (n=38), concomitant with ongoing valproate (50–125 μg/mL) or lithium (0.6–1.2 mEq/L).

Results: Among patients who achieved symptomatic remission of bipolar disorder at the end of the acute therapy, 55.3% and 36.7% of placebo- and olanzapine-treated patients, respectively, relapsed into either mania or depression (bipolar relapse) during this 18-month trial (P=.149). Time to bipolar relapse, however, was significantly different (P=.023) between groups: 25% of placebo- and olanzapine-treated patients had relapsed into either mania or depression by days 15 and 124, respectively. Relapse to mania was observed in 28.9% and 20.0% of placebo-treated and olanzapine-treated patients, respectively (P=.574), whereas rates of relapse to depression were 39.5% and 23.3% (P=.197).

Conclusion: In bipolar patients stabilized on olanzapine plus lithium or valproate, continued treatment with olanzapine significantly delayed symptomatic relapse compared with treatment with lithium or valproate alone.

REFERENCES:

1. Tohen M, Zarate CA Jr: Antipsychotic agents and bipolar disorder. J Clin Psychiatry 1998; 59:38–49.
2. Tohen M, Sanger TM, McElroy SL, Tollefson GD, Chengappa KN, Daniel DG, Petty F, Centorrino F, Wang R, Grundy SL, Greaney MG, Jacobs TG, David SR, Toma V: Olanzapine versus placebo in the treatment of acute mania. Am J Psychiatry 1999; 156:702–709.

Poster 169 **Friday, October 11 4:00 p.m.-5:30 p.m.**

OLANZAPINE AND OLANZAPINE-FLUOXETINE COMBINATION IN THE TREATMENT OF BIPOLAR DEPRESSION

Eli Lilly and Company

Mauricio Tohen, M.D., Ph.D., *Medical Advisor and Research Fellow, Lilly Research Laboratories, Eli Lilly*

and Company, One Lilly Corporate Center, DC-1758, Indianapolis, IN 46285; Eduard Vieta, M.D., Ph.D., *Research Physician, Department of Psychiatry, University of Barcelona Hospital and Clinic, RD St. Antoni 58 6-1, Barcelona 08001, Spain 00284*; Terence A. Ketter, M.D.; Franca Centorrino, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the attendee should be able to determine the relative strengths and weaknesses of olanzapine and the combination of olanzapine plus fluoxetine in treating bipolar depression.

SUMMARY:

Objective: Determine the efficacy and safety of olanzapine compared with placebo in the treatment of bipolar depression.

Methods: Patients with bipolar depression and baseline MADRS rating ≥20 were randomized for eight weeks of double-blind treatment with olanzapine (5–20 mg/d, n=370) or placebo (n=377). Additionally, 86 patients were randomized to the combination of olanzapine (6 or 12 mg/d) plus fluoxetine (25 or 50 mg/d).

Results: Starting at Week 1 and sustained throughout the study, improvement for both olanzapine and olanzapine+fluoxetine groups was superior to the placebo group. Endpoint mean MADRS change was significantly greater on olanzapine (−12.7) or olanzapine+fluoxetine (−17.1) than on placebo (−9.4, p<.001). Improvement on olanzapine+fluoxetine was significantly greater than on olanzapine alone (p=.002). Induction of mania (baseline YMRS < 15 and ≥ 15 anytime subsequently) did not differ between groups (olanzapine 5.7%, placebo 6.7%, olanzapine+fluoxetine 6.4%). Common (>10%) and significant adverse events reported in the olanzapine group compared with placebo were somnolence, weight gain, increased appetite, and dry mouth, whereas headache and insomnia were more common and significant on placebo.

Conclusion: Olanzapine demonstrated superiority to placebo in the treatment of bipolar depression; olanzapine+fluoxetine also showed superiority compared with placebo and to olanzapine.

REFERENCES:

1. Sachs GS, Koslow CS, Ghaemi SH: The treatment of bipolar depression Bipolar Disord 2000; 2 (3 Pt 2):256–60.
2. Tohen M, Jacobs TG, Grundy SL, Banov MC, McElroy SL, Janicak PG, Zhang F, Toma V, Francis BJ, Sanger TM, Tollefson GD, Breier A: Efficacy of olanzapine in acute bipolar mania: a double-blind, placebo-controlled study. Arch Gen Psychiatry 2000; 57:841–849.

Poster 170 **Friday, October 11**
4:00 p.m.-5:30 p.m.

ESCITALOPRAM IS SAFE AND WELL TOLERATED IN THE LONG-TERM TREATMENT OF DEPRESSION

H. Lundbeck A/S

Alan G. Wade, M.D., *Director, Community Pharmaceutical Services, Clydebank, Glasgow, England G811X*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the long-term safety profile of escitalopram in the treatment of depression.

SUMMARY:

Background: Escitalopram is a highly selective SSRI that has been proven safe and effective in the treatment of depression in short-term phase III studies.

Objective: The clinical long-term safety of escitalopram has now been evaluated in three recently completed long-term studies.

Method: Escitalopram was administered at doses of 10 or 20 mg/day in two follow-up studies (of up to one year duration) conducted in outpatients with depression (DSM-IV) in specialist and GP primary care settings. Escitalopram also was administered to outpatients in a GP primary care setting at 10 mg/day in a six-month study. The total escitalopram exposure time was 708 patient-years.

Results: Escitalopram was well tolerated in all three studies and the adverse event withdrawal rate ranged from 4% to 9%. Escitalopram's long-term adverse event profile was, in general, similar to that observed in the short-term studies. Overall, the most frequent adverse event was headache, which initially occurred at a frequency comparable to that seen with placebo and which subsided over time.

Conclusion: Escitalopram had a favorable safety profile in long-term treatment of moderately to severely depressed patients.

REFERENCES:

1. Montgomery SA, Loft H, Sanchez C, Reines EH, Papp M: Escitalopram (S-enantiomer of citalopram): clinical efficacy and onset of action predicted from a rat model. Pharmacol Toxicol 2001; 88: 282–286.
2. Muldoon C: The safety and tolerability of citalopram. Int Clin Psychopharmacol 1996;11 Suppl 1:35–40.

TARGET AUDIENCE:

Practicing psychiatrists.

Poster 171 **Friday, October 11 4:00 p.m.-5:30 p.m.**

ADEQUATE ANTIDEPRESSANT TRIALS WITH VENLAFAXINE IR/XR VERSUS SSRIS

Wyeth Pharmaceuticals

Jeffrey B. Weilburg, M.D., *Depression Clinical and Research Program, Department of Psychiatry, Massachusetts General Hospital, 55 Fruit Street, Boston, MA 02114*; Kathleen M. O'Leary, B.A., *Data Analyst, Depression Clinical and Research Program, Department of Psychiatry, Massachusetts General Hospital, 50 Staniford Street, Fourth Floor, Boston, MA 02114*; Randall S. Stafford, M.D., Ph.D.; James B. Meigs, M.D.; Paul Pirraglia, M.D.; George J. Wan, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should know how adequate trials can be used as a measure for effective antidepressant medication management and recognize that adequate trial rates vary by treatment choice.

SUMMARY:

Background: "Effectiveness" is a measure of both how antidepressants are used under "real-world" conditions and of their efficacy. Relatively high rates of adequate treatment may predict increased effectiveness. Relative adequacy among selected agents is reported.

Objective: Examine adequate antidepressant trials with venlafaxine IR/XR (an SNRI), versus selected SSRIs (citalopram, fluoxetine, paroxetine, sertraline).

Methods: Retrospective analysis was performed using pharmacy claims (7/1/99–12/31/01) from patients in an HMO and cared for by physicians affiliated with Partners Community Health Care. Antidepressant trials were defined as adequate if there was any period where the average daily dose was maintained (≥75 mg/day for venlafaxine IR/XR; ≥20 mg/day for citalopram, fluoxetine, paroxetine; ≥50 mg/day for sertraline) for ≥90 continuous days.

Results: Adequate trial rate was 40.5% for SSRIs (n= 16,407 trials) versus 45.6% for venlafaxine IR/XR (n= 1,364 trials) (P=0.0002). The odds ratio of achieving adequate trials with venlafaxine IR/XR versus SSRIs was 1.23 (95% CI=1.10–1.38).

Conclusions: Patients taking venlafaxine IR/XR had about 23% increased odds of an adequate trial compared with patients taking SSRIs. Agent class (venlafaxine IR/XR versus SSRI) may be one of the determinants of treatment adequacy. Treatment adequacy as a proxy for optimal treatment may be an important factor to consider when selecting an antidepressant medication.

REFERENCES:

1. Simon, G, Wagner E, Vonkorff M: Cost-effectiveness comparisons using "real world" randomized trials: the case of new antidepressant drugs. J Clin Epidemiol 1995;48:363–73.
2. Donoghue J, Hylan TR: Antidepressant use in clinical practice: efficacy v. effectiveness. Br J Psychiatry (Suppl) 2001;42:S9–S17.

TARGET AUDIENCE:

Psychiatrists and clinicians.

Poster 172 **Friday, October 11 4:00 p.m.-5:30 p.m.**

ARIPIPRAZOLE VERSUS PLACEBO IN ACUTE MANIA

Bristol-Myers Squibb Company and Otsuka Pharmaceuticals

Frances E. Borian, R.N., M.B.A., *Director, Neuroscience Medical Affairs, Bristol-Myers Squibb Company, 777 Scudders Mill Road, Plainsboro, NJ 08536*; Paul E. Keck, Jr., M.D., *Professor of Psychiatry and Pharmacology, Biological Psychiatry Program, and Vice Chair for Research, University of Cincinnati, P.O. Box 670559, 231 Bethesda Avenue, Cincinnati, OH 45267-0559*; Anutosh R. Saha, Ph.D.; Taro Iwamoto, Ph.D.; Darlene N. Jody, M.D.; Stavros Tourkodimitris, Ph.D.; Donald G. Archibald, M.Phil.; Ronald Marcus, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will understand the safety and efficacy of aripiprazole in the treatment of acute mania in bipolar disorder.

SUMMARY:

Objective: To compare the efficacy and safety of aripiprazole, the first next-generation atypical antipsychotic with a unique mechanism of action (dopamine-serotonin system stabilizer) to placebo in patients with acute bipolar mania.

Methods: This Phase III, multicenter, double-blind, placebo-controlled study randomized 262 patients with acute mania to aripiprazole 30 mg (reduced to 15 mg if unable to tolerate) or placebo for three weeks. Patients remained hospitalized for a minimum of two weeks of the treatment phase. The primary measure of efficacy was the change in Y-MRS Total score. Response was defined as a decrease of ≥ 50% in Y-MRS Total score.

Results: Aripiprazole produced statistically significant improvements in Y-MRS Total score (−8.15 vs. −3.35, p≤0.01) compared with placebo. The response rate was significantly higher in the aripiprazole group than the placebo group (40% vs. 19%, p≤0.01). For all

efficacy variables, aripiprazole separated from placebo by day 4. Discontinuations due to adverse events did not differ between the aripiprazole and placebo groups, and there were no significant changes in weight versus placebo.

Conclusion: Aripiprazole was effective and well tolerated in the treatment of acute mania in patients with bipolar disorder in this randomized, placebo-controlled trial.

REFERENCES:

1. Ghaemi SN: New treatments for bipolar disorder: the role of atypical neuroleptic agents. J Clin Psychiatry 2000;61 Suppl 14:33–42.
2. Kikuchi T, Tottori K, Uwahodo Y, Hirose T, Miwa T, Oshiro Y, Morita S: 7-(4-[4-(2,3-Dichlorophenyl)-1-piperazinyl]butyloxy)-3,4-dihydro-2(1H)-quinolinone (OPC-14597), a new putative antipsychotic drug with both presynaptic dopamine autoreceptor agonistic activity and postsynaptic D2 receptor antagonistic activity. J Pharmacol Exp Ther 1995;274(1):329–36.

TARGET AUDIENCE:

Psychiatrists and other clinicians who treat bipolar mania.

Poster 173 **Friday, October 11**
4:00 p.m.-5:30 p.m.

PREDICTORS OF RESPONSE TO DIVALPROEX OR PLACEBO TREATMENT IN ACUTE MANIA

Abbott Laboratories

Jeffrey A. Welge, Ph.D., *Biological Psychiatry Program, Department of Psychiatry, University of Cincinnati, 231 Bethesda Avenue, P.O. Box 670559, Cincinnati, OH 45267*; Paul E. Keck, Jr., M.D., *Professor of Psychiatry and Pharmacology, Biological Psychiatry Program, and Vice Chair for Research, University of Cincinnati, P.O. Box 670559, 231 Bethesda Avenue, Cincinnati, OH 45267-0559*; Jane M. Meinhold, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify variables that affect treatment outcomes with divalproex and placebo in clinical trials. These variables can be extrapolated to possible treatment outcomes in clinical practice.

SUMMARY:

Individual patient response to divalproex or placebo varied substantially in two randomized, controlled, parallel-group trials for the treatment of manic or mixed episodes (bipolar I disorder).

Pooled data from these trials were analyzed to assess clinical outcome as a function of number of prior hospitalizations, initial symptom severity (baseline total MRS), age at initial manic episode, and duration of illness.

Within both the divalproex and the placebo groups, degree of symptom improvement correlated positively with baseline total MRS and age at initial manic episode.

Responders, as defined by either of two criteria (≥30% or ≥50% reduction from baseline MRS score), had later occurrence of first manic episodes (at age 27.5 versus 23.7, p=0.036) and fewer prior hospitalizations (5.7 versus 7.4, p=0.042) than non-responders. The odds of achieving 50% reduction in MRS total score decreased by 4.4% per previous hospitalization and increased by 3.2% per year of delay of index manic episode. Odds of response increased by 61.8% with divalproex treatment.

Incorporating stratification and/or covariance adjustment on the basis of illness history into future clinical trials may lead to increased precision for tests of treatment effects.

REFERENCES:

1. Bowden CL, et al: Efficacy of divalproex vs lithium and placebo in the treatment of mania. JAMA 1994; 271:918–924.
2. Swann AC, et al: Differential effect of number of previous episodes of affective disorder on response to lithium or divalproex in acute mania. Am J Psych 1999; 156:1264–66.

TARGET AUDIENCE:

Psychiatrists, other clinical practitioners, clinical researchers.

Poster 174 **Friday, October 11**
4:00 p.m.-5:30 p.m.

FLORIDA MEDICAID COSTS OF ATYPICAL ANTIPSYCHOTICS IN BIPOLAR DISORDER

Janssen Pharmaceutica and Research Foundation

Dennis Meletiche, Pharm.D., *Manager, Outcomes Research, Janssen Pharmaceutica and Research Foundation, 1125 Trenton Harbourton Road, Titusville, NJ 08560-0200*; Kay Sadik, Ph.D., Pharm.D.; Amy Grogg, Pharm.D.; Anne Damiano, Sc.D., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate the differences in costs

associated with atypical antipsychotics in the treatment of bipolar disorder, based on Florida Medicaid costs.

SUMMARY:

Objective: Using Florida Medicaid claims, we evaluated the association between atypical antipsychotic therapies and payer costs among nonelderly bipolar patients.

Methods: Patients who received risperidone (n=113) or olanzapine (n=131) in the first half of 1998 and no other atypical antipsychotics the year prior were included. The primary outcome was change in total payer costs from one year prior to one year after study therapy initiation. Secondary outcomes included differences in mental health inpatient, outpatient, and medication costs. Each outcome was modeled (median regression with bootstrapping) as a function of study therapy, demographics, mental health comorbidities, and prior inpatient stays and duration of conventional therapy.

Results: Total costs decreased an average of $857 after risperidone initiation and increased $2,667 after olanzapine initiation (p=0.003). After controlling for all other variables, olanzapine was associated with significantly greater increases in total costs, with an adjusted median difference between treatments of $2,256 (p= 0.002). Differences in mental health medication costs were marginally greater for olanzapine ($523; p=0.092).

Conclusion: Risperidone was associated with decreased total costs, whereas olanzapine was associated with increased total costs among Medicaid patients with bipolar disorder.

Importance: Rising health care costs dictate careful consideration of therapy choices.

REFERENCES:

1. Ghaemi SN: New treatments for bipolar disorder: the role of atypical neuroleptic agents. J Clin Psychiatry 2000;61 Suppl 14:33–42.
2. Begley CE, Annegers JE, Swann AC, et al: The lifetime cost of bipolar disorder in the US: an estimate for new cases in 1998. Pharmacoeconomics 2001;19:483–495.

TARGET AUDIENCE:

Psychiatrists, health economists.

Poster 175 **Friday, October 11**
4:00 p.m.-5:30 p.m.

CALIFORNIA MEDICAID COSTS OF ATYPICAL ANTIPSYCHOTICS IN BIPOLAR DISORDER

Janssen Pharmaceutica and Research Foundation

Dennis Meletiche, Pharm.D., *Manager, Outcomes Research, Janssen Pharmaceutica and Research Foundation, 1125 Trenton Harbourton Road, Titusville, NJ 08560-0200*; Jesse Malkin, Ph.D.; Amy Grogg, Pharm.D.; Anne Damiano, Sc.D., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to evaluate the relative California Medicaid costs associated with risperidone and olanzapine therapy among patients with bipolar disorder who are naïve to atypical antipsychotics but receiving mood stabilizing agents.

SUMMARY:

Objective: Analyzing California Medicaid claims, we evaluated the association between atypical antipsychotics and payer costs among nonelderly bipolar patients.

Methods: Patients who received risperidone (n=384) or olanzapine (n=752) in the first half of 1998 and no atypical antipsychotics the year prior were included. The primary outcome was change in total costs from one year prior to one year after study initiation. Secondary outcomes included differences in mental health inpatient, outpatient, and medication costs. Each outcome was modeled (median regression with bootstrapping) as a function of study therapy, demographics, mental health comorbidities, prior inpatient stays, and prior duration of conventional therapy.

Results: After controlling for all other variables, olanzapine was associated with marginally significantly greater increases in total costs (adjusted median difference of $562; p=0.060). Treatment differences in mental health inpatient and outpatient costs were not significant. Differences in mental health medication costs were significantly greater for olanzapine than for risperidone ($761; p<0.001).

Conclusion: Among Medicaid bipolar disorder patients initiating antipsychotic therapy, olanzapine was associated with marginally greater increases in total costs and significantly greater increases in mental health medication costs than was risperidone.

Importance: Rising health care costs call for analysis of total costs associated with antipsychotics.

REFERENCES:

1. Ghaemi SN: New treatments for bipolar disorder: the role of atypical neuroleptic agents. J Clin Psychiatry 2000;61 Suppl 14:33–42.
2. Begley CE, Annegers JF, Swann AC, Lewis C, Coan S, Schnapp WB, Bryant-Comstock L: The lifetime cost of bipolar disorder in the US: an estimate for new cases in 1998. Pharmacoeconomics 2001;19(5 Pt 1):483–95.

TARGET AUDIENCE:

Psychiatrists, health economists.

Poster 176 **Friday, October 11 4:00 p.m.-5:30 p.m.**

ALCOHOL ABUSE AND INCREASED SUICIDALITY IN MANIA

Abbott Laboratories

Alexander H. Fan, M.D., *Research Fellow, Mood Disorders Research Program, Department of Psychiatry and Behavioral Sciences, University of California at Los Angeles, 300 UCLA Medical Plaza, Suite 1544, Los Angeles, CA 90095-7057*; Mark A. Frye, M.D., *Assistant Professor, Department of Psychiatry and Behavioral Sciences, University of California at Los Angeles, 300 UCLA Medical Plaza, Suite 1544, Los Angeles, CA 90095-7057*; Lori L. Altshuler, M.D.; Michael J. Gitlin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have a better understanding of the association between alcohol abuse and suicidality in bipolar mania.

SUMMARY:

Previous studies have indicated that a past history of alcohol abuse complicates the recovery from a manic episode. In addition, both bipolar disorder and alcoholism have been associated with a significant risk for suicide. This retrospective study was done to assess the effect of recent alcohol abuse on suicidality and treatment response for bipolar patients hospitalized for mania. Medical records of 74 manic patients hospitalized at the UCLA Neuropsychiatric Institute (1988–1992) were reviewed. Clinical and demographic information was harvested from medical records. Patients who were discharged against medical advice, transferred to or from another facility, or with active medical comorbidity were excluded. A total of 23 of 74 (31%) patients met DSM-IV criteria for alcohol abuse or alcohol abuse in early remission. Preliminary analyses of alcoholic manic and non-alcoholic manic patients found significant differences in two categorial measures: suicidality on admission and current polysubstance abuse/dependence. The alcoholic manic group, in comparison to the non-alcoholic manic group, had a greater percentage of patients with suicidal ideation on admission (43.5% vs. 9.8%). The Etoh-manic group also had a greater percentage of polysubstance abusers on admission (43.5% vs. 9.8%). These data suggests that alcohol abuse increases the risk of suicidal ideation and polysubstance abuse in manic patients.

REFERENCES:

1. Goldberg JF, Garno JL, Leon AC, Kocsis JH, Portera L: A history of substance abuse complicates remission from acute mania in bipolar disorder. J Clin Psychiatry 1999;60:733–40.
2. Goldberg JF, Singer TM, Garno JL: Suicidality and substance abuse in affective disorders. J Clin Psychiatry 2001;62(Suppl.)25:35–43. Review.

TARGET AUDIENCE:

Psychiatrists, psychologists.

Poster 177 **Friday, October 11 4:00 p.m.-5:30 p.m.**

A NATURALISTIC STUDY OF LONG-TERM RISPERIDONE VERSUS HALOPERIDOL PLUS MOOD STABILIZERS IN PSYCHOTIC BIPOLAR DISORDER

Janssen Pharmaceutica and Research Foundation

Conte Giovanni, *Psychiatric Unit, Brescia University School of Medicine, Brescia, Italy 25125*; Emilio Sacchetti

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participant will recognize the beneficial effects obtained with adjunctive risperidone therapy versus haloperidol therapy in patients with bipolar disorder and psychotic features that are refractory to mood stabilizer therapy.

SUMMARY:

Objective: To evaluate the efficacy and safety of risperidone versus haloperidol as adjunctive maintenance treatment in patients with treatment-resistant bipolar disorder and psychotic features.

Methods: A retrospective, naturalistic, crossover study included 20 patients with a DSM-IV diagnosis of bipolar I disorder with psychotic features and a history of poor response to long-term treatment with at least one mood stabilizer. All participated in consecutive trials of haloperidol plus lithium or valproate (or both) and risperidone plus the same mood stabilizers. The primary outcome measure was the time to any affective relapse, defined as need for hospitalization or treatment modification or substantial impairment of >1 week.

Results: Patients were treated with risperidone (mean dose 3.0 mg/day) or haloperidol (mean dose 4.7 mg/day). The mean (±SD) time to relapse was 20.3 ± 17.5 months among those treated with risperidone co-therapy and 10.3 ± 13.9 months among those treated with haloperidol co-therapy (p=0.03). Treatment response (defined as complete functional recovery) was noted in 10 patients receiving risperidone co-therapy and three receiving haloperidol co-therapy (p=0.023).

Conclusion: These results suggest that risperidone is more effective than haloperidol as adjunctive maintenance treatment in treatment-resistant bipolar patients with psychotic features.

REFERENCES:

1. Ghaemi SN, Sachs GS, Baldassano CF, Truman CJ: Acute treatment of bipolar disorder with adjunctive risperidone in outpatients. Can J Psychiatry 1997;42:196–199.
2. Ghaemi SN, Sachs GS: Long-term risperidone treatment in bipolar disorder: 6-month follow-up. Int Clin Psycholpharmacol 1997;12:333–338.

TARGET AUDIENCE:

Psychiatrists.

Poster 178 **Friday, October 11 4:00 p.m.-5:30 p.m.**

COST IMPACT OF ADJUNCTIVE ATYPICAL ANTIPSYCHOTIC USE IN BIPOLAR DISORDER

Janssen Pharmaceutica and Research Foundation

Michael T. Johnsrud, M.D., *Research Associate, Center for Pharmacoeconomics Studies, University of Texas at Austin, 2409 University Avenue, Room 3210-E, Austin, TX 78712*; Amy Grogg, Pharm.D.; M. Lynn Crismon, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to evaluate the relative Texas Medicaid costs associated with risperidone and olanzapine in the treatment of bipolar disorder.

SUMMARY:

Objective: To compare the economic impact of selected atypical antipsychotic agents as adjunctive therapy for bipolar disorder on total mental health-related expenditures.

Methods: Texas Medicaid patients with bipolar disorder who were undergoing continuous mood stabilizer therapy and given risperidone (n=159), olanzapine (n=217), or quetiapine (n=48) between January 1998 and September 1999 were retrospectively analyzed in an intent-to-treat pharmacy and mental health service database for a period of one year before and one year after initiation of atypical antipsychotic therapy. Post-initiation comparisons were made between study groups after controlling for any differences in demographics, preinitiation expenditures and utilization patterns.

Results: Patients taking risperidone had significantly lower ($P<0.01$) mental health-related pharmacy costs (mean [SD], $2,492 [$1,584]) than those receiving olanzapine ($3,315 [$2,055]) and numerically but not significantly lower costs than those given quetiapine ($2,947 [$1,679]). Total postinitiation mental health payer costs were not significantly different between risperidone ($5,429 [$5,985]), olanzapine ($6,448 [$6,143]) and quetiapine ($6,620 [$5,277]) groups.

Conclusion: When compared with olanzapine, risperidone as adjunctive therapy to mood stabilizers had a more positive economic impact on mental health-related pharmacy costs, despite the lack of differences in total mental health-related expenditures.

Importance: Analysis of total costs associated with antipsychotics is a major priority.

REFERENCES:

1. Ghaemi SN: New treatments for bipolar disorder: the role of atypical neuroleptic agents. J Clin Psychiatry 2000:61 Suppl 14:33–42.
2. Begley CE, Annegers JF, Swann AC, Lewis C, Coan Schnapp WB, Bryant-Comstock L: The lifetime cost of bipolar disorder in the US: an estimate for new cases in 1998. Pharmacoeconomics 2001;19(5 Pt 1):483–95.

TARGET AUDIENCE:

Psychiatrists, health economists.

Poster 179 **Friday, October 11 4:00 p.m.-5:30 p.m.**

RISPERIDONE VERSUS OLANZAPINE IN LONG-TERM MAINTENANCE TREATMENT OF BIPOLAR DISORDER

Janssen Pharmaceutica and Research Foundation

Klara Rosenquist, B.S., *Research Coordinator, Department of Psychiatry, The Cambridge Health Alliance, 1493 Cambridge Street, Cambridge, MA 02139*; Nassir Ghaemi, M.D.; Jacob J. Katzow, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize the benefit of risperidone for patients with bipolar disorder who do not respond adequately to olanizapine or are susceptible to its adverse effects.

SUMMARY:

Objective: To compare the long-term efficacy and safety of risperidone versus olanzapine as adjunctive maintenance treatment of bipolar disorder.

Methods: Charts of 29 outpatients (16 males; mean age, 41 years) treated at two university-affiliated psychopharmacology clinics with risperidone (n=15) or olanzapine (n=14) for bipolar or schizoaffective disorder

(Type I, n=16; Type II, n=3 NOS, n=5) or schizoaffective bipolar subtype (n=5) were reviewed for clinical response (7-point CGI-I scale,) and side effects.

Results: The duration of risperidone treatment (mean 2.0 mg/day) was longer than olanzapine treatment (mean 8.8 mg/day), 1.7 vs. 0.85 years, respectively (p=0.07). Similar percentages of patients exhibited a mild or better response: a higher percentage of risperidone vs. olanzapine-treated patients exhibited a moderate to marked response (27% vs. 0%, respectively; P=0.10). A significantly greater percentage of olanzapine- vs. risperidone-treated patients experienced weight gain of ≥5 lb (57% vs. 13%, P=0.02). Rates of extrapyramidal symptoms were similar. Tardive dyskinesia was not observed.

Conclusion: Treatment with risperidone or olanzapine improved bipolar disorder symptoms, although the duration of risperidone treatment was longer, and a greater percentage of risperidone-treated patients exhibited a moderate to marked clinical response. Both treatments were well tolerated, however, weight gain occurred more frequently in olanzapine-treated patients.

REFERENCES:

1. Ghaemi SN: New treatments for bipolar disorder: the role of atypical antipsychotic agents. J Clin Psychiatry 2000;61(suppl 14):33–42.
2. Guille C, Sachs GS, Ghaemi SN: A naturalistic comparison of clozapine, risperidone, and olanzapine in the treatment of bipolar disorder. J Clin Psychiatry 2000;61:638–642.

TARGET AUDIENCE:

Psychiatrists.

Poster 180 **Friday, October 11 4:00 p.m.-5:30 p.m.**

ADJUNCTIVE RISPERIDONE PROVIDES ADDED BENEFIT IN ACUTE MANIA

Janssen Pharmaceutica and Research Foundation

Lakshimi N. Yatham, M.B., B.S., *Associate Professor of Psychiatry, and Director, Department of Psychiatry, Mood Disorders Clinical Research Unit, University of British Columbia, 2255 Westbrook Mall, Vancouver, BC, Canada V65 1K6*; Carin Binder; Vivek Kusumakar, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should understand the benefit of combining risperidone with standard lithium and valproate regimens to treat acute mania or provide continuation therapy for the disorder.

SUMMARY:

Objective: Evaluate efficacy between lithium+risperidone and valproate+risperidone for acute mania/continuation therapy.

Methods: In a 12-week open trial, manic patients taking lithium or valproate who had given informed consent received risperidone (range, 0.5–4.0 mg) in addition to their current therapy. No other antipsychotic or benzodiazepine was allowed.

Results: Thirty-four patients received lithium+risperidone; 48 received valproate+risperidone. Risperidone significantly decreased YMRS/HAMD scores from baseline at weeks 1, 3, and 12 (P<0.0001). Reduction in χ50% YMRS for lithium vs valproate at week 1 was 33% vs 28%; week 3; 67% vs 70%; week 12; 88% vs 85%. There was no difference in efficacy between mood stabilizer groups. Patients with remission (YMRS α8) were 46% at week 3 and 87% at week 12. No difference in remission observed was between MS. Reductions in mean HAMD on lithium (baseline mean= 12.7) or valproate (baseline mean=12) at week 3: −6.7 and −5.3 (P=6), week 12: −5.9 and −5.5 (P=9) indicated no difference in efficacy between groups. CGI change improved significantly in both groups with no significant differences between the MS groups.

Conclusions: Adding risperidone to lithium or valproate is equally efficacious as a treatment for acute mania and as continuation therapy.

REFERENCES:

1. Sachs GS, Grossman F, Ghaemi SN, et al: Risperidone plus mood stabilizer versus placebo plus mood stabilizer for acute mania of bipolar disorder: a double-blind comparison of efficacy and safety. Am J Psychiatry, in press.
2. American Psychiatric Association: Practice Guideline for the Treatment of Patients with Bipolar Disorder (revision). Am J Psychiatry 2002; 159 (April suppl).

TARGET AUDIENCE:

Psychiatrists.

POSTER SESSION 4

Posters 181–242

Poster 181 **Saturday, October 12 10:30 a.m.-12 noon**

METABOLIC DYSFUNCTIONS IN HOSPITALIZED PSYCHIATRIC PATIENTS

Janssen Pharmaceutica and Research Foundation

Marvin J. Miller, M.D., *Assistant Professor of Psychiatry, Indiana University School of Medicine, Larue D.*

Carter Memorial Hospital, 2601 Cold Spring Road, Indianapolis, IN 46222; Joyce G. Small, M.D., *Professor of Psychiatry, Indiana University School of Medicine, Larue D. Carter Memorial Hospital, 2601 Cold Spring Road, Indianapolis, IN 46222*; Marietta H. Klapper, R.N., M.S.; Jeffrey J. Kellams, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the health risks of medication management of mentally ill patients, institute appropriate physical and laboratory monitoring, recommend preventive dietary and exercise programs.

SUMMARY:

The metabolic syndrome, defined as three or more abnormalities in waist circumference, serum glucose, triglycerides, HDL, and blood pressure is prevalent among U.S. adults. Chronic mental illness and standard and atypical antipsychotic drugs increase these risks. To evaluate the current magnitude of these problems, we approached 165 newly admitted consecutive adult tertiary care referrals. A total of 94 patients agreed to participate fully; 55 objected to venipunctures and 16 were excluded for other reasons. Sixty eight percent of 19 adult-onset diabetics and 28% of the remainder met criteria for the metabolic syndrome as compared with prevalence of 22% in the civilian population. Data collected included information about risk factors; weight, body mass index and bioimpedance; cultural, dietary, and exercise habits; blood chemistries including glucose, triglycerides, insulin and leptin; and PANSS, CGI, and AIMS psychiatric ratings. Measurements were done at baseline and after three and six months hospitalization. Most patients were taking atypical antipsychotics before and during hospitalization with few physical and laboratory differences between the five marketed atypicals. Fifteen patients on standard antipsychotics or no such drugs showed similar findings. Risks of metabolic syndrome in chronically ill, medicated, psychiatric patients, particularly those already diagnosed with diabetes, exceed general population figures.

REFERENCES:

1. Ford ES, Giles WH, Dietz WH: Prevalence of metabolic syndrome among US adults. JAMA 2002;287:356–359.
2. Newcomer JW, Haupt DW, Fucetola R, Melson AK, Schweiger JA, Cooper BP, Selke G: Abnormalities in glucose regulation during antipsychotic treatment of schizophrenia. Arch Gen Psychiatry 2002;59:337–345.

TARGET AUDIENCE:

Hospital and outpatient psychiatrists, family practitioners, internists, pharmacists, and industry professionals.

Poster 182 **Saturday, October 12**
10:30 a.m.-12 noon

HIGHER DOSES OF QUETIAPINE PROVIDE IMPROVED EFFICACY

AstraZeneca Pharmaceuticals

Joyce G. Small, M.D., *Professor of Psychiatry, Indiana University School of Medicine, Larue D. Carter Memorial Hospital, 2601 Cold Spring Road, Indianapolis, IN 46222*; Jeffrey J. Kellams, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand data demonstrating the greater efficacy achieved with a higher dose of quetiapine compared with a lower dose of quetiapine.

SUMMARY:

Objectives: To investigate the efficacy and dose-response profile of quetiapine in treating schizophrenia.

Methods: Post-hoc analyses of data from a six-week, placebo-controlled trial of lower- and higher-dose (150 to ≤250 and >250 to ≤750 mg/day) quetiapine were performed. Positive symptoms, mood, and overall response to treatment were assessed with the BPRS, and negative symptoms with the SANS.

Results: Significant changes ($p<0.05$) in BPRS positive symptom cluster, mood cluster, and SANS summary scores were observed for quetiapine overall versus placebo. The higher-dose group had the greatest reduction in mood symptoms (baseline to Week 6 BPRS mood cluster score decreases: −0.65 placebo; −1.83 lower dose [$p=0.039$ versus placebo]; −2.34 higher dose [$p=0.003$ versus placebo]). A ≥40% decrease in total BPRS was noted in 20%, 25% and 40% of patients, respectively. Response differences were highly significant between higher-dose quetiapine and placebo ($p<0.01$), and between higher- (mean 439 mg/day) and lower-dose (mean 229 mg/day) quetiapine ($p<0.05$), indicating a better response with higher doses. Significant improvements in BPRS total score from Week 1 were noted for higher-dose quetiapine versus placebo.

Conclusions: Greater efficacy is obtained with higher doses of quetiapine, supporting an initial target dosing recommendation of 400 mg/day.

REFERENCES:

1. Kasper S, Müller-Spahn F: Review of quetiapine and its clinical applications in schizophrenia. Expert Opin Pharmacother 2000; 1:783–801.
2. Small JG, Hirsch SR, Arvanitis LA, Miller BG, Link CG: Quetiapine in patients with schizophrenia. A high- and low-dose double-blind comparison with placebo. Seroquel Study Group. Arch Gen Psychiatry 1997; 54:549–557.

TARGET AUDIENCE:

Psychiatrists.

Poster 183 **Saturday, October 12**
10:30 a.m.-12 noon

DIFFERENTIAL RATE OF WEIGHT GAIN PRESENT AMONG PATIENTS TREATED WITH OLANZAPINE

Eli Lilly and Company

Lisa Jaton, *Medical Liaison, Neuroscience Medical Affairs, Eli Lilly and Company, 728 East 61st Street, Sioux Falls, SD 57108*; Bruce J. Kinon, M.D.; Matthew D. Rotelli

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the proportion of patients likely to experience rapid weight gain during olanzapine treatment and discuss factors for identifying such patients early in treatment.

SUMMARY:

Previous studies demonstrate varied weight responses in olanzapine-treated patients: losing, maintaining, or gaining varied amounts of weight. In patients who gain weight, the increase occurs early in treatment, reaching a plateau after 39 weeks. A retrospective analysis of weight gain was performed for 1,336 schizophrenia or schizoaffective patients treated with olanzapine for ≤52 weeks (average olanzapine dose, 13.2 mg). Patients were dichotomized by percentage of body weight gained during the first six weeks of olanzapine treatment: (1) patients gaining ≥7% of their body weight (Rapid Weight Gain Group, RWG), and (2) patients gaining ≤7% of their body weight (NonRapid Weight Gain Group, NRWG). Approximately 15% of patients showed rapid weight increases (RWG group), while 85% gained weight more slowly or not at all (NRWG group). The RWG group gained >2% of body weight (approximately four to seven pounds) within two weeks of treatment and were more likely to report appetite increases compared with the NRWG group. Patients gaining weight during olanzapine treatment showed robust clinical improvement in psychopathology. By measuring patients' weight early in olanzapine treatment and assessing appetite changes, clinicians may predict patients likely to gain weight rapidly, who may benefit most from behavioral and pharmacologic interventions to limit weight gain.

REFERENCES:

1. Basson BR, Kinon MS, Taylor CC, Szymanski KA, Gilmore JA, Tollefson GD: Factors influencing acute weight change in patients with schizophrenia treated with olanzapine, haloperidol, or risperidone. J Clin Psychiatry 2001; 62: 231–238.
2. Kinon BJ, Basson BR, Gilmore JA, Tollefson GD: Long-term olanzapine treatment: Weight change and weight-related health factors in schizophrenia. J Clin Psychiatry 2001; 62: 92–100.

TARGET AUDIENCE:

Psychiatrists treating patients with schizophrenia.

Poster 184 **Saturday, October 12**
10:30 a.m.-12 noon

EFFECTIVENESS OF RAPID INITIAL DOSE ESCALATION OF ORAL OLANZAPINE FOR ACUTE AGITATION

Eli Lilly and Company

Lisa Jaton, *Medical Liaison, Neuroscience Medical Affairs, Eli Lilly and Company, 728 East 61st Street, Sioux Falls, SD 57108*; Robert W. Baker, M.D.; Bruce J. Kinon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the relative findings of rapid initial dose escalation versus standard dosing of olanzapine for acute agitation.

SUMMARY:

Objective: Clinical reports suggest dose loading approaches with olanzapine may achieve faster therapeutic effect in acutely agitated patients.

Method: 142 acutely agitated inpatients (Positive and Negative Syndrome Scale [PANSS] Excited ≥ 20) with schizophrenia spectrum or bipolar I disorder were randomized to four days of double-blind oral olanzapine by Rapid Initial Dose Escalation (RIDE): 20 mg followed by two or one 10 mg doses as needed on days 1–2 and 3–4, respectively; or Usual Clinical Practice (UCP): 10 mg followed by two or one lorazepam 2 mg dose(s) as needed, days 1–2 and 3–4, respectively. After four days of double-blind treatment, all patients received standard, open-label olanzapine doses (5–20 mg on days 5–7). Primary efficacy measure was PANSS Excited subscale.

Results: PANSS excited ratings improved significantly in both groups ($p<.001$ within group at 24 hours). Over the double-blind phase, RIDE dosing was significantly more effective than UCP ($p=0.019$) and this difference was first significant at 24 hours ($p=0.04$). No significant group differences existed in treatment-emergent adverse events or laboratory abnormalities. Final mean olanzapine dose was similar in both groups.

Conclusions: Subjects experienced greater agitation improvement with a RIDE approach than standard dosing. Loading dose strategies merit further evaluation.

REFERENCES:

1. Callahan JT, Bergstrom RF, Ptak LR, Beasley CM: Olanzapine: pharmacokinetic and pharmacodynamic profile. Drug Disposition 1999; 37: 177–193.
2. Meehan K, Zhang F, David S, Tohen M, Janicak P, Small J, Koch K, Rizk R, Walker D, Tran P, Breier A: A double-blind, randomized comparison of the efficacy and safety of intramuscular injections of olanzapine, lorazepam, or placebo in treating acutely agitated patients diagnosed with bipolar mania. Journal of Clinical Psychopharmacology 2001; 21: 389–397.

TARGET AUDIENCE:

Psychiatrists prescribing medications to patients with acute agitation symptoms.

Poster 185 **Saturday, October 12 10:30 a.m.-12 noon**

OLANZAPINE REDUCTION OF NEUROLEPTIC-INDUCED HYPERPROLACTINEMIA IN SCHIZOPHRENIA

Eli Lilly and Company

John Niewoehner, *Medical Liaison, Neuroscience Medical Affairs, Eli Lilly and Company, 746 Southern Hills Drive, St. Louis, MO 63025*; Bruce J. Kinon, M.D.; Jonna Ahl, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify mean prolactin level decreases in schizophrenic patients with neuroleptic-induced hyperprolactinemia that have switched to olanzapine therapy compared with patients continuing treatment on conventional antipsychotics or risperidone.

SUMMARY:

Objective: To demonstrate that prolactin levels decrease in schizophrenic patients with neuroleptic-induced hyperprolactinemia switched to olanzapine therapy compared with patients continuing treatment on conventional antipsychotics or risperidone.

Methods: Patients screened for hyperprolactinemia (> 18.77 ng/ml for males, and >24.20 ng/ml for females.) entered a four-month prospective, open-label study and randomized to remain on current therapy (N=26) or switched to olanzapine (OLZ), 5–20 mg/day, (N=24). Change from baseline to endpoint mean serum prolactin level was the primary outcome.

Results: Baseline to endpoint (LOCF) prolactin levels decreased significantly ($p<0.002$) in OLZ patients (26.04 $\pm$ 35.71 ng/ml); whereas the non-switched patients had a mean increase of 4.47 $\pm$ 24.53 ng/ml. Prolactin levels returned to normal and were sustained in 90% of OLZ-treated subjects by study end. Patients in both treatment groups had improved PANSS, BPRS, and CGI scores at study end. There were no significant between-group differences in treatment-emergent adverse events, or acute EPS.

Conclusions: Olanzapine treatment may offer a rapid and sustained reduction in prolactin for schizophrenic patients who would otherwise continue to experience hyperprolactinemia and associated morbidity while receiving treatment with prolactin-elevating antipsychotic drugs.

REFERENCES:

1. Crawford AMK, Beasley CM, Tollefson GD, et al: The acute and long-term effect of olanzapine compared with placebo and haloperidol on serum prolactin concentrations. Schizophr Res 1997; 26:41–54.
2. Dickson RA, Dalby JT, Williams R, Edwards AL: Risperidone-induced prolactin elevations in premenopausal women with schizophrenia. Am J Psychiatry 1995;152:1102–1103.

TARGET AUDIENCE:

Psychiatrists treating patients with schizophrenia.

Poster 186 **Saturday, October 12 10:30 a.m.-12 noon**

ZIPRASIDONE VERSUS RISPERIDONE IN SCHIZOPHRENIA: AN EIGHT-WEEK, DOUBLE-BLIND TRIAL

Pfizer Inc.

Donald E. Addington, M.D., *Foothill Medical Center, 1403 29th Street, N.W., Calgary, AB, Canada T2N 2T9*; Christos Pantelis, M.B., B.S.; Isma Benattia, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to discuss the comparative efficacy and tolerability of ziprasidone and risperidone as demonstrated in a randomized, double-blind clinical trial.

SUMMARY:

Objective: To compare the efficacy and tolerability of ziprasidone and risperidone in patients with acute exacerbation of schizophrenia or schizoaffective disorder.

Methods: In an eight-week, multicenter, double-blind trial, patients were randomly assigned to ziprasidone 40–80 mg BID or risperidone 3–5 mg BID. Primary efficacy evaluations were PANSS Total and CGI-S scores; secondary variables included PANSS Negative Subscale score, BPRSd Total and Core items scores, and GAF. Primary analysis was based on evaluable patients (≥14 days of treatment).

Results: On the basis of a predetermined criterion (lower limit of 95% CI for ratio of mean change with ziprasidone to mean change with risperidone exceeding 0.60), equivalent improvements were observed in both groups for PANSS Total score (mean change ratio 0.95, lower limit 0.78) and CGI-S (mean change ratio 0.87, lower limit 0.70). Similarly, equivalent improvements were seen in PANSS Negative score, BPRSd Total and Core scores, and GAF. In tolerability assessments, ziprasidone (n=149) and risperidone (n=147) were comparable; however, risperidone had a significantly higher movement disorder burden score and higher incidences of prolactin elevation and clinically significant weight gain.

Conclusion: Ziprasidone demonstrated antipsychotic efficacy comparable to risperidone, with lower movement disorder burden and less effect on prolactin.

REFERENCES:

1. Daniel DG, Zimbroff DL, Potkin SG, Reeves KR, Harrigan EP, Lakshminarayanan M, and the Ziprasidone Study Group: Ziprasidone 80 mg/day and 160 mg/day in the acute exacerbation of schizophrenia and schizoffective disorder: a 6-week placebo-controlled trial. Neuropsychopharmacology 1999; 20(5):491–505.
2. Simpson G, Potkin S, Weiden P, O'Sullivan RL, Romano S: Benefits of ziprasidone in stable outpatients with schizophrenia switched from conventional antipsychotics, olanzapine or risperidone. Presented at the 2000 Annual Meeting of the American Psychiatric Association, May 13–18, 2000; Chicago, Illinois.

TARGET AUDIENCE:

Psychiatrists, psychiatric nurses.

Poster 187 **Saturday, October 12**
10:30 a.m.-12 noon

USE OF THE ATYPICAL ANTIPSYCHOTIC QUETIAPINE IN THE TREATMENT OF PSYCHOSIS ASSOCIATED WITH LEWY BODY DEMENTIA

AstraZeneca Pharmaceuticals

Andrius Baskys, M.D., Ph.D., *Assistant Professor, Department of Psychiatry and Human Behavior, University of California at Irvine, and Department of Veterans Affairs, 5901 East Seventh Street, Long Beach, CA 90822*; Paul Davis

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that quetiapine is an effective treatment for patients with psychosis associated with Lewy body dementia.

SUMMARY:

Objective: One prominent characteristic of Lewy body dementia (LBD) is psychosis; however, no effective treatments have been identified. We studied the efficacy of the atypical antipsychotic quetiapine in the treatment of psychiatric disturbances associated with LBD.

Methods: Nine male patients (mean age, 73±4 years) meeting clinical criteria for LBD (McKeith et al., 1999) received quetiapine 25 mg/d for 12 weeks. Evaluations were done at baseline and every three weeks for 12 weeks. Outcome measures included cognitive (Mini-Mental Status Exam [MMSE]), behavioral (Neuropsychiatric Inventory [NPI], Brief Psychiatric Rating Scale [BPRS], Geriatric Depression Scale [GDS], Functional Assessment Questionnaire [FAQ], Clinical Global Impression [CGI]) and extrapyramidal symptoms (AIMS, Simpson-Angus, record of falls) ratings.

Results: Preliminary data indicate that quetiapine reduced the overall NPI score at six weeks by 56±13% (mean ± s.e.m., $P<0.05$, t-test) as compared with baseline. There was a marked decrease (86±4%, $P<0.05$) on the combined delusions and hallucinations subscales and a 37±5% ($P<0.05$) reduction on the combined agitation, anxiety, and irritability subscales. There was a significant reduction (39±3%, $P<0.05$) from the baseline on the combined hallucinations, suspicions, anxiety, and hostility subscales of the BPRS. There was no significant change on Simpson-Angus and AIMS scales (16±28% and 17±67% reduction from the baseline, respectively). MMSE scores showed an average (not significant, $P>0.05$) improvement of two points. There was no significant ($P>0.05$) change in FAQ and GDS (0±4% and 5±5% change from the baseline, respectively) scores and no clinically significant changes occurred in laboratory values and vital signs.

Conclusions: These preliminary findings suggest that quetiapine may be an effective and well-tolerated therapeutic agent for the treatment of psychosis associated with LBD.

REFERENCES:

1. McKeith, et al: Neurology 1996;47(5)1113–24.

TARGET AUDIENCE:

Professional.

Poster 188 **Saturday, October 12 10:30 a.m.-12 noon**

SEQUENTIAL INTRAMUSCULAR/ORAL ZIPRASIDONE VERSUS HALOPERIDOL IN SEVERE SCHIZOPHRENIA

Pfizer Inc.

Shlomo Brook, M.D., *Staff Psychiatrist, Department of Psychiatry, Research Unit, Sterkfontein Hospital, Private Bag x2010-1740, Krugersdorp, South Africa 1740*; Jorge Walden, M.D.; Isma Benattia, M.D.; C. Mertens, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the efficacy of sequential IM/oral ziprasidone, compared with haloperidol, in managing patients with severe, acute exacerbation of schizophrenia or schizoaffective disorder.

SUMMARY:

Objective: To assess efficacy of sequential IM/oral ziprasidone versus haloperidol in severe, acute exacerbation of schizophrenia or schizoaffective disorder.

Methods: Six-week trial randomizing patients to ziprasidone (≤40 mg IM, then 80–160 mg oral; n=429) or haloperidol (≤10 mg/day IM, then 5–20 mg/day oral; n=138). We analyzed changes in BPRS Total from baseline to last IM dose (Visit 1) and to last visit in subset of severely ill patients (baseline CGI-S ≥5).

Results: Ziprasidone patients (n=359) demonstrated significantly greater improvement at Visit 1 (−6.51 ± 11.4) than haloperidol patients (n=118) ($P \leq 0.05$). Improvement in BPRS Total continued with both agents throughout oral phase (last-visit difference: NS). In patients not given benzodiazepines, BPRS Total showed significantly greater improvement with ziprasidone (n=262) than with haloperidol (n=77) at Visit 1 ($P<0.001$). Results paralleled those of total study population. Haloperidol patients had greater mean change in BAS and ESRS scores ($P<0.0001$ at last IM treatment and endpoint), and double the rate of AE-related discontinuation during first two weeks of oral therapy. No patient experienced QT_c ≥500 msec.

Conclusions: Ziprasidone was better tolerated than, and as efficacious as, haloperidol in patients with severe, acute exacerbation of schizophrenia, and elicited superior responses during IM treatment.

REFERENCES:

1. Daniel DG, Potkin SG, Reeves KR, Swift RH, Harrigan EP: Intramuscular (IM) ziprasidone 20 mg is effective in reducing acute agitation associated with psychosis: a double-blind, randomized trial. Psychopharmacology (Berl) 2001; 155(2):128–34.
2. Brook S, Lucey JV, Gunn KP (for the Ziprasidone Study Group): Intramuscular ziprasidone compared with intramascular haloperidol in the treatment of acute psychosis. J Clin Psychiatry 2000; 61:933–941.

TARGET AUDIENCE:

Psychiatrists, psychiatric nurses.

Poster 189 **Saturday, October 12 10:30 a.m.-12 noon**

SEQUENTIAL INTRAMUSCULAR/ORAL ZIPRASIDONE VERSUS HALOPERIDOL IN SCHIZOPHRENIA WITH ANXIETY

Pfizer Inc.

Shlomo Brook, M.D., *Staff Psychiatrist, Department of Psychiatry, Research Unit, Sterkfontein Hospital, Private Bag x2010-1740, Krugersdorp, South Africa 1740*; Jorge Walden, M.D.; C. Mertens, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the efficacy of sequential IM/oral ziprasidone, compared with haloperidol, in managing patients with acute exacerbation of schizophrenia or schizoaffective disorder that included anxiety.

SUMMARY:

Objective: To assess efficacy of sequential IM/oral ziprasidone versus haloperidol in acute exacerbation of schizophrenia and anxiety.

Methods: In a six-week trial comparing ziprasidone (≤40 mg IM, then 80–160 mg oral) and haloperidol (≤10 mg/day IM, then 5–20 mg/day oral), changes in BPRS Total, BPRS anxiety-related items, and Covi Anxiety Scale from baseline to last IM dose (Visit 1) and to last visit were analyzed in a patient subset with baseline BPRS anxiety score ≥2.

Results: At Visit 1, ziprasidone patients (n=402) demonstrated significantly greater improvement than haloperidol patients (n=135) in BPRS Total (−6.1 vs −4.0, $P<0.005$), BPRS tension (−0.62 vs −0.40, $P<0.05$), and Covi Anxiety scores (−0.249 vs 0.275, $P<0.05$). The groups did not differ significantly in BPRS somatic concern, anxiety, guilt, or suspiciousness. BPRS Total and individual items and Covi improved with both agents throughout oral treatment, with no significant between-group differences at endpoint.

Conclusions: Ziprasidone was as efficacious as haloperidol in improving BPRS Total, BPRS anxiety-related items, and Covi Anxiety scores in patients with acute exacerbation of schizophrenia. Ziprasidone provided greater improvement in BPRS Total, BPRS tension, and

COVI scores during IM treatment, a finding that was independent of concomitant benzodiazepine use.

REFERENCES:

1. Cosoff SJ, Hafner RJ: The prevalence of comorbid anxiety in schizophrenia, schizoaffective disorder, and bipolar disorder. Aust N Z J Psychiatry 1998;32:67–72.
2. Brook S, Walden J, Benattia I: Ziprasidone vs Haloperidol in Sequential IM/Oral Treatment of Acute Schizophrenia. Presented at the 11th Biennial Winter Workshop on Schizophrenia, February 24-March 1, 2002, Davos, Switzerland.

TARGET AUDIENCE:

Psychiatrists, psychiatric nurses.

Poster 190 **Saturday, October 12 10:30 a.m.-12 noon**

SAFETY AND TOLERABILITY OF INTRAMUSCULAR ZIPRASIDONE: REVIEW OF CLINICAL TRIAL DATA

Pfizer Inc.

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to discuss the safety and tolerability of IM ziprasidone as demonstrated by clinical trials.

SUMMARY:

Objective: To evaluate the safety and tolerability of IM ziprasidone, as demonstrated in randomized clinical trials.

Methods: We reviewed data from three fixed-dose and two flexible-dose trials that included 940 adult patients with acute psychosis who received IM ziprasidone at doses up to 20 mg a maximum of four times daily.

Results: Discontinuation rates for treatment-emergent adverse events (AEs) in IM ziprasidone groups ranged from 1.1% to 6.1%. The most common AEs among patients receiving 10- or 20-mg doses for up to three days were headache, nausea, dizziness, insomnia, and anxiety. The vast majority of treatment-emergent AEs in all studies were mild or moderate in severity. Compared with haloperidol, IM ziprasidone was consistently associated with a lower movement disorder burden (eg, akathisia, dystonia, EPS, hypertonia) at all doses investigated. In all studies, clinically significant changes in blood pressure and heart rate associated with IM ziprasidone were isolated and transient; treatment-emergent postural hypotension was observed in one ziprasidone-treated patient in one study. There were no QTc values ≥500 msec with IM ziprasidone.

Conclusion: In clinical trials, IM ziprasidone in divided doses up to 80 mg/day was well tolerated, with low incidences of AE-related discontinuations and movement disorder AEs.

REFERENCES:

1. Daniel DG, Potkin SG, Reeves KR, Swift RH, Harrigan EP: Intramuscular (IM) ziprasidone 20 mg is effective in reducing acute agitation associated with psychosis: a double-blind, randomized trial. Psychopharmacology (Berl) 2001; 155(2):128–134.
2. Brook S, Lucey JV, Gunn KP: Intramuscular ziprasidone compared with intramuscular haloperidol in the treatment of acute psychosis. Ziprasidone IM Study Group. J Clin Psychiatry 2000; 61(12):933–941.

TARGET AUDIENCE:

Psychiatrists, psychiatric nurses.

Poster 191 **Saturday, October 12 10:30 a.m.-12 noon**

AN OPEN-LABEL TRIAL OF QUETIAPINE FOR ANTIPSYCHOTIC-INDUCED SEXUAL DYSFUNCTION

AstraZeneca Pharmaceuticals

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EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to realize that switching patients with antipsychotic-induced sexual dysfunction to quetiapine treatment may result in improved sexual functioning.

SUMMARY:

Objectives: The primary objective of the present study was to evaluate the effect of switching patients with antipsychotic-induced sexual dysfunction to open-label quetiapine treatment. The secondary aims were to compare the prolactin-related and antipsychotic effects of quetiapine versus pre-study antipsychotic treatment.

Methods: Eight outpatients with schizophrenia treated with risperidone (n=7) or haloperidol (n=1) with at least

moderately severe antipsychotic-induced sexual dysfunction were evaluated prospectively after a switch to six weeks of quetiapine treatment. Sexual functioning was assessed with the five-item Arizona Sexual Experience Scale (ASEX). Psychopathology was assessed with the Positive and Negative Syndrome Scale (PANSS).

Results: The switch to quetiapine treatment was associated with consistent and statistically significant improvement in ASEX total scores (p=0.008). In addition, PANSS total scores decreased significantly (P=0.03). Improvements in PANSS General Psychopathology subscale scores were larger than those seen on Positive and Negative Symptom subscales, suggesting that changes in PANSS total scores may have resulted from improvements in sexual functioning. Plasma prolactin levels tended to decrease after the transition to quetiapine (P= 0.09).

Conclusions: Switching patients with antipsychotic-induced sexual dysfunction to open-label quetiapine treatment resulted in consistent and marked improvements in the sexual functioning of outpatients with schizophrenia.

REFERENCES:

1. Mullen B, Brar JS, et al: Frequency of sexual dysfunctions in patients with schizophrenia on haloperidol, clozapine or risperidone. Schizophr Res 2001; 48: 155–158.
2. Maguire GA: Prolactin elevation with antipsychotic medications: mechanisms of action and clinical consequences. J Clin Psychiatry 2002; 63 Suppl 4: 56–62.

TARGET AUDIENCE:

Professional.

Poster 192 **Saturday, October 12**
10:30 a.m.-12 noon

META-ANALYSIS OF PROLACTIN EFFECTS WITH ARIPIPRAZOLE

Bristol-Myers Squibb Company and Otsuka Pharmaceuticals

William H. Carson, Jr., M.D., *Director, Clinical Research, Neuroscience Medical Affairs, Bristol-Myers Squibb Company, P. O. Box 74, Plainsboro, NJ 08536*; Anutosh R. Saha, Ph.D., *Director, Clinical Development, Otsuka-Maryland Research Institute, 2440 Research Boulevard, Rockville, MD 20850*; Taro Iwamoto, Ph.D.; Chin-Yu Lin, Ph.D.; Mary J. Kujawa, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have learned that aripiprazole is not associated with hyperprolactinemia.

SUMMARY:

Objective: A meta-analysis was done to assess the effects on prolactin with aripiprazole, a newly developed antipsychotic with a different mechanism of action than current typical and atypical antipsychotics. Common side effects associated with elevated prolactin in women and men include amenorrhea, impotence, and gynecomastia.

Methods: Prolactin effects were based on five four- to six-week, double-blind, controlled studies in 1,648 patients with schizophrenia or schizoaffective disorder, randomized to aripiprazole, placebo, or active control (haloperidol 10 mg/day or risperidone 6 mg/day). Prolactin blood samples were collected at baseline and at endpoint in 1,343 patients.

Results: The incidence of patients with prolactin levels ≥ upper limit of normal with aripiprazole was 1.8% versus 7% placebo, 54% haloperidol, and 89% risperidone. Compared with placebo, both haloperidol and risperidone produced significant increases in plasma prolactin levels (125% and 607% change from baseline, respectively). In contrast, aripiprazole did not produce increases in plasma prolactin (50% decrease from baseline occurred, with all values but one remaining within normal limits).

Conclusion: Aripiprazole is not associated with hyperprolactinemia. This effect may reflect the novel partial agonist activity of aripiprazole at D_2 dopamine receptors.

REFERENCES:

1. Esel E, Basturk M, Saffet Gonul A, Kula M, Tayfun Turan M, Yabanoglu I, Sofuoglu S: Effects of olanzapine and haloperidol on serum prolactin levels in male schizophrenic patients. Psychoneuroendocrinology 2001;26(6):641–7.
2. Kikuchi T, Tottori K, Uwahodo Y, Hirose T, Miwa T, Oshiro Y, Morita S: 7-(4-[4-(2,3-Dichlorophenyl)-1-piperazinyl]butyloxy)-3,4-dihydro-2(1H)-quinolinone (OPC-14597), a new putative antipsychotic drug with both presynaptic dopamine autoreceptor agonistic activity and postsynaptic D2 receptor antagonistic activity. J Pharmacol Exp Ther 1995;274(1):329–36.

TARGET AUDIENCE:

Psychiatrists and other clinicians who treat schizophrenia.

Poster 193 **Saturday, October 12 10:30 a.m.-12 noon**

TRANSITION FROM INTRAMUSCULAR TO ORAL ZIPRASIDONE: CLINICAL EFFICACY AND SAFETY DATA

Pfizer Inc.

David G. Daniel, M.D., *Employee, Bionic H.E. Development, P.O. Box 4254, Falls Church, VA 22044*; Shlomo Brook, M.D.; Isma Benattia, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this presentation, participants should be able to discuss the efficacy and tolerability of ziprasidone during the transition from IM to oral treatment in patients with psychotic disorders, including schizophrenia.

SUMMARY:

Objective: To evaluate the efficacy and tolerability of ziprasidone during the transition from intramuscular (IM) to oral treatment in patients with psychosis.

Methods: Data were analyzed from three studies in which 1,005 patients received sequential IM and oral ziprasidone (n=725) or haloperidol (n=280): two seven-day, open-label, randomized studies (one using flexible dosing; the other, fixed dosing) and a six-week, flexible-dose, randomized trial in acute schizophrenia. Efficacy measurements in all studies included BPRS Total and CGI-S.

Results: In all three studies, improvements in BPRS Total score and CGI-S observed during IM treatment with ziprasidone were sustained or increased through the transition to oral drug. In the seven-day studies, fewer ziprasidone- than haloperidol-treated patients were discontinued for any reason (3.7% vs 7.5%). Discontinuations due to adverse events were comparable (1.5% vs. 0.7%). In the six-week trial, during the first two weeks of oral treatment, the rate of discontinuation due to adverse events was lower with ziprasidone than with haloperidol (4.2% vs. 9.6%). Rates of discontinuation from lack of efficacy were low in both groups (3.5% and 1.5%).

Conclusions: In these studies, transition from IM to oral ziprasidone was well tolerated, with sustained or increasing improvement in symptoms.

REFERENCES:

1. Brook S, Walden J, Benattia I: Ziprasidone vs haloperidol in sequential IM/oral treatment of schizophrenia. Presented at the 2001 Annual Meeting of the American Psychiatric Association Institute of Psychiatric Services, Orlando, Florida, October 10–14, 2001.
2. Brook S, Lucey JV, Gunn KP (for the Ziprasidone Study Group): Intramuscular ziprasidone compared with intramuscular haloperidol in the treatment of acute psychosis. J Clin Psychiatry 2000; 61:933–941.

TARGET AUDIENCE:

Psychiatrists, psychiatric nurses.

Poster 194 **Saturday, October 12 10:30 a.m.-12 noon**

IMPROVED CLINICAL GLOBAL IMPRESSION AND POSITIVE AND NEGATIVE SYNDROME SCALE SCORES IN SCHIZOPHRENIA AFTER SWITCHING TO QUETIAPINE

AstraZeneca Pharmaceuticals

Andrè De Nayer, M.D., *Department of Psychiatry, Hospital Sainte Therese, Rue Trieu Kaisin 134, Montignies/Sambre, Belgium 6061*; A. Martin Jones, M.S.; John L. Whiteford, B.S.; Charles A. Altman, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand the efficacy of quetiapine in patients switched from other antipsychotic therapies due to intolerance or inadequate response, as assessed by improvement in Clinical Global Impression (CGI) and Positive and Negative Syndrome Scale (PANSS) scores.

SUMMARY:

Introduction: Inadequate response or intolerance may necessitate switching from one antipsychotic to another. The efficacy of quetiapine was investigated in patients with schizophrenia switched from other antipsychotics.

Methods: Previous antipsychotics were gradually discontinued and quetiapine simultaneously increased (to 400 mg/day) over seven days. Thereafter, quetiapine was flexibly dosed from 300–750 mg/day for 11 weeks (mean modal dose 505 mg/day; n=509). Change from baseline to Week 12 in PANSS and CGI scores was assessed (last observation carried forward).

Results: Significant improvements in PANSS and CGI scores were observed irrespective of previous antipsychotic medication and regardless of reason for switching treatment, although a greater decrease in PANSS scores was observed in patients switched because of inadequate response. Least squares mean (standard error) decreases were −21.9 (1.3) for PANSS total score and −1.1 (0.1) for Severity of Illness (both statistically significant, $p<0.001$). The Week 12 Global Improvement score was 2.6 (0.1) for all patients and 1.9 (0.2) for those switched because of extrapyramidal symptoms. Decreases were −5.4 (0.4) for the positive, −6.1 (0.4) for the negative, and −10.6 (0.7) for the general psychopathology PANSS subscales ($p<0.001$).

Conclusions: Switching to quetiapine is effective in patients with schizophrenia suboptimally treated with other antipsychotic medication.

REFERENCES:

1. Emsley RA, Raniwalla J, Bailey PJ, Jones AM: A comparison of the effects of quetiapine ('Seroquel') and haloperidol in schizophrenic patients with a history of and a demonstrated, partial response to conventional antipsychotic treatment. PRIZE Study Group. Int Clin Psychopharmacol 2000; 15(3):121–131.
2. Weiden PJ, Aquila R, Dalheim L, Standard JM: Switching antipsychotic medications. J Clin Psychiatry 1997; 58 (Suppl 10):63–72.

TARGET AUDIENCE:

Psychiatrists.

Poster 195 **Saturday, October 12 10:30 a.m.-12 noon**

MEDICATION PERSISTENCE AND CONCOMITANT USE IN SCHIZOPHRENIA

Eli Lilly and Company

P. Joseph Gibson, Ph.D., *Senior Research Scientist, Health Outcomes Affairs, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285*; Robert M. Damler, F.S.A., *Health Outcomes Affairs, Eli Lilly and Company, 111 Monument Circle, Suite 601, Indianapolis, IN 46204-5128*; E. Anne Jack; Teresa Wilder

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to select medications for treating schizophrenia with increased insight into the potential impacts on persistence and concomitant antipsychotic use.

SUMMARY:

Introduction: Schizophrenia treatment guidelines recommend long-term medication use, but medication persistence often ends after one prescription. Concomitant antipsychotic medication use is not recommended. Persistence and concomitant use were compared among olanzapine, risperidone, and haloperidol.

Methods: Michigan Medicaid claims (1/1996 to 9/1997) were analyzed in individuals with schizophrenia initiating treatment with olanzapine (n=1259), risperidone (n=1087), or haloperidol (n=540). Persistence and concomitant antipsychotic use were compared three months after initiation.

Results: At treatment initiation, 61% of olanzapine, 45% of risperidone, and 21% of haloperidol initiators were using another antipsychotic medication, indicating medication transitions rather than new episodes of medication use. After three months, olanzapine's concomitant use had decreased, while risperidone's and haloperidol's had increased (O=–6%, R=+11%, H=+40%, $p < .01$ for each change). Compared with olanzapine, more haloperidol and risperidone initiators discontinued their medication after three months (35%, 44%, and 55%; $p < 0.0001$ for all pair-wise comparisons), and more had discontinued all antipsychotic medication (19%, 28%, and 40%; $p < 0.0001$).

Conclusion: Three months after initiation, olanzapine was associated with significantly greater persistence and decreased concomitant antipsychotic use compared with risperidone and with haloperidol. Risperidone had significantly greater persistence and a smaller increase in concomitant use than haloperidol.

REFERENCES:

1. Fenton WS, Blyler CR, Heinssen RK: Determinants of medication compliance in schizophrenia: empirical and clinical findings. Schizophrenia Bulletin 1997; 23:637–651.
2. McCombs JS, Nichol MB, Stimmel GL, Shi J, Smith RR: Use patterns for antipsychotic medications in Medicaid patients with schizophrenia. J Clin Psychiatry 1999; 60(suppl 19):5–11.

Poster 196 **Saturday, October 12 10:30 a.m.-12 noon**

AUGMENTATION OF CLOZAPINE PARTIAL RESPONDERS WITH CONVENTIONAL ANTIPSYCHOTICS

Sadia Gilani, M.D., *Resident in Psychiatry, Wayne State University, 2751 East Jefferson, Detroit, MI 48201*; Rajaprabhakaran Rajarethinam, M.D., *Research Fellow, Department of Psychiatry, University of Michigan, 2751 East Jefferson, Detroit, MI 48201*; Manuel Tawcer, M.D.; John DeQuardo, M.D.

EDUCATIONAL OBJECTIVES:

Preliminary data supporting augmentation by conventional antipsychotics of patients with schizophrenia who only partially responded to clozapine will be presented. The possible neuro-chemical mechanisms involved will also be discussed.

SUMMARY:

Many patients with schizophrenia do not respond to clozapine even though it is considered as gold standard. Combination of antipsychotics is considered unscientific, as it is not studied well. We report preliminary data of an open trial of patients who responded well to such a combination. D2 receptor occupancy, believed

to be the major aspect of antipsychotic action, is shown to increase from 55% with clozapine alone to 79% on addition of 4 mg of haloperidol. If the benefits of clozapine are obtained without an optimal D2 blockade, an addition of haloperidol that can increase the D2 blockade, resulting in 'optimum' of atypical and conventional effects. Similarly, it is also argued that a combination of 5HT2a antagonism only with good D2 blockade is the possible mechanism for atypical antipsychotics. So, it is possible that combining atypical antipsychotics with high 5HT2a antagonism to low dose conventional antipsychotics can result in a very desirable action profile. At this point, all of these assumptions lack scientific merit. There is no clear proof other than clinical observation that a combination of antipsychotics may be useful. Systematic double-blind studies and studies of receptors can clarify what combination, if any, is biochemically and clinically meaningful.

REFERENCES:

1. Stahl SM: Antipsychotic polypharmacy, Part 1: Therapeutic option or dirty little secret? J Clin Psychiatry 1999;60(7):425–6.
2. Kapur S, Roy P, Daskalakis J, Remington G, Zipursky R: Increased dopamine D2 receptor occupancy and elevated prolactin level associated with addition of haloperidol to clozapine. Am J Psychiatry 2001;158(2):311–4.

TARGET AUDIENCE:

Practicing psychiatrists, clinical staff, psychopharm researchers.

Poster 197 **Saturday, October 12 10:30 a.m.-12 noon**

AMANTADINE AND TOPIRAMATE IN THE TREATMENT OF ANTIPSYCHOTIC-INDUCED WEIGHT GAIN

Faiq A. Hameedi, M.D., *Assistant Professor of Psychiatry, Yale University School of Medicine, 3600 Jerome Avenue, Bronx, NY 10467*; Barbara Gallo, R.N., N.P.P., *Department of Psychiatry, Bronx Mental Health Center, 3600 Jerome Avenue, Bronx, NY 10467*; V. J. Laxmi, M.D.; Rukhshinda Hameedi, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participant should be able to understand the biological reasons for antipsychotics-induced weight gain and learn to use adjunctive agents to prevent and treat weight gain associated with antipsychotics.

SUMMARY:

Schizophrenia has been associated with weight gain and obesity even before the introduction of the typical antipsychotics. Presently, the atypical antipsychotics are widely used because of their superior efficacy, lack of EPS, and better patient acceptance. These medications have been associated with propensity to cause weight gain, possibly due to 5HT2c and H1 receptor antagonism. Various reports have indicated the usefulness of H2 antagonist Nizitadine, dopamine antagonist, Amantadine, and serotonin norepinephrine antagonist sibutramine in the management of weight gain associated with antipsychotics. We report the use Amantadine and Topiramate in the management of antipsychotic induced weight gain.

Fifty patients with the diagnosis of schizophrenia, schizoaffective disorder, and bipolar disorder who had gained significant weight with the atypical antipsychotics were treated in an open-label study with Amantadine 200–300mg/day or Topiramate 50–200mg/day. The preliminary results show that adjunctive treatment with Amantadine and Topiramate prevented further weight gain in about 80% of the patients, while 55% of the patients had significant weight loss with these treatments over six months. All three treatments were well tolerated. One patient reported slight dizziness, while another reported hallucinations with the use of Amantadine, Topiramate was associated with increased sedation in one patient. Our data support the findings from prior studies. Data from a larger sample will be presented.

REFERENCES:

1. Allison DB, Fontaine KR, Heo M, et al: The distribution of body mass index among individual with and without schizophrenia J Clin Psych 1999; 215–220.
2. Flori M, Lejeune J, Deberdt W: Effect of amantadine on weight during olanzapine treatment. European Neuropharmacology 2001;11:181–182.

Poster 198 **Saturday, October 12 10:30 a.m.-12 noon**

METABOLIC SIDE EFFECTS OF OLANZAPINE VERSUS CONVENTIONAL ANTIPSYCHOTICS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the effect of the atypical antipsychotic olanzapine on glucose and lipid levels as

well as body mass index as compared with the older generation neuroleptics.

SUMMARY:

Introduction: The novel antipsychotic olanzapine has been repeatedly associated in the published literature with significant metabolic side effects, including increased weight, hyperglycemia, and hyperlipidemia. We conducted a prospective study in an outpatient sample of patients with chronic schizophrenia in a community mental health setting to compare olanzapine with conventional antipsychotics (AP). We hypothesized that olanzapine patients will have higher body mass index (BMI), FBS, cholesterol, and triglyceride levels.

Methods: Twenty-five patients receiving olanzapine and 25 patients receiving conventional (13 of them on depot AP) consented to participate. Their body mass index (kg/m^2) was calculated and blood levels of fasting blood sugar (FBS), total cholesterol, and triglycerides were obtained. The group means were compared.

Results: Contrary to our hypothesis, the olanzapine patients' mean BMI (28.80) did not differ from the conventional AP group (29.96), nor did the cholesterol levels (206.32 vs 209.5 ug/dl) differ either, respectively). However, the olanzapine group did have a higher mean FBS (107.67) compared with the conventional AP group (97.0) and a higher mean triglyceride as well (279.60 vs 190.67 ug/dl). Diabetes was twice as high in the olanzapine group (16% vs 8%) and twice as many olanzapine patients (68%) had triglyceride levels exceeding the upper limit of the normal range (160 ug/dl) as the conventional AP group (36%).

Discussion: The implications for long-term medical management of psychotic patients receiving olanzapine or conventional AP will be discussed in light of these pilot findings. The results will be tested in a larger sample as well.

Not supported by any sponsor.

REFERENCES:

1. Melkerson KI, et al: Elevated levels of insulin, leptin, and blood lipids in olanzapine-treated patients with schizophrenia or related psychosis. Journal of Clinical Psychiatry 2000; 61: 742–749.
2. Osser DN, Najarian IM, Dufresne RL: Olanzapine increases weight and serum triglycerides. Journal of Clinical Psychiatry 1999; 60:760–767.

Poster 199 **Saturday, October 12 10:30 a.m.-12 noon**

IMPROVED DEPRESSIVE SYMPTOMS IN SCHIZOPHRENIA AFTER SWITCHING TO QUETIAPINE

AstraZeneca Pharmaceuticals

Syah Irman, M.D., *Professor of Psychiatry, University of Indonesia, JL Salemba, #6, Jakarta, Indonesia 10430*; A. Martin Jones, M.S.; John L. Whiteford, B.S.; Charles A. Altman, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand the effect that switching to quetiapine has on depressive symptoms in patients with schizophrenia.

SUMMARY:

Introduction: Quetiapine is known to reduce depressive symptoms in patients with schizophrenia. This analysis examines the benefits that switching to quetiapine has on these symptoms.

Methods: In this multicenter, open, non-comparative trial, patients were switched to quetiapine 400 mg/day over seven days following inadequate response or intolerance to previous antipsychotics. Quetiapine was then dosed at 300–750 mg/day for 11 weeks (mean modal dose 505 mg/day). Changes from baseline to Week 12 (last observation carried forward) in depressive symptoms were assessed using the Calgary Depression Scale for Schizophrenia (CDSS).

Results: Patients (n=449) had a mean baseline CDSS score of 6.5. Depressive symptoms significantly improved over 12 weeks ($p<0.001$), with a least squares (LS) mean (standard error [SE]) change of −3.2 (0.2). These improvements occurred regardless of the reason for switching, although patients switched for general psychopathology and affective symptoms obtained particular benefit (mean [standard deviation]: −5.0 [5.4] and −5.9 [5.8], respectively). Patients with depression at baseline (ie, CDSS >6; n=207) had the greatest improvement ($p<0.001$), with an LS mean (SE) change of −7.6 (0.3). CDSS scores improved irrespective of previous antipsychotic therapy.

Conclusion: Patients suboptimally treated with antipsychotic therapy may derive significant benefit in their depressive symptoms by switching to quetiapine.

REFERENCES:

1. Purdon SE, Malla A, Labelle A, Lit W: Neuropsychological change in patients with schizophrenia after treatment with quetiapine or haloperidol. J Psychiatry Neurosci 2001; 26:137–149.
2. Mullen J, Jibson MD, Sweitzer D: A comparison of the relative safety, efficacy, and tolerability of quetiapine and risperidone in outpatients with schizophrenia and other psychotic disorders: the quetiapine experience with safety and tolerability (QUEST) study. Clin Ther 2001; 23:1839–1854.

TARGET AUDIENCE:

Psychiatrists.

Poster 200 **Saturday, October 12**
10:30 a.m.-12 noon

NUTRITION MANAGEMENT: DETERRENT TO ANTIPSYCHOTIC-INDUCED WEIGHT GAIN?

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EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand the benefit of nutrition management in addressing/preventing antipsychotic-induced weight gain in chronic mentally ill patients.

SUMMARY:

The advent of the novel antipsychotic medications has resulted in remarkable improvements in the lives of people with psychotic disorders. However, side effects such as obesity, hypercholesterolemia, and diabetes mellitus have occurred in significant numbers to become a major concern, given the long-term negative health consequences of these conditions.

This retrospective study conducted in a Midwest state adult psychiatric hospital attempts to determine the occurrence of weight gain among hospitalized middle-aged adult patients receiving Clozaril, Risperdal, Zyprexa, and Senoquel over a 12-month period. These patients participated in the hospital's regular treatment programs, which included structured nutrition interventions centered on patients' assessed needs. Medical nutritionists collected extensive data regularly, e.g. DSM-IV Axis I and Axis III diagnoses, initial and monthly weights, blood sugar, cholesterol and TSH levels, calculated BMIs, medications, and diet prescriptions.

The 74 patients whose charts were reviewed did not show a statistically significant increase in BMI over the 12 months of the study. BMI is highly correlated with body fat and minimizes the effect of stature. We believe that this finding may be the result of the aggressive medical nutrition management conducted in a structured, well monitored setting.

Although this finding needs replication, it suggests that patients who are treated with antipsychotic medications may be well served by receiving medical nutrition therapy with appropriate interventions such as nutrient alteration, calorie restriction, nutrition skills development, exercise recommendations, etc.

REFERENCES:

1. Allison DB, Mentore JL, Heo M, et al: Antipsychotic-induced weight gain; a comprehensive research synthesis. AM J Psychiatry 1999.
2. Allison DB, Fountaine KR, Heo M, et al: The distribution of body mass index among individuals with and without schizophrenia. J Clin Psychiatry 1999;60(4):215–220.

TARGET AUDIENCE:

Treatment team members treating chronic mentally ill patients.

Poster 201 **Saturday, October 12**
10:30 a.m.-12 noon

META-ANALYSIS OF THE EFFICACY OF ARIPIPRAZOLE IN SCHIZOPHRENIA

Bristol-Myers Squibb Company and Otsuka Pharmaceuticals

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should have a better understanding of the short-term efficacy of aripiprazole in schizophrenia.

SUMMARY:

Objective: Aripiprazole is novel antipsychotic therapy, with a unique mechanism of action (dopamine-serotonin system stabilizer). A meta-analysis of efficacy data is presented.

Methods: Four four- to six-week multicenter, double-blind, fixed-dose, placebo-controlled studies were done in 1,545 patients hospitalized with acute relapse of schizophrenia or schizoaffective disorder. Patients were randomized to aripiprazole (n=898), placebo (n=381), or active control (haloperidol 10 mg/day [n=167] or risperidone 6 mg/day [n=99]). Daily aripiprazole doses ranged from 2–30 mg. Weekly efficacy assessments included PANSS and CGI.

Results: Aripiprazole demonstrated statistically superior antipsychotic efficacy to placebo at doses over 2 mg. In the meta-analysis, aripiprazole doses over 2 mg produced significant improvement in PANSS-total score

by Week 1 ($p<0.05$). In individual studies, aripiprazole 15, 20, and 30 mg consistently produced significant improvements in PANSS-total score, with similar changes from baseline observed for all aripiprazole treatment groups. Aripiprazole 15, 20, and 30 mg consistently produced significant improvements in other efficacy scores compared with placebo. In studies with active control, haloperidol and risperidone separated from placebo.

Conclusion: These data demonstrate that aripiprazole improved positive and negative symptoms of schizophrenia, with significant effects one week after starting treatment. Aripiprazole represents an important new option for the treatment of schizophrenia.

REFERENCES:

1. Joy CB, Adams CE, Lawrie SM: Haloperidol versus placebo for schizophrenia (Cochrane Review). Cochrane Database Syst Rev 2001;2:CD003082.
2. Kikuchi T, Tottori K, Uwahodo Y, Hirose T, Miwa T, Oshiro Y, Morita S: 7-(4-[4-(2,3-Dichlorophenyl)-1-piperazinyl]butyloxy)-3,4-dihydro-2(1H)-quinolinone (OPC-14597), a new putative antipsychotic drug with both presynaptic dopamine autoreceptor agonistic activity and postsynaptic D2 receptor antagonistic activity. J Pharmacol Exp Ther 1995 Jul;274(1):329–36.

TARGET AUDIENCE:

Psychiatrists and other clinicians who treat schizophrenia.

Poster 202 **Saturday, October 12 10:30 a.m.-12 noon**

ZIPRASIDONE VERSUS CHLOR PROMAZINE IN TREATMENT-REFRACTORY SCHIZOPHRENIA

Sumant Khanna, M.D., *Biological Psychiatry Laboratory, Department of Psychiatry, National Institute of Mental Health, Hosur Road, Bangalore, India 560 029*; John M. Kane, M.D.; Earl Giller, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to discuss the efficacy and tolerability of ziprasidone in treatment-refractory patients with schizophrenia, as assessed in an 18-week controlled trial.

SUMMARY:

Objective: To evaluate the efficacy and tolerability of ziprasidone in patients with treatment-refractory schizophrenia.

Methods: In an 18-week, double-blind, multicenter, parallel-group trial, patients with refractory schizophrenia who did not respond to six weeks of prospective treatment with haloperidol (up to 30 mg/d) were randomized to 12 weeks of treatment with ziprasidone (80–160 mg/d) or chlorpromazine (200–1200 mg/d). Assessments, performed at baseline and weeks 6, 9, 12, and 18, included BPRSd, CGI, and PANSS.

Results: Of 307/415 patients unresponsive to haloperidol, 154 were randomized to ziprasidone and 153 to chlorpromazine. Both groups exhibited comparable improvement in BPRSd and CGI-S, the primary efficacy measures, as well as PANSS Total, a secondary efficacy measure. There was a significant difference favoring ziprasidone in change in PANSS negative scores. Additionally, a greater number of patients on ziprasidone experienced 20%, 30%, 40%, and 50% reductions in BPRSd scores at endpoint. Ziprasidone-treated patients exhibited a greater reduction in prolactin.

Conclusion: In treatment-refractory schizophrenia, ziprasidone demonstrated overall efficacy comparable to chlorpromazine, but superior negative symptom efficacy. Ziprasidone's effect on prolactin was favorable.

REFERENCES:

1. Lindenmayer JP: Treatment refractory schizophrenia. Psychiatr Q 2000;71(4):373–84.
2. Hirsch SR, Kissling W, Bauml J, Power A, O'Connor R: A 28-week comparison of ziprasidone and haloperidol in outpatients with stable schizophrenia. J Clinical Psychiatry 2002; 63 (6):516–523

TARGET AUDIENCE:

Psychiatrists and psychiatric nurses.

Poster 203 **Saturday, October 12 10:30 a.m.-12 noon**

SWITCHING TO ARIPIPRAZOLE MONOTHERAPY

Bristol-Myers Squibb Company and Otsuka Pharmaceuticals

Mary J. Kujawa, M.D., Ph.D., *Medical Director, Neuroscience Medical Affairs, Bristol-Myers Squibb Company, 777 Scudders Mill Road, Princeton, NJ 08545*; Daniel E. Casey, M.D., *Chief, Psychiatric Research and Psychopharmacology, Mental Health Division, VA Medical Center at Portland, 3710 S.W. US Veterans Hospital Road, Portland, OR 97201*; Anutosh R. Saha, Ph.D.; Mirza W. Ali, Ph.D.; Darlene N. Jody, M.D.; Elyse G. Stock, M.D.; Gary G. Ingenito, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have learned how patients can be switched from existing therapies to aripiprazole.

SUMMARY:

Objectives: To assess the safety and tolerability of switching patients from current antipsychotic therapy to aripiprazole, a newly developed antipsychotic, with a unique mechanism of action (dopamine-serotonin system stabilizer). The impact of efficacy was also evaluated.

Methods: This Phase III study involved 311 patients with chronic, stable schizophrenia or schizoaffective disorder who had received monotherapy with a typical (haloperidol or thioridazine) or atypical (risperidone or olanzapine) antipsychotic for ≥1 month. Patients were randomized for eight weeks into three groups: Group 1—Immediate initiation of 30mg/d aripiprazole with simultaneous abrupt discontinuation of current antipsychotic (n=104). Group 2—Immediate initiation of 30mg/d aripiprazole while tapering off current antipsychotic over two weeks (n=104), Group 3—Titration of aripiprazole over two weeks (from 10mg/d to 30mg/d) while tapering off current antipsychotic (n=103).

Results: Safety and tolerability results were similar across treatment groups. There was no difference in discontinuations due to adverse events across the three groups. Antipsychotic efficacy was maintained in all groups throughout the study and improvement was seen from baseline in PANSS-total, -negative, -positive subscales, and CGI-Improvement Score.

Conclusions: Switching to aripiprazole is safe and well tolerated and can be initiated at an efficacious dose without having to gradually increase the dose of aripiprazole.

REFERENCES:

1. Weiden PJ, Aquila R, Dalheim L, Standard JM: Switching antipsychotic medications. J Clin Psychiatry 1997;58 Suppl 10:63–72.
2. Kikuchi T, Tottori K, Uwahodo Y, Hirose T, Miwa T, Oshiro Y, Morita S: 7-(4-[4-(2,3-Dichlorophenyl)-1-piperazinyl]butyloxy)-3,4-dihydro-2(1H)-quinolinone (OPC-14597), a new putative antipsychotic drug with both presynaptic dopamine autoreceptor agonistic activity and postsynaptic D2 receptor antagonistic activity. J Pharmacol Exp Ther 1995;274(1):329–36.

TARGET AUDIENCE:

Psychiatrists and other clinicians who treat schizophrenia.

Poster 204 **Saturday, October 12**
10:30 a.m.-12 noon

ARIPIPRAZOLE FOR LONG-TERM MAINTENANCE TREATMENT IN SCHIZOPHRENIA

Bristol-Myers Squibb Company and Otsuka Pharmaceuticals

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have learned that treatment with aripiprazole is sustained over the long term, and may lead to improved compliance.

SUMMARY:

Objective: To evaluate the maintenance of effect and long-term efficacy, safety, and tolerability of aripiprazole, a dopamine-serotonin system stabilizer, compared with haloperidol when administered for 52 weeks.

Methods: A multicenter, randomized, double-blind study was conducted in 1,294 patients with acute relapse of chronic schizophrenia randomized to aripiprazole 30 mg (n=861) or haloperidol 10 mg (n=433) daily. A one-time dose reduction was allowed to aripiprazole 20 mg and haloperidol 7 mg. Efficacy evaluations included PANSS and MADRS scores.

Results: A significantly greater proportion of patients treated with aripiprazole and demonstrated response and remained on treatment at weeks 8, 26, and 52 compared with haloperidol (Week 52: 40% vs. 27%, $p<0.001$). Aripiprazole produced statistically significant improvements in the PANSS negative subscale and in depressive symptoms as shown in the MADRS, compared with haloperidol. The overall incidence of EPS-related adverse events was significantly lower with aripiprazole than with haloperidol ($p<0.001$). Both treatments resulted in comparable weight gain. There was no significant difference in QT_c interval between both groups.

Conclusion: Aripiprazole may represent the next-generation antipsychotic leading to increased compliance in schizophrenia due to significantly greater improvements in negative and depressive symptoms and a superior safety and tolerability profile compared with haloperidol.

REFERENCES:

1. Campbell M, Young PI, Bateman DN, Smith JM, Thomas SH: The use of atypical antipsychotics in the management of schizophrenia. Br J Clin Pharmacol 1999;47(1):13–22.
2. Kikuchi T, Tottori K, Uwahodo Y, Hirose T, Miwa T, Oshiro Y, Morita S: 7-(4-[4-(2,3-Dichlorophenyl)-1-piperazinyl]butyloxy)-3,4-dihydro-2(1H)-quinolinone (OPC-14597), a new putative antipsychotic drug with both presynaptic dopamine autoreceptor agonistic activity and postsynaptic D2 receptor antagonistic activity. J Pharmacol Exp Ther 1995;274(1):329–36.

TARGET AUDIENCE:

Psychiatrists and other clinicians who treat schizophrenia.

Poster 205 **Saturday, October 12**
10:30 a.m.-12 noon

EPS REDUCTION IN PATIENTS WITH SCHIZOPHRENIA AFTER SWITCHING TO QUETIAPINE

AstraZeneca Pharmaceuticals

A. Martin Jones, M.S., *AstraZeneca Pharmaceuticals, Alderley House, Alderley Park, Macclesfield, Cheshire, United Kingdom 104 TF*; Ilkka Larmo, M.D.; John L. Whiteford, B.S.; Charles A. Altman, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be aware of the beneficial effects of switching to quetiapine in patients experiencing extrapyramidal symptoms (EPS).

SUMMARY:

Introduction: Quetiapine has previously been shown to have an extrapyramidal symptoms (EPS) profile no different from placebo across the full dose range. This analysis assesses the effect of switching to quetiapine in patients experiencing EPS with antipsychotic therapy.

Methods: In this multicenter, open-label trial, patients with schizophrenia were switched from their previous antipsychotic over seven days, then flexibly dosed with 300–750 mg/day quetiapine for 11 weeks. A subset of 75 patients switched due to EPS was included in the analysis. Effectiveness was assessed using Positive and Negative Symptom Scale (PANSS) and Clinical Global Improvement (CGI) scores. EPS and akathisia were assessed using the Simpson-Angus Scale (SAS) and Barnes Akathisia Scale (BAS).

Results: Over the 12-week period, patients' overall condition improved significantly, with a least squares mean (standard error) decrease in PANSS score ($p<0.001$) of −20.8 (2.1), and a CGI Global Improvement score of 1.9 (0.2). Furthermore, 65% of patients had a CGI Severity of Illness score ≤3 at Week 12. These improvements were associated with benefits in EPS, with significant reductions in SAS and BAS scores ($p<0.001$).

Conclusion: Patients switching to quetiapine because of EPS with previous medications derived significant improvement both in their overall condition and movement disorders.

REFERENCES:

1. Borison RL, Arvanitis LA, Miller BG: ICI 204,636, an atypical antipsychotic: efficacy and safety in a multicenter, placebo-controlled trial in patients with schizophrenia. U.S. SEROQUEL Study Group. J Clin Psychopharmacol 1996; 16:158–169.
2. Arvanitis LA, Miller BG: Multiple fixed doses of Seroquel (quetiapine) in patients with acute exacerbation of schizophrenia: a comparison with haloperidol and placebo. The Seroquel Trial 13 Study Group. Biol Psychiatry 1997; 42:233–246.

TARGET AUDIENCE:

Psychiatrists.

Poster 206 **Saturday, October 12**
10:30 a.m.-12 noon

NEUROCOGNITIVE EFFECTS OF ARIPIPRAZOLE VERSUS OLANZAPINE IN STABLE PSYCHOSIS

Bristol-Myers Squibb Company and Otsuka Pharmaceuticals

Heidi Liston, Pharm.D., *Medical Science Manager, Bristol-Myers Squibb Company, 1360 Woodlock Road, Mt. Pleasant, SC 29464*; Barbara A. Cornblatt, Ph.D., *Director, Recognition and Prevention Program, Zucker Hillside Hospital and Clinic, and Professor of Psychiatry, Albert Einstein College of Medicine, 75-59 263rd Street, Glen Oaks, NY 11004*; William H. Carson, Jr., M.D.; Muza W. Ali, Ph.D.; Robert S. Kern, M.D.; Xilaolong Luo, Ph.D.; Michael F. Green, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should have an understanding of the neurocognitive benefits and health advantages of aripiprazole.

SUMMARY:

Background: This multicenter, open-label study compared neurocognitive benefits, safety, and tolerability of aripiprazole, a novel dopamine-serotonin system stabi-

lizer, with olanzapine, in outpatients with clinically stable schizophrenia.

Methods: Patients randomized to aripiprazole 30 mg qd (n=76) or olanzapine 15 mg qd (n=93) were assessed at baseline, and weeks 8 and 26 (or last visit). The neurocognitive battery was reduced to three factors: general cognitive functioning, executive functioning, and secondary verbal memory.

Results: Aripiprazole produced significant improvements in secondary verbal memory at Weeks 8 and 26 (both $p<0.001$); olanzapine did not. Both aripiprazole and olanzapine produced a significant improvement at Week 8 in general cognitive functioning ($p<0.05$) and a trend toward improvement at Week 26 ($p<0.10$). There were no significant changes in executive functioning for either medication. Clinical improvement was not significantly different between the two groups. The three most prevalent adverse events with aripiprazole were insomnia, nausea, and somnolence, and with olanzapine were weight gain, somnolence, and headache. Olanzapine was associated with a greater incidence of weight gain (29%) than aripiprazole (7%). There was a significant reduction in cholesterol levels with aripiprazole versus olanzapine.

Conclusions: In addition to neurocognitive improvement, aripiprazole may be associated with health benefits and may promote treatment adherence.

REFERENCES:

1. Green MF, Braff DL: Translating the basic and clinical cognitive neuroscience of schizophrenia to drug development and clinical trials of antipsychotic medications. Biol Psychiatry 2001;49(4):374–84.
2. Kikuchi T, Tottori K, Uwahodo Y, Hirose T, Miwa T, Oshiro Y, Morita S: 7-(4-[4-(2,3-Dichlorophenyl)-1-piperazinyl]butyloxy)-3,4-dihydro-2(1H)-quinolinone (OPC-14597), a new putative antipsychotic drug with both presynaptic dopamine autoreceptor agonistic activity and postsynaptic D2 receptor antagonistic activity. J Pharmacol Exp Ther 1995;274(1):329–36.

TARGET AUDIENCE:

Psychiatrists and other clinicians who treat schizophrenia.

Poster 207 **Saturday, October 12 10:30 a.m.-12 noon**

EFFECTS OF SWITCHING FROM OLANZAPINE TO QUETIAPINE ON BODY WEIGHT IN PSYCHIATRICALLY ILL PATIENTS

AstraZeneca Pharmaceuticals

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to realize that switching patients to quetiapine treatment may be a viable strategy for patients gaining weight while taking olanzapine.

SUMMARY:

Objective: To assess effects of switching from olanzapine to quetiapine on bodyweight in chronically psychiatrically ill patients.

Methods: Sixteen patients who were psychiatrically stable on olanzapine but had gained weight were gradually switched to quetiapine and followed for 10 weeks. Enrollment criteria included body mass index (BMI) > 25 kg/m^2 and weight gain of at least 20% of body weight on olanzapine. Weight change as both a categorical and a continuous variable was examined using *t*-test for paired scores. Efficacy was measured using the Positive and Negative Syndrome Scale (PANSS). Medication-related side effects were assessed using the Simpson-Angus Scale (SAS).

Results: Eight men and seven women (n=15) completed the study. Weight decline after switching to quetiapine was statistically significant (mean change 229 to 224 lb; $P=0.03$); effect size was small (Cohen's d=0.12). PANSS variables of Somatic Concern and Guilt Feelings declined significantly after the switch ($t=2.88$; $P=0.13$ and $t=2.62$; $P=0.021$, respectively). There was no increase in psychiatric symptoms during the 10-week follow-up and no significant differences in SAS variables.

Conclusions: Switching to quetiapine may be a viable strategy for patients who experience weight gain associated with olanzapine. The switch was well tolerated; patients lost weight while taking quetiapine without symptom relapse.

REFERENCES:

1. Allison DB, Casey DE: Antipsychotic-induced weight gain: a review of the literature. J Clin Psychiatry 2001; 62(Suppl 7): 22–31.
2. Ganguli R, Brar JS, et al: Weight gain over 4 months in schizophrenia patients: a comparison of olanzapine and risperidone. Schizophr Res 2001; 49(3): 261–7.

TARGET AUDIENCE:

Professional.

Poster 208 **Saturday, October 12 10:30 a.m.-12 noon**

OPTIMAL TITRATION FOR QUETIAPINE: PILOT TRIAL

AstraZeneca Pharmaceuticals

Robin McCoy, R.N., *Senior Clinical Research Specialist, Central Nervous System, AstraZeneca Pharmaceuticals, 1800 Concord Pike, Wilmington, DE 19850*; Mark A. Smith, M.D.; Martin Brecher, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to to realize that quetiapine can be safely titrated to 400 mg more rapidly than the standard five days to effectively treat most patients with acute schizophrenia.

SUMMARY:

Objective: To determine the fastest tolerable and safe titration schedule for quetiapine in acutely ill patients with schizophrenia.

Methods: In this multicenter, double-blind, pilot study, 69 patients with schizophrenia, aged 18–65 years, were randomly assigned to one of three different titration schedules of quetiapine for five days after a two-day washout period. Titration groups A (n=22), B (n=22), and C (n=25) were given five, three, and two days, respectively, to reach 400-mg quetiapine. Safety and tolerability, including adverse events, were assessed by physical examinations, daily vital sign measurements, interviews for subjective symptomatology, and clinical laboratory tests.

Results: 86% of patients experienced adverse events; most were rated as mild to moderate in intensity. Overall frequency of adverse events was similar among the three groups. Three patients withdrew due to agitation. Vital signs and laboratory values were similar among the titration groups, including change from baseline in standing systolic blood pressure, standing pulse, and supine diastolic blood pressure.

Conclusions: These results suggest that quetiapine can be safely titrated to 400 mg for most patients with acute schizophrenia more rapidly than the standard five days. Based on these findings, trials assessing the safety and efficacy of fast titration in a larger sample are warranted.

REFERENCES:

1. Kasper S, Tauscher J, et al: Quetiapine: efficacy and tolerability in schizophrenia. Eur Neuropsychopharmacol 2001; 1 Suppl 4: S405–13.
2. Cutler A J, Goldstein JM, et al: Dosing and switching strategies for quetiapine fumarate. Clin Ther 2002; 24(2): 209–22.

TARGET AUDIENCE:

Professional.

Poster 209 **Saturday, October 12 10:30 a.m.-12 noon**

META-ANALYSIS OF WEIGHT EFFECTS WITH ARIPIPRAZOLE

Bristol-Myers Squibb Company and Otsuka Pharmaceuticals

Neveen A. Gharbia, Pharm.D., *Associate Medical Director, Bristol-Myers Squibb Company, P.O. Box 4000, Princeton, NJ 08543-4000*; Robert D. McQuade, Ph.D., *Senior Director, Global Marketing, Bristol-Myers Squibb Company, P.O. Box 4000, Princeton, NJ 08543-4000*; Darlene N. Jody, M.D.; Anutosh R. Saha, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should have learned that aripiprazole is associated with minimal weight gain.

SUMMARY:

Objective: A meta-analysis was done to assess the short-term and long-term effects on weight (≥ 7% increase from baseline) of aripiprazole, a newly developed antipsychotic with a unique mechanism of dopamine D2 and serotonin 5-HT_{1A} partial agonism, and 5-HT_{2A} antagonism.

Methods: Short-term effects were based on five four- to six-week double-blind, controlled studies in 1,648 patients with schizophrenia or schizoaffective disorder, randomized to aripiprazole, placebo, or active control (haloperidol 10 mg/day or risperidone 6 mg/day). Long-term effects were based on a 52-week haloperidol-controlled study (n=1294) and a 26-week open-label olanzapine-controlled study (n=255).

Results: In the short-term studies, aripiprazole was associated with a 0.7 kg increase in weight; haloperidol and risperidone produced 0.6 kg and 1.3 kg increases, respectively. In the long-term haloperidol study, patients with a baseline BMI <23 experienced weight gain with both haloperidol and aripiprazole, while patients with BMI >27 experienced weight loss. In the olanzapine-controlled study, aripiprazole led to a 0.9 kg weight loss versus a 3.6 kg increase with olanzapine at 26 weeks. In all BMI categories, aripiprazole resulted in weight loss and olanzapine in weight gain.

Conclusion: Aripiprazole is associated with minimal weight gain, comparable to haloperidol and less than olanzapine.

REFERENCES:

1. Sussman N: Review of atypical antipsychotics and weight gain. J Clin Psychiatry 2001;62 Suppl 23:5–12.
2. Kikuchi T, Tottori K, Uwahodo Y, Hirose T, Miwa T, Oshiro Y, Morita S: 7-(4-[4-(2,3-Dichlorophenyl)-1-piperazinyl]butytoxy)-3,4-dihydro-2(1H)-quinolinone (QPC-14597), a new putative antipsychotic drug with both presynaptic dopamine autoreceptor agonistic activity and postsynaptic D2 receptor antagonistic activity. J Pharmacol Exp Ther 1995;274(1):329–36.

TARGET AUDIENCE:

Psychiatrists and other clinicians who treat schizophrenia.

Poster 210 **Saturday, October 12 10:30 a.m.-12 noon**

ARIPIPRAZOLE VERSUS PLACEBO IN THE TREATMENT OF STABLE, CHRONIC SCHIZOPHRENIA

Bristol-Myers Squibb Company and Otsuka Pharmaceuticals

Robert D. McQuade, Ph.D., *Senior Director, Global Marketing, Bristol-Myers Squibb Company, P.O. Box 4000, Princeton, NJ 08543-4000*; Teresa A. Pigott, M.D.; Anutosh R. Saha, Ph.D.; Mirza W. Ali, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will understand the potentially important role for aripiprazole in the treatment of chronic schizophrenia.

SUMMARY:

Objective: To assess the time to relapse with aripiprazole, compared with placebo, over 26 weeks in stable patients with chronic schizophrenia.

Methods: A multicenter, randomized, double-blind, placebo-controlled study was conducted in 310 patients with chronic schizophrenia considered stable (no significant improvement or worsening in last three months and baseline PANSS = 82), randomized to aripiprazole 15 mg/day or placebo. Efficacy included time to relapse, PANSS Total Score, and CGI-Improvement Score.

Results: Treatment with aripiprazole resulted in significantly fewer patients relapsing at endpoint versus placebo (34% vs. 57%, respectively). Aripiprazole also significantly increased the time to relapse by two fold. Aripiprazole produced a small but significantly greater improvement in PANSS-total score relative to placebo. Aripiprazole was generally well tolerated with an adverse event profile comparable to placebo. No clinically significant changes occurred in SAS, AIMS, and Barnes Akathisia scores in either group. Weight gain associated with aripiprazole was comparable to placebo.

Conclusion: Aripiprazole provides effective and safe antipsychotic treatment in patients with chronic schizophrenia, representing an important addition to the current antipsychotic armamentarium.

REFERENCES:

1. Marder SR: Antipsychotic drugs and relapse prevention. Schizophr Res 1999;35 Suppl:S87–92.
2. Kikuchi T, Tottori K, Uwahodo Y, Hirose T, Miwa T, Oshiro Y, Morita S: 7-(4-[4-(2,3-Dichlorophenyl)-1-piperazinyl]butytoxy)-3,4-dihydro-2(1H)-quinolinone (OPC-14597), a new putative antipsychotic drug with both presynaptic dopamine autoreceptor agonistic activity and postsynaptic D2 receptor antagonistic activity. J Pharmacol Exp Ther 1995;274(1):329–36.

TARGET AUDIENCE:

Psychiatrists and other clinicians who treat schizophrenia.

Poster 211 **Saturday, October 12 10:30 a.m.-12 noon**

INTRAMUSCULAR ZIPRASIDONE AND INTRAMUSCULAR HALOPERIDOL HAVE COMPARABLE EFFECTS ON CORRECTED QT INTERVALS AT OBSERVED PEAK CONCENTRATIONS

Pfizer Inc.

Jeffrey J. Miceli, Ph.D., *Senior Associate Director, Central Nervous System Clinical Development, Pfizer Global Research and Development, 50 Pequot Avenue, MS 6025-B-2233, New London, CT 06320*; Richard J. Anziano, M.S.; Rachel Swift, M.D.; Thomas M. Shiovitz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the effects of IM ziprasidone and haloperidol on the corrected QT interval, as assessed in a rigorously controlled study designed to measure QT changes at peak drug concentrations.

SUMMARY:

Objective: To characterize the effects of multiple IM injections of ziprasidone and haloperidol on corrected QT interval (QT_c) at observed peak concentrations (C_{max}).

Methods: In this single-blind, randomized study, individuals with schizophrenia or schizoaffective disorder

received two injections of ziprasidone (20 mg followed by 30 mg, the second dose being 50% above maximum recommended) or haloperidol (7.5 mg followed by 10 mg) four hours apart. ECGs and blood sampling for pharmacokinetic measurements were performed at 15-minute intervals within two hours after each injection to capture C_{max} and times on either side of C_{max}. Mean QT_c (with baseline correction factor of 0.33) at C_{max} was calculated as the average of three measurements obtained at and on either side of C_{max} for each injection for each subject.

Results: Among study completers, mean increases at C_{max} were 4.6 msec for ziprasidone (n=25) and 6.0 msec for haloperidol (n=24) after injection 1, and 12.8 msec and 14.7 msec after injection 2. Mean (95% CI) QT_c increases over 24 hours after initial injection were 3.4 msec (0.86, 5.92) for ziprasidone and 6.3 msec (3.58, 8.95) for haloperidol. No subject had $QT_c \geq 500$ msec.

Conclusions: IM ziprasidone and haloperidol exhibited comparable effects on QT_c at Cmax.

REFERENCES:

1. Brook S, Lucey JV, Gunn KP (for the Ziprasidone Study Group): Intramuscular ziprasidone compared with intramuscular haloperidol in the treatment of acute psychosis. J Clin Psychiatry 2000; 61:933–941.
2. Romano SJ: Cardiovascular safety profile of ziprasidone: review of clinical development data. Presented at the 2001 Annual Meeting of the American Psychiatric Association, New Orleans, LA, May 8, 2001.

TARGET AUDIENCE:

Psychiatrists, psychiatric nurses.

Poster 212 **Saturday, October 12 10:30 a.m.-12 noon**

GLUCOSE AND LIPID METABOLISM IN RELATION TO ADIPOSITY IN SCHIZOPHRENIA

National Alliance for Research on Schizophrenia and Depression

John W. Newcomer, M.D., *Associate Professor, Department of Psychiatry, Washington University School of Medicine, 660 South Euclid, Box 8134, St. Louis, MO 63110*; Daniel W. Haupt, M.D., *Instructor, Department of Psychiatry, Washington University School of Medicine, 660 South Euclid, Box 8134, St. Louis, MO 63110*; Angela K. Melson, M.A.; Jolle A. Schweiger

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the effects of adiposity and treatment on glucose and lipid metabolism and inflammatory markers related to cardiovascular risk in patients with schizophrenia receiving antipsychotic treatment.

SUMMARY:

Increased adiposity, plasma glucose, and lipids are independent risk factors for cardiovascular disease, and schizophrenia patients experience increased cardiovascular (CV) mortality in comparison to the general population. Increased adiposity during antipsychotic treatment can disturb glucose and lipid metabolism. High sensitivity C reactive protein (hs-CRP) is an acute-phase reactant secreted in response to increased adiposity. Elevated fasting plasma lipids and hs-CRP can predict future CV events. Reports suggest that hyperglycemia and hypertriglyceridemia can occur during antipsychotic treatment, even without increased adiposity. We measured fasting plasma lipids, glucose, insulin, hs-CRP, and body mass index (BMI) in healthy controls (n=69) and non-diabetic schizophrenia or schizoaffective patients (n=70) treated with typical antipsychotics, risperidone, or olanzapine. BMI significantly predicted fasting plasma triglycerides, glucose, and hs-CRP in patients and controls, with no significant difference in the effect of BMI across disease or treatment conditions. In contrast, a significant difference in the effect of BMI across treatment conditions was observed for fasting plasma insulin and homeostasis model assessment (HOMA) insulin resistance, suggesting that insulin resistance may increase with adiposity to a greater extent on certain medications. Increased adiposity, independent of treatment conditions tested, is associated with dyslipidemia and inflammatory products that predict CV risk.

REFERENCES:

1. Haupt D, Newcomer JW: Hyperglycemia and antipsychotic medications. J Clin Psychiatry 2001, 62(27) Suppl: 15–26.
2. Newcomer JW, Fucetola R, Melson AK, Haupt DW, Schweiger JA, Cooper BP, Selke G: Abnormalities in glucose regulation during antipsychotic treatment in schizophrenia. Arch Gen Psychiatry 2002, 59:337–345.

TARGET AUDIENCE:

Psychiatrists, pharmacists, administrators, nurses.

Poster 213 **Saturday, October 12 10:30 a.m.-12 noon**

USE OF CONVENTIONAL VERSUS ATYPICAL ANTIPSYCHOTICS AND INCIDENCE OF DIABETES IN PATIENTS WITH SCHIZOPHRENIA

Eli Lilly and Company

Daniel A. Ollendorf, M.P.H., *Director of Analytic Services, PharMetrics, Inc., 150 Collidge Avenue, Watertown, MA 02472*; Malcolm Rucker, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should gain insight into the one-year incidence of diabetes for schizophrenia patients treated with conventional versus atypical antipsychotic medications in a usual care setting.

SUMMARY:

The potential association between atypical antipsychotic use and risk of diabetes has recently received significant attention. A retrospective analysis of a national integrated claims database was conducted to examine this risk. Patients with schizophrenia who had one or more paid pharmacy claims for an atypical (olanzapine, risperidone, quetiapine, clozapine) or conventional antipsychotic between September 1996 and June 2000 were identified and stratified by type of antipsychotic. The sample was restricted to those enrolled for 12 months before and after therapy initiation. Risk of diabetes was compared using logistic regression, controlling for demographic and clinical characteristics as well as duration of initial therapy. A total of 1,316 patients were identified; atypical users were younger, more likely to be female, and had a longer duration of therapy than conventional users. The crude one-year incidence of diabetes did not differ between groups (1.78% vs 1.65% for atypicals vs. conventionals, p= .871; 2.45% vs. 1.44% vs. 1.01% for risperidone vs. olanzapine vs. other atypicals, p=0.448). Atypical antipsychotic use also did not increase diabetes risk in logistic regression analyses (OR=1.21, 95% CI=0.45, 3.24). Our findings suggest that atypical antipsychotic use does not increase the risk of diabetes relative to conventional use among patients with schizophrenia.

REFERENCES:

1. Wirshing DA, Wirshing WC, Cysar L, et al: Novel antipsychotics: comparison of weight gain liabilities. Journal of Clinical Psychiatry 1999; 60(6): 358–63.
2. Mohan D, Gordon H, Hindley N, et al: Schizophrenia and diabetes mellitus. British Journal of Psychiatry 1999; 174: 180–81.

TARGET AUDIENCE:

Clinicians and health services researchers concerned about the relative risks of diabetes onset for patients receiving antipsychotic medications.

Poster 214 **Saturday, October 12**
10:30 a.m.-12 noon

RANDOM-ASSIGNMENT, DOUBLE-BLIND CLINICAL TRIAL OF ONCE VERSUS TWICE DAILY ADMINISTRATION OF QUETIAPINE IN PATIENTS WITH SCHIZOPHRENIA OR SCHIZOAFFECTIVE DISORDERS

AstraZeneca Pharmaceuticals

Haranath Parepally, M.D., *Department of Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213*; K.N. Roy Chengappa, M.D.; Jaspreet S. Brar, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to realize that it is clinically feasible to switch from a twice-daily quetiapine regimen to a once-daily regimen in a majority of patients with schizophrenia or schizoaffective disorder.

SUMMARY:

Objective: To evaluate the efficacy and safety of administering quetiapine once versus twice daily.

Methods: Using a double-blind design, 21 hospitalized patients with schizophrenia (n=7) or schizoaffective disorder (n=14) who had received unchanged doses (for two weeks) of either 400 or 600 mg of quetiapine administered twice daily were randomized to once- or twice-daily administration for four weeks and then crossed over to the opposite regimen for an additional four weeks. Patients receiving mood stabilizers or antidepressants for schizoaffective disorder remained on those agents. Standard psychopathology and safety measures were used.

Results: Nearly 70% (15/21) of the patients met the a priori efficacy responder criteria with no statistical differences in response between those assigned to once or twice daily. Other statistical analyses confirmed that the majority of patients tolerated the switch to once- or twice-daily administration with quetiapine. A minority experienced worsening of symptoms or orthostatic hypotension during the crossover.

Conclusions: Results suggest that it is clinically feasible to switch a majority of quetiapine-treated patients receiving a twice-daily regimen to a once-daily regimen. Quetiapine was generally well tolerated at either dosing schedule. The strategy of administering quetiapine once daily at bedtime may promote improved adherence to treatment.

REFERENCES:

1. Cutler AJ, Goldstein JM, et al: Dosing and switching strategies for quetiapine fumarate. Clin Ther 2002; 24(2): 209–22.

2. King DJ, Link CG, et al: A comparison of bid and tid dose regimens of quetiapine (Seroquel) in the treatment of schizophrenia. Psychopharmacology (Berl) 1998; 137(2): 139–46.

TARGET AUDIENCE:

Professional.

Poster 215 **Saturday, October 12 10:30 a.m.-12 noon**

ANTIPSYCHOTIC USE PATTERNS AND HEALTH CARE COSTS FOR INDIVIDUALS WITH SCHIZOPHRENIA BEING TREATED WITH HALOPERIDOL, OLANZAPINE, OR RISPERIDONE IN A MEDICAID POPULATION

Eli Lilly and Company

Janet L. Ramsey, M.S., *Senior Research Associate, Health Outcomes Research, Eli Lilly and Company, Lilly Corporate Center, DC-4025, Indianapolis, IN 46285*; Baojin Zhu, Ph.D., *Statistical Sciences, Health Outcomes Research, Eli Lilly and Company, Lilly Corporate Center, DC-4025, Indianapolis, IN 46285*; David S. Hutchins, M.B.A.; Zhongyun Zhao, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have some understanding of the differences in medication and medical service use patterns among schizophrenia patients treated with haloperidol, olanzapine or risperidone.

SUMMARY:

Objective: To evaluate medication use patterns and health care costs for individuals with schizophrenia treated with haloperidol, olanzapine, or risperidone in a Medicaid program.

Methods: Medicaid recipients who were diagnosed with schizophrenia (ICD-9 295.XX) and began treatment with haloperidol (n=302), olanzapine (n=895), or risperidone (n=479) between 1/1997 and 6/1997 were followed for one year. Medical service and pharmacy claims one-year prior and post-initiation were extracted and analyzed. Length of treatment and total and component health care costs were compared using regression models controlling for demographic and clinical characteristics, and previous service and medication use.

Results: Compared with haloperidol and risperidone users, patients using olanzapine stayed on therapy significantly longer (+69 days vs. haloperidol, $p < 0.0001$; +29 days vs. risperidone, $p < 0.0001$). Olanzapine patients had higher antipsychotic medication costs (+$1,269 vs. haloperidol, $p < 0.0001$; +$562 vs. risperidone, $p<0.0001$) but lower psychiatric inpatient costs (–$1,713 vs. haloperidol, p=0.02; –$305 vs. risperidone, p=0.62). There were no significant differences in total health care costs (–$304 vs. haloperidol, p=0.74 and –$49 vs. risperidone, p=0.95).

Conclusion: Longer treatment duration, reductions in hospitalization costs, and similar total costs associated with olanzapine treatment may be indicative of better patient outcomes.

REFERENCES:

1. Svarstad BL, Shireman TI, Sweeney JK: Using drug claims data to assess the relationship of medication adherence with hospitalization and costs. Psychiatric Services 2001; 52(6):805–811.
2. McCombs JS, Nichol MB, Johnstone BM, Stimmel GL, Shi J, Smith R: Antipsychotic drug use patterns and the cost of treating schizophrenia. Psychiatric Services 2000; 51(4):525–527.

TARGET AUDIENCE:

Psychiatric physicians and health care providers.

Poster 216 **Saturday, October 12 10:30 a.m.-12 noon**

USE OF ANTIPSYCHOTICS IN PATIENTS WITH SCHIZOPHRENIA IN THE VETERANS HEALTH ADMINISTRATION

Eli Lilly and Company

Xinhua Ren, Ph.D., *Assistant Professor and Research Scientist, Health Services, Boston University, 200 Springs Road, Building 70, Bedford, MA 01730*; Austin Lee, Ph.D.; Alaa Hamed, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should learn more about the use (e.g., initiation and switching) of atypical antipsychotics among patients with schizophrenia in the Veterans Health Administration. They should also be able to recognize patients' sociodemographic and clinical characteristics associated with the use of atypical antipsychotics.

SUMMARY:

Objective: To describe use of atypical antipsychotics among patients with schizophrenia in the Veterans Health Administration (VHA).

Methods: We identified 89,107 patients with schizophrenia (≥ 1 inpatient or ≥2 outpatient ICD-9-CM codes ≥7 days apart) during 7/1/98–6/30/99, of whom 74,715 were on antipsychotics. To describe switching patterns, we defined a prior (1/1/99 to 6/30/99) and post (10/1/99 to 12/31/99) period.

Key Findings: About 58% of the patients with schizophrenia were prescribed atypical antipsychotics. More patients (22.7%) were prescribed olanzapine than risperidone (19.7%) ($p < 0.001$ for all comparisons). Among those not prescribed any atypical antipsychotics in the prior period (N=36,498), 10% more patients subsequently initiated olanzapine than risperidone. About 8% more patients continued on olanzapine from the prior to the post period, as compared with risperidone, and 10% more patients on risperidone switched to olanzapine than vice versa. Among those on ≥2 atypical antipsychotics, 31.1% (N=1,040) switched to monotherapy with olanzapine as compared with 18.7% (N=625) with risperidone.

Conclusions: Among atypical antipsychotics, olanzapine was widely prescribed (both in terms of initiation and switching). Given that olanzapine is often prescribed for treating schizophrenia in the VA, there is a need to assess the cost-effectiveness associated with each of the atypical antipsychotics.

REFERENCES:

1. Andreason N, et al: Symptoms of schizophrenia: methods, meanings, and mechanisms. Arch Gen Psychiatry 1995; 52(5): 341–351.
2. Kane JM: Drug therapy: schizophrenia. N Engl J Med Volume 1996; 334(1):34–41.

TARGET AUDIENCE:

Health services researchers and care providers interested in the treatment of schizophrenia.

Poster 217 **Saturday, October 12**
10:30 a.m.-12 noon

ADJUNCTIVE USE OF ANTI-PARKINSONIAN AGENTS WITH OLANZAPINE OR RISPERIDONE AMONG PATIENTS WITH SCHIZOPHRENIA IN THE VETERANS HEALTH ADMINISTRATION

Eli Lilly and Company

Xinhua Ren, Ph.D., *Assistant Professor and Research Scientist, Health Services, Boston University, 200 Springs Road, Building 70, Bedford, MA 01730*; Austin Lee, Ph.D.; Alaa Hamed, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to recognize the extent to which some antiparkinsonian agents (e.g., amantadine, benztropine, biperidin, diphenhydramine, procyclidine, or trihexyphenidyl) were adjunctively used with olanzapine or risperidone among patients with schizophrenia in the Veterans Health Administration.

SUMMARY:

Objective: Using unique databases from the Veterans Health Administration (VHA), the study examined the relationship between the adjunctive use of antiparkinsonian agents with the initiation of olanzapine or risperidone among patients with schizophrenia.

Methods: We defined initiation as patients who were not on any antipsychotics for six months (10/1/98–3/31/99) and subsequently initiated olanzapine (N=900) or risperidone (N=964) (4/1/99–9/30/00). The adjunctive use of antiparkinsonian agents refers to overlapping use > 7 days or same day prescription of ≥ 1 of the six agents (e.g., amantadine, benztropine, biperidin, diphenhydramine, procyclidine, or trihexyphenidyl) with olanzapine or risperidone.

Findings: Among olanzapine or risperidone initiators, patients who used at least one antiparkinsonian agents adjunctively were on each of the target drugs significantly longer than those who did not use any antiparkinsonian agents adjunctively with each of the target drugs. Olanzapine initiators were less likely than risperidone initiators to use adjunctively ($p < 0.02$) or be prescribed on the same day ($p < 0.01$) antiparkinsonian agents. This difference is more pronounced at high dosage ($p < 0.01$ and 0.001, respectively, for each type of adjunctive uses).

Conclusions: Future research should evaluate various patient outcomes and adverse events resulting from the use of each of the atypical antipsychotics.

REFERENCES:

1. Andreason N, et al: Symptoms of schizophrenia: methods, meanings, and mechanisms. Arch Gen Psychiatry 1995;52(5):341–351.
2. Rosenheck R, Douglas L, Michael S: From clinical real-world practice: use of atypical antipsychotic medication nationally in the Department of Veterans Affairs. Med Care 2001; 39:302–308.

TARGET AUDIENCE:

Health services researchers and clinicians interested in the treatment of schizophrenia.

Poster 218 **Saturday, October 12**
10:30 a.m.-12 noon

ZIPRASIDONE'S EFFECTS ON WEIGHT AND LIPIDS IN PATIENTS WITH SCHIZOPHRENIA

Pfizer Inc.

Steven J. Romano, M.D., *Employee, Pfizer Inc., 235 East 42nd Street, New York, NY 10017*; Neal R. Cutler, M.D.; Peter J. Weiden, M.D.; George M. Simpson, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this presentation, participants should be able to discuss the effects of ziprasidone on weight and lipid measurements in patients with schizophrenia or schizoaffective disorder.

SUMMARY:

Objective: To assess ziprasidone's effects on weight and lipids in patients with schizophrenia.

Methods: Data from the following five short-term studies (n=703; 40–160 mg/day): six-week, double-blind comparison of ziprasidone and olanzapine; open-label comparison of ziprasidone, risperidone, olanzapine, quetiapine, thioridazine, and haloperidol (14–24 days mean duration); three six-week, open-label studies of outpatients switched to ziprasidone from olanzapine, risperidone, or conventional agents. Additionally, pooled analysis of >900 patients exposed to ≥28 weeks of ziprasidone (10–160 mg/day).

Results: Weight: Ziprasidone patients gained significantly less weight than olanzapine patients ($P<0.0001$). Weight gain >7% of baseline was 10–23% with olanzapine, risperidone, quetiapine, and thioridazine, versus 6% with ziprasidone. Weight loss was significant in patients switched to ziprasidone from olanzapine ($P<0.0001$) or risperidone ($P<0.05$). Pooled analysis showed mean weight change of −1.13 to +1.70 kg. Lipids: Ziprasidone improved fasting lipid measures in short-term studies, with significant changes for TChol ($P<0.001$) and triglycerides ($P<0.001$). Changes were significant versus olanzapine for TChol, triglycerides, and LDL-C ($P<0.01$). Significant reductions in median TChol and triglycerides occurred in patients switched from olanzapine ($P<0.0001$) or risperidone ($P<0.01$).

Conclusions: Ziprasidone exhibits a weight-neutral profile and favorable effects on serum lipids. These effects have important implications for patients' overall health.

REFERENCES:

1. Allison DB, Mentore JL, Moonseong H, Chandler LP, Cappelleri, JC, Infante MC, Weiden PJ: Antipsychotic-induced weight gain: a comprehensive research synthesis. Am J Psychiatry 1999; 156(11):1686–1696.
2. Meyer JM: Novel antipsychotics and severe hyperlipidemia. J Clin Psychopharmacol 2001; 21:369–374.

TARGET AUDIENCE:

Psychiatrists, psychiatric nurses.

Poster 219 **Saturday, October 12**
10:30 a.m.-12 noon

RISK FACTORS FOR TREATMENT-EMERGENT GLUCOSE ABNORMALITIES IN PATIENTS WITH SCHIZOPHRENIA

Eli Lilly and Company

Margaret O. Sowell, M.D., *Research Physician, Lilly Research Laboratories, Eli Lilly and Company, Lilly Corporate Center, DC-1758, Indianapolis, IN 46285*; Nitai Mukhopdh, Ph.D., *Senior Statistician, Lilly Research Laboratories, Eli Lilly and Company, Lilly Corporate Center, DC-1758, Indianapolis, IN 46285*; Patrizia A. Cavazzoni, M.D.; John Buse, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that risk factors for diabetes in patients with schizophrenia overlap those of the general population.

SUMMARY:

A database of pooled information from multiple randomized, double-blind clinical trials of antipsychotic medications for treatment of schizophrenia was retrospectively analyzed to characterize diabetes risk factors.

Subject demographics and specific diabetes risk factors (age ≥45 years, body mass index (BMI) of ≥27 kg/m^2, use of antihypertensive medications, non-Caucasian background, and evidence of abnormal glucose tolerance) were assessed in 5,013 non-diabetic subjects (olanzapine n=3,068, haloperidol n=1,164, risperidone n=364, clozapine n=211, or placebo n=206).

Random glucose values obtained during the observation period (205 ± 283 days; range three to 1,775 days) were used to identify subjects with treatment emergent diabetes (TED, two random glucose values or final glucose ≥200 mg/dl, clinical diagnosis of diabetes, or initiation of anti-diabetic medications). Individuals without repeated glucose values ≥140 mg/dl were considered to have normal glucose tolerance (NGT). Comparing entry characteristics, TED cohort patients (n=94) were significantly ($p\geq0.001$) older (44 vs. 37 years), more obese (BMI 31.5 vs. 25.8 kg/m^2), and had higher mean non-fasting glucose levels (127 vs. 94 mg/dl) than NGT cohort patients (n=4637). The TED cohort had more non-Caucasian patients (38 vs. 27%), patients with hypertension (23 vs. 9%), and patients with multiple diabetes risk factors (25% vs. 5% with ≥3 risk factors).

REFERENCES:

1. Dixon L, Weiden P, Delahanty J, Goldberg R, Postrado L, Lucksted A, Lehman A: Prevalence and correlates of diabetes in national schizophrenia samples. Schizophrenia Bulletin 2000; 26:903–912.

2. Rolka DB, Narayan KM, Thompson TJ, Goldman D, Lindenmayer J, Alich K, Bacall D, Benjamin EM, Lamb B, Stuart DO, Engelgau MM: Performance of recommended screening tests for undiagnosed diabetes and dysglycemia. Diabetes Care 2001; 24:1899–1903.

Poster 220 **Saturday, October 12 10:30 a.m.-12 noon**

ANTIPSYCHOTICS AND DIABETES: AN EVIDENCE-BASED APPROACH

Eli Lilly and Company

Surana Roychowdhury, Ph.D., *Senior Research Communications Associate, Lilly Research Laboratories, Eli Lilly and Company, Lilly Corporate Center, DC-1758, Indianapolis, IN 46285*; Margaret O. Sowell, M.D., *Research Physician, Lilly Research Laboratories, Eli Lilly and Company, Lilly Corporate Center, DC-1758, Indianapolis, IN 46285*; Patrizia A. Cavazzoni, M.D.; Alan F. Breier, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that there are no differential risks among the atypical antipsychotics for developing diabetes. Olanzapine and risperidone did not affect insulin secretion.

SUMMARY:

Objective: Determining risk of and risk factors for treatment emergent diabetes during antipsychotic therapy and evaluating the effect of olanzapine on insulin secretion.

Methods: Three retrospective cohort analyses were performed to evaluate incidence, relative risk, and risk factors for diabetes among patients receiving antipsychotics. A prospective randomized, placebo-controlled study was performed to evaluate effect of olanzapine and risperidone on insulin secretion.

Results: There were no consistent or substantial differences in the risk for treatment-emergent diabetes among antipsychotics, but significantly higher incidence of diabetes in patients taking antipsychotics compared with a general population. Risk factors for diabetes in schizophrenic patients overlap those of the general population. Insulin secretion assessed by a hyperglycemic clamp was not decreased during treatment of healthy volunteers with olanzapine or risperidone.

Conclusions: Patients treated with antipsychotics had a higher risk of diabetes than a general patient population. The data do not support a consistent or substantial difference in risk of diabetes among antipsychotic drugs. Risk factors for diabetes in schizophrenic patients receiving antipsychotics are similar to the general population. Results from the hyperglycemic clamp do not suggest that olanzapine or risperidone decrease insulin secretion.

REFERENCES:

1. Muench J, Carey M: Diabetes mellitus associated with atypical antipsychotic medications: new case report and review of the literature. J Am Board Fam Pract 2001;14(4):278–282.
2. DeFronzo RA, Tobin JD, Andres R: Glucose clamp technique: a method for quantifying insulin secretion and resistance. Am J Physiol 1979;237(3):E214–E223.

Poster 221 **Saturday, October 12 10:30 a.m.-12 noon**

ZIPRASIDONE VERSUS OLANZAPINE IN SCHIZOPHRENIA: A SIX-MONTH CONTINUATION STUDY

Pfizer Inc.

George M. Simpson, M.D., *Interim Chair, Department of Psychiatry, University of Southern California Medical Center, 2020 Zonal Avenue, IRD Room 204 POC, Los Angeles, CA 90033*; Peter J. Weiden, M.D.; Teresa A. Pigott, M.D.; Steven J. Romano, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participant should be able to discuss the long-term efficacy and tolerability of ziprasidone, as compared with olanzapine, in the treatment of patients with schizophrenia or schizoaffective disorder.

SUMMARY:

Objective: To compare long-term efficacy and tolerability of ziprasidone and olanzapine in schizophrenia or schizoaffective disorder.

Methods: This six-month, blinded continuation study followed hospitalized patients who had completed a six-week randomized trial with satisfactory clinical response (CGI-I ≤2 or ≥20% reduction in symptom severity by PANSS Total) and were discharged on olanzapine 5 mg–15 mg QD (n=71) or ziprasidone 40 mg–80 mg BID (n=62). Primary efficacy measures were BPRS and CGI-S; secondary variables included PANSS Total and Positive and Negative Subscale scores. Tolerability assessments included fasting lipids, insulin, glucose, and weight.

Results: Ziprasidone- and olanzapine-treated patients demonstrated comparable changes in BPRS, CGI-S, and PANSS Total and Subscale scores from baseline of six-week study to endpoint of six-month continuation.

Changes during continuation phase did not differ significantly between groups. Olanzapine-treated patients exhibited significant mean increases versus ziprasidone in endpoint weight ($P<0.001$) and BMI ($P=0.001$), and significant median increases versus baseline in LDL-C ($P<0.01$), insulin ($P<0.05$), glucose ($P=0.05$), and fasting liver enzymes ($P<0.05$). Both agents displayed low incidences of movement disorders. No patients had QTc ≥500 msec.

Conclusions: Ziprasidone and olanzapine demonstrated comparable antipsychotic efficacy in long-term treatment. Olanzapine patients alone exhibited sustained weight gain and deleterious metabolic changes.

REFERENCES:

1. Simpson G, Horne RL, Weiden P, Pigott T, Bari M, Romano SJ: Ziprasidone vs olanzapine in schizophrenia: results of a double-blind trial. Presented at the 2001 Annual Meeting of the American Psychiatric Association Institute of Psychiatric Services, Orlando, Florida, October 10–14, 2001.
2. Simpson G, Potkin S, Weiden P, O'Sullivan RL, Romano S: Benefits of ziprasidone in stable outpatients with schizophrenia switched from conventional antipsychotics, olanzapine or risperidone. Presented at the 2000 Annual Meeting of the American Psychiatric Association, Chicago, Illinois, May 13–18, 2000.

TARGET AUDIENCE:

Psychiatrists, psychiatric nurses.

Poster 222 **Saturday, October 12**
10:30 a.m.-12 noon

EXPLORATION OF THE RELATIONSHIP BETWEEN ATYPICAL ANTIPSYCHOTICS USAGE AND NEW-ONSET DIABETES MELLITUS: A REVIEW OF THE SCIENTIFIC EVIDENCE

Eli Lilly and Company

Patrick Toalson, R.Ph., *Medical Liaison, Neuroscience Medical Affairs, Eli Lilly and Company, 6116 Rosemont Court, Birmingham, AL 35242*; Hillary McGuire, M.Ed.; Kristine Healey, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand the literature from a broader perspective on a critical issue to patients and clinicians concerning long-term health consequences of antipsychotic therapy.

SUMMARY:

Introduction: Significant attention has focused on the increased rate of glucose intolerance, hyperglycemia, and new-onset diabetes mellitus among psychiatric patients. Cases of new-onset diabetes are reported with all of the atypical antipsychotics. However, the question remains whether an association exists between antipsychotic use and diabetes or whether reports reflect the high risk of diabetes in this population, irrespective of medication use.

Methods: Most articles on this topic are case reports or small, cross-sectional laboratory studies highlighting the suspected potential for differing rates of new-onset diabetes cases. We conducted a retrospective meta-analysis of the literature including recent studies presented at major psychiatric meetings to create a broader perspective on the issue and aggregate the relative scientific evidence for or against an association.

Results: We identified over 70 abstracts and manuscripts, including case reports, cross-sectional studies, retrospective analyses of controlled clinical studies, pharmacoepidemiology studies, and prospective head-to-head studies.

Conclusions: Data indicate that the psychiatric patient population is at a higher risk for the development of glucose intolerance and new-onset diabetes mellitus compared with the general population. As a whole, the data support a comparable rate of new-onset diabetes across the various atypical antipsychotic agents. No definitive associations have been established.

REFERENCES:

1. Newcomer JW, Haupt DW, Fucetola R et al: Abnormalities in glucose regulation during antipsychotic treatment of schizophrenia. Arch Gen Psychiatry 2002;59:337–345.
2. Sernyak MJ, Leslie DL, Alarcon RD, Losonczy MF, Rosenheck R: Association of diabetes mellitus with use of atypical neuroleptics in the treatment of schizophrenia. Am J Psychiatry 2002;159: 561–566.

TARGET AUDIENCE:

Prescribing psychiatrists.

Poster 223 **Saturday, October 12**
10:30 a.m.-12 noon

SEXUAL DYSFUNCTION AND ADHERENCE TO ANTIPSYCHOTIC THERAPY IN SCHIZOPHRENIA

Pfizer Inc.

Peter J. Weiden, M.D., *Director of Schizophrenia Research, State University of New York Downstate Medical Center, 450 Clarkson Avenue, Box 1203, Brooklyn, NY*

11203; Joan A. Mackell, Ph.D.; Diana D. McDonnell, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss findings of a survey of individuals with schizophrenia indicating an association between perceived sexual dysfunction from medication and reduced adherence to antipsychotic therapy.

SUMMARY:

Background: We investigated the association between sexual dysfunction and noncompliance with antipsychotic therapy in individuals with schizophrenia.

Methods: In June 2001, 842 people with schizophrenia completed a self-administered questionnaire. Respondents rated frequency of sexual dysfunction as a side effect of medication, including the degree of distress and general satisfaction with sexual health and sexual relationships. Nonadherence (noncompliance) was scored by self-reported frequency of missed or skipped antipsychotic doses in an average week. The association between sexual dysfunction and compliance was evaluated through bivariate analysis and a multivariate linear regression model, including Drug Attitude Inventory scores, demographic factors, and use of other classes of psychotropic medications.

Results: Among self-reported side effects, distress from sexual dysfunction was very common, and was second only to weight gain in how much it bothered respondents. Reported sexual dysfunction was also negatively associated with satisfaction with sexual health and sexual relationships ($P<0.001$). Sexual dysfunction was associated with self-reported nonadherence, both in bivariate analysis ($P=0.024$) and multivariate linear regression ($P=0.035$).

Conclusion: In this survey, sexual dysfunction was associated with reduced adherence to antipsychotic therapy. These data underscore the importance of assessing side effects related to sexual function in patients receiving antipsychotics.

REFERENCES:

1. Hamner MB, Arana GW: Hyperprolactinaemia in antipsychotic-treated patients: guidelines for avoidance and management. CNS Drugs 1998;10:209–222.
2. Weiden PJ, Olfson M: Cost of relapse in schizophrenia. Schizophr Bull 1995;2:419–429.

TARGET AUDIENCE:

Psychiatrists, psychiatric nurses.

Poster 224 **Saturday, October 12**
10:30 a.m.-12 noon

SUCCESSFUL SWITCHING OF PATIENTS TO QUETIAPINE: A MULTICENTER, OPEN-LABEL TRIAL

AstraZeneca Pharmaceuticals

Elmar Windhager, M.D., *Staff Psychiatrist, Psychiatrische Klinik Wels, Linizer Street 89, Wels, Austria A-4600*; A. Martin Jones, M.S.; John L. Whiteford, B.S.; Charles A. Altman, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have obtained information on the process, practicalities, and clinical benefit of switching patients to quetiapine.

SUMMARY:

Objective: Quetiapine is well tolerated and effective in patients with schizophrenia. This study aimed to determine the clinical benefit of switching patients to quetiapine.

Methods: In this multicenter, open-label, noncomparative trial, patients who had schizophrenia (DSM-IV criteria) with poor tolerance or inadequate response to previous antipsychotic medication (eg, persistent aggression/hostility; cognitive impairment, negative, positive or general psychopathology symptoms) were included. The trial design comprised a cross-titration period of seven days followed by an 11-week flexibly dosed quetiapine treatment phase. During Days 1–7 patients were gradually discontinued from their previous antipsychotic medication while receiving increasing doses of quetiapine, titrated up to 300 mg/day over Days 1–4 before dosing at 400 mg/day on Days 5–8. During the treatment phase, flexible dosing was permitted between 300–750 mg/day. Dose adjustments were permitted at any time during the trial.

Results: A total of 509 patients were switched onto quetiapine and received a mean modal dose of 505 mg/day over the 12-week trial. Quetiapine proved to be effective (there were significant improvements in PANSS and CGI scores) and well tolerated (only 6% of patients withdrew due to adverse events).

Conclusions: This trial demonstrated an effective methodology for switching patients to quetiapine.

REFERENCES:

1. Arvanitis LA, Miller BG: Multiple fixed doses of "Seroquel" (quetiapine) in patients with acute exacerbation of schizophrenia: a comparison with haloperidol and placebo. The Seroquel Trial 13 Study Group. Biol Psychiatry 1997; 42:233–246.

2. Small JG, Hirsch SR, Arvanitis LA, Miller BG, Link CG: Quetiapine in patients with schizophrenia. A high- and low-dose double-blind comparison with placebo. Seroquel Study Group. Arch Gen Psychiatry 1997; 54:549–557.

TARGET AUDIENCE:

Psychiatrists.

Poster 225 **Saturday, October 12**
10:30 a.m.-12 noon

INCIDENCE OF HYPERLIPIDEMIA DURING TREATMENT OF SCHIZOPHRENIA: FINDINGS IN A CLAIMS DATABASE

Eli Lilly and Company

Zhongyun Zhao, Ph.D., *Research Consultant, Outcomes Research, Eli Lilly and Company, Lilly Corporate Center, DC-4025, Indianapolis, IN 46285*; Haya Ascher-Svanum, Ph.D., *Research Scientist, Outcomes Research, Eli Lilly and Company, One Lilly Corporate Center, DC 4025, Indianapolis, IN 46285*; Robert W. Baker, M.D.; Patrizia A. Cavazzoni, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to recognize the relative impact of the use of typical and atypical antipsychotics on the incidence of hyperlipidemia in schizophrenia patients.

SUMMARY:

Objective: To compare incidence rates of hyperlipidemia among schizophrenia patients treated with conventional or newer antipsychotics.

Methods: Integrated claims from a large insured population were used. Analysis included 614 individuals who were diagnosed with schizophrenia (ICD9 295.xx); initiated a typical antipsychotic, or olanzapine or risperidone; had no use of any antipsychotics in the prior six-months. New-onset hyperlipidemia was defined as either two hyperlipidemia diagnoses (ICD9 272.xx) or prescription for lipid-lowering agents. One-year incidence rates were compared using logistic regressions controlling for demographics and medical comorbidities. Cox proportional hazard method and Kaplan-Meier survival curves of time-to-incidence were compared between treatment groups.

Results: Adjusted odds ratios of incidence of hyperlipidemia (based on diagnosis and/or treatment) were the following: atypical vs. typical 1.684 (p=0.32); risperidone vs. typical 1.622 (p=0.42); olanzapine vs. typical 1.878 (p=0.26); and olanzapine vs. risperidone 1.084 (p=0.87). Furthermore, adjusted odds ratios of being treated with a lipid-lowering agent were the following: atypical vs. typical 1.553 (p=0.46); risperidone vs. typical 1.711 (p=0.42); olanzapine vs. typical 1.474 (p=0.55); and olanzapine vs. risperidone 0.775 (p=0.66).

Conclusion: Based on a claims database, one-year incidence of hyperlipidemia was generally comparable in schizophrenia patients receiving treatment with typical antipsychotics, olanzapine, or risperidone, though typical-treated patients had numerically lower incidence compared with those atypical-treated patients.

REFERENCES:

1. Gupta S, Steinmeyer C, Lockwood K: Novel antipsychotics: hyperglycemia, hyperlipidemia, and EKG changes in the "real world." Poster 78 presented at the 53rd Institute on Psychiatric Services, Oct 10–14, 2001, Orlando, FL.
2. Lund BC, Perry PJ, Brooks JM, Arndt S: Clozapine use in patients with schizophrenia and the risk of diabetes, hyperlipidemia, and hypertension: a claims-based approach. Arch Gen Psychiatry 2001; 58:1172–1176.

TARGET AUDIENCE:

Psychiatrists, outcomes researchers, and mental health professionals.

Poster 226 **Saturday, October 12**
10:30 a.m.-12 noon

EFFECTS OF ANTIPSYCHOTICS ON APOLIPOPROTEIN D IN RAT BRAIN: A NOVEL MECHANISM FOR THEIR ACTIONS

Janssen Pharmaceutica and Research Foundation

Mohammad M. Khan, Ph.D., *Department of Psychiatry, VA Medical Center, One Freedom Way, Augusta, GA 30904*; Vinay V. Parikh, Ph.D.; Sahebarao Mahadik, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will understand the neuroprotective mechanism of the atypical antipsychotics risperidone and clozapine and their ability to reverse or prevent haloperidol-associated apoliprotein D loss in the brain, benefits that can lead to improved cognitive performance and clinical outcome in schizophrenic patients.

SUMMARY:

Objective: To examine the neuroprotective effects of atypical antipsychotics, apolipoprotein D (ApoD) levels were studied in the brains of rats treated first with halo-

peridol and then with risperidone or clozapine, or vise versa.

Methods: Adult male Wistar rats, weighing between 250 and 300 grams, received oral formulations of haloperidol, 1.0 or 2.0 mg/kg/day, and either risperidone, 1.25 or 2.5 mg/kg/day, or clozapine, 20.0 mg/kg/day, for 45 or 90 days. Animals were treated first with either haloperidol for 45 days and then with risperidone or clozapine for next 45 days, or vice versa. ApoD levels in brain were measured by ELISA and immunohistochemistry.

Results: On Day 45, ApoD was significantly reduced in the haloperidol-treated group only. Treatment for 90 days with haloperidol but not with risperidone or clozapine further reduced apoD levels in the cortex and hippocampus. Analysis of brain tissue in crossover animals indicated that posttreatment with risperidone or clozapine reversed and pretreatment with these drugs prevented ApoD loss associated with haloperidol treatment.

Conclusion: Increased brain ApoD levels associated with atypical antipsychotics may explain the drugs' neuroprotective action and may also explain the reported improved cognitive performance and clinical outcome in schizophrenic patients treated with risperidone or clozapine.

REFERENCES:

1. Mahadik SP, Helio L, Korenovsky A, Karpiak SE: Haloperidol alters rat cholinergic system: enzymatic and morphological analysis. Biol Psychiatry 1988; 24:199–217.
2. Mahadik SP, Evans DR, Terry A, Hill WD: Neuroprotective action of atypical antipsychotics in schizophrenia: impaired cognitive performance and underlying mechanism of action. Schizophr Res 2001; 49:94.

TARGET AUDIENCE:

Psychiatrists.

Poster 227 **Saturday, October 12 10:30 a.m.-12 noon**

LONG-TERM SAFETY AND EFFICACY OF LONG-ACTING INJECTABLE RISPERIDONE

Janssen Pharmaceutica and Research Foundation

Marielle Eerdekens, M.D., M.B.A., *Senior Director, Global Medical Leader Antipsychotics, Johnson & Johnson Pharmaceutical Research and Development, Turnhoutseweg 30, 2340 Beerse, Belgium*; W. Wolfgang Fleishhacker, M.D.; Linda Beauclair, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participant will appreciate the safety and efficacy profile observed in a long-term study of patients with schizophrenia or schizoaffective disorder treated with the new injectable formulation of risperidone.

SUMMARY:

Objective: To investigate the long-term safety and efficacy of the injectable formulation of risperidone in patients with schizophrenia or schizoaffective disorder.

Methods: A one-year, multicenter, open-label trial was performed. Patients completed a run-in on oral risperidone (dose of up to 6 mg/day) prior to being switched to flexible doses of long-acting risperidone (25, 50, or 75 mg) every two weeks for 50 weeks.

Results: A total of 725 patients with schizophrenia (85%) or schizoaffective disorder (15%) were enrolled. The most common spontaneously reported (>10%) treatment-emergent adverse events were anxiety (25%), insomnia (23%), psychosis (18%), depression (16%), headache (13%), hyperkinesias (12%), and rhinitis (11%). Only 5% of all patients discontinued the one-year trial due to adverse events. PANSS total scores were significantly reduced from baseline at all time points over the 12-month treatment period ($p \leq 0.004$).

Conclusion: Long-acting risperidone is well tolerated and produced additional therapeutic benefits, even in patients with stable schizophrenia or schizoaffective disorder.

REFERENCES:

1. Ghaemi SN, Goodwin FK: Use of atypical antipsychotic agents in bipolar and schizoaffective disorders: review of the empirical literature. J Clin Psychopharmacol 1999;19(4):354–361.
2. Conley RR, Mahmoud R: A randomized double-blind study of risperidone and olanzapine in the treatment of schizophrenia or schizoaffective disorder. Am J Psychiatry 2001;158:765–774.

TARGET AUDIENCE:

Psychiatrists.

Poster 228 **Saturday, October 12 10:30 a.m.-12 noon**

LONG-ACTING INJECTABLE RISPERIDONE: EFFICACY AND SAFETY

Janssen Pharmaceutica and Research Foundation

John M. Kane, M.D., *Department of Psychiatry, Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004-1150*; Marielle Eerdekens, M.D., M.B.A.; Linda Beauclair, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participant will be familiar with the clinical efficacy and safety profile observed with a long-acting injectable formulation of risperidone in patients with schizophrenia.

SUMMARY:

Objective: To evaluate the efficacy and safety of a long-acting injectable formulation of risperidone.

Methods: Patients with schizophrenia were withdrawn from their current antipsychotic therapy and treated for one week with oral risperidone at a dose of up to 4 mg/day. Patients were then randomized in a double-blind fashion to 12 weeks of placebo injection or long-acting risperidone injection (25, 50 or 75 mg), once every two weeks. Oral risperidone was continued during the first three weeks of the double-blind phase.

Results: PANSS total scores were significantly, greater in all long-acting risperidone groups than in placebo patients ($p \leq 0.002$ for all doses). PANSS positive and negative symptom scores were significantly improved in all risperidone groups ($p < 0.05$). Clinical improvement ($\geq$ 20% reduction in PANSS total scores at endpoint) was seen in twice as many patients in the three risperidone groups as in the placebo group ($p \leq 0.001$ for all doses). The incidence of extrapyramidal symptoms was similar in the placebo and 25-mg risperidone groups. Cardiovascular profile was similar in the placebo and risperidone groups.

Conclusion: These findings demonstrate that long-acting risperidone provides continued relief or symptom improvement and is well-tolerated over a three-month period.

REFERENCES:

1. Lewis DA: Atypical antipsychotic medications and the treatment of schizophrenia. Am J Psychiatry 202;159:177–179.
2. Kelleher JP, Centorrino F, Albert MJ, Baldessarini RJ: Advances in atypical antipsychotics for the treatment of schizophrenia: New formulations and new agents. CNS Drugs 2002;16:249–261.

TARGET AUDIENCE:

Psychiatrists.

Poster 229 **Saturday, October 12**
10:30 a.m.-12 noon

A COMPARATIVE STUDY OF THE DEVELOPMENT OF DIABETES IN PATIENTS TAKING RISPERIDONE AND OLANZAPINE

Janssen Pharmaceutica and Research Foundation

Kenneth Shermock, Pharm.D., *Pharmacy Research Manager and Associate Researcher, Health Outcomes Research, The Cleveland Clinic Foundation, 9500 Euclid Avenue, QQB-32, Cleveland, OH 44195*; Matthew A. Fuller, Pharm.D.; Michelle Secic, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to state the relative risk of developing diabetes with the atypical antipsychotics olanzapine, risperidone, haloperidol, or fluphenazine.

SUMMARY:

Objectives: Atypical antipsychotics, especially olanzapine and clozapine, may induce glucoregulatory dysfunction. We examined diabetes risk during treatment with olanzapine, risperidone, haloperidol, or fluphenazine.

Methods: Patients in the VISN-10 Veterans' Administration database who received olanzapine, risperidone, haloperidol, or fluphenazine between January 1997 and December 2000 were analyzed retrospectively. Diabetes was defined as any ICD-9 diagnosis of diabetes (250 xx) or prescription for antidiabetic medication. Excluded were patients with markers for diabetes within one year prior, females, racial groups not Caucasian or African American, and those who received clozapine. We performed a Cox regression analysis using antipsychotic therapy as a time-dependent covariate. Other covariates included days supply of antipsychotic medication, age, race, psychiatric diagnoses, and use of other antipsychotic agents.

Results: The overall rate of the development of diabetes was 6.3% (368/5837). Olanzapine therapy was associated with a statistically significantly higher risk of development of diabetes than was risperidone (RR=1.36; 95% CI=1.06–1.76; P=0.017), while controlling for covariates. No differences in the rate of developing diabetes were detected between fluphenazine or haloperidol (RR=1.11; P=0.69) and risperidone (RR=0.89; P=0.41).

Importance: Olanzapine was associated with a significantly higher risk of development of diabetes than was risperidone in a VA population.

REFERENCES:

1. Popli AP, Konicki PE, Jurjus GJ, et al: Clozapine and associated diabetes mellitus. J Clin Psychiatry 1997;58:108–11.
2. Newcomer JW, Haupt DW, Fucetola R, et al: Abnormalities in glucose regulation during antipsychotic treatment of schizophrenia. Arch Gen Psychiatry 2002;59:337–45.

TARGET AUDIENCE:

Psychiatrists.

Poster 230 **Saturday, October 12 10:30 a.m.-12 noon**

ATYPICAL ANTIPSYCHOTICS AND COGNITIVE BRAIN ACTIVATION IN SCHIZOPHRENIA

Janssen Pharmaceutica and Research Foundation

Javier Quintana, M.D., Ph.D., *Neuropsychiatric Institute and Hospital, University of California at Los Angeles, 760 Westwood Plaza, Room C8-846, Los Angeles, CA 90024-1759*; Tiffany Wong, B.S.; Elena Ortiz-Portillo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the changes in brain activity during cognitive performance noted in patients with schizophrenia treated with rispenidone or olanzapine.

SUMMARY:

Objective: To compare the effects of risperidone and olanzapine on brain activity during cognitive performance in patients with schizophrenia.

Methods: We used functional magnetic resonance imaging to study brain activity in patients performing various working memory and facial affect discrimination (cognitive) tasks.

Results: We analyzed data from 13 patients with chronic schizophrenia who had not been hospitalized or had a change in treatment for one year before study enrollment. Five patients were being treated with risperidone (3 to 6 mg/day) and eight were receiving olanzapine (10 to 20 mg/day). We found treatment group differences in brain activity during cognitive tasks. Patients treated with risperidone activated more critical areas during facial affect processing and anticipatory working memory, both of which are important in social functioning and decision making. Patients treated with risperidone or olanzapine activated to a similar extent a distributed network involved in mnemonic working memory, an important but more logical cognitive process less directly linked to social functioning.

Conclusions: Risperidone and olanzapine have specific effects on brain function during cognitive performance in patients with schizophrenia.

Importance: Differential drug treatment may be possible based on neuropsychologic, cognitive, and neurofunctional patient profiles.

REFERENCES:

1. Green MF: What are the functional consequences of neurocognitive deficits in schizophrenia? Am J Psychiatry 1996;153:321–330.
2. Sharma T: Cognitive effects of conventional and atypical antipsychotics inschizophrenia. Br J Psychiatry 1999;38:44–51

TARGET AUDIENCE:

Psychiatrists, neurologists.

Poster 231 **Saturday, October 12 10:30 a.m.-12 noon**

ANTICHOLINERGIC EFFECT OF ATYPICAL ANTIPSYCHOTICS IN ELDERLY PATIENTS

Janssen Pharmaceutica and Research Foundation

Larry E. Tune, M.D., *Department of Psychiatry and Behavioral Science, Emory University School of Medicine, 265 Ledgemont Court, Atlanta, GA 30342*; Benoit H. Mulsant, M.D.; Georges Gharabawi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will appreciate the clinical benefits of risperidone treatment in elderly patients with schizophrenia or schizoaffective disorders.

SUMMARY:

Objective: A previous eight-week study of elderly patients with schizophrenia or schizoaffective disorders treated with risperidone (1 to 3 mg/day) or olanzapine (5 to 20 mg/day) as well as published studies have found significant advantages in functional and behavioral symptoms with risperidone. This study was performed to confirm the clinical advantages of risperidone compared with olanzapine and establish a correlation between drug-induced changes in serum anticholingeric levels and function in elderly patients with schizophrenia or schizoaffective disorder.

Methods: A randomized, double-blind, multicenter study was performed in elderly patients with dementia-related psychosis treated with risperidone or olanzapine for six weeks.

Results: To date, 86 patients were randomized to study medication, of which 69 patients have completed the study. Mean scores on nighttime sleep visual analog scales improved significantly ($P < .0001$). Improvement in nighttime sleep occurred as early as Week 1. Six patients withdrew because of adverse effects.

Conclusions: Patients with dementia treated with atypical antipsychotics for six weeks had significant improvements in nighttime sleep. Results of other cognitive and behavioral assessment and their relationship to anticholinergic activity and differences between treatment groups regarding anticholinergic adverse effects will be reported when available.

REFERENCES:

1. Ghaemi SN, Goodwin FK: Use of atypical antipsychotic agents in bipolar and schizoaffective disorders: review of the empirical literature. J Clin Psychopharmacol 1999;19(4):354–361.
2. Conley RR, Mahmoud R: A randomized, double-blind study of risperidone and olanzapine in the treatment of schizophrenia or schizoaffective disorder. Am J Psychiatry 2001;158:765–774.

TARGET AUDIENCE:

Psychiatrists, geriatricians.

Poster 232 **Saturday, October 12**
10:30 a.m.-12 noon

EFFECT OF CONVENTIONAL AND ATYPICAL ANTIPSYCHOTICS ON NEUROGENESIS IN RATS

Janssen Pharmaceutica and Research Foundation

Sahebarao Mahadik, Ph.D., *Professor of Psychiatry, Medical Research, VA Medical Center, One Freedom Way, Augusta, GA 30904*; Alex Fung Chow Chiu, M.D.; Chandramohan Wakade, M.B.B.S.

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participant will be familiar with animal data suggesting that treatment with an atypical antipsychotic increases brain cell neurogenesis and may result in improved cognition and functional outcome when these agents are used clinically.

SUMMARY:

Objective: To investigate the possible mechanisms of the neuroprotective actions of atypical antipsychotics.

Method: Adult rats received risperidone 2.5 mg/kg, or haloperidol 2 mg/kg ad lib in drinking water. Control animals received vehicle only. After 20 days of treatment, rats were injected IP 50 mg/kg bromo-deoxyuridine (BrdU) to label newly divided cells. After sacrifice, brains were embedded for frozen sectioning and immunostained for BrdU+ cells.

Results: BrdU+ cells were found in subependymal zone and dentate gyrus in hippocampus. Compared with haloperidol and control, atypical antipsychotic stimulated a 300% to 400% increase of BrdU+ cells in the subependymal zone. Significant thickening of the subependymal layer was observed with atypical antipsychotic. In hippocampus, compared with haloperidol, risperidone induced a significant increase of BrdU+ cells. With atypical antipsychotic, BrdU+ cells were found in cortex, septum, and corpus callosum, suggesting migration of newly divided cells.

Conclusions: Chronic treatment with atypical antipsychotics may increase neurogenesis in adult rat brain. The neuroprotective effects of atypical antipsychotics might offset the recently observed progressive decline in hippocampal volumes after onset of schizophrenia and lead to improved cognition and functional outcome. The induction of neurogenesis in hippocampus by risperidone may parallel the cognitive improvements.

REFERENCES:

1. Yao JK, Reddy RD, van Kammen DP: Oxidative damage and schizophrenia: an overview of the evidence and its therapeutic implication. CNS Drugs 2001;15:287–310.
2. Mahadik SP, Mukherjee S: Free radical pathology and antioxidant defense in schizophrenia: a review. Schizophr Res 1996; 19:1–17.

TARGET AUDIENCE:

Psychiatrists, researchers, neurologists.

Poster 233 **Saturday, October 12**
10:30 a.m.-12 noon

ZIPRASIDONE VERSUS OLANZAPINE FOR COGNITIVE FUNCTION IN SCHIZOPHRENIA

Pfizer Inc.

Philip D. Harvey, M.D., Ph.D., Steven J. Romano, M.D., *Employee, Pfizer Inc., 235 East 42nd Street, New York, NY 10017;* George M. Simpson, M.D.; Antony D. Loebel, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participant should be able to discuss the effects of ziprasidone on cognitive domains previously shown to affect functional outcome in patients with schizophrenia or schizoaffective disorder.

SUMMARY:

Objective: To compare cognitive changes associated with ziprasidone and olanzapine in patients with schizophrenia or schizoaffective disorder.

Methods: This was a six-week, randomized study of ziprasidone (n=136) versus olanzapine (n=133). Cognitive battery, given at baseline and endpoint, included measures of vigilance, executive functioning, verbal learning/memory, verbal fluency, and visuomotor speed.

Results: At least 49 patients contributed endpoint data for ziprasidone; at least 60, for olanzapine. Statistically significant improvements from baseline performance were observed with both agents in attention/vigilance, as measured by the Computerized Continuous Performance

Test; visuomotor speed, as measured by the Trailmaking Test, Part A; and learning/memory, as measured by the Rey Verbal Learning Test and the Spatial Working Memory Test. Executive function improved in both groups by the Trailmaking Test, Part B. Olanzapine patients showed a statistically significant benefit in category fluency ($P<0.05$), but this finding would not have withstood correction for the overall number of tests performed.

Conclusions: Ziprasidone exerted a beneficial effect on several domains of cognition that affect functional outcome in schizophrenia. Improvements in cognitive domains were comparable with those seen with olanzapine.

REFERENCES:

1. Green MF: What are the functional consequences of neurocognitive deficits in schizophrenia? Am J Psychiatry 1996; 154:443–444.
2. Harvey PD, Meltzer H, Romano SJ, Schooler NR, Siu C: Improvement in cognition and an exploratory analysis of the effect on anxiety following a switch to open-label ziprasidone in outpatients with schizophrenia treated with conventional antipsychotics, olanzapine, or risperidone. Presented at the 2000 Annual Meeting of the American Psychiatric Association, May 13–18, 2000; Chicago, Ill.

TARGET AUDIENCE:

Psychiatrists, psychiatric nurses.

Poster 234 **Saturday, October 12 10:30 a.m.-12 noon**

COGNITION IN ELDERLY PATIENTS WITH SCHIZOPHRENIA: RISPERIDONE VERSUS OLANZAPINE

Janssen Pharmaceutica and Research Foundation

Philip D. Harvey, M.D., Ph.D., *Associate Professor of Psychiatry, Mount Sinai School of Medicine, 1425 Madison Avenue, New York, NY 10029*; Lian Mao, M.D.; Judy Napolitano, R.N., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will appreciate the clinical benefits of risperidone versus olanzapine treatment on cognitive function in elderly patients with schizophrenia.

SUMMARY:

Objective: To evaluate the clinical efficacy of risperidone on cognition in elderly patients with schizophrenia.

Methods: In an eight-week, double-blind study, elderly patients with schizophrenia were randomly assigned to receive flexible dosages of risperidone (1–3 mg/day) or olanzapine (5–20 mg/day). Cognitive tests were administered at baseline, Week 4, and Week 8. Data from patients who completed one or more post-baseline cognitive tests were included in the analysis.

Results: Significant improvements at end point in the Serial Verbal Learning Test trials 1 to 3 occurred in both groups, but only the risperidone group showed significant improvements in the Verbal Fluency Examinations and Trail Making Test B ($P < .05$). Although no significant changes occurred in the Continuous Performance Test or Wisconsin Card Sorting Test, no decrease in cognitive function occurred at any time point in either group. The adverse effect profile was similar in both groups.

Conclusions: After only eight weeks, and at appropriate doses, both risperidone and olanzapine were associated with improved cognitive function in elderly patients with schizophrenia. Risperidone appeared to provide wider ranging significant improvements in cognitive function compared with olanzapine.

REFERENCES:

1. Ghaemi SN, Goodwin FK: Use of atypical antipsychotic agents in bipolar and schizoaffective disorders: review of the empirical literature. J Clin Psychopharmacol 1999;19(4):354–361.
2. Conley RR, Mahmoud R: A randomized double-blind study of risperidone and olanzapine in the treatment of schizophrenia or schizoaffective disorder. Am J Psychiatry 2001;158:765–774.

TARGET AUDIENCE:

Psychiatrists, geriatricians.

Poster 235 **Saturday, October 12 10:30 a.m.-12 noon**

ORAL RISPERIDONE PLUS LORAZEPAM VERSUS INTRAMUSCULAR HALOPERIDOL PLUS LORAZEPAM IN THE EMERGENCY TREATMENT OF ACUTE PSYCHOSIS

Janssen Pharmaceutica and Research Foundation

Georges Gharabawi, M.D., *Senior Director, Medical Affairs Department, Central Nervous System, Janssen Pharmaceutica, 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Jacqueline D. Morein

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participant will appreciate the clinical role of oral risperidone plus lorazepam treatment in patients with acute psychotic agitation.

SUMMARY:

Objective: To investigated the efficacy and safety of oral risperidone in the management of patients with psychotic agitation.

Method: Patients with active psychosis were randomized to oral risperidone (2 mg) plus lorazepam (2 mg) or intramuscular (IM) haloperidol (5 mg) plus lorazepam (2mg IM). Efficacy was determined by changes in scores on a 5-item psychotic-agitation cluster from the Positive and Negative Syndrome Scale (hallucinatory behavior, excitement, hostility, uncooperativeness, and poor impulse control). Safety assessments included the Simpson-Angus scale and adverse event reports.

Results: Oral risperidone/lorazepam was administered to 83 and 79 patients to IM haloperidol/lorazepam. Mean changes in scores on the five-item psychotic-agitation cluster from baseline to 0.5 hr (−4.9 and −5.8 for oral and IM treatment, respectively), 1.0 hr (−6.9 and −7.2), and 2.0 hours (−7.8 and −8.2) after dosing were comparable in the two treatment groups. A range of symptoms including hostility and excitement improved with both treatments. Significantly more patients who received oral risperidone/lorazepam than IM haloperidol/lorazepam treatment remained awake and could be evaluated up to 3 hours postdose (P=0.0006). Both treatments were well tolerated.

Conclusion: Oral risperidone plus lorazepam is a safe and efficacious alternative to IM treatment in patients with psychotic agitation.

REFERENCES:

1. Feifel D: Rationale and guidelines for the inpatient treatment of acute psychosis. J Clin Psychiatry 2000;61 (Suppl 14): 27–32.
2. Hillard JR: Emergency treatment of acute psychosis. J Clin Psychiatry 1998;59 (Suppl 1):57–60.

TARGET AUDIENCE:

Emergency room psychiatrists.

Poster 236 **Saturday, October 12**
10:30 a.m.-12 noon

APPLICATION OF ADVANCED DRUG-DELIVERY TECHNOLOGY TO PSYCHIATRY: RISPERIDONE MICROSPHERES

Johnson & Johnson Pharmaceutica Research and Development

Peter D'Hoore, M.D., *Research and Development, Johnson & Johnson Pharmaceutica, Belgium, Turnhoutseweg 30, Beerse, Belgium 6-2340*; Robert A. Lasser, M.D.; Erik Mannaert, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be familiarized with the pharmacokinetic parameters of risperidone when delivery via a unique advanced delivery technology that, following injection, produces a controlled and predictable release of drug over several weeks.

SUMMARY:

Introduction: Long-acting psychotropic drug delivery options are limited to oil-based intramuscular injections of typical antipsychotics. We report on the innovative use of risperidone encapsulated into polymeric microspheres (MS) using poly (d,l-lactide-co-glycolide) (PLG), a common, biodegradable medical copolymer.

Methods: MS are manufactured using a water-based solvent extraction process, yielding a homogeneous risperidone distribution in microparticles (25–150 μm). The sterile dry MS risperidone powder is suspended in aqueous diluent for administration.

Results: Copolymer hydrolysis produces a controlled, predictable release of risperidone. Based on *in-vitro* analysis, a slight amount of drug (≤ 3.5%) at the MS surface is released within 24-hours, followed by a latent period of approximately 3-weeks. Initial release is controlled by diffusion; majority of release occurs by PLG erosion during a 3-week period. The copolymer is broken down into naturally occurring smaller units, lactic and glycolic acid, which are eliminated as carbon dioxide and water. The *in-vivo* release profile of MS confirms the *in-vitro* profile including a very small initial release, initial latent period, and main release between weeks 4–6.

Conclusion: Risperidone MS is the first application of advanced delivery technology, creating a long-acting injectable atypical antipsychotic. The formulation shows both *in-vitro* and *in-vivo* sustained and predictable release of risperidone.

REFERENCES:

1. Marder SR, Hubbard JW, Van Putten T, Midha KK: Pharmacokinetics of long-acting injectable neuroleptic drugs: clinical implications. Psychopharmacology 1989;98(4):433–439.
2. Heykants J, Huang ML, Mannens G, Meuldermans W, Snoeck E, Van Beijsterveldt L, Van Peer A, Woestenborghs R: The pharmacokinetics of risperidone in humans: a summary J Clin Psychiatry 1994;55(Suppl):13–17.

TARGET AUDIENCE:

Psychiatrists.

Poster 237 **Saturday, October 12 10:30 a.m.-12 noon**

ONE-YEAR HOSPITALIZATION RATES IN PATIENTS WITH SCHIZOPHRENIA DURING LONG-TERM TREATMENT WITH LONG-ACTING INTRAMUSCULAR RISPERIDONE

Janssen Pharmaceutica and Research Foundation

Pierre S. Chue, M.D., *Department of Psychiatry, University of Alberta Hospital, 8440 112th Street, Edmonton, AB, Canada T6G 2B7*; Inge Duchesne; Angelika Mehnert, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to state the significantly lowered hospitalization rate over one year with long-acting biweekly risperidone treatment.

SUMMARY:

Objective: To examine one-year hospitalization rates in schizophrenic patients treated long-term with risperidone every two weeks.

Methods: Hospitalizations in the previous three months were recorded at baseline and every three months thereafter during a one-year multicenter, open-label study in schizophrenic patients.

Results: Hospitalizations decreased significantly during treatment, from 38% during the three months before study entry to 28% during months 1–3, 18% during months 4–6, 14% during months 7–9, and 12% during months 10- ($P<.0001$, using generalized estimation equation). One-year hospitalization rate, defined as first hospitalization for outpatients (301 at baseline) and new hospitalization after discharge for inpatients (96 at baseline), was used as a proxy measure for relapse. A total of 27 inpatients were not discharged and therefore not analyzed. The overall one-year rehospitalization/hospitalization rate was 17.6% (65/369): 15.9% (48/301) for outpatients, 25.0% (17/68) for inpatients. Most (82%) of the hospitalized patients experienced one hospitalization episode, while 15% experienced two, and 3% had three or more episodes.

Conclusion: The need for hospitalization decreased continuously and significantly over a 1-year period of treatment with long-acting risperidone, with a final rehospitalization rate of 17.6%.

Importance: Hospitalization contributes heavily to direct and indirect disease costs. Biweekly risperidone injections significantly reduce one-year hospitalization.

REFERENCES:

1. Gaebel W, Pietzker A: One year outcome of schizophrenic patients-the interaction of chronicity and neuroleptic treatment. Pharmacopsychiatry 1985;18: 235–239.
2. Lindstrom E, Bingefors K: Patient compliance with drug therapy in schizophrenia: economic and clinical issues. Pharmacoeconomics 2000;18:106–124.

TARGET AUDIENCE:

Psychiatrists.

Poster 238 **Saturday, October 12 10:30 a.m.-12 noon**

EFFECT OF OLANZAPINE AND RISPERIDONE ON GLUCOSE, LIPIDS, AND BODY MASS

Janssen Pharmaceutica and Research Foundation

Robert E. Litman, M.D., *Medical Director, Centers for Behavioral Health, Department of Psychiatry, Georgetown University School of Medicine, 14915 Broschart Road, Suite 250, Rockville, MD 20850*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the documented effects of atypical antipsychotics on glucoregulatory function, lipids, and body mass indices; evidence in the literature and proposed mechanisms for atypical-antipsychotic-induced hyperglycemia; effect of switching from olanzapine to risperidone on glucoregulatory function, lipids, and body mass indices.

SUMMARY:

Objective: To determine the effect of switching from olanzapine to risperidone on glucose and lipid metabolism and body mass index.

Method: We measured fasting glucose, two-hour postprandial glucose (after a 75-gram oral glucose tolerance test), fasting insulin, total cholesterol, triglycerides, hip girth, waist girth, and body mass index in seven schizophrenic patients taking olanzapine (mean [SD], 22.9 [5.7] mg/day for 69.7 [82.5] weeks) who switched to risperidone (5.8 [1.4] mg/day) for 6 weeks.

Results: Fasting glucose (olanzapine: 87.7 [8.5] mg/dL; risperidone 82.3 [6.8] mg/dL), two-hour post-prandial glucose (olanzapine: 105.5 [37.8] mg/dL; risperidone: 80.0 [19.1] mg/dL), and waist circumference (olanzapine: 104.7 [23.6] cm; risperidone: 101.1 [21.5] cm), all decreased significantly or approached significance ($P < .04$, .09, and .07, respectively). Substantial and clinically significant decreases were also observed for total cholesterol (olanzapine: 227.5 [54.1] mg/dL; risperidone: 200.8 [21.9] mg/dL) and triglycerides (olanzapine: 169.3 [145.6] mg/dL; risperidone: 102.0 [60.4] mg/dL). Fasting insulin, insulin resistance, and re-

maining body mass indices, including weight, were unchanged.

Conclusions: Switching to risperidone from olanzapine may improve glucose metabolism and may be related to redistribution of intra-abdominal fat independent from weight change.

Importance: Glucose metabolism may be improved in some schizophrenic patients who switch to risperidone from olanzapine.

REFERENCES:

1. Wirshing DA, Spellberg BJ, Erhart SM: Novel antipsychotics, and new-onset diabetes. Biol Psychiatry 1998;44:778–783.
2. Lindenmayer JP, Nathan AM, Smith RC: Hyperglycemia associated with the use of atypical antipsychotics. J Clin Psychiatry 2001;62(suppl 23):30–38.

TARGET AUDIENCE:

Psychiatrists.

Poster 239 **Saturday, October 12**
10:30 a.m.-12 noon

DIFFERENTIAL EFFECTS OF ANTIPSYCHOTICS ON ANTIOXIDANT ENZYMES AND MEMBRANE LIPID PEROXIDATION IN RAT BRAIN

Janssen Pharmaceutica and Research Foundation

Vinay V. Parikh, Ph.D., *Medical Research Services, Veterans Affairs, One Freedom Way, 5B-103, Augusta, GA 30904*; Mohammad M. Khan, Ph.D.; Peter F. Buckley, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize that long-term exposure to haloperidol can impair antioxidant enzyme activity in the brain and that atypical antipsychotic drugs such as risperidone and clozapine not only do not produce such an effect but can in fact raise antioxidant enzyme levels in patients who have undergone extended haloperidol therapy.

SUMMARY:

Objective: The present study is designed to study the effect of chronic exposure of typical antipsychotic haloperidol and atypical antipsychotics risperidone and clozapine on antioxidant defense enzymes and lipid peroxidation in rat brain.

Methods: Adult male wistar rats were treated orally with haloperidol, risperidone and clozapine for 45 and 90 days respectively. In the crossover study, animals were treated for 45 days either with risperidone or clozapine after or before 45 days of haloperidol treatment. Levels of hydroxyalkenals (HAEs), manganese-superoxide dismutase (MnSOD), copper-zinc superoxide dismutase (CuZnSOD), catalse (CAT) and glutathione peroxidase (GPx) were determined in brain.

Results: Chronic haloperidol treatment for both 45 and 90 days significantly decreased antioxidant enzymes with parallel marked increase in HAEs in rat brain. However, risperidone and clozapine treatments did not produce any alterations. Crossover treatment with atypical antipsychotics showed improvement in the levels of antioxidant enzymes in haloperidol treated rats.

Conclusions: These findings indicate that chronic administration of haloperidol induces oxidative stress by changes in expression of antioxidant enzymes resulting in membrane lipid peroxidation. In contrast, risperidone and clozapine neither alter the level of antioxidant enzymes nor induce lipid peroxidation, which may reflect few or no side effects with their treatment.

REFERENCES:

1. Mahadik S, Wakade C, Chiu F-C: Effects of conventional and atypical antipsychotics on neurogenesis in rats. American Psychiatric Association, 2002 Annual Meeting, Philadelphia, Pa, May 81-23, 2002. New Research Abstracts, NR435.
2. Shivakumar BR, Ravindranath V: Oxidative stress and thiol modification induced by chronic administration of haloperidol J Pharmacol Exp Ther 1993;265:1137–1141.

TARGET AUDIENCE:

Psychiatrists.

Poster 240 **Saturday, October 12**
10:30 a.m.-12 noon

IMPROVEMENT OF INSULIN INDICES AFTER SWITCHING FROM OLANZAPINE TO RISPERIDONE

Janssen Pharmaceutica and Research Foundation

Sally A. Berry, M.D., Ph.D., *Associated Director, Central Nervous System Medical Affairs, Janssen Pharmaceutica, 1125 Trenton-Harabourton Road, Titusville, NJ 08560-0200*; Ramy Mahmoud

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe documented effects of switching from olanzapine to risperidone on the Homeostasis Model Assessments insulin resistance index and insulin release index.

SUMMARY:

Objective: To measure diabetes-related laboratory values in schizophrenic patients who switched their olanzapine therapy to risperidone.

Method: Patients with unsatisfactory response to at least 30 days of stable-dose olanzapine (total Positive and Negative Syndrome Scale score > 60) or with glucose tolerance test results indicative of increased cardiovascular risk were randomly assigned to one of three strategies for switching their olanzapine regimen to risperidone.

Results: Insulin resistance and beta cell function were evaluated using Homeostasis Model Assessments (HOMA): insulin resistance index (HOMA IR) is the product of fasting plasma insulin and glucose divided by 22.5; insulin release index (HOMA Beta Cell) is the product of fasting plasma insulin and 3.33 divided by the difference of fasting plasma glucose and 3.5. Mean insulin index for the first 40 patients was 9.24 at baseline (after at least 30 days olanzapine) and 4.63 at endpoint (after 6 weeks of risperidone). Mean insulin release index (measure of beta cell function) improved after patients switched to risperidone (305 at baseline versus 231 at endpoint.)

Conclusions: Insulin resistance and beta cell function improved significantly in schizophrenic patients six weeks after they switched their olanzapine regimen to risperidone.

Importance: Diabetes is a major health problem.

REFERENCES:

1. Wirshing DA, Spellberg BJ, Erhart SM: Novel antipsychotics, and new-onset diabetes. Biol Psychiatry 1998;44:778–783.
2. Lindenmayer JP, Nathan AM, Smith RC: Hyperglycemia associated with the use of atypical antipsychotics. J Clin Psychiatry 2001;62(suppl 23):30–38.

TARGET AUDIENCE:

Psychiatrists.

Poster 241 **Saturday, October 12 10:30 a.m.-12 noon**

CLOZAPINE AUGMENTATION WITH RISPERIDONE IN REFRACTORY SCHIZOPHRENIA

Janssen Pharmaceutica and Research Foundation

Richard C. Josiassen, Ph.D., *Chief Scientist, Arthur P. Noyes Research Foundation, 1001 Sterigere Street, Norristown, PA 19401*; Ashok Joseph, M.D.; Eva Kohegyi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to explain the benefit of risperidone as a safe and effective adjunct to standard clozapine regimens for patients with schizophrenia or schizoaffective disorder who do not respond adequately to clozapine therapy.

SUMMARY:

Objective: To assess the efficacy and safety of risperidone augmentation in patients with schizophrenia or schizoaffective disorder receiving clozapine.

Methods: In a single-blind study, patients treated with clozapine (≥3 months) at a dose of 600 mg/day or serum clozapine level of 350 ng/mL who failed to show an adequate response (Brief Psychiatric Rating Scale [BPRS] total score ≥45) were randomized to risperidone (n=20) or placebo (n=20) for 12 weeks. Efficacy (BPRS, Clinical Global Inventory [CGI], and Scale for the Assessment of Negative Symptoms [SANS]) and safety (Neurological Rating and Barnes Akathisia Scales) assessments were performed biweekly.

Results: All patients exhibited clinical improvement by BPRS and CGI. Risperidone treatment produced a significantly ($p<0.05$) greater improvement in BPRS percent change from baseline to weeks 6 and 12. No clinical change occurred in the sum of global SANS scores from baseline to week 6 or 12. No between treatment difference extrapyramidal symptoms occurred. Two patients required risperidone dosage adjustment to resolve a clinically significant increase in akathisia.

Conclusion: These results suggest that augmentation of clozapine treatment with risperidone provides additional clinical benefit in patients who are non- or partial responders without compromising the safety or tolerability of the regimen.

REFERENCES:

1. Henderson DC, Goff DC: Risperidone as an adjunct to clozapine therapy in chronic schizophrenia. J Clin Psychiatry 1996;57:395–97.
2. McCarthy RH, Terkelsen KG: Risperidone augmentation of clozapine. Pharmacology 1995;28:61–63.

TARGET AUDIENCE:

Psychiatrists.

Poster 242 **Saturday, October 12 4:00 p.m.-5:30 p.m.**

MEASURING GLUCOSE METABOLISM DURING ANTIPSYCHOTIC TREATMENT

Janssen Pharmaceutica and Research Foundation

Daniel W. Haupt, M.D., *Instructor, Department of Psychiatry, Washington University School of Medicine, 660*

South Euclid, Box 8134, St. Louis, MO 63110; John W. Newcomer, M.D., *Associate Professor, Department of Psychiatry, Washington University School of Medicine, 660 South Euclid, Box 8134, St. Louis, MO 63110*; Jolle A. Schweiger; Angela K. Melson, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the effects of adiposity on sensitive measures of glucose metabolism in schizophrenia patients receiving antipsychotic therapy.

SUMMARY:

Hyperglycemia and type 2 diabetes mellitus may be more common in schizophrenia patients than in the general population. Recent evidence indicates an association between antipsychotic medications and disturbances in glucose metabolism, with some early evidence suggesting a possible association between schizophrenia itself and diabetes. Diabetes can cause increased morbidity and mortality due to acute (e.g., diabetic ketoacidosis) and long-term (e.g., cardiovascular disease) complications. Controlled studies indicate medication-related disturbances in insulin action, although changes in insulin secretion have not been ruled out. Frequently sampled insulin-modified intravenous glucose tolerance tests (FSIVGTT) and analyses that include Bergman's Minimal Model (MINMOD) can be used to assess insulin action and beta cell function in humans. Nondiabetic schizophrenia and schizoaffective patients and healthy controls receive insulin-modified FSIVGTTs along with measures of adiposity and clinical status. BMI (body mass index, kg/m2) strongly predicts insulin sensitivity, with a significant interaction between BMI and either subject (patients vs control) or treatment condition (olanzapine, clozapine, risperidone, typical vs controls). Similar differences were seen across all patient groups indicating either similar medication effects or effects of disease state. No other significant effects were observed on MINMOD measures. The current results support concerns about treatment-induced increases in adiposity.

REFERENCES:

1. Haupt D, Newcomer JW: Hyperglycemia and Antipsychotic Medications. J Clin Psychiatry 2001; 62(27) Suppl: 15–26.
2. Newcomer JW, Fucetola R, Melson AK, Haupt DW, Schweiger JA, Cooper BP, Selke G: Abnormalities in glucose regulation during antipsychotic treatment in schizophrenia. Arch Gen Psychiatry 2002; 59:337–345.

TARGET AUDIENCE:

Psychiatrists, pharmacists, administrators, nurses.

Psychiatric Services Achievement Awards Session 1 **Thursday, October 10 8:30 a.m.-11:30 a.m.**

THEISS CHILD DEVELOPMENT CENTER: EARLY CHILDHOOD MENTAL HEALTH SERVICES IN AN INCLUSIVE PROGRAM

Psychiatric Services Certificate of Significant Achievement

Vaughan Stagg, Ph.D., *Assistant Professor of Psychiatry, Western Psychiatric Institute and Clinic, 373 Burrows Street, Pittsburgh, PA 15213*; Barbara A. Johnson, M.D., *Assistant Professor of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213-2593*; Margot G. Feintuch, M.D., *Assistant Professor of Psychiatry, University of Pittsburgh, 6656 Northumberland Street, Pittsburgh, PA 15217-1313*; Virginia Cowell, M.Ed., *Developmental Specialist, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate knowledge about (1) the value of integrating typical and clinically troubled young children in a community-based setting, (2) professional and practical challenges posed in developing an integrated program, (3) diagnostic challenges posed by young populations.

SUMMARY:

The Theiss Child Development Center is located in a public housing community in the inner city of Pittsburgh, Pa. The center has braided-funding streams (day care, mental health, educational, and foundation) to offer mental health services in an inclusive day care setting. Two clinical programs (a licensed day treatment program, and a therapeutic nursery) are embedded in a day care setting. Ninety percent of the typical and atypical children in all of the early childhood programs (ages 0–5 years) come from families who meet income tests for subsizided meals. This innovative program has pioneered inclusive infant/toddler and preschool mental health services in the Pittsburgh area. We have demonstrated, with psychiatric leadership, that a day care program serving "typical" children can be transformed into a high-quality program that provides clinical services as well. Major accomplishments that will be discussed are (1) training of existing staff (many of whom are paraprofessional) to serve behaviorally troubled children; (2) developing or enhancing services by braiding funding from a variety of resources; (3) obtaining community acceptance by embedding clinical populations in a traditional community program, thus reducing stigma that many families feel about accessing mental health services. We will also present descriptive data on the families and children served and discuss the need for professional training in early childhood mental health.

REFERENCES:

1. Shonkoff JP, and Phillips DA (eds): From Neurons to Neighborhoods: The Science of Early Childhood Development. Washington, DC, National Academy Press, 2000.
2. Zennah CH (ed): Handbook of Infant Mental Health, 2nd edn. NY, Guilford Press, 2000.

Psychiatric Services Achievement Awards Session 2 **Thursday, October 10 8:30 a.m.-11:30 a.m.**

NATHANIEL PROJECT: BUILDING SYSTEM BRIDGES FOR FELONY OFFENDERS WITH MENTAL ILLNESS

Psychiatric Services Certificate of Significant Achievement

Sarah Bryer, M.P.P., *Deputy Executive Director, CASES, Inc., 346 Broadway, New York, NY 10013*

EDUCATIONAL OBJECTIVES:

This workshop will assist participants in identifying and overcoming the systemic barriers to serving felony-level offenders with mental illness.

SUMMARY:

The Nathaniel Project is the first program of its kind in New York to serve felony-level offenders with a serious and persistent mental illness. By bridging the criminal justice and mental health systems, the project assists this high-risk and high-need population in avoiding unnecessary and expensive incarceration and in living stably in the community. The project creates a dynamic and fluid connection between two systems that do not traditionally work in partnership. To the criminal justice stakeholder, the project demonstrates that engagement in psychiatric treatment and housing is the way to prevent renewed contact with the criminal justice system. To the mental health provider, the project demonstrates that people with mental illness who have had serious contact with the criminal justice system do not pose heightened risks for other service recipients and that they can succeed in the community, can engage in treatment, and can lead law-abiding lives. This workshop will explore the needs of the mentally ill in the criminal justice system, the nature of the system barriers facing the mentally ill who are involved in the justice system, and principles for successful intervention with this population.

Psychiatric Services Achievement Awards Session 3 **Thursday, October 10 8:30 a.m.-11:30 a.m.**

THE WESTERN PSYCHIATRIC INSTITUTE AND CLINIC HOMELESS CONTINUUM

Psychiatric Services Certificate of Significant Achievement

Diane P. Holder, M.S., *President, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213*; Paul J. Cornely, Ph.D., *Chief, Community Services and Training, University of Pittsburgh, Western Psychiatric Institute and Clinic, 4601 Baum Boulevard, Room 277, Pittsburgh, PA 15213*; Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute and Clinic; Associate Professor of Psychiatry and Public Health, University of Pittsburgh, and Former APA/Bristol-Myers Squibb Fellow, 3811 O'Hara Street, Room E-516, Pittsburgh, PA 15213*; Stephen D. Mullins, M.D., *415 Stratton Lane, Pittsburgh, PA 15206-4217*; Diane Johnson, R.N., *Director, Neighborhood Living Project, 2552 Centre Avenue, Second Floor, Pittsburgh, PA 15219*; Susan Coyle, M.P.H., *Department of Psychiatry, Western Psychiatric Institute and Clinic, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213*; Chris Lacmmle, R.N., *Outreach Specialist, Neighborhood Living Project, Western Psychiatric Institute and Clinic, 2552 Centre Avenue, Pittsburgh, PA 15219*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) replicate a recovery-based system of care for homeless individuals with serious mental illness that incorporates assertive outreach, housing and housing supports, rehabilitation, and treatment; and (2) recognize that this continuum should link with and monitor health care, drug and alcohol services, and in-vivo, community-based services and supports.

SUMMARY:

The Western Psychiatric Institute and Clinic (WPIC) of UPMC Presbyterian Homeless Continuum is located in the city of Pittsburgh and has served the homeless population for the past decade. The project directly serves over 66 individuals and families who are homeless and have a diagnosis of serious mental illness; over 80% also have a positive history for substance use. In addition, through the Community Services WPIC has served over 300 homeless individuals and families through assertive outreach efforts in the streets and shelters of the city of Pittsburgh and throughout Allegheny County.

This innovative program has pioneered supportive housing for the seriously mentally ill homeless population in the Pittsburgh area. The program has also demonstrated, with psychiatric leadership, that a high-quality program serving the homeless mentally ill population can have a tremendous impact on the health status, adherence to psychiatric and substance abuse treatment, and the quality of life for those served. Major accomplishments in this process include training of psychiatric residents and paraprofessionals, developing or enhancing services by braiding funding (and services) from a variety of resources, and reducing stigma by developing clinical and supportive services in a traditional community program.

REFERENCES:

1. Thompson KS, Griffith EH, Leaf PJ: An historical review of the Madison model of community-based care. Hospital and Community Psychiatry 1990; 41:625–634.
2. Essock SM, Frisman LK, Kontos NJ: Cost-effectiveness of assertive community treatment teams. American Journal of Orthopsychiatry 1998; 68(2).

Psychiatric Services Achievement Awards Session 4 **Thursday, October 10 8:30 a.m.-11:30 a.m.**

ARKANSAS CARES: AN INNOVATIVE PROGRAM BREAKING THE CYCLE OF ADDICTION

Psychiatric Services Gold Award

Cynthia C. Crone, M.S.N., *Executive Director, Arkansas Cares, 4301 West Markham, Slot 711-1, Little Rock, AR 72205*; Linda L.M. Worley, M.D., *Department of Psychiatry, University of Arkansas, 4301 West Markham, Slot 711-1, Little Rock, AR 72205*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) state key components of an effective prevention and treatment model for families affected by maternal addiction, (2) understand the concepts of braided funding and braided services, (3) discuss the value of coordinated, interdisciplinary service delivery, and (4) discuss the value of interactive, dynamic program evaluation.

SUMMARY:

Administratively located within the UAMS department of psychiatry, Arkansas CARES exists to decrease maternal substance abuse and promote healthy family outcomes through prevention, treatment, education, research, and advocacy. Low-income mothers with co-occurring substance abuse and psychiatric disorders are served *with their children* in an effort to break the inter-

generational cycles of addiction, abuse, poverty, and dependence. The JCAHO-accredited behavioral health program provides integrated substance abuse and mental health services, licensed child care and early intervention services, a health clinic, residential support, and aftercare services. Interdisciplinary teams address the bio-psycho-social-spiritual aspects of family recovery. Dynamic, interactive evaluation processes document program successes. Arkansas CARES hosts students from multiple disciplines at the program's two locations, the original site in Little Rock and an expansion site within a public-housing project in North Little Rock. Arkansas CARES has contributed to the field of mental health through (1) operating and evaluating a model prevention and treatment program for dually diagnosed mothers and their children; (2) sharing information about effective, family-centered treatment strategies with the public, other providers, policy makers, and the scientific community; and (3) advocating for systems change to fund, coordinate, integrate, evaluate, and expand gender-specific and family-focused services for this vulnerable population.

REFERENCES:

1. Conners NA, Bradley RH, Whiteside-Mansell L, Crone CC: A comprehensive substance abuse treatment program for women and their children: an initial evaluation. Journal of Substance Abuse Treatment 2001; 21:67–75.
2. Whiteside-Mansell L, Crone CC, Conners N: The development and evaluation of an alcohol and drug prevention and treatment program for women and children: the AR CARES Program. Journal of Substance Abuse Treatment 1999; 16:(3), 265–275.

Psychiatric Services Achievement Awards Session 5

Thursday, October 10
8:30 a.m.-11:30 a.m.

ELKHART COUNTY COMMUNITY WRAPAROUND: COMMUNITY COLLABORATION AT ITS BEST

Psychiatric Services Gold Award

Sharese Swafford, M.A., *Wraparound Team Leader and Community Coordinator, Oaklawn Psychiatric Center, Inc., 2600 Oakland Avenue, Elkhart, IN 46517*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the core principles and core values of the process, demonstrate the ability to utilize the strength-based model, and treat and support patients with traditional methods and innovative, informal services and supports.

SUMMARY:

The Elkhart County Community Wraparound Process is an innovative, successful approach to helping at-risk youth. The Wraparound Process is designed to empower families and children by building on their strengths. A network of support from within the community is created individually and ''wraps around'' each family in order to meet the individual needs of each particular family. A unique and successful aspect of this process is the use of informal supports that include family members, clergy, friends, and anyone the family trusts and respects. Wraparound is a multi-agency process that seeks to decrease the number of children in non-permanent out-of-home placements, to reduce additional abuse and neglect cases, and to prevent other families from entering the system. There are core principles and core values the community as a whole must embrace in order for the process to be successful. The process also covers numerous life domains such as housing, employment, school, medical, legal, spiritual, cultural, social, family, transportation, etc. The process is not limited to the behavioral/emotional needs of the family. The family drives this process.

REFERENCES:

1. Butler S, Atkinson L, Magnatta M, Hood E: Child maltreatment: the collaboration of child welfare, mental health and judicial systems. Child Abuse & Neglect 1995; 19: 355–362.
2. Zill N, Coiro MJ: Assessing the condition of children. Children & Youth Services Review 1992; 14: 119–136.

Symposium 1 **Wednesday, October 9**
8:30 a.m.-11:30 a.m.

PSYCHIATRIC STIGMA: CONSEQUENCES AND STRATEGIES FOR CHANGE

Beth Angell, Ph.D., *Assistant Professor, Department of Social Services Administration, University of Chicago, 969 East 60th Street, Chicago, IL 60637;* Patrick W. Corrigan, Ph.D., *Department of Psychiatry, University of Chicago, 7230 Arbor Drive, Tinley Park, IL 60477;* Robert K. Lundin

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify ways in which stereotypes and biased attributions about mental illness may affect clinical practice and treatment of clients in various systems; potential stigma change strategies; and ways that positive social experiences may counteract stigma and promote recovery.

SUMMARY:

This symposium reports on current and completed projects by the Chicago Consortium of Stigma Research, an NIMH-funded Research Infrastructure Support Program based at the University of Chicago Center for Psychiatric Rehabilitation. The consortium's goal is to apply concepts and methods from social psychology to better understand the causes and consequences of mental illness stigma and to uncover methods for eradicating stigma. The presentations focus on several key areas: four presentations (Watson, Luchins, Angell, and Mahoney) provide conceptual models and empirical evidence suggesting that stereotypes and biased attributions about mental illness can affect the way that mental health consumers are treated in the criminal justice and mental health systems. The fifth presentation (Corrigan) reports on a stigma change intervention and draws implications for public stigma change efforts. Finally, the sixth presentation (River) examines the importance of stigma by examining the effects of its absence on consumer experiences of recovery. Discussant and mental health consumer Robert Lundin will lead a discussion of the implications of this stigma research vis-a-vis the Institute's 2002 theme of creating and supporting systems of care.

No. 1A
MENTAL ILLNESS STIGMA AND POLICE DECISION MAKING

Amy C. Watson, Ph.D., *Project Director, Chicago Consortium for Stigma Research, Department of Psychiatry, University of Chicago, 7230 Arbor Drive, Tinely Park, IL 60477;* Victor Ottati, Ph.D.; Patrick W. Corrigan, Ph.D.; Mark Heyrman, J.D.

SUMMARY:

For a variety of reasons, criminal justice professionals at all levels are dealing with more and more individuals with mental illness. On the flip side, community mental health providers are serving more and more individuals with criminal justice system involvement. Police officers are generally the first point of contact with the criminal justice system, and the determinations they make regarding these individuals impact whether they receive appropriate psychiatric care or are further processed into the criminal justice system. A number of studies have examined police interactions with persons with mental illness; however, little is known about the impact of police officer attitudes and beliefs about mental illness on these interactions. Social psychological theory suggests that police officer attitudes may be even more negative than the general public's. Geared toward community mental health and law enforcement professionals, this presentation will review what is currently known about police interactions with persons with mental illness and consider the influence of stigma on police contacts with persons with mental illness as victims, witnesses, suspects, and persons in need of assistance. Addressing these issues in the community has potential for improving officer and community safety and the overall quality of life for persons with mental illness.

No. 1B
SURVEY OF PSYCHIATRISTS' ATTITUDES TOWARD MANDATED TREATMENT

Daniel J. Luchins, M.D., *Professor of Psychiatry, University of Illinois at Chicago, 5841 Maryland Avenue, MC-3077, Chicago, IL 60637;* Patricia Hanrahan, Ph.D.; Kenneth Rasinski, Ph.D.; Patrick W. Corrigan, Ph.D.; David Roberts, M.A.

SUMMARY:

The study purpose is to better understand the attitudes of psychiatrists and mental health professionals toward mandated treatment for people with mental illness and substance use disorders. Research questions include the following: How often, and in what contexts, do psychiatrists recommend involuntary commitment of clients? Are psychiatrists more likely to use involuntary commitment for persons with substance use disorders than other disorders? What rationale guides decisions on involuntary commitment? Social attribution theory suggests that perceived consumer motivation influences variation in these attitudes, especially attitudes toward the consum-

er's responsibility for the onset and recurrence of psychiatric problems.

Methods: Census survey of all members of the Illinois Psychiatric Society (N = 888). A structured questionnaire will be mailed to all members, with phone followups planned for nonresponders. Subjects will receive different versions of the questionnaire, which varies according to whether the vignettes involve persons with schizophrenia, bipolar disorder, or substance abuse.

Summary: We hypothesize that persons with serious mental illness are seen by psychiatrists and mental health professionals as not responsible for the cause of their illness, but are responsible, in part, for its solution and that responsibility rests on being "motivated" for treatment. This study will help us to understand how stigma and discrimination influence treatment decisions.

No. 1C
THE IMPACT OF CASE MANAGERS' ATTITUDES AND ATTRIBUTIONS ON THERAPEUTIC RELATIONSHIPS

Colleen Mahoney, M.A., *Doctoral Candidate, Department of Social Services Administration, University of Chicago, 969 East 60th Street, Chicago, IL 60637;* Beth Angell, Ph.D.

SUMMARY:

Assertive Community Treatment (ACT) is a community-based program that has been widely studied and shown to be effective in producing a variety of desired outcomes for consumers with serious mental illness. Although significant details of the structure and organization of ACT teams and services are specified in the model, little is known about the key interpersonal processes that are central to the delivery of services. For example, it is widely believed that the consumer–case manager relationship is a critical mediator of program effectiveness in ACT and in other case management approaches, yet the extent to which this relationship is affected by the attributes and attitudes of the service provider has not been studied. This presentation examines the importance of case manager attitudes and attributional styles to the strength of the consumer–case manager relationship. Drawing upon social psychological theories and on previous research on therapeutic alliance and on attributional style, a conceptual model relating case manager attitudes and attributions to the consumer–case manager relationship is developed and presented. Plans for empirically testing the model will also be discussed.

No. 1D
STIGMA IN THE CLINICAL DECISION-MAKING PROCESS

Beth Angell, Ph.D., *Assistant Professor, Department of Social Services Administration, University of Chicago, 969 East 60th Street, Chicago, IL 60637*

SUMMARY:

Surveys show that people with serious mental illness are stereotyped as dangerous and incompetent to care for themselves by the general public. While mental health professionals are better informed about the nature and causes of mental illness than the general public, they may nonetheless hold negative attitudes about clients. For example, they may view clients as culpable for behavior problems and respond punitively by withholding resources or help. Understanding better how clinician decision making may be clouded by subtle stereotypes about clients, particularly those seen as "difficult" or "treatment resistant," has important implications for psychiatric services and the training of new clinicians. This presentation reviews relevant previous research and applicable theories from social psychology, and uses data from two qualitative studies to examine how case managers' attitudes about mental illness influence their clinical decisions and strategies across several domains: enforcing outpatient commitment orders, managing client funds, and monitoring medication compliance and upkeep of independent residences. Results show that providers view resistance and noncompliance differently based upon diagnosis and level of impairment, and accordingly, adopt different clinical responses to these behaviors. Implications for psychiatric services will be discussed.

No. 1E
THREE WAYS TO CHANGE PUBLIC STIGMA

Patrick W. Corrigan, Ph.D., *Department of Psychiatry, University of Chicago, 7230 Arbor Drive, Tinley Park, IL 60477*

SUMMARY:

Basic behavioral research has suggested three ways to change public attitudes that stigmatize minority groups: protest (appeal to a moral authority on why prejudice is wrong), education (counter the myths that underlie stereotypes with the facts), and contact (challenge prejudice by allowing the public to interact with members of the stigmatized group). The impact of these change strategies has been tested in two experimental trials on public stigma related to mental illness. Results show that protest yields a rebound effect in terms of changing

attitudes. In responding to being told how to respond, people react negatively and are actually more likely to endorse stereotypes. Education leads to mild changes in attitudes. Contact leads to relatively strong changes that endure at follow up. Contact was also associated with behavior change. Strategies from social psychology that enhance contact are reviewed in the paper. We end with a more explicit discussion of the implications of this research for antistigma programs.

No. 1F
PERSONAL AND SOCIAL FACTORS IN RECOVERY

L. Philip River, M.A., *Doctoral Candidate, Department of Social Service Administration, University of Chicago, 1153 West 191st Street, Homewood, IL 60430;* Patrick W. Corrigan, Ph.D.

SUMMARY:

First-person accounts by and surveys of consumers suggest that recovery is impeded by experiences of prejudicial treatment by others (perceived stigma), as well as by associated feelings of low self-esteem and self-worth (self-stigma). Conversely, consumer research suggests that positive factors reflecting the *absence* of perceived stigma and self-stigma help to promote recovery. Such factors include acceptance of one's situation, feeling accepted by others, participation in meaningful activities, optimism, and the presence of supportive friends and family members. These relationships have not been rigorously examined in empirical studies to date, however.

To evaluate the relationship between positive psychosocial indicators and recovery, we are using baseline data from an evaluation of the GROW self-help program in the state of Illinois involving 180 subjects with serious mental illness. Analysis, currently in progress, will employ multivariate regression techniques to assess how much of the variance in individual recovery scores is explained by measures of family/social support; degree of acceptance of illness; sense of hope, confidence, and spirituality; symptom severity; and social activity; and demographic variables such as age, gender, race, age at the onset of illness, and employment status.

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Symposium 2 **Wednesday, October 9**
2:00 p.m.-5:00 p.m.

PSYCHIATRY IN COLLABORATION WITH FAITH-BASED ORGANIZATIONS

Laurence P. Karper, M.D., *Vice Chair, Department of Psychiatry, Lehigh Valley Hospital at Muhlenberg, 400 North 17th Street, Suite 207, Allentown, PA 18104;* H. Newton Malony, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe and understand various approaches to creating collaborative projects and treatment between psychiatric and faith-based organizations.

SUMMARY:

Faith-based organizations, often affiliated with religious denominations, aid many individuals with psychiatric diagnoses. These organizations frequently are providers of last resort for homeless individuals with mental illness and comorbid substance use disorders. Individuals who are homeless have substantial unmet needs in several important dimensions. Psychiatric treatment settings, while effective at diagnosing and treating behavioral health disorders, face numerous obstacles in providing comprehensive multidimensional care. These obstacles include difficulty obtaining adequate financial resources needed to provide care to the homeless with comorbid mental illness and substance use. Faith-based

organizations focus on spiritual needs and in addition may provide financial, shelter, vocational, and living skills assistance. These organizations lack expertise in understanding psychiatric disabilities, which may complicate their task. Collaboration provides a hoped-for bridge between these two worlds. While the spiritual dimension is seen as critical by many patients, this dimension is often overlooked by psychiatric providers. The presenters of this symposium have developed new ways to understand the spiritual dimension of their patients and have evolved new forms of collaboration to meet the needs of their patients.

No. 2A
RESCUE MISSION COLLABORATION WITH PSYCHIATRY

Gary Millspaugh, M.P.A., *Director, Allentown Rescue Mission, P.O. Box 748, Allentown, PA 18104;* Vivian Davis-Martínez, C.A.C.; Laurence P. Karper, M.D.

SUMMARY:

The gospel rescue mission movement is a Christian-based, loosely organized provider of shelter to the homeless. Gospel rescue missions are typically very independent and earnestly avoid secular and government influences, sometimes including generally accepted medical and psychiatric practices. Many of the homeless persons helped by missions are suffering from mental illness and alcohol and drug problems. In addition, they have substantial social, vocational, and financial needs. Many missions in addition to spiritual support provide guidance to their clients on living skills and job training. Diagnosing and treating psychiatric and substance use disorders is not part of the skill set of rescue mission workers. There may be open resistance on the part of rescue mission staff or psychiatric treatment providers to collaborate in the treatment of their clients who may be living at the rescue mission and seeking psychiatric treatment. Many clients can benefit from the added dimension of expert collaborative treatment. In order to obtain the expertise necessary to help these clients, various collaborative models have arisen. This study evaluates the extent of the collaboration between rescue missions and psychiatric treatment providers. A standardized instrument was used to collect data from each of the 180 rescue missions in the United States. Follow-up phone contact was made to verify and expand upon the data set. Several collaborative projects will be presented to elucidate the best of current practices.

No. 2B
INTEGRATING SPIRITUAL BELIEFS INTO PROFESSIONAL COUNSELING

Vivian Davis-Martínez, M.S.W., CAC, *Allentown Rescue Mission, P.O. Box 748, Allentown, PA 18104*

SUMMARY:

The spiritual dimension of drug and alcohol/substance abuse treatment is obvious. However, it is difficult to interact with professional counseling methods. The Allentown Rescue Mission was founded in 1900 with the goal to help restore those individuals in need. Since that time the process of restoration has evolved to include professional counseling methods and collaboration with other county resources such as mental health and drug and alcohol programs, thereby, making the Allentown Rescue Mission the first rescue mission to acquire a state license to provide professional drug and alcohol treatment services in a faith-based organization.

No. 2C
SPIRITUALITY AS EXPRESSED BY THE HOMELESS

Sister Mary Peter Kerner, O.S.F., *Our Lady of Angels, 609 South Convent Road, Aston, PA 19014*

SUMMARY:

Spirituality may be defined as the basic values lived. Homeless people, while they lack material possessions, are stripped to the basics. Having nothing frees one to rely on a Higher Power and experience freedom. This can produce spontaneity in relationship to the Higher Power and produces a need to express gratitude for any gifts. While homelessness often can be perceived as a harrowing experience, homeless people are able to feel a sense of worth through holiness. Feeling holy, they may become valuable and therefore realize the true value of material possessions. In relation to others, there is willingness to share and a renewed sense of community and a lack of tolerance for someone taking one's possessions.

This presentation focuses on people who were formerly homeless and their relationship to God (a Higher Power), self, and others, and the effects on service providers of the spiritual aspects of homelessness. Materials presented reflect readings about the experience of homelessness as well as interviews with a random sample of caregivers and providers, as well as people who were formerly homeless who were willing to share their "story." The latter live in either transitional or permanent housing. Working with/living among people who have few material possessions can truly be a gift.

No. 2D
TREATING THE HOMELESS DUAL-DIAGNOSIS PATIENT

Laurence P. Karper, M.D., *Vice Chair, Department of Psychiatry, Lehigh Valley Hospital at Muhlenberg, 400*

North 17th Street, Suite 207, Allentown, PA 18104; D. James Ezrow, M.S.W.; Evett Vega, B.A.; Gail Stern, M.S.N.; Michael W. Kaufmann, M.D.

SUMMARY:

The treatment of the homeless person who suffers from mental illness and a substance use disorder presents numerous challenges for mental health providers. These challenges include developing and coordinating the appropriate outpatient treatment for these individuals. Meeting the multidimensional needs that these individuals have puts significant stress on public health systems and the clinics and community hospitals that provide direct care.

This presentation reviews the progress of a funded collaboration between the Allentown Rescue Mission and the Lehigh Valley Hospital department of psychiatry. The project is a joint research study involving a faith-based homeless shelter, a drug treatment program, and a community hospital. The study evaluates the effectiveness of care coordination in improving the care of the homeless mentally ill with substance use disorders. Our plan has been to enroll 100 subjects over two years and to evaluate the outcomes of care at entry and at three-month intervals. Rating instruments include measures of alcohol and drug consumption, psychiatric symptoms, homelessness, satisfaction with care, and general health outcomes. This collaboration is funded through a two-year grant supported by the Dorothy Rider Pool Health Care Trust. The study has brought both organizations closer together and has helped to build bridges and greater understanding of each other's strengths and needs.

No. 2E
RELIGION, COPING, AND MENTAL ILLNESS: RESEARCH AND IMPLICATIONS

Steven A. Rogers, M.A., *Fuller Theological Seminary, Graduate School of Psychology, 180 North Oakland Avenue, Pasadena, CA 91101*

SUMMARY:

Although recent research has begun suggesting that religion plays a significant role in the lives and coping patterns of those suffering from mental illness, there remains a high level of uncertainty, ambivalence, and maybe even immobility on behalf of mental health professionals in knowing how to therapeutically approach religion among the mentally ill. Using current research from Los Angeles County mental health facilities, this presentation will explore the role of religion in clients' lives and how it relates to their coping with mental illness. In particular, it will address the role of religion in coping, diagnostic differences in the use of such coping, and the relationship between such coping and symptomatology, including the tendency for religious coping to be more pronounced among those with more debilitating mental illnesses. It will also address changes in clients' attitudes, symptoms, and coping strategies. Moreover, this presentation will discuss how to afford religious coping a natural place in our treatment, assessment, and research. This might include altering our assessments to inquire into the role of religion in clients' lives, pursuing better training for competency in religious issues, and considering new models of service provision that are characterized by: (1) more inclusivity toward clients' personal sources of coping, (2) a greater openness to a multidimensional approach to coping that includes religious sources of support, and (3) an interdisciplinary dialogue with religious leaders so that the best care and treatment for those suffering from mental illness may result.

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Symposium 3 **Wednesday, October 9**
2:00 p.m.-5:00 p.m.

PSYCHIATRY IN THE MEDIA: "GIRL INTERRUPTED" AND MODERN SYSTEMS OF CARE

Jonathan E. Morris, M.D., M.P.H., *Department of Psychiatry, Maine Medical Center, 22 Bramhall Street, Portland, ME 04102*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss current perceptions of psychiatry in the media in the context of treatment modalities, managed care realities, personality disorders, and that which makes for "good care" as seen by the public.

SUMMARY:

Susanna Kaysen was hospitalized for a year at McLean Hospital in the late 1960s. She shared her experiences 25 years later in her book *Girl, Interrupted,* subsequently made into an Academy Award–winning film.

The mental health system has changed since Ms. Kaysen's admission. The scope of available services is dramatically different, as are the reimbursement mechanisms, all of which make long-term inpatient care less common and less available. The film will serve as a trigger for discussion of the various impressions of mental health patients and care in the media and among members of the public, the process and application of psychiatric diagnosis, alternative treatment modalities, the mental health system as currently available, determining "appropriate" treatment, the role of insurance reimbursement for services, involvement of managed care and utilization review services, and consideration of the use of long-term residential care for adults.

Given the use of strong language and depiction of intense situations in the film, viewing by younger children is not recommended.

REFERENCES:

1. Kaysen S: Girl, Interrupted. New York, NY, Vintage Books, 1993.
2. Mangold J: Girl, Interrupted (a motion picture). Culver City, CA, Columbia Pictures Industries, Inc., 1999.
3. McLean Hospital Public Relations Department: A Vision, A Spirit, A Way—McLean Hospital: 1811–1976. Belmont, MA, McLean Hospital, 1976.
4. Sadock B, Sadock V: Kaplan and Sadock's Comprehensive Textbook of Psychiatry, Seventh Edition. Chapter 52: Hospital and Community Psychiatry, Philadelphia, Lippincott, 1999, p.3185.

Symposium 4 **Thursday, October 10**
8:30 a.m.-11:30 a.m.

BIOPSYCHOSOCIAL REHABILITATION OF THE SERIOUSLY AND PERSISTENTLY MENTALLY ILL

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to apply the concept of a DSM-IV-driven integrated biopsychosocial rehabilitation model of care in the rehabilitation of persons with serious and persistent mental illnesses.

SUMMARY:

Persons with serious and persistent mental illnesses often present with comorbid Axis I, II and III disorders with deficits in the social, work, educational, interpersonal, and housing spheres. Successful rehabilitation of such individuals for placement in the community requires attention to all areas of intervention, which include addressing the general physical, psychological, social, cultural, and spiritual needs.

Implementation of current conceptual model of psychosocial rehabilitation, unfortunately, often results in polarization of treatment approach that either emphasizes a predominant biological or psychosocial approach. A new, more unifying, integrated concept signified by the term *biopsychosocial rehabilitation*, which is also consistent with the conceptual approach underpinning the DSM-IV, is suggested.

This symposium aims to explicate the concept of *biopsychosocial rehabilitation.* An actual treatment case utilizing such an approach will be presented. Levels of interventions at both the clinical and systemic level enabling a successful treatment outcome will be highlighted.

No. 4A
BIOPSYCHOSOCIAL REHABILITATION: A DSM-IV APPROACH

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

SUMMARY:

The relationship between psychosocial rehabilitation and psychiatry has been described as an "uneasy alliance." Although the basic concepts that define the discipline of psychosocial rehabilitation have been summarized, interdisciplinary team members trying to implement this model often distort the concepts in actual practices. This distortion often results in polarization of

the treatment teams into camps that either emphasize a predominant biological or psychosocial approach.

This paper proposes adoption of the term *biopsychosocial rehabilitation* as a way to promote an integrated approach in the treatment and rehabilitation of the mentally ill. Consistent with a biopsychosocial approach advocated by the DSM-IV, the new term emphasizes total integration of the individual human person in the biological, psychological, social, cultural, and spiritual domains. A simple methodology of measuring goal attainment in each level of integration in the team treatment plan is suggested. Overlapping areas of the role and expertise of each member of the interdisciplinary team are highlighted. These overlapping roles and areas of expertise could become a focus of team collaboration working toward restoring the mentally ill individual as a functioning member of society.

No. 4B
BIOPSYCHOSOCIAL REHABILITATION: A CASE STUDY

Shotsy C. Faust, M.N., *Coordinator of Primary Care, San Francisco Mental Health Rehabilitation Facility, 887 Potrero Avenue, San Francisco, CA 94110;* Peggy A. Wilson, D.N.S.

SUMMARY:

The challenge of providing comprehensive rehabilitative services to individuals with severe and persistent mental illness within a psychiatric long-term-care setting requires that we revisit the biopsychosocial model of human functioning and acknowledge the detrimental impact of our fragmented system of care delivery. The biological, psychological, interpersonal, cultural, and spiritual components of the biopsychosocial model are reflected in DSM-IV axes I, II, III, and IV. We will use a case study of a young man with significant Axis I, II, and III disorders, complicated by severe Axis IV deficits, morbid obesity, and psychogenic seizures to illustrate the integrated approach of biopsychosocial rehabilitation.

No. 4C
MANAGEMENT OF EPISODIC CRISES: A CLINICAL AND SYSTEMS APPROACH

Mozettia Henley, D.N.S., *Associate Hospital Administrator, San Francisco Mental Health Rehabilitation Facility, 887 Potrero Avenue, San Francisco, CA 94110;* Albert C. Gaw, M.D.

SUMMARY:

Long-term-care settings are being called upon to provide comprehensive biopsychosocial rehabilitative services to clients who present complex rehabilitation issues. On occasion, individuals exhibit behaviors that are generally viewed as high risk and undesirable. During the rehabilitative phase of care, due to the complexity of the care needs as well as the high-risk nature of the behaviors, episodic crises will occur. These crises present numerous challenges to the care providers as well as the mental health system of care. In order to follow a rehabilitation trajectory and return these individuals to the community, it is essential to use an approach that addresses the goals of clinical management within the facility and mobilizes the system of care to be responsive to the individuals' care needs.

This paper proposes an integrated clinical and systems approach to the management of one aspect of biopsychosocial rehabilitative care during episodic crises involving individuals with severe and persistent mental illness in a long-term-care setting. We propose a proactive approach that

- involves all stakeholders in a mental health managed care environment;
- begins prior to admission and includes interdisciplinary team involvement and ownership of the rehabilitation process;
- provides support and expertise from expert clinical staff within the facility; and
- creates a seamless flow across levels of the system of care.

REFERENCES:

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Symposium 5 **Thursday, October 10**
8:30 a.m.-11:30 a.m.

MENTAL ILLNESS IN THE DEVELOPMENTALLY DISABLED: TREATMENT IN THE COMMUNITY

Terry D. Swanson, M.S., *Program Manager, Active Treatment Department, Pinecrest Development Center, P.O. Box 80966, Lafayette, LA 70598;* Ramakrishnan

S. Shenoy, M.D., *Consultant, Department of Psychiatry, Central State Hospital, 1309 Port Elissa Landing, Midlothian, VA 23114*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate the importance of designing and implementing transitional plans for patients diagnosed with mental illness and developmental disorders who move from institutions into the community. In addition, they will understand the importance of comprehensive psychiatric, psychological, behavioral, and vocational programming to help those patients succeed in the community.

SUMMARY:

Psychiatric disorders in the developmentally disabled were traditionally treated in large state institutions. With deinstitutionalization and changes in federal and state laws, the majority of these patients are now served in the community. The shift to community care can be difficult. In this symposium, we will address some of these challenges and suggest solutions. The transition from a large psychiatric institution to the community will be reviewed. An emphasis will be placed on the development of systematic planning and focused community supports. Coordination of residential care, day programs, and crisis intervention are different aspects of transitional care. Psychopharmacology, behavioral treatments, medical care, vocational involvement, and recreation/leisure skills and their modifications for use in community residences will be discussed using two different paradigms of care. The role of the psychiatrist in providing after-care in the office and the group home will be covered using case examples and charts. In addition, a comparison of discharge planning in patients with a primary diagnosis of mental illness and those who are developmentally disabled and psychiatrically ill will be presented.

No. 5A
DIFFERENCES IN MENTALLY ILL AND MENTALLY RETARDED SERVICES: BEHAVIOR PROGRAMS AND DISCHARGE PLANS

Donna K. Moore, Psy.D., *Psychology Director, Central State Hospital, 2433 Lindbergh Avenue, Chesapeake, VA 23325;* Bethany A. Marcus, Ph.D.

SUMMARY:

There are significant differences between transitional behavioral programming and discharge planning for adults diagnosed as mentally ill (MI) or mentally retarded (MR). The basic difference is that the focus of treatment for clients with MR is training to meet optimum levels of adaptive functioning. Adults diagnosed with MI need stabilization of psychiatric symptoms and maintenance of stability. Medications play a key role in this process. There are differences in availability of community resources. Clients diagnosed with MR often have access to specialized funding, more supervised placement opportunities, and access to comprehensive day treatment programs. Clients with MI are usually served in psychosocial day programs and adult care residences with less structure and supervision. Behavioral programming is a mainstay in the field of mental retardation. Training centers, group homes, school settings, and some home placements frequently use this tool to manage behavior. This is often an unfamiliar concept when working with individuals diagnosed with MI. Behavioral programming can be equally effective with this population, especially for difficult transitions into the community. A case illustration will be presented in which a long-term client diagnosed with MI was transitioned from a state hospital to a group home with comprehensive behavior supports.

No. 5B
PREPARING PERSONS WITH MENTAL RETARDATION FOR COMMUNITY LIVING

Bethany A. Marcus, Ph.D., *Psychology Supervisor, Central State Hospital, 633 Rosear Lane, Virginia Beach, VA 23464;* Ramakrishnan S. Shenoy, M.D.; Daphne W. Southall, M.Ed.; Mary J. Smith, OTR/L

SUMMARY:

Person-centered planning entails identifying and creating resources, focusing on strengths, building a web of safety networks, and supporting a "good match" between an individual and a provider. There is a delicate balance that needs to form between a facility and a community provider to ensure success. Emerging from decades in an institution to community living can be an exciting, yet complicated transition. Preparing the individual as well as the system at large for transition takes great care and meticulous planning. In this presentation, a description of a model of transition within and between systems will be described. Case examples will illustrate strategies for working through barriers that may be rooted in patient fears, system breakdowns, or by missing critical details. Comprehensive assessments, interventions for challenging behaviors, programmatic issues, and responsibilities will be discussed. Although this process is time consuming, the outcome is both beneficial to the patient and cost-effective for the system.

No. 5C
COMMUNITY RE-ENTRY: CHALLENGES FOR PERSONS WITH MENTAL RETARDATION

Daphne W. Southall, M.Ed., *Vocational Rehabilitation Counselor, Central State Hospital, 1008 Timber Trace Road, Powhatan, VA 23139;* Ramakrishnan S. Shenoy, M.D.; Bethany A. Marcus, Ph.D.; Mary J. Smith, OTR/L

SUMMARY:

Patients with developmental disabilities who enter the community from large institutions face many obstacles. In the institution, a person's needs are well taken care of. Services available include medical, psychological, psychiatric, social services, day programming, dietary services, and client advocacy. These are coordinated within the same system of delivery. In the community, these services are frequently available but not readily accessible because they come from different sources and often require incompatible systems to work together. Coordination of these community-based services presents many challenges. For a person with knowledge and access to resources, this process is complicated but can be accomplished through the use of tools like the Internet, telephone, newspapers, and community contacts. For the developmentally disabled and their families, this process can be impossible. Their limited resources and difficulty in negotiating the complicated maze of bureaucratic systems can lead to decomposition and return to the institutions. The paper discusses specific problems with select patients and the interventions that resulted in maintaining ongoing successful community placement. Coordinated teamwork is essential to support community re-entry for persons with mental retardation.

No. 5D
BEHAVIORAL CONSULTATION FOR PERSONS IN TRANSITION TO INDEPENDENT LIVING

Victoria Swanson, Ph.D., *Director of Psychology, Southwest Louisiana Developmental Center, P.O. Box 80966, Lafayette, LA 70598;* Terry D. Swanson, M.S.; Frankie Humbles, B.S.

SUMMARY:

Behavior consultation teams routinely provide services in congregate settings. In large clinical environments, systems are in place to integrate multidisciplinary assessments into an effective treatment plan. Behavioral data can be collected to drive medical and behavioral treatment decisions. When the patient moves into less-restrictive settings in the community, the behavior consultation team must provide comprehensive psychiatric, medical, psychological, nursing, and behavioral assessments to develop appropriate programs to ease the individual into a community environment. Finally, the behavioral consultant must help the receiving team develop a plan that can be maintained by less-familiar staff through in-service training. The Southwest LA Developmental Center (SWLDC) model for providing diversified services for persons in residential (ICF-MR), community home, supported independent living (SIL), extended family living (foster care), and vocational day programs will be reviewed. Data illustrating systematic transitions for two individuals who moved from residential to SIL settings within this model will be presented. Results will be discussed in terms of assessment, program development and implementation, staff training, and diversification of professionals.

No. 5E
COMMUNITY TREATMENT OF MENTAL ILLNESS IN THE DEVELOPMENTALLY DELAYED

Ramakrishnan S. Shenoy, M.D., *Consultant, Department of Psychiatry, Central State Hospital, 1309 Port Elissa Landing, Midlothian, VA 23114;* Bethany A. Marcus, Ph.D.

SUMMARY:

With the change in federal and state laws and the closing down of large institutions for the developmentally disabled, community agencies are forced to develop new strategies and modify their models of care. The psychiatrist faces many challenges in treating patients in the community who are mentally ill and developmentally disabled. Community treatment of psychiatric illness in the developmentally disabled requires a flexible approach and is different from traditional psychiatric office practice. In this paper, we will discuss the advantage of group home visits by the psychiatrist. Behavioral interventions, crisis management, and staff training are integral to this approach. The use of rational psychopharmacology, early detection of side effects, and appropriate management of adverse reactions are important aspects of care. The psychiatrist has an expanded role in detecting medical problems in patients who are uncooperative and nonverbal. This enables referrals to appropriate specialists. The rewards are improved patient care and efficient delivery of services.

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Symposium 6 **Thursday, October 10**
2:00 p.m.-5:00 p.m.

PRACTICAL PSYCHOTHERAPY OF SCHIZOPHRENIA AND THE PERSON INSIDE

Joel Kanter, M.S.W., *Senior Clinician, Fairfax City Health Services, 8850 Richmond Highway, Alexandria, VA 22309;* Marcia Kraft Goin, M.D., Ph.D., *President-Elect, APA Board of Trustees, and Clinical Professor of Psychiatry, University of Southern California, Keck School of Medicine, 1127 Wilshire Boulevard, Suite 1115, Los Angeles, CA 90068*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify practical strategies for psychotherapy with severely mentally ill patients in community settings.

SUMMARY:

As biological interventions with schizophrenia and other psychotic disorders have received increasing attention, the utility of psychotherapeutic approaches has been questioned as ineffective and unaffordable. However, significant functional impairments continue even after treatment with the most advanced pharmacological interventions. These impairments can often be effectively addressed with psychotherapeutic approaches, in conjunction with medications, tailored to contemporary community settings.

In this symposium, the presenters will share their clinical experiences regarding treating persons with schizophrenia and other psychotic disorders. These interventions focus both on the illness itself and the personal functioning of the patient apart from the illness. Recent research findings on the use of psychotherapy within a contemporary biopsychosocial understanding of these disorders will also be presented, and the implementation of such interventions in community treatment programs will be discussed.

No. 6A
THE PERSON BEHIND THE DIAGNOSIS

David A. Garfield, M.D., *Professor of Psychiatry, Chicago Medical School, 600 Burton Avenue, Highland Park, IL 60035*

SUMMARY:

This paper details the way in which the DSM-IV diagnosis can lull the treating clinician into low or no expectations for the patient. It also describes the way in which the DSM-IV diagnosis can serve as a "mask" behind which the patient can hide. Specific case examples are presented and specific practical techniques are offered to illustrate ways in which practical, meaningful contact with severely disturbed patients can be effected.

No. 6B
ENGAGING THE PATIENT WITH SCHIZOPHRENIA IN PSYCHOTHERAPY

Joel Kanter, M.S.W., *Senior Clinician, Fairfax City Health Services, 8850 Richmond Highway, Alexandria, VA 22309*

SUMMARY:

As the locus of treatment has shifted from the hospital to the community, mental health clinicians encounter special challenges in engaging persons with schizophrenia and other severe mental illnesses in a psychotherapeutic process. Wary of human relationships in general, and skeptical of psychotherapy in particular, these patients are often quite reluctant to initiate or continue in psychotherapeutic treatment. This presentation will discuss how clinicians can directly address this reluctance, educating patients about how psychotherapy, in coordination with medication, can enhance their personal and social functioning. Various modifications of traditional psychotherapy technique will also be discussed.

No. 6C
PERSONAL THERAPY: AN EVIDENCE-BASED PSYCHOTHERAPY

Gerard E. Hogarty, M.S.W., *Professor of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

Personal therapy (PT) is the first evidence-based psychotherapy for schizophrenia. Efficacy was established in two studies involving 151 patients who were treated and studied for three years. PT seeks to achieve and maintain clinical stability using appropriate pharmaco-

therapy as well as the incremental acquisition of adaptive, self-regulating strategies. The latter are designed to counter the stress-induced, affective dysregulation that frequently precipitates an episode of psychosis. Given the well-established vulnerability of schizophrenia patients to environmental stress, PT is intended to be applied in three distinct phases that accommodate the various stages of clinical stabilization and reintegration that follow a psychotic episode. It is a collaborative intervention that utilizes the patient's own self-protective strategies as well as a repertoire of well-tested techniques for prodrome management and the mastery of environmental stress.

No. 6D
PSYCHOTHERAPY FOR SCHIZOPHRENIA: RESEARCH TO PRACTICE

Wayne S. Fenton, M.D., *Deputy Director, Behavioral Research and AIDS, National Institute of Mental Health, 6001 Executive Boulevard, Room 6217, Bethesda, MD 20892-9621*

SUMMARY:

Some form of individual psychotherapy in combination with the prescription of antipsychotic medications is likely the most common treatment offered to patients with schizophrenia in the U.S. In the absence of empirical data supporting the efficacy of a particular approach, psychotherapy has been guided by ideology and deference to authority. In recent years, the reformulation of schizophrenia as a disorder requiring individualized and comprehensive treatment has allowed the development and empirical testing of new targeted and illness-phase-specific individual psychotherapies. This presentation will review randomized clinical trials that have evaluated individual psychotherapy for schizophrenia in the context of changing contemporaneous beliefs about the disorder's etiology and treatment. A general approach, termed "flexible psychotherapy," derived from historical approaches, but consistent with contemporary research findings, will be described. Simple research questions such as "What is the best treatment for schizophrenia?" must now be supplanted by the assessment of what combination of treatments will be most effective for particular patients, with particular life circumstances at a particular phase of illness. Barriers to the diffusion of research-based psychotherapies into clinical practice will be discussed.

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3. Hogarty GE, et al: Three-year trials of personal therapy among schizophrenic patients living with or independent of family I: description of study and effects on relapse rates & II: effects on adjustment of patients. American Journal of Psychiatry 1997; 154(11): 1504–1524.
4. Fenton WS: Evolving perspectives on individual psychotherapy for schizophrenia. Schizophrenia Bulletin 2000; 26:47–72.

Symposium 7 **Thursday, October 10**
2:00 p.m.-5:00 p.m.

COMMUNITY PSYCHIATRY'S RESPONSE TO THE SURGEON GENERAL'S REPORT ON MENTAL HEALTH

American Association of Community Psychiatrists

Fred C. Osher, M.D., *Director, Center for Behavioral Health, Justice and Public Law, Associate Professor of Psychiatry, University of Maryland, Baltimore, and Former APA/Bristol-Myers Squibb Fellow, 645 West Redwood, Suite PIG-08, Baltimore, MD 21201;* Andrés J. Pumariega, M.D., *Professor and Director, Child and Adolescent Psychiatry, James H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70567, Hillrise Hall, Johnson City, TN 37614-9567;* Paul S. Appelbaum, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify key action steps required to implement recommendations with the Surgeon General's Report on Mental Health.

SUMMARY:

In 1999, the first Surgeon General's Report on Mental Health was issued. This seminal document highlighted both the neuroscience of mental health and the disparities in the availability and access to mental health services. This symposium will both look back at the impact the report has had over its first two years since release and articulate action that will address the central challenge laid down by Dr. Satcher to knock down the "unwarranted sense of hopelessness about the opportunities for recovery from mental illness." It is the belief of symposium presenters that only through an ongoing inspection of the barriers to care imposed by race, culture, age, gender, and financial status can the advances in science find their application in practice. An overview of the impetus for the report, its development, and subsequent release will be provided by Howard Goldman, M.D., Ph.D., the report's senior scientific editor. Subsequent presentations will focus on the reports implied action items for specific target populations, ways to

improve access and quality of care, and the ongoing generation of new knowledge. Paul Appelbaum, M.D., President of the American Psychiatric Association, will discuss the overall implications for the mental health field.

No. 7A
OVERVIEW OF THE SURGEON GENERAL'S REPORT

Howard H. Goldman, M.D., Ph.D., *Professor of Psychiatry, University of Maryland School of Medicine, 10600 Trotters Trail, Potomac, MD 20854-4241*

SUMMARY:

The Surgeon General issued a report on mental health in December 1999 and then issued a supplement on culture, race, and ethnicity in August 2001. These reports grew out of a sense that there was a need to review the state of scientific understanding of mental health and mental illness to provide an awareness of advances in science and of the public health importance of the field. The imprimatur of the Surgeon General provides some needed lustre, objectivity, and independence to science-based advocacy for mental health services and research. The review established the magnitude of the burden associated with mental illness and the potential for reducing the burden in the scientific advances of the past several decades. The optimism inherent in the potential is balanced by an awareness of the stigma associated with mental illness and the barriers that prevent individuals from seeking help. Even when people seek help, they may not get the effective services recommended by research. This problem is even worse for members of ethnic minority groups, particularly for individuals who are poor. The reports outline courses of action to advance the mental health of the nation and its diverse population.

No. 7B
ACTION FOR PERSONS WITH DISABLING MENTAL ILLNESS: A CELEBRATION AND A CRITIQUE

Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute and Clinic, Assistant Professor of Psychiatry, University of Pittsburgh Medical Center, and former APA/Bristol-Myers Squibb Fellow, 3811 O'Hara Street, Room E-516, Pittsburgh, PA 15213*

SUMMARY:

The Surgeon General's report on mental health marks the first time in over 20 years that the mental health care system, especially public mental health services, has received significant federal attention. The implications of the report for persons with disabling psychiatric conditions, who are disproportionately cared for with public funds, are profound. This paper will consider the report's perspective, with its underlying focus on demonstrating the scientific evidence about mental illness and the impact of mental illness across the life span. The report's attention to the economics of mental illness and mental health services will also be highlighted.

The science and the economics are the context against which the Surgeon General offers a vision for the future. Actions called for include increasing the science base further, combating stigma, and improving public awareness of mental illness. Progress and barriers encountered will be considered to answer the question: Is the Surgeon General's report a platform for advocates to work from?

The paper will end with a consideration of what more may need to be done to bring significant change to the lives of persons with disabling psychiatric illnesses.

No. 7C
SYSTEMS OF CARE FOR CHILDREN'S MENTAL HEALTH: RESPONSE TO THE SURGEON GENERAL'S REPORT

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

SUMMARY:

The Surgeon General's report on mental health addressed the ongoing crisis in children's mental health services in America. Though such services have received more attention in the past 10 to 20 years, as the report indicates there are still significant gaps in access to such services (including funding and number of trained clinicians), the evidence base of clinical interventions, and their coordination with other children's health and human services. This presentation will review the report's main points on children's mental health services and present recommendations on how psychiatry in general, and community psychiatry particularly, can contribute to the response to this important area. Current initiatives in training and workforce, pilot demonstrations of interdisciplinary service and preventive approaches, and the development of evidence-based interventions being pursued by various professional organizations and federal agencies will be highlighted and expanded upon. The benefits of community-based systems of care philosophy as an ongoing framework within which we can address these challenges will be discussed. The concept of health disparities (also introduced by the Surgeon

General) will be applied to the mental health needs of children, with psychiatry's response to this part of the report being critical in addressing them.

No. 7D
ACTION ITEMS FOR IMPROVING MENTAL HEALTH CARE FOR OLDER ADULTS

Warachal E. Faison, M.D., *Geriatric Psychiatry Research Fellow, Medical University of South Carolina, and former APA/Bristol-Myers Squibb Fellow, 523 Legends Club Drive, Mt. Pleasant, SC 29466*

SUMMARY:

It is clear now more than ever that the gap in mental health services for the elderly must be eradicated due to the rapid growth of the aging population. In 1990, the percentage of the U.S. population over the age of 65 and 85 was 12.5% and 1.2%, respectively. It is projected that the percentage of the population over the age of 65 and 85 in 2010 will be 13.3% and 1.91%, respectively. Further, this population is becoming more racially and ethnically diverse.

Psychiatric disorders of late life often are undiagnosed and undertreated. Lack of appropriate diagnosis and treatment results in excessive disability. This is a likely consequence of a shortage of health professionals trained in geriatric mental health. Further, elderly patients, who do seek treatment do so in primary care settings, where the diagnosis and treatment are often inadequate. In order to successfully close the gap in mental health services for the elderly, a number of obstacles will need to be tackled including (1) lack of integration between primary and mental health care, (2) inadequate pool of health professionals with geriatric mental health training, (3) lack of awareness of late-life psychiatric disorders and preventive factors by the lay public.

No. 7E
ACTION ITEMS FOR IMPROVING ACCESS AND QUALITY

Fred C. Osher, M.D., *Director, Center for Behavioral Health, Justice and Public Law, Associate Professor of Psychiatry, University of Maryland, Baltimore, and former APA/Bristol-Myers Squibb Fellow, 645 West Redwood, Suite PIG-08, Baltimore, MD 21201*

SUMMARY:

Two key findings of the Surgeon General's Report on Mental Health are that the majority of Americans with mental health needs are not accessing mental health treatment, and that when people receive care it is often not the most up-to-date and advanced forms of treatment. Central to removing barriers to care will be concerted efforts by community mental health providers to lead a fight against stigma and discriminatory health policy. This effort must include the dissemination of the facts that a range of effective treatments exist for most mental disorders, and insurers will cover many of these services. When insurers do not pay for needed services, this too must be exposed. Improved access will require the training and deployment of sufficient providers and the development of support services (including housing and supported employment). Quality of care will be greatly enhanced by closing the gap between what we know works in the treatment of mental illnesses and the types of treatment people receive. The author will discuss action steps to close this gap.

REFERENCES:

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Symposium 8 **Friday, October 11**
8:30 a.m.-11:30 a.m.

SEPTEMBER 11: THE MENTAL HEALTH RESPONSE

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should have a deeper understanding of the clinical and administrative dynamics of the September 11 disaster.

SUMMARY:

The world changed for us all on September 11, 2001. This date has particular significance for New Yorkers and their mental health community, which responded to the World Trade Center attack with an outpouring of activity. This symposium will present descriptions of the experiences of several mental health organizations that became deeply involved in New York's disaster relief effort. These organizations represent different facets of the disaster relief system that evolved in the aftermath of the bombings. The New York City Department of Mental Health, Alcoholism, and Retardation took a lead role in organizing the many different mental health agencies and practitioners involved. Disaster Psychiatry Outreach provided psychiatric leadership and expertise. The Visiting Nurse Service of New York provided mental health clinicians with disaster experience who worked with affected individuals in both relief centers and in the community. The Columbia Presbyterian Medical Center of New York Presbyterian Hospital was involved at the emergency services and hospital level. Presentations will focus on administrative and provider perspectives, as well as ongoing efforts related to recovery. The discussant will provide an overview regarding disaster preparedness, demands on the clinician, and the importance of the recovery environment.

No. 8A
THE MENTAL HEALTH ROLE IN GOVERNMENT EMERGENCY MANAGEMENT SYSTEMS

Isaac Monserrate, A.C.S.W., *Assistant Commissioner, New York Department of Mental Health, Crisis Intervention Services, 93 Worth Street, New York, NY 10013;* Calvin Drayton

SUMMARY:

The New York City Department of Mental Health, Alcoholism, and Mental Retardation (DMH) has been deeply involved in the mental health response to the September 11 attack on the World Trade Center. DMH has a long history of providing assistance and support to victims and loved ones affected by tragic events in New York City, including the Happy Land Social Club Fire, TWA 800 and other major aviation disasters, and the 1993 World Trade Center bombing. In addition, the department has been involved in post 9/11 disaster events, such as the anthrax bioterrorism threat and the American Airlines 587 crash in Far Rockaway.

In the disaster situation, DMH functions as a central organizing agency. This is a complex administrative task that must always be responsive to the unique and unanticipated nature of each disaster. However, certain functions are typically involved, such as enlisting for participation and organizing mental health agencies and providers, and helping to coordinate the different levels of government emergency management systems. This last task is particularly critical, requiring integration of local, state, and federal agencies. Integration with the Red Cross is also required in this context. In addition, DMH is involved with disaster preparedness activities, providing training for individuals and organizations to develop clear understandings of their roles and responsibilities, as well as the development of internal and external disaster plans. This presentation will discuss these important issues in light of the DMH experience with the World Trade Center attack.

No. 8B
THE WORLD TRADE CENTER DISASTER: THE DISASTER PSYCHIATRY OUTREACH PERSPECTIVE

Anthony T. Ng, M.D., *Medical Director, Disaster Psychiatry Outreach of New York, 311 President Street, #2, Brooklyn, NY 11231*

SUMMARY:

On September 11, 2001, the United States suffered one of the most devastating attacks on its soil. Two planes crashed into the World Trade Center early that morning, along with a simultaneous attack on the Pentagon and a failed attempted hijacking that resulted in the crash of United Flight 93 in Pennsylvania. The attack on the World Trade Center resulted in the collapse of those two towers, killing over 3,000 people and injuring scores of others. Disaster Psychiatry Outreach (DPO) responded from the early moments of this disaster in New York City, and I was designated the clinical director of operation for this disaster response, subsequently the medical director. DPO's response over the next several months illustrated several key important elements in both pre- and acute-disaster management. The aim of this presentation will be to provide a detailed personal chronological account of DPO's response. This will also include a depiction of the various systems and clinical and personal issues that arose. It is my hope that at the end of the presentation, the participants will have a better understanding of some of the critical issues involved in disaster psychiatry and be able to identify ways to address these issues so as to enhance future disaster mental health response.

No. 8C
THE VISITING NURSE SERVICE'S RESPONSE TO THE TWIN TOWERS ATTACK

Linda Sacco, A.C.S.W., *Director, Community Mental Health Services, Visiting Nurse Service, Bronx Office, 1250 Broadway, New York, NY 10001;* Neil Pessin, Ph.D.; David C. Lindy, M.D.

SUMMARY:

For over a decade, the Visiting Nurse Service of New York's Community Mental Health Services (VNS) has provided psychiatric disaster relief services in response to disasters occurring in New York City. These have included the Happy Land Social fire in the South Bronx, the 1993 bombing of the World Trade Center, and airplane crashes such as TWA 800, Swiss Air 111, and the recent American Airlines 587 tragedy. Our experience functioning within New York's disaster response system helped prepare us to respond to the September 11 attacks on the World Trade Center. However, because this event affected us more directly than any before, we were, at the same time, utterly unprepared.

This presentation will discuss the roles that community-based mental health providers can play within disaster response systems, the various functions that we performed in response to 9/11 events, and the nature of the stresses that we experienced working within this world-changing event. We will focus in particular on providing services to others in the context of a disaster that also profoundly affected us.

No. 8D
THE HOSPITAL EXPERIENCE OF THE SEPTEMBER 11 ATTACK

Madeleine M. O'Brien, M.D., *Assistant Clinical Professor of Psychiatry, Columbia University, 251 Benedict Avenue, Tarrytown, NY 10591-4301*

SUMMARY:

In the immediate aftermath of the attack on the World Trade Center, medical centers in New York City prepared for thousands of casualties. Scenes of empty emergency rooms are among the most poignant memories of the September 11 tragedy. However, in the days and weeks following, psychiatric ERs began to see patients presenting with clinical syndromes related to the disaster. These initially included patients with acute stress disorder and individuals suffering from the "found vs. not found" syndrome, i.e., were loved ones known to be in the Twin Towers or not. Not knowing appeared to create greater psychopathology. Effects of secondary traumatization were seen in patients who elaborated psychotic fantasies based on the attacks. Later, patients presented with posttraumatic stress disorder, substance abuse, and domestic violence.

In addition to providing direct care, medical centers play a critical role in disaster preparedness. This presentation will discuss various clinical pictures seen in the psychiatric emergency service of Columbia Presbyterian Medical Center, New York Presbyterian Hospital. It will also address aspects of the role of hospitals in disaster response systems.

REFERENCES:

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Symposium 9 **Friday, October 11**
8:30 a.m.-11:30 a.m.

ETHICS IN COMMUNITY MENTAL HEALTH CARE: COMMONPLACE CONCERNS

American Association of Community Psychiatrists

David L. Cutler, M.D., *Member, APA Institute Scientific Program Committee, and Director, Public Psychiatry Training Program, Oregon Health Sciences University, 3181 S.W. Sam Jackson Park Road, Portland, OR 97201-3011;* Patricia Backlar, *Professor, Department of Philosophy, Portland State University, P.O. Box 751, Portland, OR 97201*

EDUCATIONAL OBJECTIVES:

At the end of this session, the participant should be able to recognize and respond to the range of ethical concerns and dilemmas that arise in community mental health care practice with persons who suffer from severe and persistent mental disorders that may impede their ability to protect their own interests.

SUMMARY:

Socrates' question "how best to live?" is not an insignificant or esoteric query. Indeed, ethics is not a highfalutin subject. Many of us reflect on and ask a similiar question. It is a question appropriate for all of us, whatever our abilities and disabilities.

Our purpose in presenting this symposium is to prompt—perhaps provoke—the audience to recognize, to reflect upon, to analyze, and to respond to the range of everyday commonplace ethical concerns and dilemmas that arise in community mental health care practice with persons who suffer from severe and persistent mental disorders that may impede their ability to protect their own interests.

The concerns that we have chosen to explore encompass and interweave personal, social, and policy matters. The topics addressed include: ethical issues relevant to mental health services in culturally diverse communities; boundary conflicts in community settings; violence and mental disorders at home and in the workplace; psychiatric anticipatory planning; ethics in neurobiological research; and conflicting interests in pharmaceutical industry support of psychiatric research and education.

Problems and conflicts in any kind of system or policy emanate from personal positions. No solution is appropriate if it does not deal with the issues at the source. For community mental health providers the issue at the source is the consumer. The well-being is the raison d'etre for community mental health programs.

No. 9A
AT HOME WITH THREATS AND VIOLENCE

Carl C. Bell, M.D., *President and Chief Executive Officer, Community Mental Health Council, Inc., and Professor of Public Health and Psychiatry, University of Illinois at Chicago School of Medicine, 8704 South Constance Avenue, Chicago, IL 60617-2746;* Morris A. Blount, Jr., M.D.; Tanya R. Anderson, M.D.

SUMMARY:

Just like everyone else, mentally ill patients are occasionally violent. The question is, when should mentally ill patients be held accountable for their violent behavior The answer is sometimes they should be held accountable and sometimes they should not be held accountable. Clinical vignettes will be given to illustrate the various shades of gray regarding when violence by mentally ill should be handled legally. In addition, the delicate subject of outpatient commitment will be discussed, and guidelines will be given for when such action is appropriate and when it is not.

No. 9B
ETHICS IN NEUROBIOLOGICAL RESEARCH

Frederick Frese, Ph.D., *Clinical Psychologist, 283 Hartford Drive, Hudson, OH 44236*

SUMMARY:

Dr. Frese discusses the issue of ethical concerns about human neurobiological research from the perspective of a person who has both been diagnosed and treated for serious mental illness (schizophrenia) and who has been a psychologist responsible for treatment of persons with mental illnesses.

He focuses attention on the recommendations of the National Bioethics Advisory Commission (NBAC) as embodied in its report, Research Involving Persons with Mental Disorders That May Affect Decision Making Capacity. In this regard he reviews newspaper reports on this topic as well as published views of senior psychiatric researchers and research administrators. Views of consumers, family members, and other advocates are also examined.

From this overview, the presenter draws conclusions and makes four specific recommendations as to how conditions can be improved with regard to the conduct of neurobiological research. His views stress the importance of input of recovering persons and more openness on the part of researchers and other professionals.

No. 9C
ETHICAL ASPECTS OF SERVING CULTURALLY DIVERSE PATIENTS

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

SUMMARY:

A basic ethical issue for clinicians is their promise to be a viable helping resource for their patients and to do no harm. Competence in treating patients from cultures other than one's own requires conceptual clarity in communication and knowledge of variables that may affect a correct diagnosis as well as treatment planning with the most potential for success.

In this presentation, ethnocultural variables are distinguished from socioeconomic minority and migration status in understanding unique stressors and strengths that affects patients' progress in treatment. Cultural issues in diagnostic and therapeutic practices, confidentiality issues, and support systems are discussed. The ethics of cultural relativism and cultural absolutism are discussed as well as situations in which the ethical obligation of healers may require modifying accepted practice in order to best serve their patient. Research data are given indicating that clinicians' cultural sensitivity and awareness of their own cognitions and values can generalize to better treatment of patients from all cultures, including their own.

No. 9D
BOUNDARY ISSUES IN COMMUNITY SETTINGS

David A. Pollack, M.D., *Associate Professor of Psychiatry, and Associate Director, Public Psychiatry Training Program, Oregon Health Sciences University, 3181 S.W. Sam Jackson Park Road, Portland, OR 97201*

SUMMARY:

Boundary issues in community-based mental health programs are more complex than those in individual psychotherapy settings, especially with respect to the increased diversity of circumstances, relationships, and locations, and the transformation of care delivery systems. Providers are often overwhelmed with service demands and obligations to meet shifting regulatory requirements, and have not consistently attended to some of the ethical dilemmas that have developed. This is a mistake that we hope to avoid.

This presentation will focus on how an urban mental health agency responded to a wide range of ethical dilemmas. In addition to the usual boundary dilemmas, such as confidentiality concerns and the relationship limits between clinician and patient that are seen in private practice settings, additional factors contributed to new ethical concerns.

Some were related to the expansion of the workforce to include staff and volunteers who are not trained in the mental health professions and who have no formal exposure to professional codes of ethics. The growing and positive movement to include consumers and families as active participants in their own and other clients' care has also created boundary dilemmas that must be addressed. The diversity of locations in which treatment services are provided, especially residential and milieu-based treatment programs, not to mention the in vivo treatment experience that are provided.

No. 9E
PSYCHIATRIC ANTICIPATORY PLANNING

Patricia Backlar, *Professor, Department of Philosophy, Portland State University, P.O. Box 751, Portland, OR 97201;* Bentson McFarland, Ph.D.; Jo Mahler, M.S.; Jeffrey Swanson, Ph.D.

SUMMARY:

Psychiatric advance directives (PADs) are modeled upon advance directives (ADs) for end-of-life care. Yet, they differ in substance and there are critical distinctions between them. PADs are intended for persons who have experienced the sort of crisis that they anticipate will recur. Patients are able to use such experience to plan for similar situations in the future, or perhaps prevent them.

Pilot research shows that patients and informal and formal caregivers found PADs to be acceptable. Yet, as currently implemented into the system, PADs are generally ignored by clinicians in outpatient and inpatient facilities. The study results substantiate that a piece of paper by itself may not change patients' attitudes, remedy a lack of resources, or improve clinical outcomes.

In a fragmented treatment system complicated by disparate treatment locations, PADs' most tangible significance may be as a mechanism in which patients (playing the central role as self-advocate) in collaboration with their service providers prepare a document, which when needed, is easily retrieved. The processes involved in the collaborative development of PADs—assessment of past crises, recognition of prodromal symptoms, surrogate appointment—may be a psychosocial intervention that that encourages stakeholder communication and enhances patients' recovery.

No. 9F
PHARMACEUTICAL INDUSTRY SUPPORT OF RESEARCH

Charles R. Goldman, M.D., *Professor of Psychiatry, University of South Carolina School of Medicine, 15 Medical Park, Columbia, SC 29203*

SUMMARY:

Ethical problems associated with conflicts of interest between the needs of the public and the profit motives of industry are having a greater and greater impact on the lives and safety of patients. This is true both in the case of the managed care industry and also the pharmaceutical industry, particularly with respect to its influence on research and education of physicians. Since the enactment of the Baye-Dole legislation in 1980, which supported the transfer of research technology from universities to commercial sources, academic-industry partnership has grown at a rate of 8.1% annually. This dramatic increase in academic-industry partnership has produced an impressive array of scientific breakthroughs and new medical treatments. It has also resulted in a disturbing degree of interdependence between academic centers and the pharmaceutical industry. At the end of the 20th century, pharmaceutical companies were spending more than $3 billion per year in the United States on clinical drug trials and over $6 billion worldwide. Seventy percent of money for clinical trials in the U.S. comes from this industry (not NIH) (Bodenheimer, 2000). At the same time, at least $11 billion is spent each year by pharmaceutical companies in promotion and marketing, which amounts to $8,000 to $13,000 per year spent on

each physician (Wazana, 2000). We discuss the ethical problems and implications of these trends.

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Symposium 10 **Friday, October 11**
2:00 p.m.-5:00 p.m.

CHILD AND ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM: DEVELOPING TOOLS FOR SYSTEMS OF CARE FOR CHILDREN'S MENTAL HEALTH

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

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should (1) understand the principles and structure underlying CALOCUS; (2) understand its utility in clinical, administrative, and research contexts; (3) understand its psychometric properties.

SUMMARY:

An important process in the treatment of children and adolescents that has long required a more objective and systematic approach is the determination of level of care. This is a complex process involving multiple determining factors that need to be considered, such as dangerousness, stability of the child's holding environment, and level of function. The system of care movement in child mental health has placed a greater emphasis on level of care placement process through its advocacy for least restrictive levels of care, treatment in the context of the child's family and community, and family empowerment. Economic factors also play a major role in level of care determination in the era of managed care, as more restrictive levels of care are linked with higher costs. However, to date there are have been few objective, open guidelines for level of care placement of children outside of the proprietary protocols developed by industry. The American Academy of Child & Adolescent Psychiatry and the American Association of Community Psychiatrists joined forces to create a tool named the Child and Adolescent Level of Care Utilization System (CALOCUS), an objective, open, and psychometrically sound instrument for level of care determination. This symposium reports the status of the development of CALOCUS, including the results of a national multisite evaluation of its reliability and validity, current experience with the instrument at multiple sites, and its potential for clinical, utilization review, and epidemiological/services research applications. A review of the instrument's development and construction as well as a demonstration with a case from the audience will be included.

No. 10A
LEVEL OF CARE UTILIZATION SYSTEM: DEVELOPMENT AND CURRENT UTILIZATION

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

SUMMARY:

Community general psychiatrists were first faced with the restriction of access to more restrictive and intensive levels of care for the treatment of patients with serious mental illness and substance abuse. Increasingly, they saw the need for an objective tool to guide decisions on level of care provision and on discharge planning. Different strategies, such as defining the criteria for admission to different levels of care or demographically based profiles such as the Level of Need-Care Assessment, have not proven to be effective for clinical decision making. The American Association of Community Psychiatrists used a number of principles and elements in the developed of LOCUS: (1) flexibility across different systems of care, (2) organization for ease of use, (3) limited and clearly defined assessment dimensions, (4) dimensions applicable to both substance abuse and psychiatric disorders, (5) dimensional variables directly relevant to service need and placement decisions rather than being diagnostically driven, (6) quantifiable dimensional ratings to allow the interaction across different dimensional variables. This presentation will review the construction and operation of the LOCUS. It will also review the psychometric properties of the instrument, which has now undergone two rounds of revisions and reliability/validity evaluation.

No. 10B
CHILD AND ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM: PRINCIPLES, CONSTRUCTION, AND SCORING

Charles W. Huffine, Jr., M.D., *Member, APA Institute Scientific Program Committee, Assistant Medical Director for Child and Adolescent Programs, King County Mental Health Division, and Past President, American Association of Community Psychiatrists, 3123 Fairview Avenue, East, Seattle, WA 98102-3051*

SUMMARY:

The determination of levels of care for the psychiatric treatment of children and adolescents is performed based on given conceptual principles that underlie the assessment of a number of factors that clinicians determine to be predictive. The literature on level of care placement has pointed to five significant factors in the determination of level of care: individual level of function; the level of dangerousness faced by the child; the stability of the child's environment; the presence of comorbidity of psychiatric, substance abuse, and medical conditions; and the engagement of the child and family in the treatment process. This presentation reviews the principles underlying the CALOCUS instrument, particularly the principles associated with community-based systems, the construction of the assessment dimensions in the development of the instrument, and the operational definitions of levels of care within a system of care that it provides. Modifications from the adult version, which account for the impact of development on children in general and developmental differences between children and adolescents, the centrality of the child's relationship with his/her family, and both the vulnerability and resiliency found in emotionally disturbed/mentally ill children and adolescents, will be highlighted. The different methods of scoring for the assessment dimensions and critical cut-offs for mandatory assignment to particular levels of care will also be discussed.

No. 10C
CHILD AND ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM: RELIABILITY AND VALIDITY

Theodore J. Fallon, Jr., M.D., M.P.H., *Clinical Assistant Professor, Hahnemann Medical College of Pennsylvania, 2162 Miller Road, Chester Springs, PA 19425*

SUMMARY:

The construction of CALOCUS was undertaken from a conceptual basis using an expert consensus process to establish face validity. However, psychometric testing to evaluate its validity and reliability are essential to demonstrate its objectivity and utility. In this presentation, we will present the results of a four-site, CMHS-funded national evaluation (Philadelphia; Portland, Oregon; Hawaii; and regions in North Carolina) of its reliability and validity. Reliability testing involved case vignettes developed by members of the combined task force for different levels of care. Intraclass correlation coefficients for two of 17 vignettes for 16 child psychiatrists (involved in CALOCUS construction) and 78 non-psychiatrists (mostly Masters-level social workers) were calculated. For psychiatrists, coefficients for subscales ranged from 0.73–0.93 and 0.89 for composite scores. For nonphysicians, coefficients for subscales ranged from 0.57–0.95, and 0.93 for composite scores. Validity was compared in actual clinical ratings with the Children's Global Assessment Scale (N = 182) and the Child and Adolescent Functional Assessment Scale (N = 614). Pearson correlation coefficients were higher (0.52–0.26) between CALOCUS dimensions that measured some aspect of child function and the C-CGAS and the CAFAS total scores, but low (0.22 to 0) with those dimensions measuring aspects not related to the child. Correlations between CALOCUS total score and each of these instruments were strong (with CGAS–0.33; with CAFAS–0.62). Additional data on predictive validity and on its operation with demographic and clinical subgroups will be also presented.

No. 10D
CHILD AND ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM: CLINICAL AND SYSTEMS UTILITY

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

SUMMARY:

The CALOCUS promises to provide significant assistance for the clinician or treatment team faced with the often difficult decision of determining the level of care placement of a child, offering a level of objectivity for this process without sacrificing clinical judgment and flexibility needed in the treatment planning for a child and family with multiple clinical, developmental, and social needs. CALOCUS also has the potential of enhancing the information management systems that are essential to operate effective community-based systems of care. This presentation will first report on the current experience of multiple sites with the clinical and administrative use of the CALOCUS. This has ranged from its use to reduce excess child residential bed capacity in one state (Alabama), its use in addressing the requirements of a class-action lawsuit in another state (Hawaii), and in multiple sites for preauthorization, utilization review, and quality assurance. Special attention will be devoted to the experience of users with its burden of use and required expertise in its operation. The presenter will then use audience-generated case presentations to demonstrate its clinical utility, guiding the participants through the steps of dimensional assessment and scoring, decision-tree algorithm, and the assignment of a level of care rating. This presentation will also discuss the possible application of the CALOCUS within large systems of care for information management and system decision support/quality improvement as well as its uses in services research.

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Symposium 11 **Saturday, October 12**
8:30 a.m.-11:30 a.m.

THE DIFFICULT-TO-TREAT PSYCHIATRIC PATIENT

Mantosh J. Dewan, M.D., *Chair, Department of Psychiatry, State University of New York, Upstate Medical University, 750 East Adams Street, Syracuse, NY 13210*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to enumerate and prioritize the available somatic and psychotherapeutic options for difficult-to-treat patients with schizophrenia, borderline personality disorder, and posttraumatic stress disorder.

SUMMARY:

Data show that psychiatric practice is increasingly comprised of difficult-to-treat patients in every diagnostic category. In fact, many clinicians consider several categories e.g., eating disorders and post-traumatic disorder, to be synonymous with "difficult to treat." This symposium asks four leading clinician-scholars to present clear, user-friendly clinical algorithms for difficult-to-treat patients in their area of expertise. Data found in standard textbooks e.g., diagnostic definitions, epidemiology, etiological theories are avoided. Instead, there is a brief presentation on the efficacy of first-line treatments, which identifies the significant number (often 30%–50%) of patients who do not respond adequately to either biological or psychological treatments. The emphasis is on presenting the next steps with the aim of maximizing treatment effectiveness based on a critical review of the biological and psychotherapies literature. These experts are also challenged to share their clinical wisdom when scientific data have been exhausted but the patient continues to be ill. Clinical vignettes are used to illustrate treatment considerations. Four areas—schizophrenia, post-traumatic stress disorder, borderline disorder, and depression are presented followed by a panel discussion with the audience on common themes that arise when working with the difficult-to-treat patient.

No. 11A
THE DIFFICULT-TO-TREAT BIPOLAR PATIENT

Frederick K. Goodwin, M.D., *Director, Psychopharmacology Research Center, George Washington University Medical Center, 2300 Eye Street, N.W., Roff Hall, Room 514, Washington, DC 20037*

SUMMARY:

Bipolar disorder is often a refractory illness. Treatment resistance is particularly prominent in particular diagnostic subtypes of bipolar disorder, such as mixed episodes and rapid cycling, and it also appears to be associated with chronic antidepressant treatment. Clinical correlates of treatment resistance include onset of illness with a major depressive episode, substance abuse, mood-incongruent psychotic features, and psychiatric and medical comorbidities.

Management involves replacing or combining lithium treatment with anticonvulsants or atypical antipsychotic agents. Other adjuncts include benzodiazepines, thyroid hormone, and ECT for the most refractory cases. Antidepressants should be used cautiously, mainly in the acute depressive episode, and always with concomitant mood stabilizers. Above all, the treatment of bipolar disorder, whether refractory or not, is complex and requires careful attention to the therapeutic alliance.

No. 11B
THE DIFFICULT-TO-TREAT PATIENT WITH BORDERLINE PERSONALITY DISORDER

Kenneth R. Silk, M.D., *Professor and Associate Chair, Department of Psychiatry, University of Michigan Health System, 1500 East Medical Center Drive, CFOB-Box 0704, Ann Arbor, MI 48109–0704;* Mary Zanarini, Ph.D.

SUMMARY:

Borderline personality disordered patients are often considered to be synonymous with difficult-to-treat patients. They are taxing on treatment systems and suffer from high morbidity, dysfunction, and mortality. This presentation will emphasize the importance of establishing a therapeutic alliance despite the patient's consistent and chaotic interpersonal style. The principles specific to establishing an alliance and setting up the ground rules for treatment will be elucidated. The importance of transference issues will be addressed.

Equally important is the management of medication in these patients. Medications can often be helpful but must be used carefully, particularly since they can become pawns in the therapeutic relationship. Specific classes of medications will be evaluated for their efficacy in borderline personality disorder, and the principles for their use will be enumerated.

No. 11C
THE DIFFICULT-TO-TREAT PTSD PATIENT

Randall D. Marshall, M.D., *Associate Professor of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 69, New York, NY 10032;* Elizabeth A. Hembree, Ph.D.; Lee A. Fitzgibbons, Ph.D.; Edna Foa, Ph.D.

SUMMARY:

Knowledge regarding effective treatment of post-traumatic stress disorder (PTSD) has advanced considerably in recent years. Empirically based expectations of treatment course and outcome alert us early when a patient is not responding. However, the existing body of literature informs us little about the characteristics of PTSD sufferers who are difficult to treat or respond poorly to interventions of proven effectiveness. In this presentation, we combine clinical wisdom and experience with what the literature does offer and make recommendations for working with difficult-to-treat PTSD patients.

Most of the controlled studies of PTSD treatment have been conducted with cognitive-behavioral and pharmacological interventions. We briefly review the treatment literature for both biological and cognitive-behavioral therapies, present a summary of our knowledge of nonresponders, discuss treatment strategies for the difficult-to-treat PTSD patient with special emphasis on strategies that may be implemented with psychosocial treatment, and present a case vignette that serves to illustrate such a person.

No. 11D
TREATMENT-RESISTANT SCHIZOPHRENIA

Mantosh J. Dewan, M.D., *Chair, Department of Psychiatry, State University of New York, Upstate Medical University, 750 East Adams Street, Syracuse, NY 13210;* Ronald W. Pies, M.D.

SUMMARY:

Despite the evident benefits of neuroleptics, about 40% of neuroleptic-treated patients continue to show moderate to severe psychotic symptoms, and 8% show no improvement or become worse. Between 5% and 25% of schizophrenia patients can be considered unresponsive to standard neuroleptics. However, these figures do not take into consideration several important measures of treatment outcome, including social function, cognitive function, work function, rehospitalization, and suicide risk. When these issues are considered, the incidence of treatment resistance is undoubtedly higher. Depending on operational criteria and patient characteristics, some 30% to 50% of patients with symptoms of schizophrenia do not respond to conventional neuroleptics. Standard agents have minimal long-term effects on negative symptoms, neurocognitive symptoms, and mood symptoms of schizophrenia. Clozapine—arguably the "gold standard" of efficacy among the atypical agents—is effective in about 40% of neuro-

leptic-refractory patients. Rates of response in well-defined refractory populations have not yet been determined for the other atypical agents, though clinical data look promising for risperidone and olanzapine. In this presentation, we will discuss the various reasons for treatment resistance in schizophrenia, including inherent biological factors (metabolic, pharmacodynamic, absorptive, neurodevelopmental); medication-related issues; duration of trial; adequacy of dose; adequacy of plasma antipsychotic level; patient compliance factors; patient comorbidity; and inappropriate use of psychosocial intervention. The management of these problems will also be discussed.

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Symposium 12 **Saturday, October 12**
8:30 a.m.-11:30 a.m.

CONSUMER MENTAL HEALTH AIDES IN A CRISIS SERVICE: PUSHING THE ENVELOPE

Elizabeth M. Lucht, M.S.S.W., *Program Director, Mental Health Center of Dane County, Madison, Wisconsin, 625 West Washington Avenue, Madison, WI 53703;* Donald A. Coleman, M.S.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss advantages of using consumer aides in a crisis service, as well as recognize useful supervision strategies, boundary issues, and other concerns that can arise and methods of addressing these.

SUMMARY:

There is growing acceptance that consumers can have important roles as staff workers in community mental health centers. This has brought clinical gains but has also brought to the forefront many issues; these include questions about ethics and boundaries, appropriate and useful supervision strategies, and liability and other legal concerns. Consumer employees can find their work meaningful but also can experience significant stress from serving in dual roles. Despite these complex issues, there are good reasons to use consumer aides, including better outreach capabilities, better ability to engage with hard-to-reach consumers, an increased sense of trust on the part of service utilizers, and a change in client-staff relationship to one that models collaboration. The Mental Health Center of Dane County has been using consumer aides in our crisis unit for more than five years. We have found that even people with a very significant disability can be effective in aide positions with appropriate supervision and support. This symposium is designed for community mental health professionals and will discuss general principles as well as our experience with consumer crisis aides.

No. 12A
CLINICAL ADVANTAGES OF USING CONSUMER CRISIS AIDES

Elizabeth M. Lucht, M.S.S.W., *Program Director, Mental Health Center of Dane County, 625 West Washington Avenue, Madison, WI 53703*

SUMMARY:

Within the emergency services unit of the Mental Health Center of Dane County, consumer mental health aides provide many services. They deliver medications, offer informal supportive counseling and social support, assist with transportation, help apply for services, and provide assertive outreach to hard-to-serve individuals. Aides have even spent the night at a client's home as an alternative to inpatient psychiatric hospitalization. Consumer service providers can do many things professionals can't—the sense that they have "been there" often increases compliance with treatment recommendations, openness about symptoms, and willingness to work collaboratively. For clients, consumer service providers can often provide a positive role model and a sense of hope, particularly when clients with a newly diagnosed illness have the belief that they will never again lead a productive life. For colleagues, they can offer insight into the experience of clients, increasing cultural sensitivity and appropriateness of treatment methods offered. This presentation will discuss ways in which utilizing consumer providers increases quality of care and will briefly review recent research.

No. 12B
SUPERVISION STRATEGIES TO EMPOWER CONSUMER PROVIDERS

Jennifer Koberstein, *Director, Soar Case Management, 1810 South Park Street, Madison, WI 53713*

SUMMARY:

Supervising consumer providers of mental health services can provide challenges to even experienced supervisors. While many of the issues are the same as in any other supervisory relationship, additional issues arise as well. A supervisor may be unsure of how to respond when an employee is experiencing an increase in psychiatric symptoms. Employees who are former or current clients may still be affected by the treater/client power differential and may have difficulties resolving conflicts. Supervisors who are not used to working collaboratively with consumers may find themselves behaving more directively than they need to. Conversely, supervisors who take a more "hands-off" approach may not be directive enough, particularly when supervising employees with a significant disability. Employees may experience role confusion and might need additional support in order to negotiate this without experiencing burnout or an increase in symptoms. This presentation will address some possible supervisory problems and strategies to manage them within a recovery-oriented framework.

No. 12C
CONSUMERS AS PROVIDERS: A CONSUMER'S PERSPECTIVE

Jean B. DeJong, *Mental Health Aide, Emergency Services Unit, Mental Health Center of Dane County, 625 West Washington Avenue, Madison, WI 53703*

SUMMARY:

For mental health consumers who are hired to work as service providers, this life transition usually represents one step in a long journey. Some consumers find the transition easy; for others there are many struggles involved, including role confusion and boundary issues. Becoming a paid caregiver can also be a positive experience, formally recognizing the strides the consumer has made in his or her own recovery from mental illness. The very assistance that a consumer gives to help another person recover his or her life and sense of self in turn can increase the consumer's sense of self-worth. For many consumers, the sense of having come full circle is therapeutic, while for others it can also be spiritually fulfilling. In this presentation, a mental health consumer will talk about her journey from being a homeless "paranoid schizophrenic" to becoming an invaluable member of an emergency mental health treatment team.

No. 12D
ETHICS AND BOUNDARIES WHEN CONSUMERS BECOME STAFF

Lori L. Blahnik, M.A., R.N., *Associate Manager, Emergency Services Unit, Mental Health Center of Dane County, 625 West Washington Avenue, Madison, WI 53703*

SUMMARY:

As consumer crisis aides have become an integral part of the emergency services unit of the Mental Health Center of Dane County, issues regarding ethics and boundaries have arisen. Professional staff and consumer crisis aides grapple with many challenges including determining the level of involvement in the workplace (i.e., a "fully integrated" staff member vs. limited role provider), determining the appropriateness of access to client records, dealing with exacerbations of psychiatric symptoms in consumer crisis aides if/when they occur, addressing safety issues, making hiring decisions about clients currently in treatment in the unit and/or those committed to involuntary treatment, discussing the professional staff/crisis aide boundary issues, level of comfort with social gatherings, etc. This presentation will address some of the ethical and boundary issues encountered and discuss currently used and potential strategies for dealing with them. Current research will be reviewed, and recommendations will be made for future research.

No. 12E
A PSYCHIATRIST'S PERSPECTIVE

Robert M. Factor, M.D., Ph.D., *Medical Director, Emergency Services Unit, Mental Health Center of Dane County, and Clinical Professor of Psychiatry, University of Wisconsin Medical School, 625 West Washington Avenue, Madison, WI 53703*

SUMMARY:

In using consumers as crisis aides on our community-based crisis intervention and resolution team, we have "pushed the envelope" programmatically, as described by the other presenters. For psychiatrists, who in many respects represent the most conservative discipline within mental health, pushing this envelope presents special challenges. The psychiatrist feels ultimately responsible and liable for all that goes on, and is very often viewed this way by those inside and outside the mental health center. However, in the case of crisis aides, the psychiatrist may be the team member who has the least knowledge of and the least direct supervision of what they do.

The psychiatrist will feel more comfort, and the program will benefit more from the work of all its members, to the extent that the psychiatrist can do both of the following: be open to creative solutions to difficult clinical problems, and trust the aides, their supervisors, and the integrity and value of the aide program. For our mental health team, using aides was a logical next step in our evolution to share responsibility, to increase the

integration and diversity of our staff, and to enhance our use of a recovery model of care for persons with chronic illness.

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Symposium 13 **Saturday, October 12**
2:00 p.m.-5:00 p.m.

MEETING THE TRAINING NEEDS OF COMMUNITY MENTAL HEALTH STAFF

Neil Pessin, Ph.D., *Director, Community Mental Health Services, Visiting Nurse Service of New York, 1250 Broadway, Third Floor, New York, NY 10001;* David C. Lindy, M.D., *Clinical Director and Chief Psychiatrist, Community Mental Health Services, Visiting Nurse Service of New York, and Associate Clinical Professor of Psychiatry, Columbia University, 1250 Broadway, Third Floor, New York, NY 10001;* Paula G. Panzer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should have an appreciation for some of the training needs of community mental health staff and some methods for meeting those needs.

SUMMARY:

As a complex organizations with multiple constituencies, community mental health programs must provide a large variety of clinical services. Accordingly, there are many different kinds of demands placed upon staff. Services grow, roles change, problems emerge. An array of urgent training needs arise, but responding to these needs can be very challenging in light of the disparate nature of clinical problems and staff backgrounds. Addressing these needs also occurs in an economy of scarce resources.

The Visiting Nurse Service of New York's Community Mental Health Services (VNS) operates 24 programs throughout New York City, spanning a wide range of clients, psychosocial issues, and psychiatric disorders. Training needs are complicated by the outreach nature of all VNS clinical services, raising difficult supervisory and logistical issues. This symposium will present projects that we have developed to address very different training needs. They include: 1) a counter-transference-oriented training to enhance engagement of geriatric patients, 2) a disaster relief training for mental health clinicians in the wake of the September 11 attacks, 3) a group for supervision of supervisors with a focus on psychodynamic process, and 4) the Community Mental Health Services University, a 13-part curriculum design to cover the essentials of clinical psychiatry for all mental health workers.

A discussant expert in training and community services will offer her thoughts on the issues raised, and we will seek active audience participation.

No. 13A

TRAINING STAFF TO HELP ELDERLY PATIENTS ACCEPT MENTAL HEALTH TREATMENT

Leila B. Laitman, M.D., *Psychiatrist, Community Mental Health Services, Visiting Nurse Service of New York, 1601 Bronxdale Avenue, Bronx, NY 10462;* Rebecca Morales, C.S.W.

SUMMARY:

Many people refuse referral into the mental health system because of factors such as stigma, lack of mobility, finances, presence of cognitive deficits, medical comorbidity, lack of social support, and others. Staff can develop feelings of frustration in constantly dealing with help-rejecting patients. They can collude with a patient's belief that no additional services are necessary or lose faith in the efficacy of mental health linkage for geriatric patients. Training staff in specific techniques of interviewing and engagement that are appropriate for the geriatric population can address some of these difficulties.

The goal of the In-Home Geriatric Mental Health Program of the Visiting Nurse Service of New York is to assess geriatric clients with psychiatric symptoms in their homes and link them with ongoing care by community resources within eight weeks. The resources can include mental health treatment, medical treatment, social services, case management, home care, or legal services. While developing a quality improvement plan, we discovered that only 14% of patients from the service over a one-year period actually accepted a mental health treatment referral. In response, we developed a 12-session training program focused on interviewing and engagement techniques to overcome patients' and family resistances to mental health follow up. Countertransferential feelings of the workers were addressed as well. Dispositions were monitored, and the mental health referral acceptance rate was calculated throughout the course of training, up through the following year. There was a 20% increase in mental health linkage compared with the year before the training. Quality of service provided also improved.

Our presentation will describe this educational program, which was found to be very effective in teaching a multidisciplinary team better ways to manage a homebound elderly population with complex psychiatric problems, including cognitive deficits.

No. 13B
COMMUNITY MENTAL HEALTH SERVICES UNIVERSITY: THE ESSENTIALS FOR MENTAL HEALTH OUTREACH WORKERS

Howard Telson, M.D., *Associate Clinical Director, Community Mental Health Services, Visiting Nurse Service of New York, 1250 Broadway, New York, NY 10001;* Annette Cutrino, M.S.W.; David C. Lindy, M.D.; Neil Pessin, Ph.D.

SUMMARY:

Community mental health workers perform assessment and provide care for mentally ill individuals with complex clinical presentations in a variety of programs operated by the Visiting Nurse Service of New York. While some staff have professional degrees and training, others have more limited education and experience. Nonetheless, over time it became clear that many staff could benefit from further formal instruction to understand and plan for the clinical care of psychiatric patients in the community.

The Community Mental Health Services University (CMHSU) is a 13-module curriculum designed to educate field staff about core issues involved in their work. Topics include the mental status examination, psychiatric diagnosis and assessment, engagement, writing and presenting cases, safety in the field, and psychotropic medication. Courses are taught by a multidisciplinary faculty from within our service and use didactic as well as interactive methods.

This presentation will describe the development of CMHSU since 1998. It will also highlight its value in promoting staff cooperation and enhancing employee effectiveness and satisfaction.

No. 13C
DISASTER RESPONSE TRAINING

Keri L. Hicks, C.S.W., *Administrative Coordinator, Community Mental Health Services, Visiting Nurse Service of New York, 1250 Broadway, New York, NY 10001;* Neil Pessin, Ph.D.; David C. Lindy, M.D.

SUMMARY:

In the wake of the September 11 attack on the World Trade Center, New York's mental health community was called upon for many different forms of disaster relief work. Initially, families, loved ones, and coworkers often needed support undergoing the process of victim identification. Some required further assistance when they learned the truth. Families and colleagues of lost rescue workers from FDNY, NYPD, and EMS became another group in need. In the following weeks, businesses, corporations, and agencies requested mental health support for staff, sometimes in large numbers.

Mental health staff of the Visiting Nurse Service of New York (VNS) became very involved in providing psychiatric disaster relief services, including work at the FEMA Family Assistance Center, mobile crisis visits, and conducting "debriefing" support groups. We also were involved in bioterrorism preparedness and response activities. As the need for services continued, it became clear that VNS staff required additional training and support to conduct this stressful work in an ongoing fashion. We designed a program that included training for group leaders, grand rounds, debriefing sessions, and participation in outside trainings. This presentation will describe our program.

No. 13D
THE SUPERVISION GROUP: ROLE OF PSYCHODYNAMICS

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

SUMMARY:

Supervisors of community-based mental health programs must frequently deal with complicated clinical situations and challenging supervisees. They can feel isolated and uncertain as they confront difficult decisions, and worry that they are the only ones who feel this way. They may also be reluctant to share such concerns with their supervisors, in parallel process with their supervisees who are reluctant to share their concerns with them. In addition, it is easy for all of us to lose sight of the dynamics that play out over time between people as we get caught up in the urgencies of the moment, even as these dynamics bear on what unfolds in the moment.

A psychodynamic framework can illuminate many of these supervisory issues as they relate to ideas such as group process and transferencecounter-transference paradigms. These ideas can be central, yet underappreciated. We designed a group experience to promote supervisory skills in supervisors by learning about psychodynamics. Supervisors managing some of the 25 programs operated by the Visiting Nurse Service of New York's Community Mental Health Services have participated in the groups. The group, which meets monthly over a six-month period, is co-led by the two clinical/administrative leaders of the service. Staff directly reporting to the group leaders is not included in this group. Each group develops its own fascinating process, which becomes a major focus of the group and is related to relevant aspects of the supervisory issues raised by group participants. This presentation will discuss the benefits and dangers of this mode of supervision.

REFERENCES:

1. Pearlin LI, Skaff MM: Stressors and adaptation in late life, in Emerging Issues in Mental Health and Aging. Edited by Gatz M, Walsh, D.C. American Psychological Association, 1995; pp. 97–123.
2. Kennedy G: Mental health consultation in the general hospital, home or nursing facility, in Geriatric Mental Health Care. Kennedy G. New York, The Guilford Press, 2000 pp. 248–281.
3. Williams J, Swartz M: Treatment boundaries in the case management relationship: a clinical case and discussion. Community Mental Health Journal 1998; 34:299–311.
4. CMHS Disaster Response and Recovery: A Handbook for Mental Health Professionals. Department of Health and Human Services, 1994.
5. Freud S: Group psychology and the analysis of the ego. The Standart Ed 1955; 18:67–143.

Symposium 14 **Saturday, October 12**
2:00 p.m.-5:00 p.m.

THE SURGEON GENERAL'S REPORT ON CULTURE AND MENTAL HEALTH: PSYCHIATRY'S RESPONSE

American Association of Community Psychiatrists

Andrés J. Pumariega, M.D., *Professor and Director, Child and Adolescent Psychiatry, James H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70567, Hillrise Hall, Johnson City, TN 37614-9567;* Russell F. Lim, M.D., *Clinical Assistant Professor of Psychiatry, University of California at Davis, and Medical Director, Northgate Point, 601 West North Market Boulevard, #100, Sacramento, CA 95834*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should become familiar with the Surgeon General's supplement on race, ethnicity, and mental health; how America's diversity impacts the practice of psychiatry at all levels; and action steps in the areas to care, training/workforce, research, and standards of care that American psychiatry can undertake to respond to the report.

SUMMARY:

A rapidly growing proportion of the population of the United States comes from non-European cultural/racial backgrounds, especially among the young. By the year 2050, there will be no majority group within the population of the United States. The "Surgeon General's Supplement on Race and Ethnicity in Mental Health" not only highlights the challenges presented by these changes, but also the consequences of not addressing them in terms of mental health disparities for these important populations. This symposium extends the discussion of the Surgeon General's reports into this seminal volume and presents action steps in critical areas (access to care, training, research, and quality improvement/standards of care) that American psychiatry can take in order to address the challenges that stem from our greater diversity as a nation. Our success in facing this challenge will determine the future relevance and success of American psychiatry, both within our borders as well as internationally.

No. 14A
THE SURGEON GENERAL'S REPORT ON CULTURE AND MENTAL HEALTH: AN OVERVIEW

Steven Lopez, M.D., *Professor of Psychiatry, University of California at Los Angeles, Los Angeles, CA 90095*

SUMMARY:

The Surgeon General provided a groundbreaking report concerning the mental health status of the four main ethnic minority groups in the United States. The report's background is presented, specifically, the impetus for the report and how it was carried out. Then the main findings are reviewed. In particular, attention is given to the shifting demographics, the need for mental health services, inadequate access to services, and the poor quality of care. The main message of the report—culture counts—will be discussed as it pertains to the conceptualization of culture and its implications for the delivery of culturally competent mental health services. The Surgeon General provided a roadmap for improving services to ethnic minority groups. The responsibility resides with stakeholders to work together to ensure that quality mental health services are available for all Americans.

No. 14B
ACCESS TO CARE: RESPONSE TO THE SURGEON GENERAL'S REPORT ON CULTURE

Annelle B. Primm, M.D., M.P.H., *Associate Professor and Director, Community Psychiatry Program, Johns Hopkins School of Medicine, 600 North Wolfe Street, Meyer 144, Baltimore, MD 21287-7180*

SUMMARY:

A significant proportion of ethnic minorities with mental health needs do not seek specialty mental health care. Reasons include under-recognition of symptoms, stigma, lack of insurance, use of alternate sources (primary care providers, faith community, traditional healers), and limited education about mental health. Lack of awareness among health providers of important cultural and ethnic factors in mental health further contributes to inadequate treatment of diverse patient populations. This presentation will address strategies for overcoming barriers to access and utilization of mental health services for ethnic minorities including those involving models of educational outreach to patients, communities, providers, and policymakers.

No. 14C
ACTION ITEMS FOR WORKFORCE RECRUITMENT AND TRAINING

Francis G. Lu, M.D., *Clinical Professor of Psychiatry, University of California at San Francisco and, Director, Cultural Competence and Diversity Program, San Francisco General Hospital, 1001 Potrero Avenue, San Francisco, CA 94110-3518*

SUMMARY:

"The Surgeon General's Report on Mental Health: Culture, Race, and Ethnicity" recommended human resource development both to increase the number of underrepresented minorities among mental health providers, researchers, administrators, and policy, as well as to encourage development of culture competence in training programs. This presentation will review the current demography of the psychiatric resident workforce and outline recruitment strategies from the AADPRT-led Workforce Consortium, composed of representatives from six psychiatric organizations. Secondly, it will present recommendations from a June 2001 APA conference, funded by CMHS, on "Cultural Competence in Psychiatry Residency Programs: Moving Toward Consensus and Implementation."

No. 14D
ACTION ITEMS FOR QUALITY OF CARE AND CARE SYSTEMS

Russell F. Lim, M.D., *Clinical Assistant Professor of Psychiatry, University of California at Davis, and Medical Director, Northgate Point, 601 West North Market Boulevard, #100, Sacramento, CA 95834*

SUMMARY:

The Surgeon General of the United States released a supplement to his report on mental health entitled "Culture, Race, and Ethnicity," which stated that "culture counts" in the diagnosis and treatment of the four identified ethnic groups. The increasing cultural diversity of the United States, as shown by U.S. Census data, requires that clinicians understand how cultural differences affect diagnosis and treatment. Between 1980 and 2000, the number of Asian Americans increased by 230%, American Indians by 139%, Hispanic Americans by 142%, and African Americans by 32%. In contrast, the Caucasian population increased by 11%. In addition, DSM-IV-TR has added new emphasis to the influence of culture on diagnosis by including an outline for cultural formulation and a glossary of culture-bound syndromes. The presentation will outline the Surgeon General's Supplement to Report on Mental Health as it pertains to improving quality of care, and how some of its recommendations parallel aspects of currently existing standards, such as found in the Cultural Competence Standards in Managed Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups, published by SAMHSA (Substance Abuse and Mental Health Services Administration)-WICHE (Western Interstate Commission for Higher Education), and the California Cultural Competence Plan. A culturally competent community mental health center will be pre-

sented as an example of how cultural competence can be implemented in county settings.

(Eds) Promoting Culturally Competence in Systems of Care. Baltimore, MD, Brookes Publishing Company, 1998.

No. 14E
ACTION AGENDA FOR CULTURALLY COMPETENT RESEARCH

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

SUMMARY:

The knowledge and skill base upon which current psychiatric practice is built relies heavily on data and concepts of European origin. However, an ever increasing proportion of the population of the United States comes from non-European cultural/racial backgrounds, especially among the young. This presents a challenge to the relevance of much of our evidence base for psychiatric diagnostic and treatment interventions to an increasing proportion of our nation and to the largely non-Western populations of the world. Our field faces the enormous task of both testing these interventions with increasingly diverse populations as well as developing an evidence base for the growing number of culturally specific interventions that have been developed to address the needs of identified populations. This presentation will review the current state of cross-cultural/ethnic evidence base in psychiatry (including diagnostic, biological, and psychological interventions) as well as outline action steps that funding agencies and professional organizations can take to address these science-based disparities.

REFERENCES:

1. U.S.D.H.H.S. Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General, Edited by Miranda J. U.S.D.H.H.S., 2001.
2. Pumariega AJ, Cross TL: Cultural Competence in Child Psychiatry, in, Basic Handbook of C&A Psychiatry, Volume IV. Edited by Noah Fitz J, Alessi N. New York, John Wiley & Sons, 1997, pp. 473–484.
3. Pumariega AJ: Cultural Competence in Treatment Interventions, in, Climate Assessment of Child & Adolescent Behavior. Edited by Vance H, Pumariega, AJ. New York: Wiley & Sons 2001, pp. 494–512.
4. CMHS, Cultural Competence Standards for Managed MH Services for Four Underserved/Underrepresented Racial/Ethnic Groups Rockville, MD, USDHHS, SAMHSA, 2000.
5. Glover S, Pumariega AJ: The Importance of Child MH Epidemiological Research with Culturally Diverse Populations, in: Hernandez M & Isaacs, M.

Symposium 15 **Sunday, October 13**
8:30 a.m.-11:30 a.m.

CURRENT LEVEL OF CARE ASSESSMENT TOOLS FOR PSYCHIATRIC AND SUBSTANCE DISORDERS

American Association of Community Psychiatrists

Kenneth M. Minkoff, M.D., *Medical Director, Choate Health Management, and Consultant and Trainer, Integrated Treatment Systems and Interventions for Co-Occurring Disorders, 12 Jefferson Drive, Acton, MA 01720*

EDUCATIONAL OBJECTIVES:

The participant should be able to: (1) describe the concept of independent de-linked dimensions of service intensity, and identify four such dimensions, (2) discuss the concept of multidimensional service intensity assessment, and identify six assessment dimensions for addiction patients and for psychiatric patients, (3) describe the current availability, utility, validity, and reliability of the ASAM PPC2R, the LOCUS, the CHOICE, and the CHOICE-Dual.

SUMMARY:

Despite the fact that there has been extensive controversy regarding managed care and concern that managed care reviewers may inappropriately deny access to intensive services, there has been surprisingly little available objective data on the process of utilization management and level of care determination. Fortunately, in recent years, this has begun to change, as there has been increasing development and investigation of more sophisticated instruments for assessment of level of care or service intensity requirements.

This symposium attempts to bring together in a single forum a presentation of the most up-to-date level of care assessment tools available in the public domain. The symposium begins with a presentation of general principles of utilization management, including the description of independent dimensions of service intensity and the concept of multidimensional service intensity assessment, and illustrates the application of these concepts to the development of utilization management manuals (CHOICE - the Choate Outline for Intensity of Care Evaluations) in a managed care oriented service continuum. The symposium continues with a description of the latest version of the American Society of Addiction Medicine Placement Criteria (2R), which incorporates increased sophistication regarding assessment of comorbid psychiatric disorders in the addiction placement pro-

cess. This presentation is followed by a presentation on the NIDA-funded ASAM Criteria Validity Study, which is attempting to demonstrate objective support for the ASAM PPC2.

The next section of the symposium focuses on the latest version of a level of care assessment tool that originated on the psychiatric side, (though also incorporating addressing comorbidity): LOCUS 2.001, developed by the American Association of Community Psychiatrists (AACP). The instrument will be described, along with current research supporting validity and reliability.

The final section of the symposium will emphasize audience participation in the level of care assessment process. Sample cases (one addiction focused, one psychiatric focused) will be distributed, and the audience will be invited to use ASAM 2R, LOCUS, and CHOICE-Dual to help determine appropriate level of care. The strengths and limitations of each instrument will then be discussed.

In total, the symposium will present the listener with an accurate portrayal of the current field of level of care assessment and the directions of future research. This material will be invaluable for anyone involved or planning to be involved in the development of, or delivery of service in, managed care systems.

No. 15A
PRINCIPLES OF UTILIZATION MANAGEMENT AND LEVEL OF CARE ASSESSMENT

Kenneth M. Minkoff, M.D., *Medical Director, Choate Health Management, and Consultant and Trainer, Integrated Treatment Systems and Interventions for Co-Occurring Disorders, 12 Jefferson Drive, Acton, MA 01720*

SUMMARY:

The presentation begins with an outline of basic principles of utilization management. This will include the concept of independent dimensions of service intensity, including biomedical, residential, treatment, and case-management intensity, which lead in turn to the reconceptualization of "levels of care" as "matrices of service intensity." In this model, the independent dimensions are de-linked so that program models can vary flexibly across dimensional categories.

The second key concept is that of multidimensional service intensity assessment. Level of care instruments are based on identifying these dimensions, and connecting ratings on each dimension, separately and together, to the identification of patient service intensity requirements. Later talks in the symposium will illustrate how this is currently being done for individuals who present with substance disorders, psychiatric disorders (for adults), and child and adolescent psychiatric disorders.

The final component of this presentation will be the application of the above concepts to the creation of a behaviorally descriptive utilization management manual (CHOICE, CHOICE-DUAL) that has been utilized in a public-sector managed care case-rate program in a vertically integrated continuum of care with a wide range of available service intensities.

No. 15B
UNDERSTANDING AND USING THE AMERICAN SOCIETY OF ADDICTION MEDICINE PATIENT PLACEMENT CRITERIA

Kenneth M. Minkoff, M.D., *Medical Director, Choate Health Management, and Consultant and Trainer, Integrated Treatment Systems and Interventions for Co-Occurring Disorders, 12 Jefferson Drive, Acton, MA 01720*

SUMMARY:

Clinicians involved in planning and managing care often lack a common language and systematic assessment and treatment approach that allows for effective, individualized treatment plans and level of care placement. The Patient Placement Criteria for the Treatment of Psychoactive Substance Used Disorders of the American Society of Addiction Medicine (ASAM), first published in 1991, provided common language to help the field develop a broader continuum of care. They were updated, and the second edition (PPC-2) was published in 1996, and a revised second edition (PPC-2R) will be published.

This presentation will explain the underlying principles that guided the original development and current edition of the ASAM Patient Placement Criteria (PPC). It will update participants about what changes and revisions were made in PPC-2R and inform participants about how to use the criteria in clinical practice.

No. 15C
PLACEMENT CRITERIA: ADVANCES AND OUTCOMES FOR SYSTEMWIDE IMPLEMENTATIONS

David R. Gastfriend, M.D., *Associate Professor of Psychiatry, Harvard Medical School, 15 Parkman Street, Wall-812, Boston, MA 02114*

SUMMARY:

The ASAM Patient Placement Criteria have benefited from multiple research trials, to the point that a new, computerized tool offers comprehensive, reliable, feasi-

ble, and high-resolution implementation. In prior research, an independent panel of the U.S. Center for Substance Abuse Treatment found sufficient face validity to recommend that states proceed with implementation and evaluation of criteria such as the ASAM criteria. A high degree of concordance of decisions between MCOs and the ASAM criteria has been reported. Support for concurrent validity and outcome comes from two trials in the ASAM Criteria Validity Study at the Massachusetts General Hospital and a third study at Roosevelt Hospital in New York City. In a V.A. hospital, naturalistic ASAM matching was associated with less subsequent service utilization than mismatching.

Standardization through the use of criteria seems likely to facilitate improved care and efficiency of addictions treatment. The result of this research is that a new computerized algorithm has been developed for clinician use that prompts assessment via structured interview and provides quantitative, standardized scoring for routine use.

No. 15D
LEVEL OF CARE UTILIZATION SYSTEM: A SIMPLE METHOD FOR LEVEL OF CARE DECISIONS

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

SUMMARY:

The Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) was developed by the American Association of Community Psychiatrists in 1995. The instrument attempts to assist in making level of care determinations while balancing the interests of maintaining quality with the demands for providing care in the most cost-effective manner possible. It is designed to be easily understood and used by clinicians. A number of other principles were identified to guide the development of LOCUS: (1) integration of mental health and addiction variables, (2) dimensional and quantifiable assessment parameters, (3) levels of care defined flexibly in terms of resource intensity rather than rigidly defined program requirements, and (4) adaptable to the variety of circumstances encountered in behavioral health environments. LOCUS has been field tested over the past five years and has been revised to accommodate suggestions obtained from that process. Preliminary testing has shown it to be reliable and consistent with expert determinations for placement decisions. This workshop will discuss the practical applications of LOCUS and will use a case example to demonstrate its utility.

REFERENCES:

1. Minkoff & Regner: Innovations in dual Dx treatment in patient care: The Cheate Dual Dx Case Rate Program. J. Psychoactive Drugs, Jan 17, 1994, pp 1–11
2. Minkoff, Level of care determination for individuals with co-ocurring psychiatric & substance disorders. J. Bon H. Admin, in press 2001
3. American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised (ASAM PPC-2R). Chevy Chase, MD, The Society, in press.
4. Mee-Lee D: Use of patient placement criteria in the selection of treatment, 370, Section 5: overview of addiction treatment in Principles of Addiction Medicine, Second Edition. American Society of Addiction Medicine Inc., Chevy Chase, MD, 1998, pp 363–370.
5. Gastfriend DR, Sharon E, Lu S: Patient Placement Criteria: Clinical Challenges and Technical Progress. Substance Abuse & Misuse, in press.
6. Gastfriend D: Patient placement criteria, in Textbook of Substance Abuse Treatment, second ed. Edited by Galanter M, Kleber HD, Washington, American Psychiatric Press, 1999, pp 121–127.
7. Sowers W: Level-of-care determinations in psychiatry. Harvard Rev Psychiatry 1998; 5:286–90.
8. Sowers W, George C, Thompson K: Level of care utilization system for psychiatric and addiction services (LOCUS): a preliminary assessment of reliability and validity. CMHJ 1999; 35(6):545–563.

Workshop 1 **Wednesday, October 9**
10:00 a.m.-11:30 a.m.

IS IT OKAY NOT TO PRESCRIBE? EXPLORING THE PRESSURES TO PRESCRIBE

Robert W. Hierholzer, M.D., *Chief, Mental Health Service, Central California Health Care System, and Associate Clinical Professor, University of California, San Francisco, 2615 East Clinton Avenue, Fresno, CA 93703*; Matthew A. Battista, Ph.D.; Néstor Manzano, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify at least three factors that have contributed to the widespread utilization of psychopharmacologic agents; recognize at least two limitations or problems associated with psychotropic medications; consider the factors at play that cause him/her to recommend medications to a patient/client.

SUMMARY:

It is impossible to deny the beneficial impact of psychopharmacologic advances of the last several years. Apart from their proven efficacy, however, there are several factors that likely contribute to the widespread prescription of these agents. This workshop aims to identify and then examine some of these factors. Among these are the rise of "medication only" appointments of decreasing duration, direct-to-consumer advertising by the pharmaceutical companies, aggressive "detailing" of mental health professionals by the pharmaceutical industry, third-party reimbursement issues, and shifts in our perceptions of what constitutes a pharmacologically responsive condition. In such a treatment climate it can be difficult to even ask whether medications should be used, much less overtly consider the limitations of medications. This workshop is not a global "antimedication" denunciation, but a forum to provoke thoughtful prescribing, or referral for medications, in a culture that often militates against that. These issues will also be considered from the perspective of psychiatry residency training. This workshop will utilize case presentations, debate, formal presentation, possibly role-playing of vignettes, and lively discussion to explore this topic. All mental health professionals are encouraged to attend and participate.

TARGET AUDIENCE(S):

Psychiatrist and those who refer patients for medications.

REFERENCES:

1. Kramer PD: Listening to Prozac. New York, Penguin Books, 1997.
2. Nesse RM: Is depression an adaptation? Arch Gen Psychiatry 2000; 57:14–20.

Workshop 2 **Wednesday, October 9**
10:00 a.m.-11:30 a.m.

CURRENT TRENDS IN THE EMPIRICALLY-SUPPORTED TREATMENT OF GAD

S. Atezaz Saeed, M.D., M.S., *Chair, Department of Psychiatry and Behavioral Medicine, University of Illinois College of Medicine at Peoria, 5407 North University, Suite C, Peoria, IL 61614-4736*; Barbara J. Zebb, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe the currently available empirically supported treatment options for generalized anxiety disorder.

SUMMARY:

Generalized anxiety disorder (GAD) is a common psychiatric disorder with a lifetime prevalence in community samples of 5%, and the prevalence reported from anxiety disorder clinics as high as 25%. The disorder is characterized by excessive anxiety and worry about a number of events or activities that have been present most days for at least six months. The person with GAD finds it difficult to control the worry. In addition GAD is also associated with behavioral and physiological manifestations. The illness typically has its onset in childhood or adolescence, and its course is usually chronic with waxing and waning of symptoms. There are a number of empirically supported treatment options available, including pharmacological approaches as well as a variety of cognitive-behavioral interventions such as cognitive therapy, worry exposure, relaxation training, worry behavior prevention, time management, and problem solving.

This workshop will summarize the best evidence in the efficacy of various treatment options and will help participants advance their understanding of these evidence-based treatment options for generalized anxiety disorder. Input from participants about their own experiences and insights will be strongly encouraged.

TARGET AUDIENCE(S):

Psychiatric clinicians and other mental health professionals

REFERENCES:

1. Brown TA, O'Leary TA, Barlow DH: Generalized anxiety disorder, in Clinical Handbook of Psycholog-

ical Disorders. Edited by Barlow D. 3rd ed., New York, Guilford, pp 154–208, 2001.
2. Gale C, Oakley-Browne M: Generalized anxiety disorder. Clinical Evidence 2001; 5, 668–678.

Workshop 3 **Wednesday, October 9**
10:00 a.m.-11:30 a.m.

INTEGRATING PRIMARY AND MENTAL HEALTH CARE IN COMMUNITY SETTINGS

Jerry Dincin, Ph.D., *Executive Director, Thresholds, 4101 North Ravenswood Avenue, Chicago, IL 60613*; Marion L. McCoy, Ph.D., *Director of Research, Thresholds, 4101 North Ravenswood, Chicago, IL 60613*; Susan C. Braun, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize psychiatric clients' critical need for access to and help with follow-through in medical care systems; recognize common comorbid illnesses for poor, urban psychiatric clients; identify essential components in an integrated primary and mental health care practice model; and have increased awareness of potential implementation pitfalls.

SUMMARY:

Integrating primary and mental health care represents a crucial, but largely unmet need, for persons with severe and persistent mental illness. Since 1998, Thresholds (a large, psychosocial rehabilitation provider in greater Chicago) has been a partner in an Integrated Health Care (IHC) Project with the University of Illinois at Chicago College of Nursing (UIC-CON). The IHC portends promising developments for community psychiatry. This innovative model brings primary health care to Thresholds' community-based programs. Coordinating efforts with program staff, clinical nurse specialists, family and advanced nurse practitioners provide hands-on health care, individual case assessments and management, medical chart documentation, and group education sessions for clients, staff, and UIC-CON students. Through the IHC, holistic care management is provided to an underserved, largely African-American population living at or near the poverty level who receive mental health treatment at Thresholds. Clients commonly suffer from comorbid conditions requiring advanced, specialty care (e.g., mental illness and diabetes). Advanced care referrals to UIC family medicine residents and faculty are built into IHC routines. Through an interactive format, presenters identify leading IHC implementation challenges, present descriptive evaluation results (e.g., top 10 health conditions affecting clients, perceptions of IHC benefits, issues in navigating health systems), and report on client satisfaction with clinics.

REFERENCES:

1. Burke N, Niezgoda S, Rose D, Marion LN: Integrating primary and mental health care: an innovative model of practice. J Am Psychiatric Nursing Assn 2001; 13:8.
2. Schwab B, Drake RE, Burghardt EM: Health care of the chronically mentally ill: the culture broker model. Community Mental Health J 1988; 24:174–184.

Workshop 4 **Wednesday, October 9**
10:00 a.m.-11:30 a.m.

THE BRISTOL-MYERS SQUIBB FELLOWSHIP: HISTORY AND RESULTS

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the historic goals and specifics of the Bristol-Myers Squibb Fellowship as reported by Henry Work, M.D., as well as past fellows' reports of its benefits.

SUMMARY:

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

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

TARGET AUDIENCE(S):

Residents, students, and faculty attendees

REFERENCES:

1. Goetz R, Cutler DL, Pollack D, et al: A three-decade perspective on community and public psychiatry training in Oregon. Psychiatric Services 1998; 49:1208–11.

2. Ranz J, Rosenheck S, Deakins S: Columbia University's fellowship in public psychiatry. Psychiatric Services 1996; 47:512–6.

Workshop 5 **Wednesday, October 9**
1:30 p.m.-3:00 p.m.

INCORPORATING EVIDENCE-BASED PRACTICES INTO ILLINOIS' PUBLIC MENTAL HEALTH SYSTEMS

Leigh Steiner, Ph.D., *Associate Director, Illinois Department of Human Services, 100 South Grand Avenue, Springfield, IL 62765*; Sheldon I. Miller, M.D.; Daniel Gifford, Ph.D.; Peter D. Nierman, M.D.; Chris Stout, Psy.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be better informed on the administrative considerations and challenges of rerouting resources from traditional to newly adopted evidence-based practices; have a greater awareness of the types of human resource supports that can be utilized to facilitate dissemination and implementation of evidence-based practices in a public mental health system.

SUMMARY:

This workshop is designed for psychiatrists and mental health professionals, including service providers, administrators, and researchers. Across the country localities are moving to incorporate evidence-based practices into their systems of care. This workshop will describe Illinois's effort to develop a statewide strategy for increasing the implementation of evidence-based practices within its public mental health system. Presenters will discuss: (1) the development of a clearinghouse on evidence-based practice research outcome efforts, (2) statewide training strategies, and (3) administrative obstacles and opportunities encountered in this effort, including the development of a matrix for evaluating goodness-of-fit between a given evidence-based practice and service environment.

TARGET AUDIENCE(S):

Psychiatrists, psychologists, social workers, mental health administrators, mental health researchers

REFERENCES:

1. Drake RE, Goldman HE, Leff SH: Implementing evidence-based practices in routine mental health service settings. Psychiatric Services 2001; 52:179–182.
2. Torrey WC, Drake RE, Dixon L: Implementing evidence-based practices for persons with severe mental illnesses. Psychiatric Services 2001; 52:45–50.

Workshop 6 **Wednesday, October 9**
1:30 p.m.-3:00 p.m.

ETHNIC BIO-DIVERSITY IN SUBSTANCE ABUSE AND MENTAL HEALTH DISORDERS

Jeffrey N. Wilkins, M.D., *Addiction Medicine Director, Department of Psychiatry, Cedars Sinai Hospital, 8730 Alden Drive, Room E-130, Los Angeles, CA 90048*; Katherine G. Mellott, M.D.; Jack Kuo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the audience should be familiar with the ethnic differences in the pharmacokinetics and pharmacodynamics of antidepressants, neuroleptics, and anxiolytics. Workshop participants should understand the implications of genetic polymorphism in the treatment of affective disorders and substance abuse.

SUMMARY:

The purpose of this workshop will be to familiarize the audience with recent findings regarding genetic polymorphisms and treatment response rates to antidepressants, anxiolytics, and neuroleptics, particularly response rates to the selective serotonin re-uptake inhibitors and their relation to ethnic differences in the activity of the hepatic enzyme CYP2D6 and the serotonin transporter protein. Significant differences in activity of these enzymes and transporter proteins have been demonstrated in the African-American, Hispanic, and Asian populations as compared with Caucasians. The significance of these findings as related to clinical practice and psychopharmacological treatment of affective disorders will be discussed. Possible implications of these findings in explaining differences in substance abuse patterns and treatment response rates among ethnic groups will be explored. The relative contribution of biological, societal, and cultural factors in the diagnosis and treatment of mental illness will be examined. Beyond a consideration of ethnicity, further discussion regarding the largely unexplored potential for gender and sexual orientation differences in diagnosis and treatment of affective disorders and substance abuse will take place. Lastly, the audience will be invited to suggest further avenues of research in biodiversity and mental illness.

TARGET AUDIENCE(S):

Mental health practitioners, especially those with a special interest in minority issues in mental health.

REFERENCES:

1. Lin KM, Poland RE, Nuccio I, et al: A longitudinal assessment of haloperidol doses and serum concen-

trations in Asian and Caucasian schizophrenic patients. Amer J Psychiatry 1989; 146: 1307–1311.
2. Gelernter J, Cubells JF, Kidd JR, et al: Population studies of polymorphisms of the serotonin transporter gene. Amer J Med Genet 1999; 88: 61–66.

Workshop 7 **Wednesday, October 9**
3:30 p.m.-5:00 p.m.

ETHICS IN PSYCHIATRY

Illinois Psychiatric Society

Surinder S. Nand, M.D., *Director, Mental Health Service Line, Vetarans Affairs Chicago Health Care Systems, 820 South Damen, Chicago, IL 60612*; Lesley M. Blake, M.D., *Chair, Ethics Committee, Illinois Psychiatric Society, 2501 Osage Drive, Glenview, IL 60025-1037*; Daniel J. Anzia, M.D.; Henry W. Dove, M.D.

EDUCATIONAL OBJECTIVES:

To learn how APA and the district branches define and promote ethical conduct, distinguish between the impaired and the unethical physician, and define and prevent boundary violations between physicians and patients and between supervisors and residents.

SUMMARY:

Physicians throughout history have felt the need for a set of ethical principles to guide their professional behavior. Integrity of profession and trust of peers and patients are the main reasons for such principles. The American Psychiatric Association has clearly defined ethical guidelines for psychiatrists. The ACGME and RRC expect that psychiatric residency programs will teach psychiatric ethics to psychiatry residents. Because ethical dilemmas in clinical practice for early career psychiatrists are not uncommon, this workshop will present how APA and its district branches define and enforce ethics. Workshop presenters will present case vignettes highlighting some common ethical situations that psychiatric residents and early career psychiatrists might encounter and ways to prevent/manage them.

TARGET AUDIENCE(S):

Psychiatry residents, early career psychiatrists

REFERENCES:

1. The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry - 2001 Edition. Washington DC, APA.
2. Gutheil TG, Gabbard GO: The concept of boundaries in clinical practice: theoretical and risk-management dimensions. Am J Psychiatry 1993; 150:188.

Workshop 8 **Wednesday, October 9**
3:30 p.m.-5:00 p.m.

EXPLORING COMPUTER SYSTEMS FOR CLINICAL PRACTICE

Daniel D. Nahum, M.D., *Department of Psychiatry, University of Kentucky, 3470 Blazer Parkway, Lexington, KY 40509-9941*; Patricia Jones-Bendel, R.N., B.S.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to enhance their understanding of an integrated clinical computer system, its advantages and limitations, and how to implement such a system in their practice.

SUMMARY:

The workshop begins with a brief presentation of PsychSystem, an integrated clinical computing system designed and programmed by the presenter with years of clinical experience. The goal was to translate this experience into a computer program that is practical, user friendly, well integrated, and addresses the mental health professional's clinical computing needs in a comprehensive way. The flow of the program attempts to emulate clinical practice and contains components for demographic information, treatment planning, progress notes, and other functions. Two psychological tests currently available on the program are a computerized version of the Bellac Ego Function Scales, and a public domain version of the SCL-90. The information contained in the program, such as diagnosis, goals, and treatments, can be modified by the user. Following the brief presentation, participants will have the opportunity for hands-on experience with PsychSystem. They will use the program to input diagnosis, patient problems, outcome, and psychotherapy and medication information. They will explore how this information is organized into treatment plans and problem-oriented medical records. In the closing section the participant will be encouraged to discuss confidentiality of computerized medical records; possible uses of computerized data for statistical, research, and administrative purposes; and limitations of these systems.

TARGET AUDIENCE(S):

Target audience is any mental health professional or student who has interest in clinical computing.

REFERENCES:

1. Griest J: Computers and psychiatry. Psychiatric Services 1995; 46:989–991.
2. Ishak W, Tal B: Computer applications in psychiatry: role in patient care, education, research and communication. CyberPsychology and Behavior 1998; 1:147–150.

Workshop 9 **Wednesday, October 9 3:30 p.m.-5:00 p.m.**

IMPROVING EFFICIENCY AND QUALITY OF CARE IN A COMMUNITY MENTAL HEALTH CENTER

Michael A. Hoge, Ph.D., *Associate Professor of Psychology, Yale University, 25 Park Street, Sixth Floor, New Haven, CT 06519*; Nancy L. Anderson, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify at least five practical strategies for increasing staff productivity and the appropriateness of treatment services delivered in the public sector through community mental health centers.

SUMMARY:

Reductions in state grant support and third-party reimbursement have led to a need for community mental health centers to function with improved efficiency. Simultaneously, managed care and the recent focus on practice guidelines have created increased pressure for these organizations to implement "best practices" and to enhance the appropriateness of care delivered. This workshop will provide an overview of practical strategies that were used to achieve these objectives in an urban mental health center. The interventions designed to improve efficiency focused on increasing staff productivity, providing improved administrative support to clinical teams, streamlining paperwork through computerization, and building the management skills of team leaders. The interventions designed to improve quality of care focused on the use of treatment guidelines to shape practice patterns and the implementation of level of care guidelines and internal utilization review procedures to match patients to appropriate treatments. The design, implementation, and impact of these interventions will be discussed. Special attention will be given to the challenge of creating and sustaining change in these provider organizations.

TARGET AUDIENCE(S):

Administrators and clinical supervisors

REFERENCES:

1. Dassori AM, Chiles JA, Swenson-Britt E: Implementing best-practice guidelines for schizophrenia in a public-sector institution. Psychiatric Services 2000; 51:972–974, 979.
2. Lehman AF, Steinwachs DM: Translating research into practice: the schizophrenia patient outcomes research team (PORT) treatment recommendations. Schizophrenia Bulletin 1998; 24:1–10.

Workshop 10 **Wednesday, October 9 3:30 p.m.-5:00 p.m.**

UPDATE ON PRACTICE GUIDELINES: SUBSTANCE USE DISORDERS AND SUICIDAL BEHAVIOR

APA Steering Committee on Practice Guidelines

John S. McIntyre, M.D., *Chair, Department of Psychiatry and Behavioral Health, Unity Health System, and Past President, American Psychiatric Association, 81 Lake Avenue, Third Floor, Rochester, NY 14608*; Laura J. Fochtmann, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to provide an update concerning the overall progress of the APA Practice Guidelines effort and obtain feedback on a wide variety of issues relation to the revised Substance Use Disorders Guideline and the forthcoming Guideline on the Management of Suicidal Behaviors.

SUMMARY:

Since its inception in 1991, the APA Practice Guidelines Project has published 12 guidelines. In developing each practice guideline, the use of an evidence-based process has resulted in documents that are both scientifically sound and clinically useful to practicing psychiatrists. In this workshop panelists will discuss the overall development process of the practice guidelines. In addition, panelists will review the outline and content of two practice guidelines that are under development: the revised Practice Guideline for the Treatment of Patients With Substance Use Disorders, which will update the recommendations of the original guideline published in 1995, and the Practice Guideline on Suicidal Behaviors. The latter guideline is unique in addressing clinically useful strategies to approach a specific behavior rather than addressing strategies to treat a specific disorder, as has been done in the other APA practice guidelines. Persons attending the session are invited to comment on the broad array of issues relating to these guidelines including the specific content of the guidelines, implications for the field, and strategies for evaluating and disseminating the practice guidelines.

TARGET AUDIENCE(S):

Residents, ECPs

REFERENCES:

1. The Harvard Medical School Guide to Suicide Assessment and Intervention. Edited by Jacobs DG. San Francisco, Jossey-Bass, 1999.
2. Zarin DA, Pincus HA, McIntyre JS: Practice Guidelines (editorial). Am J Psychiatry 1993; 150:2.

Workshop 11 **Thursday, October 10 8:00 a.m.-9:30 a.m.**

ENGAGING HOMELESS SUBSTANCE ABUSERS: APPLICATIONS FROM MENTAL HEALTH OUTREACH

Jennifer F. Frey, Ph.D., *Psychologist, ALSO-Cornerstone, Incorporated, Yale University, 34 Park Street, Room 144, New Haven, CT 06519*; Deborah A. Fisk, M.S.W.; Michael Rowe, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify differences in outreaching severely mentally ill individuals and substance abusing individuals; identify important areas of training to prepare outreach workers for outreach to substance abusers; identify potential service and systems-level issues involved in outreaching substance abusers.

SUMMARY:

A federally funded homeless outreach team in inner-city New Haven effectively served homeless persons with severe mental illness who were disengaged from services. This team consisted of a collaboration between multiple community agencies. At the conclusion of federal funds period, we expanded our mission to include outreach to substance abusing individuals who do not have severe mental illness. Drawing on the experiences of the outreach team during this transition, we will describe how we applied lessons learned in outreaching mentally ill individuals to outreaching substance abusing individuals and in what ways the work differs. We will describe the substance abuse treatment models we found helpful in understanding the new client population and determining how and when to intervene. We will present the rationale for providing outreach services to substance-abusing individuals, the differences in outreaching substance-abusing individuals and mentally ill individuals, and the difficulties that emerged involving service and systems-level issues.

TARGET AUDIENCE(S):

Service providers for homeless mentally ill, dually diagnosed, or substance abusing individuals.

REFERENCES:

1. Rowe M, Frey J, Davidson L, Fisk D: Engaging persons with substance abuse disorders: applying lessons from mental health outreach to homeless persons. Administration and Policy in Mental Health 2002, in press.
2. Tommasello AC, Myers CP, Gillis L, et al: Effectiveness of outreach to homeless substance abusers. Evaluation and Program Planning 1999; 22:295–303.

Workshop 12 **Thursday, October 10 8:00 a.m.-9:30 a.m.**

TEN YEARS AFTER RESIDENCY: ARE WE WHERE WE THOUGHT WE WOULD BE?

Matthew R. Schneider, M.D., *Department of Psychiatry, Montefiore Medical Center, 111 East 210th Street, Klau 1, Bronx, NY 10467*; Steven Bogen, M.D., *Department of Psychiatry, Phelps Memorial Hospital Center, 701 North Broadway, Sleepy Hollow, NY 10591*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to appreciate the many changes affecting psychiatrists who have finished psychiatric residencies in the recent past, better understand the challenges facing early career psychiatrists, particularly with regard to discrepancies between expectations and realities, and consider strategies to resolve career frustrations.

SUMMARY

For psychiatrists who finished their residencies 10 years ago, the current psychiatric field is remarkably different from the one that their supervisors practiced in, the one that they trained in, and the one they perhaps imagined they would be working in. Many of these changes have occurred in a rapid and somewhat geometric pattern over the last 10 years, leading many of us to wonder: "Are we where we thought we would be?" Taught to a large degree by psychoanalytic supervisors, were we mislead by these well-meaning and in many cases brilliant clinicians who rarely prescribed medication, largely ignored commonly accepted diagnostic nomenclature, and considered many of our patients "poor candidates" for treatment? Alternatively, did we allow ourselves to be seduced by unrealistic expectations? Regardless, we strive to fulfill our mission as dedicated healers practicing with ethical standards intact in an era of "medical necessity." In this workshop, we will examine the genesis of and discrepancies between our expectations and our realities and try to determine if we can reshape either to make our careers more fulfilling on a professional and personal level.

TARGET AUDIENCE(S):

Psychiatric educators, early career psychiatrists, and psychiatric residents.

REFERENCES:

1. Luhrman TM: Of Two Minds: The Growing Disorder in American Psychiatry. New York, Alfred A. Knopf 2000.
2. Detre T, McDonald M: Managed care and the future of psychiatry. Archives of General Psychiatry 1997 54:201–204.

Workshop 13 **Thursday, October 10 8:00 a.m.-9:30 a.m.**

CHALLENGING PATIENTS: A SYSTEM-LEVEL APPROACH

S. Atezaz Saeed, M.D., M.S., *Chair, Department of Psychiatry and Behavioral Medicine, University of Illinois College of Medicine at Peoria, 5407 North University, Suite C, Peoria, IL 61614-4736*; Deva Koster, R.N.; Linda L. Hughes, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize an effective and efficient system-level approach to challenging patients and populations.

SUMMARY:

This workshop will describe an intensive process that looked at the challenging patients and populations within an inpatient, university-affiliated, public psychiatric hospital. A task group composed of clinical and administrative leaders met regularly over the course of two years to look collectively at the work that was needed to make systemic changes and to make recommendations to refine and improve on the changes made as a result of the sentinel events. This process should be explored for the benefits that could be replicated at other institutions undergoing similar experiences.

The process included defining ''challenging'' patient populations (as compared with ''refractory''), review of literature on the programs and approaches to these patients and populations, and recommendations for targeted interventions/action plans to augment the ongoing efforts to provide evidence-based treatment in a safe environment. Specific attention was given to four areas: identifying treatment ''challenges,'' identifying and implementing evidence-based practices, measuring patient outcomes, and enhancing the patient-clinical partnership. The work completed significantly correlates with two important tasks outlined for the health care industry today: (1) improve mental health care, and (2) make health care safer. The expected outcome of this work is significant and lasting systems changes that will impact positively the care given in the hospital.

TARGET AUDIENCE(S):

Psychiatric administrators and educators

REFERENCES:

1. Vermeire E, Hearnshaw H, Van Royen P, Denekens J: Patient adherence to treatment: three decades of research. J Clinical Pharmacy 2001; 26:331–342.
2. Kohn L, Corrigan J, Donaldson M: To Err is Human: Building a Safer Health System. Washington, DC, Institute of Medicine, 1999.

Workshop 14 **Thursday, October 10 10:00 a.m.-11:30 a.m.**

DOMESTIC VIOLENCE AMONG ASIAN-AMERICAN WOMEN: A COMMUNITY'S RESPONSE

Indo-American Psychiatric Association and Apna Ghar

Surinder S. Nand, M.D., *Director, Mental Health Service Line, Vetarans Affairs Chicago Health Care Systems, 820 South Damen, Chicago, IL 60612*; Jagannathan Srinivasaraghavan, M.D., *Professor of Psychiatry, Southern Illinois University School of Medicine, and Medical Director, Choate Mental Health and Development Center, 1000 North Main Street, Anna, IL 62906*; K. Sujata, Ph.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify the signs of domestic violence and the cycle of violence; appreciate the physical, mental, and socioeconomic consequences of domestic violence; and learn about the Asian-American community's response to domestic violence in a metropolitan city.

SUMMARY:

It is estimated that approximately 4 million American women are battered by their husbands or partners each year. More than 1 million women seek medical attention for injuries caused by domestic abuse. Anxiety, depression, and posttraumatic stress disorder are some of the psychiatric sequelae of such abuse. Domestic violence occurs among all races, cultures, and socioeconomic groups. Fire setting and dowry deaths in India are examples of domestic violence. As the Asian-American population grows in the U.S., the extent and the gravity of domestic violence among this population is becoming more apparent. The need is growing for culturally sensitive and linguistically appropriate health services among Asian-American communities. Throughout the U.S., Asian-American communities have mobilized and developed a variety of programs to help battered women break away from the cycle of abuse. In Chicago, Apna Ghar (Our Home) is the first such shelter and comprehensive domestic violence program, which serves over 200 women per year.

The presenters will describe the signs of domestic violence, the cycle of violence, the medical, mental health, and socioeconomic consequences of domestic violence. Apna Ghar's accomplishments in its mission to prevent and eradicate domestic violence will be highlighted.

TARGET AUDIENCE(S):

Psychiatrists, psychologists, social workers, other health care workers

REFERENCES:

1. Abraham M: Speaking the Unspeakable: Marital Violence Among South Asian Immigrants in the United States. Rutgers University Press.
2. Merchant M: A comparative study of agencies assisting domestic violence victims: does the South-Asian community have special needs? J Social Distress and Homeless 2000; 9:249–259.

Workshop 15 **Thursday, October 10**
10:00 a.m.-11:30 a.m.

VOICES FROM GOD: RELIGIOUS OR PSYCHOTIC?

APA Center for Mental Health Services
AstraZeneca Minority Fellows

Daphne Dorce, M.D., *APA Center for Mental Health Services AstraZeneca Minority Fellow, and Department of Psychiatry, Harvard University at Longwood, 330 Brookline Avenue, Boston, MA 02301*; Rose M. Pham, M.D.; Dawn Fyler, M.D.; Quinton Moss, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant should be able to recognize the key differences in determining whether a patient is religious or psychotic. One should have a better understanding of the role of religion and the community at large on the care of a patient and how they can be incorporated in the treatment plan.

SUMMARY:

Is Mr. Jones psychotic because he comes into the emergency department stating that he speaks in tongues and hears voices from god? How does one make that determination? What is Mr. Jones's religious affiliation, and has the clinician asked him this question on the initial assessment? What role does religion play in his life? These are some of the questions that a clinician is faced with when assessing a psychotic patient who may be espousing religious beliefs or religious practices that are unfamiliar to others. When a patient presents to the emergency department and is said to be psychotic, what does that entail? The goals of the workshop are to answer the following questions: What are the guidelines in evaluating a psychotic patient? Where does one draw the line between religion and psychosis? What do clinicians need to know in regards to commonly held religious beliefs? How can we as clinicians educate the religious community about mental health; and how can the community at large be incorporated in the treatment plan of a patient with mental illness?

REFERENCES:

1. Pierre J: Faith or delusion? At the crossroads of religion and psychosis. Journal of Psychiatric Practice 2001.
2. Lukoff D: Diagnosis of mystical experiences with psychotic features. J Transpersonal Psychology 17:155–181.

Workshop 16 **Thursday, October 10**
10:00 a.m.-11:30 a.m.

THE COOK COUNTY JAIL PROJECT: LESSON IN THE POWER OF INTERGOVERNMENTAL COLLABORATION

Thomas A. Simpatico, M.D., *Consultant, APA Institute Scientific Program Committee, and Chief, Bureau of Chicago Network Operations, Chicago Read Mental Health Center, 4200 North Oak Park Avenue, Building K, Chicago, IL 60634*; Ronald Simmons, Psy.D.; Carl J. Alaimo, Psy.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) understand that Cook County jail is a key component in the mental health service system for metro Chicago; (2) understand some of the key strategies that have allowed three large bureaucracies (state, county, and city) to work together in the interests of patient care; (3) understand the types of programs that have been implemented as a result of this collaboration (4) understand the impact these programs have had o mental health service delivery in Chicago.

SUMMARY:

This workshop will describe the effectiveness of series of projects being implemented in metropoli Chicago (one of which received the APA's G Achievement Award in 2001). An analysis of the mc ment patterns of chronic mentally ill in metro Chic will be discussed. A system for screening approxim 100,000 inmates annually for serious mental illness be described, as will a new program that links them community mental health centers. Data describin impact on recidivism and treatment compliance o sons identified as having serious mental illness v discussed. New projects involving the Chicago department and the Cook County criminal cou be described. The last of the presentations will b with exportability in mind. The panel will fac discussion of how each of these programs n implemented in other areas.

TARGET AUDIENCE(S):

Provides for chronically mentally ill; mentally ill offenders

REFERENCES:

1. Du Rand CJ, Burtha GJ: Implications for community psychiatry in a major urban jail. Amer J of Psychiatry 1995.
2. Baillargion J, Contreras S: Psychiatric needs on jails. Am J Psychiatry 2000.

Workshop 17 **Thursday, October 10**
10:00 a.m.-11:30 a.m.

PREPARING A VIDEO FOR EDUCATION AND TRAINING

Laurence P. Karper, M.D., *Vice Chair, Department of Psychiatry, Lehigh Valley Hospital at Muhlenberg, 400 North 17th Street, Suite 207, Allentown, PA 18104*; Martyn O. Hotvedt, Ph.D.; Alan D. Felix, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session, the participants will be made aware of the available technology and will learn some of the techniques for producing video presentations that can be used for educational and training purposes.

SUMMARY:

The advent of digital video technology provides a ıew avenue for communicating the results of studies to ·olleagues, students, and grant-funding agencies. Tradional video productions require professional expertise ıd equipment. The quality of these productions has ·en quite high, but the expense has limited their use. ıis workshop will review various techniques to create leo presentations for both education and training. The senters have experience with both professional and ıprofessional video and multimedia productions. The ·enters will explain how widely available consumer onal computer and audiovisual equipment can be to prepare a presentation suited for various audis. Two funded research projects will be used as studies to understand the organization and creation ıultimedia presentation utilizing digital video techy. Also, the funding, dissemination, and marketing information will be discussed. After the video tations there will be an opportunity to answer : questions about the projects and to discuss how ·ojects might be best recorded and disseminated.

ET AUDIENCE(S):

rchers and clinicians interested in utilizing video ıt information.

REFERENCES:

1. Nadelson T: Audiovisual overview: journey of healing: an outpatient therapy group for war-related PTSD. Psychiatr Serv 1999; 50:627–628.
2. Reavis PA, Epstein BA: Selected list of video programs on mental illness and treatment for patients and their families. Psychiatr Serv 1995; 46:1238–1240.

Workshop 18 **Thursday, October 10**
1:30 p.m.-3:00 p.m.

TRANSGENDERED WITH AIDS: A NEW PERSPECTIVE

Association of Gay and Lesbian Psychiatrists

Melanie E. Spritz, D.O., *Department of Psychiatry, and Department of Emergency Medicine, St. Luke's Roosevelt Hospital, and Psychiatric Consultant, Department of Pediatrics, Kings County Hospital Center, 9102 Colonial Road, #4-E, Brooklyn, NY 11209-6156*; Lorraine S. Baskerville, B.S.W., *Executive Director, Transgenesis, 4554 North Broadway, Chicago, IL 60640*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to make the practitioner aware of psychiatric and medical sequelae of HIV/AIDS in the transgendered as well as the structure and function of an outreach program.

SUMMARY:

Both of the presenters are members of the Harry Benjamin Gender Dysphoria Association Inc. Committee on HIV/AIDS. The program will begin with the presentation of the structure, function, and activities of an HIV/AIDS program for the transgendered, as well as problems that are encountered by the transgendered program, and this outreach program in particular, which is based in the Chicago area. The next presenter will summarize some of the current problems encountered by the HBIGDA HIV/AIDS committee as well as current plans of the committee. This presenter will go into the neuropsychiatric, medical issues presented by the transgendered patient as well as unique problems inherent to the population.

REFERENCES:

1. Bockting W, Kirk S (eds.): HIV and the Transgendered, Haworth Press, 2000.
2. XVII Harry Benjamin International Symposium on Gender Dysphoria, October 31 to Nov 4, 2001, Abstracts of HIV Presentations.

Workshop 19 **Thursday, October 10 1:30 p.m.-3:00 p.m.**

A SURVEY OF RESIDENTS' PERSPECTIVES ON THE AMERICAN PSYCHIATRIC ASSOCIATION

2001–2003 APA/Bristol-Myers Squibb Fellows

Matthew Bernstein, M.D., *2001–2003 APA/Bristol-Myers Squibb Fellow, and Resident, Department of Psychiatry, Massachusetts General Hospital, 71 Wachusett Street, #2, Jamaica Plain, MA 02130*; Jennifer K. Coffman, M.D.; Raymond J. Kotwicki, M.D.; Susan A. Turner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should have developed a richer understanding of the conflicts that current psychiatric residents perceive in their relationship to their professional organization, the American Psychiatric Association (APA).

SUMMARY:

The American Psychiatric Association (APA) is the professional body of American psychiatry and is vital to the health of psychiatry. The future of APA is dependent on the interest young psychiatrists take in its activities and in membership. Throughout its long history, APA has attempted to balance its dual roles of representing the interests of its members and advocating for the improved care of psychiatric patients. At times, APA may be unable to effectively perform these two functions at the same time. This workshop will explore this issue and others by examining the views current resident psychiatrists hold about their own professional organization, APA. Historical background, current issues, the results of a national resident survey, as well ideas for future directions will be presented. Ample time will be provided for questions and discussion of the presentation.

TARGET AUDIENCE(S):

Members and leadership of the APA, and resident psychiatrists

REFERENCES:

1. Ruben HL: American psychiatry's fundamental policy is to foster the patient's good. Hospital and Community Psychiatry 1986; 37:501–504.
2. Sabin JE: Caring about patients and caring about money: the American Psychiatric Association code of ethics meets managed care. Behavioral Sciences & the Law 1994; 12:317–30.

Workshop 20 **Thursday, October 10 1:30 p.m.-3:00 p.m.**

EXPERT CONSENSUS RECOMMENDATIONS FOR BEST PRACTICES POLYPHARMACY

Medical Directors Council of the National Association of State Mental Health Program Directors

Joseph J. Parks, M.D., *State Medical Director, Missouri Department of Mental Health, 1706 East Elm Street, Jefferson City, MO 65102*; Stephen J. Bartels, M.D.; Robert H. Littrell, Pharm.D.; Randy Malan, R.Ph., F.A.S.C.P.; Penelope K. Knapp, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participant should be able to define and differentiate different types of polypharmacy; balance the risks and benefits of the use of polypharmacy; implement best practice recommendations for clinical practice involving polypharmacy.

SUMMARY:

This workshop will present an expert consensus technical report on polypharmacy prepared by the Medical Director's Council of the National Association of State Mental Health Program Directors. The workshop will begin with a categorization of types of polypharmacy, followed by a brief review of psychiatry's historical response to polypharmacy from the 1960s on. New data will be presented on the current prevalence of the simultaneous use of multiple antipsychotic agents nationwide. The workshop will review the scientific evidence that supports the use of polypharmacy in the areas of antipsychotics, mood stabilizers, and antidepressants. Issues specific to polypharmacy as it relates to children and the elderly will be explored. Best practice consensus recommendations of the expert panel will be presented for clinical practices that should be used before adding a second medication to a patient, during treatment with multiple medications, and after a patient has been on multiple medications. Areas of inappropriate use of polypharmacy will be identified. Recommendations for health care systems management and mental health research related to polypharmacy will be presented.

REFERENCES:

1. National Association of State Mental Health Program Medical Directors Technical Report on Psychiatric Polypharmacy, Submitted for publication.
2. Stahl SM: Antipsychotic polypharmacy, part 2: tips on use and misuse. J Clinical Psychiatry 1999; 60:506/507.

Workshop 21 **Thursday, October 10**
1:30 p.m.-3:00 p.m.

WHAT HAPPENED TO INPATIENT CARE DURING THE DECADE OF THE BRAIN: WHAT NEXT?

Patricia M. Averill, Ph.D., *Associate Professor and Director, Department of Research and Program Evaluation Studies, University of Texas Health Science Center at Houston, 2800 South MacGregor Way, Houston, TX 77021*; Robert W. Guynn, M.D., *Professor and Chair, Department of Psychiatry and Behavioral Sciences, University of Texas Health Science Center at Houston, 1300 Moursund, Suite 206, Houston, TX 77030*; Nurun N. Shah, M.D., M.P.H.; Roy V. Varner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should: (1) have a broad and detailed understanding of changes that have occurred in inpatient psychiatric settings during the past decade, (2) understand their impact on clinical practices, education, and research, (3) understand the associated administrative responsibilities, (4) speculate on future needs.

SUMMARY:

The past decade has seen rapid change in inpatient psychiatry from financial (e.g., managed care, Medicare), regulatory (e.g., JCAHO compliance, HIPAA), treatment practices (e.g., shorter LOS, new generation medications), research, and educational perspectives. A comparison of our data for 1990 and 2000 revealed that the percentage of the budget spent on direct patient care has declined by more than 5%. Meanwhile, the annual cost of servicing a patient bed has increased significantly, and the cost of psychotropic medication has more than doubled. Data reflect how we have utilized limited patient dollars to address higher patient acuity levels, shorter LOS, and earlier readmission rates. Data also reveal a shift of funding away from direct patient care into regulatory oversight and other administrative costs. This workshop will be informative for direct-care and administrative mental health professionals who wish to examine both global and specific changes in inpatient psychiatry during the past decade and consider future directions. The workshop will be divided into five sections, including literature review, data-driven examination of an inpatient setting, clinical practices, administrative oversight, and summary. Discussion will be permitted during the presentation and at the end of each section.

TARGET AUDIENCE(S):

Mental health professionals and administrators who work in inpatient settings

REFERENCES:

1. Bloom JD, Williams MH, Land C, et al: Changes in public psychiatric hospitalization in Oregon over the past two decades. Psychiatric Services 1998; 49:366–369.
2. Availability and performance of psychiatric acute care facilities in California from 1992 to 1996. Psychiatric Services 1999; 50:1453–1460.

Workshop 22 **Thursday, October 10**
1:30 p.m.-3:00 p.m.

ETHICAL PRINCIPLES IN PSYCHIATRIC ADMINISTRATION: ISSUES, CHALLENGES, AND DILEMMAS

American Association of Psychiatric Administrators

H. Steven Moffic, M.D., *Department of Psychiatry, Medical College of Wisconsin, 9200 West Wisconsin Avenue, Milwaukee, WI 53217*; S. Atezaz Saeed, M.D., M.S., *Chair, Department of Psychiatry and Behavioral Medicine, University of Illinois College of Medicine at Peoria, 5407 North University, Suite C, Peoria, IL 61614-4736*; Steven S. Sharfstein, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize and effectively process ethical dilemmas psychiatric administrators often face in various settings.

SUMMARY:

The ethical challenge for a psychiatric administrator is to help optimize the potential benefits and reduce risks of treatment and/or rehabilitation, all the while considering the costs, likely outcome, and alternatives unique to psychiatry. Psychiatric administrators have had some particular ethical challenges as compared with other medical administrators. Unique organizational settings have included state hospitals and community mental health centers. Stigma has influenced the willingness of patients to come for and stay in treatment. Confidentiality has needed more stringent vigilance. Greater prominence of other mental health disciplines has posed problems in role definition and use of funds for staffing. A more recent challenge has been managed care particularly affecting psychiatry with the decrease in funding and an increase in carved out services and organizations. When functioning as a psychiatric administrator, what ethical principles, if any, should one follow? While different approaches could be taken, a time tested one would be to use the principles of medical ethics. Just as the American Psychiatric Association added annotations to these principles, especially applicable to psychi-

atric clinicians, the American Association of Psychiatric Administrators has suggested annotations especially applicable to psychiatric administrators. This workshop will focus on ways of looking at ethical dilemmas psychiatric administrators often face in various settings.

TARGET AUDIENCE(S):

Psychiatric administrators and educators

REFERENCES:

1. Moffic S: Ethical principles for psychiatric administrators: the AMA principles of medical ethics. AAPA Newsletter, summer 2000.
2. Green S, Bloch S: Working in a flawed mental health system: an ethical challenge. American Journal of Psychiatry 2001; 158:1378–1383.

Workshop 23 **Thursday, October 10 3:30 p.m.-5:00 p.m.**

PSYCHIATRIC ILLNESS AND THE WORKPLACE

Steven E. Pflanz, M.D., *Chief, Mental Health Services, F.E. Warren Air Force Base, U.S. Air Force, 68-A Fort Warren Avenue, Cheyenne, WY 82001*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the relationship between work stress and mental health and the role of the psychiatrist in minimizing the impact of job stress on the emotional health of employed patients.

SUMMARY:

Increasingly, both industry and mental health professionals are recognizing that work stress is a major factor in determining the mental health of employees. Psychiatrists and mental health professionals are often faced with patients suffering from emotional distress that is attributed to job stress. Importantly, 15% of American workers experience at least one episode of psychosocial disability every year. Mentally ill workers exhibit decreased productivity, increased workforce turnover, and have higher absenteeism and increased medical care utilization. These combined factors cost industry $150 billion annually. The relationship between the work environment and the mental health of employees has received little research attention. Nonetheless, 10% of American workers report exposure to mental stress at work, and 5% believe that their experience of work stress could be deleterious to their mental health. At work, both exposure to sudden traumatic events and to chronic daily stress can produce or exacerbate psychiatric symptoms. In this workshop, the audience will discuss the complex relationship between the work environment and mental health. We will examine the common sources of job stress and the mechanisms by which work stress can lead to psychiatric illness. Lastly, we will explore how the mental health professional can forge a partnership with patients and employers to reduce work stress and ameliorate or eliminate psychiatric illness in working patient populations.

TARGET AUDIENCE(S):

General psychiatry, occupational and organizational psychiatry

REFERENCES:

1. Pflanz SE: Psychiatric illness and the workplace. Military Medicine 1999; 164:401–406.
2. Pflanz SE: Occupational stress and psychiatric illness in the military. Military Medicine 2001; 166:457–462.

Workshop 24 **Thursday, October 10 3:30 p.m.-5:00 p.m.**

COMMUNITY-BASED CARE FOR MENTALLY ILL MINORS IN JUVENILE DETENTION CENTERS

Gene Griffin, J.D., Ph.D., *Chief of Juvenile Forensic Services, Illinois Department of Human Services, 160 North LaSalle, Tenth Floor, Chicago, IL 60601*; John S. Lyons, Ph.D., *Department of Psychiatry, Northwestern University, 39 East Chicago Avenue, Chicago, IL 60611*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the juvenile justice process, recognize the prevalence of mental illness in the juvenile justice system, and identify mental health interventions targeting different points of the juvenile justice process.

SUMMARY:

An increasing number of minors are being prosecuted in the juvenile justice system. Many of these minors do not receive adequate mental health services either before, during, or after their time in the juvenile justice system. Minorities are overrepresented in the juvenile justice system, and the lack of services can have a disproportionate impact. National experts have called for programs to address these problems. This presentation will review the juvenile justice process and the mental health system. It will explore theories of treatment in both systems and theories for studying evidence-based practices. The presenters will discuss the prevalence of mental illness among minors in the juvenile justice system and obstacles to mental health treatment. They will review different mental health interventions and compare these pro-

grams. In particular, they will review a new program in Illinois that targets severely mentally ill minors being held in juvenile detention centers. Finally, they will discuss the implications for national policy in dealing with mentally ill minors in the juvenile justice system.

TARGET AUDIENCE(S):

MH providers in juvenile justice system, mental health policy leaders

REFERENCES:

1. Lyons JS, Baerger DR, et al: Mental health service needs of juvenile offenders: a comparison of detention, incarceration, and treatment settings. Children's Services: Social Policy, Research, and Practice; 4:69–85.
2. U.S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, DC, 2000.

Workshop 25 **Thursday, October 10**
3:30 p.m.-5:00 p.m.

CULTURAL ADVOCACY FOR PATIENTS AND RESIDENTS

2001–2003 APA/Bristol-Myers Squibb Fellows

Hagit Bat-Avi, M.D., *2001–2003 APA/Bristol-Myers Squibb Fellow, and Department of Psychiatry, Beth-Israel Medical Center, 353 East 17th Street, # 8-G, New York, NY 10003*; Jaime M. Benítez, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) understand the nature and purpose of advocacy, (2) learn about the concept of advocacy, and (3) utilize tools for advocacy.

SUMMARY:

The topic of advocacy is a basic issue essential to the maintenance of balanced alliance between patients and their psychiatrists. Advocacy carries the paternalism of the medical field. Residents must advocate for their sick patients, assist them, and stand to help them to overcome the obstacles of mental illness. There is a cultural need in advocacy as well, being culturally sensitive and understanding etiology of diseases as it applies to patients.

REFERENCES:

1. Meyerson AT, Moss JE, Belville R, Smith H: Influence of experience on major clinical desicions: training implications. Archieves of General Psychiatry 1979; 36 (4) 423–7.
2. Henn RF: Patient suicide as part of psychiatric residency. American Journal of Psychiatry 1978; 135 (6) 745–749 1978.

Workshop 26 **Thursday, October 10**
3:30 p.m.-5:00 p.m.

FROM PSYCHIATRIC HOSPITAL TO PSYCHIATRIC REHABILITATION

Satyanarayana Chandragiri, M.D., *Chief Medical Officer, Department of Psychiatry, East Oregon Psychiatric Training Centers, and Former APA/Bristol-Myers Squibb and APIRE/Janssen Fellow, 2600 Westgate, Pendelton, OR 97801*; Elizabeth Pearson, M.S.W.; Maria Walchli, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand complexities involved in designing and implementing a psychiatric rehabilitation program in a hospital, and to appreciate the positive benefit of a rehabilitation program to the patients and staff.

SUMMARY:

In the quest for deinstitutionalization and briefer hospital stay, the often forgotten aspect of treatment is the psychiatric rehabilitation of the patients. The focus of most inpatient units is rapid stabilization and discharge to community care. Often the quality and capacity of community care is variable to cater to this need. State hospitals play a major role in the care of long-stay inpatients. This workshop will focus on the challenges of reorganization that went into designing a psychiatric rehabilitation program designed to improve the quality of life of the patient with the aim of smoother community re-entry. The benefits of rehabilitation programs in terms of overall functioning of the patients, change in violence and aggression experienced, rates of seclusion and restraints, staff injury, and clinical benefits to the patients and involvement from the patients, families, and the community will be discussed. The participants will have an opportunity to compare their programs and interact with the presenters.

TARGET AUDIENCE(S):

State hospital psychiatrist, psychiatrists in partial program, administrators

REFERENCES:

1. Sullivan M: The unique roles of state hospital programs: keeping what works in an evolving system. New Dir Ment Health Serv 1999; 84:47–55.
2. Munk J, et al: From psychiatric hospital to rehabilitation: the Nordic experience. Encephale 2000; 26:3–6.

Workshop 27 **Thursday, October 10**
3:30 p.m.-5:00 p.m.

PSYCHIATRIC SERVICES PRESENTATION OF URBAN SYSTEMS OF CARE

Peter D. Nierman, M.D., *Clinical Director of Child and Adolescent Services, Department of Mental Health, Illinois Department of Human Services, 4200 North Oak Park Avenue, Annex, Chicago, IL 60634*; Adjoa D. Blalock, M.S.W.; Tim Gawron, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should become familiar with a novel program to address outreach to populations that have been underserved by traditional mental health programming for children, understand challenges to implementation and administration of a unique program that has significant "cultural competency" implications and instructive experience for future efforts toward these goals, discuss the challenge of establishing the evidence basis for novel programming.

SUMMARY:

The Metropolitan Child and Adolescent Network (Metro C & A) of the Illinois Department of Human Services Office of Mental Health has introduced the Urban Systems of Care (USC) program into its constellation of services. The program serves families residing in specific Chicago Housing Authority developments. Urban Systems of Care began in 1998 and was developed in response to Metro C & A's recognition that urban-dwelling children, adolescents, and their families who lived in public housing were not accessing the services provided by state-funded community mental health agencies. The USC program employs and trains public housing residents to join mental health professionals to reach out to families who are in need of services, links families to appropriate services, and provides them with local on-site support to enhance the process. This presentation will describe the policy development and implementation of the program as well as provide initial data on utilization and performance of funded programs in Chicago. A 30-minute film will be shown that highlights the early development of one of our selected sites. Also covered will be the challenge of striving for an evidence basis for continued support of a novel program.

TARGET AUDIENCE(S):

Child, adolescent, adult psychiatrists, psychologists, policy leaders, social workers

REFERENCES:

1. McKernan M: Addressing the barriers to mental health services for inner city children and their caretakers. Comm Mental Health Journal 1996; 32:4.
2. Krefzman & McKnight: Building Communities From the Inside Out: A Path Toward Finding and Mobilizing a Community Asset. Center for Urban Affairs and Policy Research, Neighborhood Innovations Network, Northwestern University, Distributed by ACTA Publications, 1993.

Workshop 28 **Friday, October 11**
8:00 a.m.-9:30 a.m.

RECONNECTING PUBLIC HEALTH AND PSYCHIATRY

Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute and Clinic, Assistant Professor of Psychiatry, University of Pennsylvania Medical Center, and Former APA/Bristol-Myers Squibb Fellow, 3811 O'Hara Street, Room E-516, Pittsburgh, PA 15213*; Mario Cruz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate an awareness of the relationship between psychiatry and public health.

SUMMARY:

The events of September 11 and the anthrax attack have shown in stark relief how critical mental health is to the public's health. Panic, traumatic grief, and depression are part and parcel of the injuries our nation now endures.

Yet public health—the approach and the skills associated with it—has been systematically devalued, not least by community psychiatry, which focused almost entirely on clinical care for persons with severe mental illness. This is a curious turn of events, given that community psychiatry was initially formulated as the public health approach to psychiatry.

The presenter will discuss ways in which community psychiatry can rediscover its public health roots and reconnect with the evolving public health infrastructure. Among the topics to be discussed will be new theories linking mental health with the overall health of the public, such as the emerging theory of social capital, and new ways of conceptualizing public health work in psychiatric practice, such as the recently released core competencies for public health professionals.

TARGET AUDIENCE(S):

Mental health professionals interested in community practice and public policy.

REFERENCES:

1. Core Competencies for Public Health Professionals: Council on Linkages Between Academia and Public Health Practice, April 2001.
2. Public Health Leadership: Putting Principles into Practice. Louis Rowitz Aspen Publishers Inc., 2001.

Workshop 29 **Friday, October 11 8:00 a.m.-9:30 a.m.**

IMPROVING THE MEDICAL CLEARANCE OF PSYCHIATRIC PATIENTS

Randy L. Thompson, M.D., *Medical Director, Chicago Read Mental Health Center, 4200 North Oak Park Avenue, Chicago, IL 60634*; Leslie Zun, M.D.; Deepak Kapoor, M.D.; Louis Shicker, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to articulate specific problems in the medical clearance of psychiatric patients, and develop a protocol for improving medical clearance that is broadly applicable across service systems.

SUMMARY:

This workshop reports on the first prospective study of the medical clearance of patients with known psychiatric illness. The target audience of the workshop is all persons involved with or interested in the subject of medical clearance of psychiatric patients. "Medical clearance" of psychiatric patients signifies an initial medical evaluation in the emergency department, before transfer to a psychiatric facility, of patients whose symptoms may be psychiatric in origin. This medical clearance is commonly fraught with problems. In order to resolve these concerns, a team of emergency physicians and psychiatrists developed a consensus protocol for the medical clearance of patients with a history of psychiatric illness, in the emergency department, prior to transfer to a state psychiatric hospital. The protocol includes both a psychiatric assessment and clinically indicated physical assessment. The performance of any laboratory tests is based on the clinical indications and not on routine. The study goals were to determine if there is a set of psychiatric patients who do not need laboratory testing in the emergency department; to demonstrate the accuracy of a protocol for medically clearing patients with psychiatric complaints; and to improve the working relationship between emergency department physicians and psychiatrists in the state hospital.

REFERENCES:

1. Riba M, Hale M: Medical clearance: fact or fiction in the hospital emergency room. Psychosomatics 1990; 31:400–404.
2. Tintinalli JE, Peacock FW, Wright MA: Emergency medical evaluation of psychiatric patients. Ann Emerg Med 1994; 23:859–862.

Workshop 30 **Friday, October 11 8:00 a.m.-9:30 a.m.**

SHACKLES AND GOLD: ADVOCATING FOR PATIENTS AND PSYCHIATRISTS

2001–2003 APA/Bristol-Myers Squibb Fellows

Mathieu Bermingham, M.D., *2001–2003 APA/Bristol-Myers Squibb Fellow, and Department of Psychiatry, University of Massachusetts Medical School, Worcester, MA 01605*; Eric M. Levander, M.D., M.P.H., *2001–2003 APA/Bristol-Myers Squibb Fellow, and Department of Psychiatry, Harbor UCLA Medical Center, 26121/2 Locksley Place, Los Angeles, CA 90039*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the role organized psychiatry has played in advocating for two, at times seemingly disparate, goals: professional goals and patient advocacy.

SUMMARY:

Psychiatrists and organized psychiatry have long played an important role in shaping attitudes and beliefs about mental illness and mental health policy. As the principal organization representing American psychiatry, the American Psychiatric Association has played a significant role in advocating for changes in mental health care. The American Psychiatric Association has played a dual role, representing both psychiatrists and patients. At times, these interests can be at conflict with one another. The speakers will evaluate some recent battles in mental health advocacy to explore and gain insight into effective policy approaches to current problems in psychiatry.

In an effort to better understand this tension between self interest and patient advocacy, we will examine how the American Psychiatric Association has responded to changes in American medicine. More specifically, we will discuss how the corporatization of American medicine has affected psychiatry. Additionally, we will discuss how psychiatry's advocacy goals have changed as a result of the shift from primarily hospital-based care to private practice and community-based care.

REFERENCES:

1. Foulks EF: Advocating for persons who are mentally ill: a history of mutual empowerment of patients and profession. Adm Policy Ment Health 2000; 27:353–67.

2. Starr P: The social transformation of American medicine. Basic Books, New York, 1982.

Workshop 31 **Friday, October 11**
8:00 a.m.-9:30 a.m.

THE TIME IS NOW: DESIGNING AND FACILITATING A RECOVERY EVIDENCE-BASED MENTAL HEALTH SERVICE DELIVERY

S. Atezaz Saeed, M.D., M.S., *Chair, Department of Psychiatry and Behavioral Medicine, University of Illinois College of Medicine at Peoria, 5407 North University, Suite C, Peoria, IL 61614-4736*; Nanette Larson, B.A., *Associate Network Manager, Illinois Department of Human Services, 5407 North University Street, Peoria, IL 61614*; Robert Vyverberg, Ed.D.; Donald Wells

EDUCATIONAL OBJECTIVES:

To demonstrate an understanding of the concept and operationalizing of the recovery vision/principles across the lifespan, demonstrate an understanding of the operationalizing and service delivery design resulting from the interdependence of recovery principles and evidence-based services, and utilize a delivery evaluation instrument for the evaluation of recovery/evidence-based services.

SUMMARY:

Although understanding of and literature about the independent concepts and operation of both the recovery vision/principle and evidence-based practices have become widespread, much less may be found in the literature about the interface of the two concepts and operations, and even less about the independence of the two, and the resulting potential impact of this interdependence, on the mental health service delivery system. This workshop will explore the current concept and operation of recovery across the lifespan; the foundation recovery offers to the delivery of certain evidence-based practices, including Assertive Community Treatment; and thoughts about and materials for an initial design, implementation, and evaluation of a delivery system that incorporates the two concepts. Workshop materials presented and discussed will include an Evidence of Recovery-Based Services agency monitoring instrument, currently being used with community mental health centers.

TARGET AUDIENCE(S):

Psychiatric administrators, psychiatrists, community mental health system leadership/practitioners

REFERENCES:

1. Anthony WA: A recovery-oriented service system: setting some system level standards. Psychiatric Rehabilitation Journal 2000; 24:159–168.
2. Beale V, Lampric T: The recovery concept: implementation in the mental health system. A report by the Community Support Advocacy Program Committee: Ohio Department of Mental Health, Office of Consumer Services.

Workshop 32 **Friday, October 11**
10:00 a.m.-11:30 a.m.

INVOLVING A SYSTEM OF CARE FOR THE DEAF MENTALLY ILL: NEW TREATMENT STANDARDS

Thomas A. Simpatico, M.D., *Consultant, APA Institute Scientific Program Committee, and Chief, Bureau of Chicago Network Operations, Chicago Read Mental Health Center, 4200 North Oak Park Avenue, Building K, Chicago, IL 60634*; Bruce Munroe-Ludders, L.C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) have an understanding of some of the aspects of deafness and deaf culture that challenge our ability to provide effective mental health care, (2) understand the standards of care that are being used in Illinois, (3) understand practical ways of moving a system toward being able to provide minimally acceptable mental health services to deaf persons.

SUMMARY:

This workshop will describe how the system of care for deaf persons with mental illness has been designed and implemented in Illinois. Some of the common pitfalls of putting such a system together will be described. Clinical vignettes will illustrate problem situations that commonly occur, and are amenable to easily implemented solutions. The process of minimally acceptable standards of care that were devised in Illinois will be described. A collaboration between the Illinois Office of Mental Health and Gallaudet University that seeks to establish nationally recognized standards will be presented. The practical distinction between systems change that can occur by virtue of new information and policies vs. systems change that requires new resources will be discussed. All elements of presentations will be designed to promote general discussion. Particular attention will be paid to help audience members improve mental health services for deaf persons in their home area.

TARGET AUDIENCE(S):

Psychologists, psychiatrists, social workers, deaf service providers

REFERENCES:

1. Steinberg, Annie, Sullivan, VJ: Cultural and linguistic barriers to mental health service access: the deaf consumers perspective. Am J Psychiatry 1998; 864–869.
2. A Psychiatric Prog for the Deaf: Experiences & Implications. American Journal of Psychiatry 1991; 267–272.

Workshop 33 **Friday, October 11**
10:00 a.m.-11:30 a.m.

BIASES OF NONPSYCHIATRY PHYSICIANS IN THE GENERAL MEDICAL CARE OF PATIENTS WITH MENTAL ILLNESS

2001–2003 APA/Bristol-Myers Squibb Fellows

Melva I. Green, M.D., *2001–2003 APA/Bristol-Myers Squibb Fellow, and Department of Psychiatry, Johns Hopkins Medical Institutions, 109 Persimmon Circle, Reisterstown, MD 21136*; Alison M. Barnes, M.D.

EDUCATIONAL OBJECTIVES:

To understand the climate of general medical care for mentally ill patients and the stigma inadvertently perpetuated by our non-mental-health clinicians; be able to formulate strategies in educating them and gain other avenues for advocating for patients with mental illness.

SUMMARY:

The U.S. Surgeon General has recently brought the disparity of the treatment of mentally ill patients to the forefront of health care in the new millennium. The purpose of this workshop is to further illuminate this disparity by exploring some of the biases within the health care community that lead to suboptimal general medical care for these patients. Survey data collected from nonpsychiatry residents in the Baltimore area will be presented to facilitate this discussion. Participants will have an opportunity to gain a comprehensive understanding of the climate of general medical care for mentally ill patients and the stigma inadvertently perpetuated by our non-mental-health clinicians. At the conclusion, participants will have an opportunity to discuss and formulate additional strategies in educating our nonpsychiatry physician peers and ultimately gain other avenues for advocating for patients with mental illness.

TARGET AUDIENCE(S):

All mental health professionals especially those interested in mental health legislation advocacy.

REFERENCES:

1. Wilkinson G, Boone BK, Greer S: Attitudes to psychiatry in doctors at the end of their first postgraduate year: two year follow-up of a cohort of medical students. Psychol Med 1986; 16:457–460.
2. Mental Health: A Report of the Surgeon General.

Workshop 34 **Friday, October 11**
10:00 a.m.-11:30 a.m.

BUILDING A CARING COMMUNITY FOR CHILDREN AND YOUTH WITH EMOTIONAL DISORDERS

Katherine G. Levine, M.S.W., *Program Director, Community Mental Health Services, Visiting Nurse Service of New York, 450 East 149th Street, Third Floor, Bronx, NY 10455*; Nicolás Dávila-Katz, M.D.; Yvette C. Miller, R.N.; Paul Gray, A.A.

EDUCATIONAL OBJECTIVES:

To describe an assessment tool useful in delineating family and youth connections to their community, and to describe three ways to build a caring community around a seriously emotionally disturbed child.

SUMMARY:

The Visiting Nurse Service of New York's Community Mental Health Service operates a Mobile Community Support Service (MCS) in the Mott-Haven Section of the South Bronx. The treatment model is built on the idea that the community in which the child lives needs to be included in the treatment process. Involving community, particularly a community such as Mott Haven, known more for violence than for caring, is not easy. This program details the efforts of this team to build a caring community around the youngsters it serves. This process has ranged from recruiting community residents as employees to developing the Camino de Paz Labyrinth Project. This project has involved the families and youth served by the agency in building labyrinths throughout Mott Haven. The project has constructed five labyrinths. The most recent labyrinth was opened last November 12th and was used in a walk to honor and remember those hurt by the attack on the World Trade Center. Following a case presentation the workshop will be opened for discussion.

TARGET AUDIENCE(S):

Child and adolescent psychiatrists, community psychiatrists, program directors

REFERENCES:

1. Garbarino J: Lost Boys: Why Our Sons Turn Violent and How We Can Help. New York, Anchor Books, 2000.
2. Building Communities from the Inside Out: A Path With Community Building: What Makes It Work. New York, ACTA Publications, 1999.

Workshop 35 **Friday, October 11**
1:30 p.m.-3:00 p.m.

TEACHING BEHAVIORAL SCIENCES TO FAMILY DOCTORS

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

EDUCATIONAL OBJECTIVES:

To understand a longitudinal method of teaching behavioral sciences to family medicine residents.

SUMMARY:

In this workshop, we describe the approach to the teaching of behavioral sciences to family medicine residents at McMaster University in Hamilton, Ontario. Instead of a block placement in the psychiatric unit, teaching takes place in a weekly half-day, devoted to behavioral sciences, for the entire duration of the two-year residency. During this time, a psychiatric consultant is present on site in the family medicine unit. The training is problem based, usually within small groups, and utilizes examples from cases residents are seeing in their practice. A videotape showing part of a session will be aired.

In addition, we discuss a new program at McMaster in which psychiatrists work directly with family doctors in the community. Psychiatrists go to the family doctor's office on a weekly or biweekly basis and work on site. This type of work affords many opportunities for educational activities with family doctors already established in the community. Different approaches to CME in this setting are discussed. There will be question-and-answer periods after the presentation of each of these two models.

TARGET AUDIENCE(S):

Psychiatrists, family physicians, and mental health specialists

REFERENCES:

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

Workshop 36 **Friday, October 11**
1:30 p.m.-3:00 p.m.

CULTURAL DISPARITIES IN MENTAL HEALTH SERVICE USE FOR MENTALLY ILL OFFENDERS

Thomas A. Simpatico, M.D., *Consultant, APA Institute Scientific Program Committee, and Chief, Bureau of Chicago Network Operations, Chicago Read Mental Health Center, 4200 North Oak Park Avenue, Building K, Chicago, IL 60634*; Carl J. Alaimo, Psy.D.; Alonzo DeCarlo, Ph.D.; Marion Perkins, J.D.; Tadesse Giorgis, Ph.D.

EDUCATIONAL OBJECTIVES:

To better understand sources of cultural/ethnic disparities in mental health service access and use for offenders with mental illness; gain knowledge regarding the value of public academic partnerships with minority institutions to address disparity; acquire knowledge regarding action steps for addressing barriers to mental health service use.

SUMMARY:

This workshop is designed for mental health professionals, including service providers, administrators, and researchers. Increasing attention is being focused upon racial and ethnic disparities in the access to and use of mental health services. This workshop will describe how such disparities have been identified for a particular subpopulation—persons with mental illness who enter the Cook County Criminal Justice System—and the formation of a public-academic partnership designed to address them. Quantitative baseline data identifying racial and ethnic disparities in this population's utilization of public mental health services will be presented. An evolving partnership between the Bureau of Chicago Network Operations for the Illinois Department of Human Services Office of Mental Health (the state's mental health authority for the metropolitan Chicago area), the Cook County Department of Corrections, the Cook County Bureau of Health, and Chicago State University will be described, as will the initial action steps and needs assessment data that have resulted from this partnership.

TARGET AUDIENCE(S):

Psychiatrists, psychologists, social workers, mental health administrator, mental health researchers

REFERENCES:

1. Schwartz M, Wagner H, Swanson J, et al: Comparing use of public and private mental health services: the enduring barriers of race and age. Community Mental Health Journal 1996; 34:133–134.
2. US Department of Health and Human Services: Mental Health: Culture, Race and Ethnicity—A supplement to mental health: a report of the Surgeon General. Rockville, MD, Dept of Health and Human Services, Substance Abuse and Mental Health Service Administration, Center for Mental Health Services, 2001.

Workshop 37 **Friday, October 11**
1:30 p.m.-3:00 p.m.

THRESHOLDS PEER EDUCATOR PROJECT: CONSUMERS AS EDUCATORS

Marion L. McCoy, Ph.D., *Director of Research, Thresholds, 4101 North Ravenswood, Chicago, IL 60613*; Shauna Labriola, B.A.; Ronald Kirkland; Willie Scott; David Cicciarelli

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the value of consumer insight and peer-led support. Participants should leave with an appreciation of the complexity surrounding medication adherence and the benefits of nonconventional treatment relationships.

SUMMARY:

Medication nonadherence and high rates of psychiatric recidivism are realities of the mental health system. The Thresholds Peer Educator Project (PEP) is a consumer-based intervention designed to educate consumers on medications. With the goal of increasing knowedge, members serving as peer educators (PE) share their experiences (e.g., obstacles and accomplishments in treatment, maintaining hope) with other members. PEs undergo a comprehensive training to become ''experts'' on medication, facilitated by research staff. At agency locations, a panel of PEs present to medication groups and clubhouse meetings. Discussion regarding side effects, stigma, and talking with psychiatrists are common. This forum educates and encourages adherence while providing support from a unique vantage point that differs from traditional professional roles. Qualitative results are based on participant feedback. Common themes include a sense of hope, independence, and confidence, which replace feelings of frustration, ambivalence, and resignation toward mental health treatment, particularly medications. In 2001, PEP was an award-winning recipient of the Compassion and Competency Award by the Illinois Department of Human Services and Office of Mental Health. The recognition that those who live with mental illness can provide insight and knowledge that others may not have proves this program is heading in the right direction.

TARGET AUDIENCE(S):

Community psychiatrists

REFERENCES:

1. Draine J, Solomon P: The state of knowledge of consumer-provided services. Pychiatric Rehabilitation J 2001; 25:20–27.
2. Shireman T, Svarstad B, Sweeney JK: Using drug claims data to assess the relationship of medication adherence with hospitalization and costs. Psychiatric Services 2001; 52:805–811.

Workshop 38 **Friday, October 11**
1:30 p.m.-3:00 p.m.

SECLUSION AND RESTRAINT: STRATEGIES AND PRACTICES

Alan Q. Radke, M.D., M.P.H., *State Medical Director, Minnesota Department of Human Services, 444 Lafayette Road, North St. Paul, MN 55155-3826*; Joseph J. Parks, M.D., *State Medical Director, Missouri Department of Mental Health, 1706 East Elm Street, Jefferson City, MO 65102*; Thomas W. Hester, M.D.; Richard B. Spencer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant should understand the recommended strategies and best practices for preventing, reducing, and eliminating seclusion and restraint and their rationale.

SUMMARY:

The National Association of State Mental Health Program Directors (NASMHPD) has published two technical reports on reducing the use of seclusion and restraint in public mental health settings. The reports reviewed findings from the literature, developed principles for the use of seclusion and restraint, and recommended strategies and best practices for preventing, reducing, and eliminating seclusion and restraint. This workshop will present the response of states to the reports' recommendations. It will focus on practical application of the principles and best practices. Each state will summarize its efforts in developing policies and procedures to reduce and eventually eliminate seclusion and restraint.

REFERENCES:

1. NASMHPD Medical Directors Council: Reducing the Use of Seclusion and Restraint. Alexandria, Va,

National Association of State Mental Health Program Directors, 1999.
2. NASMHPD Medical Directors Council: Reducing the Use of Seclusion and Restraint. Part II. Alexandria, Va, National Association of State Mental Health Program Directors, 2001.
3. Vissali H, McNasser G: Striving toward a best practice model for a restraint-free environment. Performance Improvement Ideas and Innovations 1997; 1–4.

Workshop 39 **Friday, October 11**
1:30 p.m.-3:00 p.m.

CHANGING PERSPECTIVES IN RESIDENTIAL CARE: TRADITIONAL AND INNOVATIVE MODELS

Marilyn Seide, Ph.D., *Division Chief, Los Angeles County Department of Mental Health, 1925 North Daly Street, 2nd Floor, Los Angeles, CA 90031*; Richard A. Miller, M.D.; Carol Wilkens, M.P.P.; Suzanne Wagner, M.A.

EDUCATIONAL OBJECTIVES:

To recognize the essential elements necessary to have in place in order to implement a comprehensive continuum of residential care, as well as to develop more permanent, independent options for chronic, seriously mentally ill persons.

SUMMARY:

Across the country, shrinking state budgets have mandated a steady decrease in the number of state mental hospital beds. Although the original intent was for funds to follow former hospital patients into the communities to which they were released, this in fact did not generally occur. Therefore, chronic mentally disabled people wound up in a variety of supposedly "less restrictive" settings, ranging from locked, community-based facilities (called Institutes for Mental Disease in California) to board and cares, from there possibly to the street or the jail, and frequently back into an acute hospital setting to begin the process again. In an effort to address these concerns—who were these clients, what were their characteristics, were they referred to the appropriate settings, did these settings in fact exist—the Los Angeles Department of Mental Health implemented an initiative called the Access and Transitions Project. This workshop will address the findings of this project, as well as look at some innovative residential settings that seem to address the needs of these clients for safe and effective residential care and treatment appropriately, including supportive independent housing offering more independence and normality. Participants will include those involved in the L.A. initative and others who have helped develop some of these alternative settings.

TARGET AUDIENCE(S):

Clinicians, program developers, administrators responsible for effecting long-term placement solutions for this population.

REFERENCES:

1. Lamm HR: Deinstitutionalization at the beginning of the new millennium. Harvard Review of Psychiatry 1998; 5–6; 1–10.
2. Minkoff K: Beyond deinstitutionalization: a new ideology for the postinstitutional era. Hospital and Community Psychiatry 1987; 38:945–950.

Workshop 40 **Friday, October 11**
3:30 p.m.-5:00 p.m.

THE MANY FACES OF TRAUMA AND THE MULTIFACETED TREATMENT OF NEW IMMIGRANTS

Guillermo Olivos, M.D., *Staff Psychiatrist, Montgomery County Mental Health Administration, 8818 Georgia Avenue, Suite 200, Silver Spring, MD 20910*; Lidia R. Carnota-Cohen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the many faces of trauma the new immigrants present, how to deal with the cultural differences among immigrants who speak the same language, and learn to organize a multifaceted team approach by working with other community based agencies.

SUMMARY:

This workshop is targeted to mental health professionals working with Latino and Vietnamese new immigrants. The Metropolitan Washington area has always attracted new immigrants. Recently, the racial and cultural composition of Montgomery County, a suburb of Washington, D.C., where we practice, has changed dramatically, provoking changes in the delivery of mental health services.

The majority of patients we treat at the Silver Spring Multicultural Program have a history of multiple psychological traumas, do not speak English, do not have medical insurance, and live below the poverty level. The new immigrants seen in our program usually present severe forms of chronic posttraumatic stress disorder accompanied by symptoms of depression, panic disorder, dissociation, phobias, substance abuse, and psychosis. The majority of our Vietnamese patients are refugees, while the

Latino population is undocumented. The program's main features consist of multidisciplinary team approach, time-limited treatment, outreach, work in partnership with other community agencies, and use of the media to inform, engage, and advertise services.

REFERENCES:

1. Alarcon RD: Hispanic Psychiatry From Margin to Mainstream. APA Simon Bolivar Award Lecture, May 1999.
2. Giorgis T: Multicultural Competence—A Case Study in Mental Health Service Delivery. DMH, Government of Washington, D.C., 2001.

Workshop 41 **Friday, October 11**
3:30 p.m.-5:00 p.m.

ON-SITE TREATMENT TO THE HOMELESS: PROGRAM PLANNING AND REPLICATION

Project for Psychiatric Outreach to the Homeless, Inc.

Katherine Falk, M.D., *Clinical Assistant Professor of Psychiatry, Columbia University College of Physicians and Surgeons, New York State Psychiatric Institute, and President and Founder, Project for Psychiatric Outreach to the Homeless, Inc., 74 Trinity Place, Suite 800, New York, NY 10006*; Cathy Treiber, C.S.W.; Marilyn A. Kneeland, J.D.; Amy Cohen

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the unique treatment needs of homeless, mentally ill persons and understand the benefits and challenges of designing a program to provide on-site psychiatric treatment that addresses those needs.

SUMMARY:

The Project for Psychiatric Outreach to the Homeless, Inc. (PPOH) is a not-for-profit organization in New York City designed to meet the unique treatment needs of homeless, mentally ill persons. PPOH recruits and trains psychiatrists to go on site to social service programs for homeless persons to provide psychiatric outreach and treatment in partnership with caseworkers and other agency staff. This model of treatment makes use of existing resources and is appropriate for replication in other communities.

This workshop will describe the administrative and supervisory aspects of PPOH's current program. In addition, techniques for engaging homeless persons and providing psychiatric treatment in a "nontraditional" setting will be explored. Finally, a description of how this program was successfully replicated in a rural setting will be presented.

TARGET AUDIENCE:

This workshop is targeted to mental health professionals (psychiatrists, social workers, psychologists) interested in innovative solutions to the problem of providing accessible psychiatric treatment to homeless persons.

REFERENCES:

1. Susser E, et al: Preventing recurrent homelessness among mentally ill men: a "critical time" intervention after discharge from a shelter. American Journal of Public Health 1997; 87:256–261.
2. Susser E: Working with people who are mentally ill and homeless: the role of a psychiatrist. Homelessness: A Prevention Oriented Approach. Edited by Jahiel I. Baltimore, The Johns Hopkins University Press, 1992, pp 207–217.

Workshop 42 **Friday, October 11**
3:30 p.m.-5:00 p.m.

FROM JAIL TO TREATMENT: DIVERTING THOSE WITH SERIOUS CRIMES AND SERIOUS DISORDERS

Stephen M. Goldfinger, M.D., *Liaison, APA Institute Scientific Program Committee, and Professor and Vice Chair, Department of Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, Brooklyn, NY 11203*; Anne Swern, J.D.; Nahama Broner, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the learner will be able to describe impediments to effective interventions with dually diagnosed criminal offenders, and propose three new approaches to successfully engage them in needed treatment.

SUMMARY:

Mentally ill individuals are admitted to jails at approximately eight times the rate at which they are admitted to public psychiatric hospitals, and there are more people with severe mental illness in U.S. jails than there are in state hospitals. The New York Dept. of Correction (NYC DOC) averages a daily inmate population of 15,000–19,000. Three to five thousand SPMI offenders are admitted to Rikers Island annually. 80% to 90% of these are estimated to have co-occurring substance abuse problems. Preliminary findings from a pre-arraignment prevalence study in Kings County found that 30% of offenders were SPMI and 43% endorsed a dual diagnosis. In Brooklyn, last year there were a total of 98,668 arrests.

A third faced low-level misdemeanor charges and two thirds committed more serious crimes. Approximately 19,452 (30% of all misdemeanor and felony arrests) mentally ill offenders are currently systematically excluded from diversion.

The primary purpose of our project is to reduce the cycle of drug use, decompensation, and incarceration of mentally ill offenders in Kings County (Brooklyn) criminal justice system. An existing "best practice model of DTAP" (Drug Treatment Alternative to Prison) program, initiated by the Kings County District Attorney, combines intensive case management, court monitoring, and diversion with community-based treatment. We are adding a mental health component to the existing diversion efforts (such as case identification and assessment, linkage to treatment, and treatment monitoring) as well as other needed services. We believe that enhancing services will increase our ability to treat this population, improve inter-agency and provider communication to increase continuity of care, and thus increase treatment retention. Lasting benefits of diversion will include greater consumer and family satisfaction, decreased recidivism, reduced homelessness, and improved mental functioning.

A unique part of this effort is the diversity of perspectives among the project leadership. In this workshop, the three co-principal investigators, coming from varying professional backgrounds and system positions, will share the challenges we are facing in implementing a SAMHSA grant to provide on-site, court based diversion for these dually diagnosed offenders. Anne Swern, J.D., the P-I, is the Deputy District Attorney for Kings County and the designer and recipient of many innovative diversion programs and activities. Stephen Goldfinger, M.D., is a community psychiatrist and professor and vice chair of psychiatry at SUNY Downstate Medical Center, New York city's only public medical school. Nahama Broner, Ph.D., is a research psychologist at NYU with extensive experience in evaluating forensic diversion programs and research director of NYU's Institute Against Violence. All of us realize that, at a meeting like the IPS, those with experience in jail diversion come to learn, but also to teach. Our intention is to use the preliminary organizing efforts we are making as a jumping-off point for a broader, interactive discussion with attendees of the shared problems, existing expertise and future ideas.

REFERENCES:

1. Swern A, Heslin D: Drug Treatment Alternative to Prison (DTAP) 10th Annual Report, 2000.
2. Steadman HJ, Morris SM, Dennis DL: The diversion of mentally ill persons from jails to community based services. AJPH 1995; 85:1630–1635.

Workshop 43 **Saturday, October 12**
8:00 a.m.-9:30 a.m.

PSYCHIATRIC LEADERSHIP AND CONTINUITY OF CARE IN THE RURAL PUBLIC SECTOR OF ILLINOIS

Jagannathan Srinivasaraghavan, M.D., *Professor of Psychiatry, Southern Illinois University School of Medicine, and Medical Director, Choate Mental Health and Development Center, 1000 North Main Street, Anna, IL 62906*; S. Atezaz Saeed, M.D., M.S.; Abraham R. Frenkel, M.D.; Basil P. Spyropoulos, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participants should understand the role of psychiatric leadership in implementing appropriate evidence-based clinical practices; understand effective public sector continuity of care for seriously mentally ill living in the rural areas.

SUMMARY:

Integration and continuity of care of services for the seriously mentally ill between state hospitals and community mental health centers has been a growing trend and a goal. In Illinois, systems of care are developed on this principle. Southern Network, with nearly 600,000 people in 28 counties, is served by a university-affiliated state hospital and 16 community mental health centers. North Central Network, with nearly 1.3 million people in 23 counties, is served by a university-affiliated state hospital and 21 mental health centers. The hospital and community agencies participate in individual patient care from admission, treatment planning, discharge planning, to continuity of care. The hospital and community agencies are developing joint clinical ventures in which they share resources and clinical expertise, allowing for best clinical practices as well as smooth transition from one level of care to another. The success of any system of care depends on the quality of psychiatric leadership. There is enormous emphasis placed on identifying and implementing evidence-based clinical practices, outcome measures, enhancing patient-clinical partnership, and clinical training. Audience participation will be encouraged to discuss the steps taken by the two networks in Illinois and to explore other possibilities.

REFERENCES:

1. Ranz J, Stueve A: The role of the psychiatrist as program medical director. Psychiatric Services 1998; 49:1203–1207.
2. Drake RE, et al: Implementing evidence-based practices in routine mental health settings. Psychiatric Services 2001; 52:2.

Workshop 44 **Saturday, October 12**
8:00 a.m.-9:30 a.m.

MENTAL HEALTH AND CRIMINAL JUSTICE CONSENSUS PROJECT

American Association of Community Psychiatrists

Fred C. Osher, M.D., *Director, Center for Behavioral Health, Justice, and Public Law, Associate Professor of Psychiatry, University of Maryland at Baltimore, and Former APA/Bristol-Myers Squibb Fellow, 645 West Redwood, Suite PIG-08, Baltimore, MD 21201*; Jacqueline M. Feldman, M.D.; Hunter L. McQuistion, M.D.

EDUCATIONAL OBJECTIVES:

To demonstrate an understanding of the issues related to the interface between systems of corrections and mental health, and the importance of the process of the mental health/criminal justice consensus project.

SUMMARY:

A consensus project has been coordinated by the Council of State Governments in association with the National Association of State Mental Health Program Directors, the Police Executive Research Forum, the Pretrial Services Research Center, and the Association of State Corrections Administrators. The development of the project was predicated on the staggering statistics of increasing involvement with the criminal justice system by persons with mental illness (PMI). Acknowledging the precarious sequelae for both PMIs and their communities when criminal justice systems are compelled to respond, the consensus project developed recommendations for improved services to both divert and treat PMIs when they encounter law enforcement, the courts, and correctional settings. Three ''tracks'' (law enforcement, courts, and corrections) met for over two years to develop a report. Representatives from state and local executive, legislative, and judicial branches of government, as well as representatives from law enforcement, corrections, and mental health served on these tracks. The presenters at this workshop are the three psychiatrists who served on these committees. The workshop will focus on recently released recommendations for public policy development that are the product of the consensus project.

TARGET AUDIENCE(S):

All mental health providers, administrators, and consumers

REFERENCES:

1. Position statement on post-release planning by the Committee on Persons with Mental Illness Behind Bars of the American Association of Community Psychiatrists. Community Psychiatrists 2000; 14:4–6.
2. Substance Abuse and Mental Health Services Administration: The Courage to Change: A Guide for Communities to Create Integrated Services for People with Co-Occurring Disorders in the Justice System, DHHS, 1999.

Workshop 45 **Saturday, October 12**
8:00 a.m.-9:30 a.m.

THE ART OF THE UNCONSCIOUS: SHAKESPEARE, POETRY, FILM, AND PSYCHIATRY

Steven E. Pflanz, M.D., *Chief, Mental Health Services, F.E. Warren Air Force Base, U.S. Air Force, 68-A Fort Warren Avenue, Cheyenne, WY 82001*; Scott D. Pflanz, B.F.A., *518 Court Street, Brooklyn, NY 11231*

EDUCATIONAL OBJECTIVES:

To understand that the various forms of art are windows into the human unconscious and examine both literature and the performing arts for the connection between art and the unconscious for both ourselves and our patients.

SUMMARY:

Theater, film, literature, and poetry are forms of expression that allow artists and their audiences to explore the compelling issues of their lives. On a very basic level, the various forms of art are windows into the emotions and impulses that populate the human unconscious. In a real sense, art, both in its creation and its enjoyment, can be as healing for the psyche as psychotherapy. This workshop examines the role of drama and literature in both the professional and personal lives of psychiatrists. The themes explored in literature help us understand from a different perspective the difficult issues that our patients grapple with in therapy. The films, poems, and plays that we find most gripping or poignant tell us something about our own unconscious world and help us reach a greater degree of self-understanding. In creating our own poetry or performing in theater, we are revealing something of ourselves to others that is important for us to share. In this workshop, the audience will listen to readings of poetry and view short film clips, discussing each piece as it is presented. The material chosen will contain universal themes touching on human lives. The poetry readings will include selections from our own writings as well as from our favorite poets. The coup de grace will be a short performance of a classic scene from Shakespeare by the two facilitators. Throughout the workshop, we will lead the audience in a lively discussion exploring the connection between art and the unconscious for both ourselves and our patients.

TARGET AUDIENCE(S):

General psychiatrists

REFERENCES:

1. Pflanz SE: Winter's ill wind. West Virginia Medical Journal 2000; 96:573.
2. Shakespeare W: William Shakespeare: The Complete Works. New York, Barnes and Noble, Inc., 1994.

Workshop 46 **Saturday, October 12**
10:00 a.m.-11:30 a.m.

WHAT'S HAPPENING IN SYSTEM OF CARE REFORM IN CHILDREN'S SERVICES?

American Association of Community Psychiatrists

Charles W. Huffine, Jr., M.D., *Member, APA Institute Scientific Program Committee, Assistant Medical Director for Child and Adolescent Programs, King County Mental Health Division, and Past President, American Association of Community Psychiatrists, 3123 Fairview Avenue, East, Seattle, WA 98102-3051*; Andrés J. Pumariega, M.D.

EDUCATIONAL OBJECTIVES:

To understand the history of system of care reform in children's services, the problems it addressed, and the evolving "best practices" derived from the CMHS Children's Mental Health Initiative grants.

SUMMARY:

System of care reform in children's services emerged out of frustrations with the fragmented nature of services to children and youth highlighted in many studies in the 60s and 70s. It began with the CASSP initiative in 1984 and has evolved into a major grant program of SAMHSA and, before that, of RWJ. These grants have promoted CASSP values, mandating that services to children and youth be family centered, child focused, community based, and integrated and that they are culturally competent. Experiments with blended funding, family empowerment, cultural-competency consultation, and wraparound services will be touched on. Problems in program evaluation will also be discussed along with promising practices emerging from the grant programs. The program will serve as an overview for child and adolescent psychiatrists who have an interest in the activities of the CMHS grants, and it will be of interest to general psychiatrists who are eager for a summary of current trends in child and adolescent services.

REFERENCES:

1. Stroul BA, Friedman RM: A System of Care for Children and Youth With Severe Emotional Disturbances (rev. ed.). Washington D.C., Georgetown University Child Development Center, CASSP Technical Assistance Center.
2. VanDenBerg JE, Grealish EM: Individualized services and supports through the wraparound process: philosophy and procedures. Journal of Child and Family Studies 1996; 5:7–21.

Workshop 47 **Saturday, October 12**
10:00 a.m.-11:30 a.m.

MENTAL ILLNESS PORTRAYED IN THE PRESS

Illinois Psychiatric Society

Sue Ellen Christian, Ph.D., *Chicago Read Mental Health Center, 4200 North Oak Park Avenue, Building K, Chicago, IL 60634*; Thomas A. Simpatico, M.D.; Peter D. Nierman, M.D.; Suzanne M. Andriukaitis, M.A., L.C.S.W.; Linda Dinsin, Ph.D.

EDUCATIONAL OBJECTIVES:

To understand what different factions of the press and media consider newsworthy, and how stories get past editorial review to the general public; learn strategy to better work with members of the press so that more balanced accounts of persons with mentall illness reach the general public; understand more effective ways to influence public policy.

SUMMARY:

There is a sense among mental health professionals that the press is responsible for educating the general public about the consequences of mental illness and for setting the stage for social policy by creating a favorable climate among legislative constituencies. This workshop will address the ways in which various factions of the press and media understand what stories are newsworthy and ultimately get to the public. Issues such as "duty to educate" and inform the public will be addressed from the perspectives of psychiatrists and other mental health professionals, leaders in the mental health advocacy community, and prominent members of the mass media.

TARGET AUDIENCE(S):

Psychiatrists, psychologists, social workers, mental health advocates

REFERENCES:

1. Wahl O: Media Madness: Public Images of Mental Illness. Rutgers, University Press, 1999.
2. Marcos CR: Media power and public mental health policy. American Journal of Psychiatry, 1999.

Workshop 48 **Saturday, October 12 10:00 a.m.-11:30 a.m.**

CULTURE, CARE, AND RESOURCES IN MENTAL HEALTH CARE FOR IMMIGRANTS

APA Committee on Poverty, Homelessness and Psychiatric Disorders

Hunter L. McQuistion, M.D., *Medical Director, Project Renewal, Inc., National Development and Research Institutes, and Former APA/Bristol-Myers Squibb Fellow, 200 Varick Street, Ninth Floor, New York, NY 10014*; Manoj R. Shah, M.D.; Florence Samperi, C.S.W.; Elsie DelCampo, C.S.W.

EDUCATIONAL OBJECTIVES:

At the completion of this workshop, participants will understand the extent of social and health care needs of immigrant populations, will be acquainted with novel outreach and treatment interventions, and have awareness of the need for political advocacy to enable such interventions to take place.

SUMMARY:

The 1990s witnessed more immigration than at nearly any other time in our nation's history. The growing number of immigrants has demanded mental health programming that is culturally competent, accessible, reliable, and of high technical quality. This has proved a challenge for a system with limited resources, leading to stresses in delivery of care. The situation is worsened for immigrants who are also here illegally. Undocumented status brings with it a host of problems, including relative lack of social support, absence of financial stability, and often, severe housing instability. It is also a particularly stigmatized social status, sometimes scapegoated by racial, ethnic, or religious discrimination.

This workshop will examine public policy and explore two unique clinical interventions targeting the mental health needs of all immigrant populations, focusing on those who are undocumented. Through a discussion of how public policy translates to ground-level services, the panel will discuss ideas on how the mental health system may better meet the increasing demands of immigrants and how health care providers may advocate for services to this growing population.

TARGET AUDIENCE(S):

Clinicians, program managers, health care advocates, policy makers

REFERENCES:

1. Giordano J: Mental health and the melting pot: an introduction. Am J Orthopsychiatry 1994; 64:342–345.
2. American Psychological Association: Guidelines for Providers of Psychological Services to Ethnics, Linguistic, and Culturally Diverse Populations. Am Psychologist 1993; 48:45–48.

Workshop 49 **Saturday, October 12 1:30 p.m.-3:00 p.m.**

OUTCOMES OF A RESIDENTIAL INTEGRATED TREATMENT STUDY FOR PEOPLE WITH DUAL DIAGNOSES

Marion L. McCoy, Ph.D., *Director of Research, Thresholds, 4101 North Ravenswood, Chicago, IL 60613*; Roy Clay, B.A.; L. Mark Harris, M.S.; Timothy Devitt

EDUCATIONAL OBJECTIVES:

To diagnose and treat persons with a comorbid diagnosis within a residential context, using the general approach and specific services discussed in the workshop; demonstrate a working knowledge of the tools used in the study; and gain the ability to replicate the study presented in the workshop.

SUMMARY:

Twenty years of research testing interventions for persons with mental illness and substance abuse disorders show that integrated treatment models surpass results achieved using sequential or parallel treatment. That is, integrated treatment consumers have higher rates of engagement, reduced hospitalization rates, and higher rates of abstinence or reductions in substance use. However, these findings are not borne out for studies of residential integrated treatment. Most residential programs report poor retention rates and only modest improvements in reducing substance use or rehospitalization.

In contrast, this workshop presents outcomes for an innovative, residential, integrated treatment program based on a blended Assertive Community Treatment plus intensive case management model, with emphasis on motivational interviewing where retention rates exceed 71%. To determine changes over time, evidence-based practice outcome tools (Stage of Substance Abuse Treatment Scale, Clinician Alcohol Use Scale, and Clinician Drug Use Scale) were administered over 18 months. Using paired samples, 2-tailed t-tests of significance analyses reveal advances in stage of treatment, and significant reductions in rehospitalization, and use of alcohol and drugs. Corroborating evidence (self-reports, collateral reports, and random, monthly drug and alcohol tests) support these findings. Details of program components and practices will be highlighted in an interactive workshop format.

TARGET AUDIENCE:

Community-based psychiatrists, mental health providers, and ACT providers

REFERENCES:

1. Mueser KT, Drake RE, et al.: Toolkit for evaluating substance abuse in persons with mental illness. Cambridge, MA, Evaluation Center at HSRI, 1995.
2. Drake RE, Mueser KT: Psychosocial approaches to dual diagnosis. Schizophrenia Bulletin 2000; 26:105–118.

Workshop 50 **Saturday, October 12**
1:30 p.m.-3:00 p.m.

INTEGRATING RECOVERY PRINCIPLES INTO BEHAVIORAL HEALTH PROGRAMMING

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

EDUCATIONAL OBJECTIVES:

To recognize various approaches to incorporation of recovery principles in behavioral health services; discuss strategies to sustain recovery-oriented services; and identify possible barriers to successful implementation of recovery oriented services.

SUMMARY:

Traditional approaches to service provision for persons with mental health or substance use disorders have been organized according to a medical model. In that model, behavioral health professionals made a determination of the nature of their clients' presenting problems and prescribed a treatment program. Illness was often perceived to be chronic and intractable. In recent years, concepts related to recovery have become more prevalent. With roots in addict populations, recovery principles emphasize disease management, personal responsibility, community support, empowerment, and hope. The relationship with service providers is transformed from paternalistic/dependent pattern to a mutual/collaborative one. This workshop will describe an organized effort in Allegheny County, Pa., to enable service providers to incorporate recovery principles into treatment and service planning in a sustainable manner through education and training of professionals, increased public awareness, and quality-improvement processes. This effort sought to integrate mental health and addiction perspectives on recovery. The use of dialogues between consumers, providers, family members, and community groups will be described as an integral tool in this process. Participants will be encouraged to share their own experiences with recovery-oriented services and attempts to facilitate these processes.

REFERENCES:

1. Anthony WA: A recovery oriented services system: setting some system level standards. Psychiatric Rehabilitation Journal 2000; 24:159–167.
2. Jacobson N, Curtis L: Recovery as policy in mental health services: strategies merging from the states. Psychiatric Rehabilitation Journal 2000; 23:333–341.

Workshop 51 **Saturday, October 12**
1:30 p.m.-3:00 p.m.

AN INTEGRATIVE PROGRAM FOR THE TREATMENT OF THE DUALLY DIAGNOSED PATIENT

Stephen M. Delisi, M.D., *Director of Psychiatry, Rush Behavioral Health, Rush Presbyterian/St. Luke's Hospital, 2001 Butterfield Road, Suite 320, Downers Grove, IL 60515*; Daniel H. Angres, M.D., *Director, Rush Behavioral Health, Rush Presbyterian/St. Luke's Hospital, 2001 Butterfield Road, Suite 320, Downers Grove, IL 60515*; Paul Feldman, M.D.

EDUCATIONAL OBJECTIVES:

This workshop provides an overview of an integrative program for the treatment of patients with addiction and a primary affective, anxiety, personality, or pain disorder. The participant should be familiar with how these programs have been integrated and what common issues arise when treating the dually-diagnosed patient.

SUMMARY:

It has long been recognized that patients with a primary affective, anxiety, or personality disorder and either (or both) addiction or chronic pain have a complicated course of treatment. These dually-diagnosed patients often cite attempts to regulate affect or reduce pain and psychological distress as triggers predisposing them to relapse. There is new emphasis on re-examining long-held attitudes about the treatment of these patients, and there are calls for disciplines of psychiatry, pain medicine, and addiction medicine to collaborate. Treatment approaches that are flexible and knowledgeable are required to adequately address the diversity with which these patients present. We will describe our attempt to integrate a comprehensive plan and a cognitive-behavioral therapy program (based upon the dialectical behavioral therapy model) into a chemical-dependency program in which there are a majority of professional

high-accountability patients (health care and other professionals). We will discuss the individual components of this integrated program as well as highlight the particular ways in which the pain-management and cognitive-behavioral therapy aspects have been incorporated into the program. In addition, we will identify issues that commonly emerge during the treatment of the dually-diagnosed patient.

TARGET AUDIENCE:

Physicians, nurses, and counselors of all levels

REFERENCES:

1. Linehan MM, et al: Dialectical behavioral therapy for patients with borderline personality disorder and drug dependence. Amer J on Addictions 1999; 8:279–92.
2. Dunbar S, Katz N: Chronic opioid therapy for nonmalignant pain in patients with history of substance abuse. J Pain Symp Manage 1996; 11:163–171.

Workshop 52 **Saturday, October 12**
1:30 p.m.-3:00 p.m.

ARE FEDERAL REGULATIONS KILLING COMMUNITY PSYCHIATRY EDUCATION?

American Association of Community Psychiatrists

John J. Haggerty, Jr., M.D., *Associate Professor of Psychiatry, University of North Carolina School of Medicine, CB-7160, Chapel Hill, NC 27599*; Edward M. Kantor, M.D.; James W. Thompson, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

To describe the foundations of community-medical school training collaboration, identify policy and funding developments that are adversely affecting collaboration, and develop strategies for rescuing threatened collaborations.

SUMMARY:

The placement of psychiatry residents in community training sites has long depended on quid pro quo financial arrangements between psychiatry departments and community-based agencies. Agencies received inexpensive clinical providers, and training programs received external funding to offset resident salaries. New Medicare/Medicaid supervision requirements that diminish trainee autonomy, combined with financial stresses affecting both agencies and training programs, are making community training collaborations less attractive to all partners. In this workshop, Dr. Kantor will describe the nature and scope of the problem, Dr. Haggerty will provide examples of alternative funding arrangements, and Dr. Thompson will examine implications for policy change. Together, audience and presenters will explore creative solutions for maintaining community-based training in the face of these new challenges.

TARGET AUDIENCE(S):

Community psychiatrists, psychiatric educators, program admin., residents

REFERENCES:

1. Henderson TM: Medicaid's role in financing graduate medical education. Health Affairs 2000; 19:221–9.
2. Goetz R, Cutler DL, Pollack D, et al: A three-decade perspective on community and public psychiatry training in Oregon. Psychiatric Services 1998; 49:1208–11.

Workshop 53 **Saturday, October 12**
3:30 p.m.-5:00 p.m.

TOBACCO-FREE ENVIRONMENTS AT STATE PSYCHIATRIC HOSPITALS

Joseph L. Black, M.D., *Chief Psychiatrist, Competency Program, North Texas State Hospital at Vernon, P.O. Box 2231, Vernon, TX 76384*; Peter G. Fadow, M.D.; Louis Kavetski, D.D.S; William H. Johnson, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to plan and implement a successful tobacco-free environment in a state psychiatric hospital with supports for both patients and staff.

SUMMARY:

In the belief that a moral, ethical, and professional obligation exists to protect our patients from products that we know to be inherently addictive and predictably deadly, the medical staff at North Texas State Hospital-Vernon, the forensic unit for the state of Texas, recommended in April 1997 that the administration establish a tobacco-free environment at that facility. The medical staff of North Texas State Hospital-Wichita Falls, a regional state hospital, also adopted such a recommendation for their facility. In response to these recommendations, the administration of those facilities developed and implemented a detailed plan of action to establish tobacco-free environments at these facilities on December 1, 1998, with supportive measures for both patients and staff. On September 1, 2001, Rusk State Hospital and San Antonio State Hospital, both regional state hospitals, adopted similar plans to establish tobacco-free environments at those facilities. A detailed action plan including administrative policy and procedure changes, the development of support measures for both patients and staff, and the measures necessary to inform and educate all

stakeholders that have interests in the care of patients at these facilities is described. The outcomes of the implementation of the tobacco-free environments at these facilities are presented in terms of patient acceptance, staff reaction, incidents of aggression, lost-time injuries, and clinical overview.

TARGET AUDIENCE(S):

Psychiatrists, psychologists, social workers, nurses, administrators, and patient advocators

REFERENCES:

1. Fiore MC, Bailey WG, Cohen SJ, et al: Treating Tobacco Use and Dependence A Clinical Practice Guideline, Rockville, MD, United States Dept. of Health and Human Services, 2000.
2. American Psychiatric Association: Practice Guideline for the Treatment of Patients with Nicotine Dependence, 1996, pp. 1–72.

Workshop 54 **Saturday, October 12**
3:30 p.m.-5:00 p.m.

THE CLINICAL EVALUATION OF COGNITIVE DYSFUNCTION

Raymond A. Faber, M.D., *Professor of Psychiatry and Neurology, University of Texas Health Science Center at San Antonio, and Chief of Neuropsychiatry, Audie Murphy VA Hospital, 7400 Merton Minter, 116-A, San Antonio, TX 78284*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to efficiently assess the nature and extent of cognitive dysfunction in psychiatric and neuropsychiatric patients.

SUMMARY:

This workshop will present the essential elements that comprise the clinical evaluation of cognitive functioning. The organization of cognitive functioning will be explained. This is best understood as a hierarchy starting with the fundamental foundations of consciousness and attention, then ranging to specialized abilities such as language and visuospatial skills. Practical methods of easily assessing cognitive functions will be demonstrated. Particular emphasis will be given to the assessment of memory and executive functions as understood from recent research. Several very practical batteries will be presented in detail. These include the Frontal Assessment Battery, the Cognistat exam, and the 7-minute Screen for Alzheimer's disease. The advantages of these instruments over the better known Mini-Mental Status Exam will be highlighted. This workshop is intended for clinicians who must efficiently determine the nature and extent of cognitive dysfunction in patients with psychiatric and neuropsychiatric disorders.

TARGET AUDIENCE(S):

Psychiatrists; other mental health professionals

REFERENCES:

1. Solomon PR, Hirsckoff A, Kelly B, et al: A 7-minute neurocognitive screening battery highly sensitive to Alzheimer's disease Arch Neurol 1998; 55:349–355.
2. Strub RL, Black FW: The Mental Status Examination in Neurology, ed. 4. Philadelphia, FA Davis, 2000.

Workshop 55 **Saturday, October 12**
3:30 p.m.-5:00 p.m.

HIV UPDATE: PREVENTION AND CARE IN DIVERSE POPULATIONS

Association of Gay and Lesbian Psychiatrists

Gene A. Nakajima, M.D., *Former APA/Bristol-Myers Squibb Fellow, CSP 1700 Jackson Street, San Francisco, CA 94109*; Raymond J. Kotwicki, M.D.; Robert P. Cabaj, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant will understand the psychodynamic reasons why HIV risk may be increasing among gay men. The participant will understand the unmet needs of mental health services for Asian and Pacific Islanders with HIV/AIDS.

SUMMARY:

HIV continues to affect diverse gay populations for whom specific mental health care needs must be addressed. In this workshop, we will highlight two important areas, HIV prevention and the met and unmet mental health care needs of people with HIV.

The first part will discuss prevention. Now that the message about HIV is several decades old, many gay men are no longer following prevention information. Many individuals in the gay male community erroneously believe that their need for HIV prevention ended with HIV therapies. Currently, statistics reveal a higher percentage of men engaging in "barebacking," or anal sex without condoms. Dr. Cabaj will discuss why gay men who abuse substances or who have a major mental illness make prevention efforts especially difficult. He will also address the role of psychotherapy in the treatment of HIV-positive men. Dr. Kotwicki will speak about psychodynamic theories behind unsafe sex and address the public health implications of this behavior.

In part two, Dr. Nakajima will speak about the met and unmet mental health needs of Asian/Pacific Americans with HIV/AIDS. Drawing from a research study

of over 200 subjects, he will highlight their unmet needs in care for depression, substance dependence, and sexual dysfunction.

TARGET AUDIENCE:

Clinicians who see or may see gay men with HIV.

REFERENCES:

1. Cabaj RP: Textbook of Homosexuality and Mental Health. Washington, DC, American Psychiatric Press, 1997.
2. King MB: AIDS, HIV and Mental Health. Cambridge, England, Cambridge Univ. Press, 1993.

Workshop 56 **Sunday, October 13**
8:00 a.m.-9:30 a.m.

INTERNATIONAL COMPARATIVE PSYCHIATRY: DIALOGING OVER THE OCEANS

Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute and Clinic, Assistant Professor of Psychiatry, University of Pennsylvania Medical Center, and Former APA/Bristol-Myers Squibb Fellow, 3811 O'Hara Street, Room E-516, Pittsburgh, PA 15213*; Clemens Witte, M.D.; Alan Rosen, M.D.; Vivienne Miller, M.A., O.T.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be aware of the issues involved in comparing mental health services across nations.

SUMMARY:

Psychiatry is an international endeavor. Yet all health care is local. As the world becomes smaller, the opportunities to share perspectives have become greater. Will greater contact lead to greater understanding? Will our mutual understandings progress from an awareness of superficial differences and similarities to something deeper? For several years, several Dutch and Australian psychiatrists have been coming to the Institute for Psychiatric Services and visiting community mental health service systems in the United States. In turn, mental health professionals from the United States have visited them. All have benefitted, yet it has become clearer that the walls of culture and history are thick, even between Western countries. Translating what is observed across cultures is not a simple task.

In this workshop the presenters will discuss their observations, comparing community mental health services cross cultures and over time. The audience will participate in a discussion about how psychiatrists can increase their capacity to learn from each other in this globalized world.

TARGET AUDIENCE(S):

Mental health professionals interested in international comparative studies of mental health services.

REFERENCES:

1. Mental Health in Our Future Cities. Edited by Goldberg D, Graham T. Psychology Press, 1998.
2. Satorius N: Psychiatry in the framework of primary care: a threat of a boost to psychiatry. American J Psychiatry 1998; 154: Festchrift Suppl.

Workshop 57 **Sunday, October 13**
8:00 a.m.-9:30 a.m.

LESBIAN AND GAY POSITIVE PRACTICE: PERSONAL AND PROFESSIONAL ISSUES

Association of Gay and Lesbian Psychiatrists

Howard C. Rubin, M.D., *Psychiatrist, South of Market Mental Health Clinic, 760 Harrison Street, San Francisco, CA 94107*; Susan A. Turner, M.D., *2001–2003 APA/Bristol-Myers Squibb Fellow; Liaison, APA Institute Scientific Program Committee; and Department of Psychiatry, Columbia University College of Physicians and Surgeons, 258 West 99th Street, #4, New York, NY 10025*; Margery Sved, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this workshop the participant should be able to understand the challenges and joys of gay parenting, appreciate the issues that gay and lesbian residents face in their training, and gain insight into how sexual orientation affects a psychotherapy.

SUMMARY:

In the nearly 30 years since APA removed homosexuality from the DSM, much progress has been made in advancing the practice of gay affirmative psychiatry and in the ability of gay men and lesbians to lead more open and fulfilling lives. In this workshop, we examine the intersection of the personal and professional issues that currently affect gay and lesbian providers and their patients. Dr. Rubin will present a case study of his psychotherapeutic work with a gay man with bipolar illness in community psychiatry. He will discuss how the sexual orientation of patient and provider affect transference and countertransference issues. Dr. Sved will present a discussion of issues related to parenting, deciding to parent, and generativity without parenting for gay men and lesbians that may arise during psychotherapy. Dr. Turner will describe the current conditions for lesbian and gay residents in psychiatry. She will focus on issues

of disclosure of sexual orientation during residency training, both to colleagues and to patients. She will review results of a survey of gay and straight residents in her own program on these issues.

TARGET AUDIENCE:

For clinicians who may see lesbian and gay patients.

REFERENCES:

1. Kirkpatrick M: Lesbians as parents, in Textbook of Homosexuality and Mental Health. Washington, DC, American Psychiatric Association Press, 1996, pp 353–370.
2. Atkins DL, Townsend MH: Issues for gay male, lesbian, and bisexual mental health trainees, in Textbook of Homosexuality and Mental Health. Washington, DC, American Psychiatric Association Press, 1996, pp 633–642.

Workshop 58 **Sunday, October 13**
8:00 a.m.-9:30 a.m.

INVOLUNTARY OUTPATIENT COMMITMENT

Alan Q. Radke, M.D., M.P.H., *State Medical Director, Minnesota Department of Human Services, 444 Lafayette Road, North St. Paul, MN 55155-3826*; Brian M. Hepburn, M.D., *State Clinical Director, Mental Hygiene Administration, Maryland Department of Health and Mental Hygiene, 201 West Preston, Room 416-B, Baltimore, MD 21201*

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participants should understand the history, criteria, and process of outpatient commitment. The potential for outpatient commitment to be a viable alternative to inpatient commitment will be debated.

SUMMARY:

Outpatient commitment is a controversial, high-profile involuntary treatment process that has emerged as a remedy for random acts of violence by people with mental illness. The use if coercion and involuntary treatment in the community is fervently debated among mental health treatment providers, legal authorities, consumers, and advocates. This workshop will focus on the development of outpatient commitment laws; what outpatient commitment is, what it is not and what it could be; the criteria for outpatient commitment; enforcement concerns; and the alternatives to outpatient commitment.

REFERENCES:

1. Applebaum P: Thinking carefully about outpatient commitment. Psychiatric Services 2001; 52: 347–350.
2. NASMHPD Medical Directors' Council: Technical Report on Involuntary Outpatient Commitment. National Association of State Mental Health Program Directors, Alexandria, VA, 2001.
3. Ridgely MS, Borum R, Petrila J: The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States. Santa Monica, CA, Rand Publications, 2001.

Workshop 59 **Sunday, October 13**
10:00 a.m.-11:30 a.m.

FRAMEWORK FOR DEVELOPING TRAUMA-INFORMED SERVICES FOR MOTHERS WITH PSYCHIATRIC DISABILITIES

Marion L. McCoy, Ph.D., *Director of Research, Thresholds, 4101 North Ravenswood, Chicago, IL 60613*; Kristin Davis, Ph.D.; Martine Sagun, M.A.; Jessica Leddy, M.S.W.

EDUCATIONAL OBJECTIVES:

To better understand the role of violence and victimization in the lives of a particular set of women with children to understand that trauma-informed services need to be tailored to an individual's needs, and to understand how a community mental health agency is using trauma informed services.

SUMMARY:

Reports of lifetime trauma rates are high among persons with severe and persistent mental illness. The rates are higher when the sample is comprised of episodically homeless women, a typical condition for many women suffering from a mental illness. This makes the adoption of "trauma-informed" services imperative for those serving this subpopulation. Being trauma informed means understanding the role that violence and victimization play in the lives of mental health consumers and using that understanding to design service systems that accomodate the vulnerabilities and needs of trauma survivors. We will detail the process the Thresholds Mothers' Project, an urban community mental health program serving episodically homeless women, is undertaking to become trauma informed. In so doing, we will examine the literature on the difficulties of assessing the prevalence of traumatic events and discuss how the Trauma Symptom Inventory assessments and qualitative interviews we conducted elicited crucial insight into victimization and pathways to homelessness. Particular atten-

tion will be given to how such an understanding has allowed us to lay the groundwork for revising a service system that understands women within a context of lifetime abuse.

TARGET AUDIENCE:

Clinicians and administrators serving women with mental illness.

REFERENCES:

1. Goodman et al: The relationship between violence dimensions and symptom severity among homeless, mentally ill women. J Traumatic Stress 1997; 10:51–70.
2. Harris M, Fallot R: Envisioning a trauma-informed service system: a vital paradigm shift. New Directions for Mental Health Services 2001; 89:3–21.

Workshop 60 **Sunday, October 13**
10:00 a.m.-11:30 a.m.

TRAINING ISSUES IN ASSERTIVE-COMMUNITY TREATMENT

American Association of Community Psychiatrists

Robert M. Goisman, M.D., *Director of Residency Training and Medical Student Education, Massachusetts Mental Health Center, and Associate Director, Harvard Longwood Psychiatry Residency Training Program, 74 Fenwood Road, Boston, MA 02115-6113*; Lillian Mezey, M.D.; Edward M. Kantor, M.D.; Elizabeth M. Oudens, M.D.

EDUCATIONAL OBJECTIVES:

To describe the basic PACT model as developed by Stein, Test et al: discuss advantages and disadvantages of participation in PACT from the resident standpoint; and discuss advantages and disadvantages of participation in PACT from the residency training program standpoint.

SUMMARY:

Assertive Community Treatment (ACT) is an empirically validated, highly effective form of treatment for some patients with serious and persistent mental illness. Although it has been used clinically for more than 20 years, its usefulness as a training experience has only more recently been explored. The purpose of this workshop is to present and discuss issues in the implementation of ACT with psychiatric residents as team members.

After an overview of the development and characteristics of the PACT model, two presenters will discuss their experiences as PACT residents (one rural, one urban), how this experience influenced their current work, and how it related to their other residency activities. Issues such as the role of the PACT psychiatrist, resident perspectives on multidisciplinary team membership, attitudes of permanent team members toward trainees, and possible role conflict between PACT and other aspects of residency training will be discussed. PACT from the standpoint of the training director will also be considered, e.g., coordination of off-site training, educational value vs. clinical value of the experience, and the impact of rotating on and off teams upon training.

TARGET AUDIENCE(S):

This workshop is intended for clinicians and educators interested in combining the staff PACT model with training program activities.

REFERENCES:

1. Dixon L: Assertive Community Treatment: twenty-five years of gold. Psychiatric Services 2000; 51:759–765.
2. Stein LI, Test MA: Alternative to mental hospital treatment: I. conceptual model, treatment program, and clinical evaluation. Archives of General Psychiatry 1980; 37:392–397.

SYLLABUS INDEX

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