The Case of Sam: Multidisciplinary Perspectives

Editor's note: **The Institute on Psychiatric Services, the annual fall meeting of the American Psychiatric Association, is being held this month in Orlando, Florida. The theme of this year's institute is "Multidisciplinary Roles in the 21st Century." To highlight the important contributions of the various mental health disciplines to the provision of psychiatric services, we invited Jeffrey L. Geller, M.D., M.P.H., to write a case summary that would reflect some of the challenges currently faced by multidisciplinary teams, and we then asked mental health professionals from different backgrounds to contribute case discussions. The discussants are Susan Sprung, L.I.C.S.W., a social worker; Stanley G. McCracken, Ph.D., L.C.S.W., and E. Paul Holmes, Psy.D., psychiatric rehabilitation professionals; Ronald M. Boggio, Ph.D., a psychologist; Mark R. Munetz, M.D., a psychiatrist; Carlos A. Zarate, M.D., a psychopharmacologist; Nazila K. Evans, D.N.Sc., R.N., a psychiatric nurse; and Marylou Sudders, M.S.W., A.C.S.W, a state mental health commissioner.**

Case Summary

Jeffrey L. Geller, M.D., M.P.H.

Samuel Adams Mercury (Sam) is a 38-year-old Caucasian man who has never been married. He was born, grew up, and continues to live in a small city in a Mid-Atlantic state. Generally, he is casually but appropriately groomed and dressed, and he has no distinguishing physical characteristics other than small tattoos on his right and left forearm that say "Left" and "Right," respectively. He has a history of marked fluctuations in his adult weight, which has varied from 115 to just under 200 pounds.

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Present status. Sam is currently a long-term resident in a short-term transitional residential program. By all accounts, he is "stuck"; providers are unsure about how to proceed.

Psychiatric history. In high school Sam was an excellent, involved, and active student. However, near the end of his high school career, he began to have difficulty concentrating, his grades plummeted, and he became isolated. He managed to complete high school, and he entered college. During his freshman year he experienced greater problems with concentration, and he began to report being "fatigued"—a description of himself he uses to the present day.

Sam had his first hospitalization when he was 18 years old, after he came to the emergency department complaining of extreme fatigue. Medical and neurological workups found no organic basis for his fatigue. A psychiatric consultation was obtained, and psychological testing found evidence of a major depressive episode. Sam was given a tricyclic antidepressant, to which he responded well.

After discharge, Sam stopped taking his medication. He became more isolated, withdrew almost entirely from contact with his family, and became preoccupied with religion. Unable to keep up with his work at college, he was put on academic probation, saw another psychiatrist, and started another tricyclic antidepressant. He became hypomanic in response to the second antidepressant. Soon he was found dazed and wandering across the campus, barely clad, in subfreezing weather. Sam was sent to a nearby state hospital for his first psychiatric admission. After a brief stay, he was transferred first to one and then to another general hospital psychiatric unit.

In a consistent pattern over the next 20 years, Sam was admitted to hospitals for similar problems and discontinued his medication after discharge. During his first psychiatric admission, he was diagnosed as having bipolar disorder, manic phase with psychotic features. This diagnosis followed him for the next 20 years. No assessment has found evidence of substance abuse. Sam has accumulated more than 40 psychiatric admissions in 20 years.

During those years Sam was offered extensive outpatient psychiatric services—some of which he used. The services he used included case management, crisis services, outpatient psychiatric medication follow-up, outpatient psychotherapy, electroconvulsive therapy (ECT), crisis beds and respite beds, a supported apart-

ment program, ancillary outreach services, and other, similar services. Sam was also offered partial hospitalization, day treatment, and clubhouse and vocational rehabilitation, all of which he repeatedly refused.

Throughout this 20-year period, Sam's medication regimen has consisted of antipsychotic drugs, including trials of conventional and atypical agents—clozapine, olanzapine, and quetiapine. Antidepressant medications were also prescribed—initially tricyclic antidepressants and later selective serotonin reuptake inhibitors. At various times Sam has also received mood stabilizers, including lithium carbonate, carbamazepine, valproate, and lamotrigine. These classes of drugs have been used alone and in various combinations.

Since his diagnosis, Sam has consistently denied the possibility that he has a psychiatric disorder. Instead, he has insisted that there is an organic basis for the symptom that he perceives as his major symptom, namely fatigue. He believes that his disorder falls within the realm of chronic fatigue syndrome or fibromyalgia. His denial of any psychiatric disorder has led providers to believe that Sam is not capable of giving informed consent to take psychiatric medications. Thus court authorization through guardianship has been obtained for the administration of psychiatric medications. When ECT was used, a medical guardianship was obtained with specific authority to approve ECT.

Sam's tenures in psychiatric inpatient settings have usually been brief, consistent with current patterns of inpatient psychiatric treatment. In some general hospital psychiatric units, his stays have been more prolonged, which has led to his characterization as an "outlier" in terms of length of stay in these units. Sam has also had several prolonged stays in what are meant to be temporary community housing placements, mainly because providers were unsure about what to do with him.

During Sam's long tenure as a psychiatric patient, no assessment has found evidence that he is a danger to others. However, he has often been deemed a danger to himself because of his depressed state and the recurring manic phase of his illness. The behaviors that endanger Sam include prolonged exposure to subfreezing weather, delusional firesetting, delusional self-injury, long periods of self-starvation, and significant periods of mutism.

Currently Sam is in a respite bed, to which he was discharged from his most recent psychiatric hospitalization. He is about to be discharged back to his supervised apartment. In the apartment program, staff ensure that Sam takes his medication twice daily. They transport him to all appointments and take him weekly on food shopping trips and planned social outings. Program staff are available for any crisis, from 8 a.m. to 9 p.m.

The same case manager has worked with Sam for more than ten years. Weekly, for the past 20 years, Sam has seen one outpatient psychotherapist—a psychologist. Sam also sees an outpatient psychiatrist monthly. The psychiatrist has managed Sam's medication for about seven years. In addition, Sam is seen by a crisis team, staffed by many workers who know him well. The team is available 24 hours a day, seven days a week. The program provides access to crisis and respite beds close to where he lives. All of the mental health professionals in Sam's life provide him with support and guidance to become more involved in community life.

Family history. Sam is the second of four children. No mental illness is known in his immediate family. Two relatives on his father's side have been diagnosed as having a major mental illness; however, neither has been given a diagnosis of bipolar affective disorder.

Social history. Sam spends most of his time alone and involved with music, a long-standing hobby to which he is committed. He has never been married but has had a number of girlfriends. Sam typically becomes involved in relationships when he is hypomanic. However, his usual contacts are with his numerous care providers.

Mental status examination. Sam's mental status is characterized by remarkable fluctuations. When euthymic and not psychotic, Sam is a taciturn, somewhat guarded individual with a capacity for dry wit; his affect, however, is generally flat, and the paucity of his verbal output can sometimes be painful to care providers. Sam is typically unresponsive to conversations and not likely to initiate them. When he is psychotic and either manic or depressed (mixed states are common), Sam's behavior can become what many of his caregivers have called "bizarre." Such behaviors include jumping among various pieces of furniture, snaking along the floor, and crawling while braying like an animal. Sam's verbal output can be so disorganized that the best description is word salad.

As noted, no assessment has documented overt homicidal or suicidal ideation. However, Sam's delusional ideation has put him in situations where he has been at risk of serious harm or even death. Sam's judgment has been extremely variable, from reasonable to virtually nonexistent. His insight is consistently poor.

Diagnosis. Sam's diagnosis is as follows: Axis I: bipolar I disorder, most recent episode mixed; eating disorder NOS. Axis II: schizoid personality disorder. Axis III: overweight. Axis IV: uncertain living arrangement; undefined future mental health services. Axis V: current GAF 35; range in GAF during past year: 15 to 45.

Treatment plan. The consensus among Sam's care providers is that his course has been one of slow but steady deterioration. A debate has been ongoing about whether Sam's current mental health services—maintenance in the community—should continue or whether he should be placed in a hospital for a long-term stay with a focus on psychosocial rehabilitation. For years Sam has had a stable cadre of professional caregivers maintaining him in the community, largely through provision of care. Is it time to provide a rehabilitation push in an effort to treat Sam and attempt to reverse his progressive decline?

Sam meets the criteria for civil commitment largely because he is unable to safely care for himself. However, will taking Sam out of his community and transferring him to a hospital lead to an improvement in

his quality of life? On the other hand, will leaving him in the community do any more than facilitate his progressive isolation and dependence on the care system? Does continuing the current treatment plan mean that Sam is really in the community only because he sleeps in an apartment rather than in a hospital bed?

The Individual and the Community: Sam, His Family, and the System of Care

Susan Sprung, L.I.C.S.W.

Sam has been involved with mental health services since his first hospitalization at age 18. Despite the abundant services provided to Sam and the relative continuity of key people in his treatment, Sam's ability to function has not significantly improved, and he is seen by some to be steadily declining.

To effectively determine what Sam needs, one might begin to look with Sam at the question, What does Sam want? How would Sam like to proceed with his life? His life was derailed shortly after he left home to begin college. What does Sam believe is possible for him to achieve? Does he feel "stuck"? Does Sam feel that he benefits from the current arrangement?

Sam's service providers clearly feel stuck about how to proceed. Do they feel this way because he has stayed beyond the expected time in a program designed for short stays? Is he actually stuck because providers cannot reach agreement on his discharge plan? If Sam and his providers see him as comfortable and doing reasonably well in his current setting, is there a way to replicate the positive elements of the program in a more permanent setting?

The case summary is replete with references to interventions that inadvertently support dependency and reinforce passivity, both reminiscent of Sam's expressed problem of "chronic fatigue." Rather than supporting the life position represented by chronic fatigue, Sam's service providers should help him overcome it. The case description suggests that his caregivers are supporting his life position. For example, the team of professionals working with Sam are "providers," people who deliver a service to a passive recipient. Sam is transported to all of his appointments. He is taken to the store for weekly grocery shopping and on outings planned by staff. He repeatedly refuses to participate in a day program. A case manager coordinates his service plan and his life. Sam consistently discontinues taking his medications after discharge from a hospital. His week may include a therapy session and a medication appointment, and when a crisis arises, access to respite or crisis services.

Is this the community Sam wants? Does he want to live in a community in which his service plan and related activities constitute the total of his life experiences and in which the management and control of his activities are given to individuals other than himself? Paid staff take him to paid staff who tell him what to do. Sam asserts what little autonomy he has by often refusing services, sometimes actively, most often passively.

Improving the quality of Sam's life experience begins with Sam. It is not necessary to challenge his definition of his problem, chronic fatigue. Sam may be able to be engaged in a plan of activity during the day—when many people Sam's age are working—that is known to increase energy. He may be motivated to engage in his own treatment if he is working to improve his nutrition and increase his daily exercise and choose some form of productive daily activity that might improve his energy level. These activities would likely create a level of structure in his daily life that is closer to cultural expectations than his current situation. Such activities would probably provide Sam with the opportunity to develop personal relationships beyond those with paid staff.

Engaging with his siblings and parents is possible for Sam if that is desirable to him. Because the case description provides no substantive information about Sam's family relationships or Sam's preferences, it is difficult to formulate a strong opinion about the involvement his family should have in his life. Generally, the decision to help an adult engage with his family should be motivated initially by the preferences of the individual. I would not see any value in contacting Sam's family if they knew he was in a respite bed and had made no effort to contact him and if Sam was unwilling to give his consent. The only circumstance in which contacting his family without his consent might be considered is in a crisis situation or when a family member is the appointed guardian.

To determine a realistic goal for family engagement, the issue of reengaging Sam with his family should be explored with Sam and, if he agrees, with his family members. Often families are hesitant about becoming involved in the lives of their relatives with mental illness, either because the relationships have previously been damaging or because they do not know how to be involved. I would be inclined to work with Sam to obtain his consent to contact family members. If a mutual interest exists, I would work to reconnect Sam and his family in a way that would respect the distance they need but would foster the connections among them. Perhaps Sam's relationship with his family could play a role in reinforcing the rehabilitation that Sam needs.

Sam's dependence on the system is a function of the system's relationship to him as an individual. It is valuable to attend to the individual and to create interventions to help an individual achieve his goals. However, it would be equally advantageous to examine a major part of Sam's community, the treatment system, and assess the need for changes in the system that might promote Sam's growth as well as the system's growth. It is crucial to identify functional changes that might help the system offer a continuity of services to help Sam accomplish his goals

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for rehabilitation. Too often, fragmentation of mental health services results in intermittent and episodic treatment interventions, which produce few lasting effects. In Sam's case the absence of rehabilitation goals, the lack of awareness among his service providers about specific issues of concern to him, and providers' polarization about what setting is suitable for Sam's treatment all contribute to maintaining his poor functioning.

To view Sam's situation with the aim of expanding the options available to him, it is important to momentarily ignore the framework initially presented in the case description. The options proposed—maintenance in the local community versus long-term hospitalization with a rehabilitation push—impose artificial limitations rather than expand Sam's opportunities. Treatment sometimes occurs in some hospitals and in some local community mental health systems. However, in both the hospital and the community, maintenance rather than treatment is often the rule. For a subset of individuals, maintenance is a legitimate treatment goal. This goal probably is not appropriate for Sam.

Sam can and should be expected to participate in the creation of the kind of future he wants for himself. All viable communities are sustained by the contributions of their members. Sam can be expected to be a contributing member of a community whose members are expected to develop their potential and to do much more than just sleep. The mental health system and its staff should be organized to support Sam's participation in a community in which he can experience a sense of belonging over time. If Sam is presented with this challenge and accepts it, he can learn to conduct his own life in the context of a community. Opportunities for rehabilitation should be structured so that Sam's participation is expected in all aspects of the rehabilitation process.

Currently, Sam's future is uncertain. Neither he nor his providers have an image of a future for Sam. He will need help to imagine a future and establish the goals to move forward. If the hospital is the only real community experience available to Sam, then hospitalization would be the optimal choice. However, one would hope that the sense of belonging and contributing that sustains an individual like Sam within his community would be available to him in settings where the rest of us live.

The Individual and the Community: Engagement

Stanley G. McCracken, Ph.D., L.C.S.W.
E. Paul Holmes, Psy.D.

The mission of psychiatric rehabilitation is to help individuals with severe and persistent mental illness improve their functioning so that they can be successful and satisfied in the environments of their choice with the least amount of support from helping professionals (1). The integrative model described by Corrigan and colleagues (2) identifies three broad dimensions of psychiatric rehabilitation: goals, settings, and services.

Some of the primary goals of psychiatric rehabilitation are recovery, empowerment, independence, and improved quality of life. These goals can be achieved through the delivery of a variety of services in several settings. However, psychiatric rehabilitation services, such as supported employment, skills training, and peer support, do not constitute rehabilitation; services exist to help make the process of recovery "available, attractive, and possible for the individual . . . who must do the very real work of self-change" (3). A core value of psychiatric rehabilitation is that all people have the right of self-determination, including the right to participate in all decisions that affect their lives. Sam's definition of the problem, his interest (or lack of interest) in treatment, and his setting of goals for his life are the starting point and the framework within which our intervention must operate.

For Sam to benefit from any of the services he is offered, he must first be engaged in the psychiatric rehabilitation process, and he clearly is not. Thus our approach focuses on the process of engaging him; the techniques used are an extension of motivational interviewing (4) and contextual behavioral approaches (5). We believe the approach should be implemented either by Sam's psychologist or by his case manager.

Our approach uses "workability" as the ultimate outcome criterion (6). In Sam's case, emphasis should be placed on assessing how well his approach to fulfilling and pursuing his particular values, goals, and wishes is working, given that he lives in communities—both the mental health community and larger communities—that have specific expectations, demands, and tolerance limitations. This approach would also be applied to the mental health community's attempts to help Sam, because it appears that direct attempts to change him have met with limited success. Three questions should be asked: What are you trying to accomplish? What methods have you used to try to accomplish your goals? How well have these methods worked for you?

Our approach begins by establishing a collaborative relationship with Sam to create a context that increases the probability that he will feel validated for his perspective. As with many other treatment modalities, the relationship established by the mental health worker serves as a powerful influence (7,8). Therefore, the initial goal of interaction is for Sam to experience the relationship as positive and rewarding.

When the case manager and other professionals acknowledge Sam's wants, needs, and desires and help him examine the costs and benefits of his approach to meeting them, Sam will learn to articulate his values rather than telling his treatment providers what he thinks they want to hear. Interacting in this way changes the control of Sam's verbal behavior from contingencies in the moment—for example, in the therapist's office—to relevant contingencies associated with past

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attempts to meet his goals (Holmes EP, Dykstra T, River LP, et al, unpublished manuscript, 2001). Rather than prescribing particular solutions or approaches, we evaluate with Sam whether his actions and behaviors are helping him to achieve his goals or hindering him.

Specifically, we would begin by talking with Sam about his lifestyle and asking him if he would like things to be different. We would ask him about how he uses his time, how well he likes his living accommodations, and whether he likes his social life. Should he identify specific problems or areas for improvement, we would review with him his past attempts to make these changes. Each attempted solution would be assessed in terms of the degree to which it helped him reach desired outcomes. Emphasis is placed on listening to and understanding Sam's attempts to create what is a meaningful lifestyle from the perspective of his values rather than from the perspective of the mental health professional.

As an accepting atmosphere is created in which Sam's values are affirmed, he may begin to consider the values that his caseworker represents. Thus the experience of acceptance may lead Sam to consider collaboration and compromise and to suggest workable solutions that meet both his own needs and the needs of the communities in which he participates. If Sam is unwilling to compromise, the caseworker maintains a neutral role and assists him by asking him to talk about some of the possible consequences of not compromising, such as involvement in the court system and problems with his landlord. The caseworker also asks Sam about the consequences of his refusing to take his medication, maintain his living space, or attend to basic self-care responsibilities.

The caseworker acts as Sam's coach. He or she assists him in identifying the predictable responses the other service providers might have to Sam's choices. For example, one predictable consequence of Sam's choosing not to take his medication is that he might engage in behaviors that would cause him harm, such as wandering naked in the snow. If his psychiatrist thinks that Sam might harm himself, hospitalization is a likely consequence. If Sam is hospitalized, the discussion will continue in the hospital, preferably with his caseworker, who will ask about the solution that Sam tried and how well it worked. It is important that the caseworker maintain neutrality; the caseworker does not try to coerce Sam into adhering to his medication regimen or self-care. Within the limits of professional ethics, the caseworker does not attempt to protect Sam from the consequences of failing to adhere to his treatment plan.

The intervention described is not contingent on Sam's accepting the fact that he has a mental illness. Regardless of whether there is a problem or what the problem is—mental illness or chronic fatigue—certain behaviors are required, such as keeping his apartment clean and free of pests, and other behaviors are not allowed, such as engaging in activities that might lead to his death. The issue of taking medication can be approached similarly. Regardless of the medication and its effects, can Sam refrain from engaging in behaviors that lead to hospitalization or other losses of freedom if he does not take his medication? Even if Sam experiences psychotic symptoms, such as delusions, it is not his beliefs that result in hospitalization but what he does as a consequence of the beliefs. The issue addressed by the caseworker, at least initially, is not the nature of Sam's illness. Rather, the caseworker talks with Sam about what he wants and whether his behavior helps him achieve his goals.

One might expect a discussion of the psychiatric rehabilitation approach to focus on implementing services for Sam, such as skills training, supported employment, enrollment in a clubhouse, and peer support. Until Sam sees that engaging in these services is relevant to achieving his goals, he is unlikely to participate or derive full benefit from them. Even though engagement is specifically targeted in our approach, it will take time for this process to occur. A primary benefit of supported housing and case management in this situation is to enable Sam to stay in the community long enough to provide an opportunity for engagement and to monitor his status so that appropriate decisions can be made to ensure his safety.

We would recommend following the advice of Mark Twain, "Put all your eggs in one basket, and watch that basket." We would put all our efforts in engagement and motivational enhancement strategies with the hope that in the future Sam might consider other psychiatric rehabilitation services.

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Settings of Care: Long-Term Hospitalization

Ronald M. Boggio, Ph.D.

Sam would be far better served in a long-term hospitalization program that emphasizes a transition from supportive care to skill building than through continued maintenance in a community program that is unable to provide the necessary structure for this type of treatment transition.

An individualized psychosocial rehabilitation program for a patient like Sam begins with an in-depth functional analysis of behavior. The analysis is based on what is currently known about Sam's behavior and its

antecedents and reinforcing contingencies. It also takes into account Sam's current desires, motivations, interests, and strengths. The functional analysis of behavior focuses treatment aimed at skill building by systematically removing or limiting the contingencies that reinforce Sam's current isolating and care-dependent behaviors and by using the contingencies to which Sam is responsive to successively reinforce approximations of the skills necessary for him to return to the community with enhanced autonomy. As his skills improve, the rehabilitation plan for Sam can increasingly incorporate community-based treatments, including day passes, periods of autonomous living, and perhaps some form of employment. A program based on such incremental improvements is most likely to lead to successful community integration; insight is not a necessary ingredient of the process.

How can such an approach be implemented that takes into account the specifics of Sam's behavioral presentation and skill deficits? At least three major reinforcers can be identified in the case description: alone time, an involvement with music, and the attention of multiple caretakers. It appears that caretaking is reinforcing a maintenance level of existence in which the skills needed for autonomous functioning are unnecessary. Presumably the acquisition of such skills would jeopardize this important reinforcer. Sam's involvement with music appears to be part of how he "self-reinforces" while alone. Isolation is, of course, part of his axis II disorder. However, a behavioral analysis of this component would not focus on isolation as a static symptom of a disease process but rather as behavior developing within the context of Sam's reinforcement history. At this point, his isolation leaves him susceptible to medication nonadherence, decompensation, and danger to self and serves as a signal summoning multiple caregivers, whose very presence reinforces the isolation they may be seeking to decrease.

A psychosocial rehabilitation program for Sam would lead to the development of an individualized skill-building plan, which would use the same reinforcers and concomitant strengths in the service of adaptive functioning and would provide additional supports when necessary to increase the likelihood of skill acquisition. Sam's interest in music could be thoroughly explored so that his treatment team would fully understand the nuances of his enjoyment of this artistic medium. For example, is it the words or the rhythms? Does he like to sing? Can he play an instrument, or would he be interested in learning to do so? Can he talk to peers about music or organize a social event focused on music? The more that is known about the topography and nuances of this strength, the wider its application in the reinforcement of new and adaptive functioning.

Sam could then be permitted specified and titrated periods of isolation, depending on his adherence to medication, his engagement in groups emphasizing the development of conversational skills, or his participation in a unit government meeting. Refinements would include allowing Sam to spend some of his time alone and engaged with his music and then asking him to report to a staff member something about his experience with the music during that time. Over time, Sam's "alone time" could be used as a reinforcer for learning how to play an instrument, playing it publicly, leading a group discussion on music, and so forth.

A similar approach to the reinforcing qualities of staff attention could be developed to run parallel with the reinforcing use of alone time. Special or extra time with staff, including individual sessions with a therapist, could be contingent on Sam's acquisition of increasingly autonomous behaviors. This reinforcement program could be constructed to function simultaneously with the use of alone time on alternating days to prevent habituation and boredom. Alternatively, if a slower approach to the shaping of desired behaviors is necessary because of Sam's regressed nature, the most desirable reinforcer (special staff time) may be saved for more significant changes in behavior.

The notion of removing a patient to a more restrictive level of care in order to achieve an eventually higher level of functioning and the use of an environment not isomorphic to the local community in order to achieve integration into that very community may seem both counterintuitive and costly. There is obviously no assurance that such a plan will be successful for Sam, because, unless care providers are vigilant, active inpatient treatment can quickly turn into institutionalized caretaking. However, the 20-year effort to provide appropriate services for Sam in a community setting has proven to be counterproductive, reinforcing the very behaviors that it seeks to change—an approach that is therefore not cost-effective.

In the outpatient context, the investment of the public mental health system's resources in long-term individual psychotherapy appears to be equally ineffective. In such a context, it is not clear what outcome the therapy is serving other than the maintenance of dependent behavior, because it is clear that increased insight is not a realistic goal for this intervention with this patient. In the inpatient psychosocial rehabilitation program proposed here, briefer individual sessions with a therapist may be a very cost-effective part of an overall skill-acquisition program. Ongoing individual coaching may also be helpful or necessary as part of maintaining Sam's increased autonomy when he returns to the community. However, future steps can be decided only when Sam's inpatient treatment plan is implemented and refined according to the outcomes it produces. This reinforcer—individual coaching—may also be phased out as Sam gains skills and as his autonomous functioning increases, which would relieve his need for the individual attention provided by coaching. Sam's increased ability to socialize with peers, begun over a shared interest in music, may lead to the development of peer-group friendships that will be ultimately more satisfying than therapy.

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Settings of Care: Assertive Community Treatment and a SAFER House

Mark R. Munetz, M.D.

Sam's story is terribly familiar and unfortunately not all that atypical. Sam reminds us that people with bipolar disorder may be only partially responsive to treatment, may deny that they are ill or need treatment, and may not experience the interepisodic return to baseline that we were taught is a distinction between bipolar disorder and schizophrenia.

What is probably atypical in Sam's case is the enormous amount of services he has received over the 20-year course of his illness and the continuity of his caregivers. Also, Sam appears to have been treated with state-of-the-art pharmacotherapy for his disorder. Also noteworthy are Sam's personal strengths: he has never abused substances, he has never been threatening or dangerous to others, he is intelligent, and he loves music.

Despite his extensive treatment and his strengths, Sam continues to deny his need for treatment and is dysfunctional even at his most stable times when medication is closely supervised. He discontinues treatment when not closely monitored and engages in behaviors that are both bizarre and a danger to himself. In this context, given unlimited resources, what should be done for Sam? The choice presented in the case summary is between continued community service as is, which is described as "maintenance in the community," or an extended hospitalization with a "rehabilitation push" in an effort to treat Sam and perhaps move him into a process of recovery.

Are these the only choices? Without question, Sam and his treatment team are stuck. Sam has had 20 years of biopsychosocial treatments that have been minimally effective. Weekly psychotherapy for two decades has not helped Sam enter a recovery process. Case management services have helped keep Sam alive but have not kept him from deteriorating. Sam has refused traditional community-based rehabilitation-oriented interventions. At his best in the community, with guardian-approved medication, he is withdrawn and isolated, with a predominance of what might be called negative symptoms. Sam needs to be engaged in a program that does not permit him to withdraw or refuse rehabilitation services. Such a program would provide the rehabilitation push. It would also clarify whether medication might be more effective if Sam were consistently compliant over time.

A highly structured program, using behavioral techniques and an emphasis on social and living skills training, can be effective for people like Sam (1). His love of music offers a clear source of motivation for this otherwise frustratingly unmotivated person. Convincing Sam that he has reasons to get out of bed, get dressed, and participate in vocational, recreational, or social activities is essential for him to get unstuck.

Must this ideal program be hospital based? What if the treatment system cannot afford it? Stein and Test's assertive community treatment model (2) was created to provide just this sort of intervention in a community setting rather than in a hospital, and it has been demonstrated to be cost-effective (3). When assertive community treatment was designed, essentially the hospital team was deinstitutionalized and the full array of treatment and rehabilitation services was made available to a cohort of patients in the community with the high staff-to-patient ratio of a hospital. Assertive community treatment is a team model, taking advantage of the expertise of different professionals and paraprofessionals. Because the care providers operate as a team, rather than as a group of individuals, the chances for burnout are minimized. Assertive community treatment involves meeting the patient on his or her own turf, persistently and assertively offering assistance, and using motivational approaches and coercion when indicated. This approach has been demonstrated to be an effective intervention for most individuals with severe and persistent mental disorders. Clearly, Sam has been offered a great many services. However, it is unclear whether the services were ever coordinated and provided by an assertive community treatment team. If not, Sam deserves such a trial.

Understandable enthusiasm about assertive community treatment as the intervention of choice for someone like Sam has led to the notion that this approach, when undertaken with fidelity to the model, will ultimately be successful. However, many clinicians believe that some people fail in the community despite the best efforts of an assertive community treatment team. Such people require more structure and support than even the team can provide. These individuals seem unable to manage the freedom and lack of structure found in the community. I suspect Sam may be such a person. Long-term hospitalization with a serious focus on rehabilitation may be an appropriate answer for such a person, but it may not be the only alternative. In some states, long-term hospitalization for the purpose of rehabilitation is no longer considered an appropriate use of the hospital. As hospitals have been downsized, their per diem costs have risen, so that in most communities long-term hospitalization for the purpose of rehabilitation is simply too expensive. Skilled nursing facilities, although inappropriate, are often the only alternative.

My colleagues and I have suggested the concept of the SAFER house (4). The acronym stands for Secure Adult Facilities to Ensure Recovery. The SAFER house was proposed to fill a perceived "gap between the active medical treatment provided in a hospital and the intensive treatment and rehabilitation provided in the most aggressive community-based treatment settings" (4). In Ohio, where I practice, the department of mental health has only recently acknowledged the need for this level of serv-

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ice (5) and has yet to create such programs. SAFER houses could be on state hospital campuses or in houses in the community. It might be argued that a community-based house will make eventual success in that community more likely (6).

For Sam to begin a meaningful recovery, he needs intensive, aggressive, and somewhat intrusive treatment and rehabilitation. In our resource-poor community mental health systems, at a minimum this approach would mean a trial of assertive community treatment with state-of-the-art pharmacotherapy. Perhaps the professionals in Sam's system of care need to rethink interminable psychotherapy and reallocate resources to ensure adequate availability of assertive community treatment. If people who, like Sam, are in the most intractable situations are to be helped, communities should consider developing long-term secure residential treatment programs, whether hospital based or community based, with the goal of promoting meaningful recovery for individuals who are unable to recover on their own.

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Psychiatric Medication: What Medications Should Be Prescribed?

Carlos A. Zarate, M.D.

In this discussion I focus on Sam's diagnosis, his course of illness, the causes for his lack of response to treatment, his noncompliance, and treatment recommendations.

Sam has been said to be psychotic during his manic, mixed, and major depressive episodes. During his affective psychotic episodes, he is described as "bizarre"—jumping on furniture, snaking along the floor, and crawling like an animal. On several occasions his thoughts have become disordered, and at times his speech is incomprehensible.

The presence of psychotic symptoms actually is quite common with bipolar disorder. Approximately 58 percent of patients with bipolar disorder have psychotic features during a manic episode (1). All forms of psychosis may occur during an affective episode, including mood-incongruent, bizarre, and Schneiderian first-rank symptoms (2,3). Psychotic symptoms that occur during an affective episode may present either as disturbances in the content of thought or as a formal thought disorder, or both. Cross-sectional assessment of the type and severity of psychotic symptoms will not consistently help differentiate whether a patient has schizophrenia or mania. The longitudinal course of illness, family history, and other characteristics are more reliable indicators of a diagnosis of mania. The presence of psychotic symptoms, particularly mood-incongruent psychotic symptoms, appears to predict a worse course of illness (4).

Sam's symptoms also suggest that he has a "depressive syndrome" that occurs between his major affective episodes. During these periods, he is described as isolated and fatigued, rarely initiating or sustaining conversation. The differential diagnosis for this depressive syndrome includes side effects of medications, including neuroleptic dysphoria; depression—that is, residual depressive symptoms—or dysthymic disorder, depending on the temporal sequence with the major depressive episode; negative symptoms of psychosis; functional impairment; and fibromyalgia or chronic fatigue syndrome.

Neuroleptic dysphoria is unlikely in Sam's case because this condition is temporarily associated with the use of neuroleptics and reverses on discontinuation of this class of medications or with the use of atypical antipsychotic drugs. The persistence of Sam's depressive syndrome since the onset of his illness appears to rule out neuroleptic dysphoria as the cause of this syndrome. The possibility that the depressive syndrome represents residual depressive symptoms is likely. However, we do not know the details of his symptoms—for example, whether he experiences guilt, anhedonia, feelings of inadequacy, and so forth. Neither do we know the specifics of the course of his illness (episodic versus sustained) or details of his previous trials of antidepressants. Therefore, it is difficult to discern whether the depressive syndrome consists of and can be attributable to residual depressive symptoms.

It is also possible that Sam is having negative symptoms of psychosis. In between his affective episodes, he is described as being flat and with poverty of speech, and he often does not initiate or follow through with conversations. Some patients with an axis I diagnosis of bipolar disorder and an axis II diagnosis of schizoid personality disorder may be misdiagnosed as having schizoaffective disorder. However, the co-occurrence of these two diagnoses is extremely rare (5).

Sam's recurrent affective psychotic episodes with bizarre behavior, the downhill course of his illness, the lack of a significant family history of affective illness, and the presence of a depressive syndrome in between his major affective episodes raise the possibility that he may in fact have schizoaf-

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fective disorder, bipolar type. However, it is difficult to distinguish schizoaffective disorder, bipolar type, from bipolar disorder type I with recurrent affective episodes with psychotic features and a poor course of illness. Deciding whether the correct diagnosis is the former or the latter is more an academic exercise, because both diagnoses generally require treatment with at least an antipsychotic drug and a mood stabilizer.

Before the introduction of atypical antipsychotic drugs for treatment and diagnostic purposes during a depressive syndrome such as Sam's, I might have recommended adequate trials of antidepressants. However, since the introduction of the atypical antipsychotic drugs, some of which appear to confer thymoleptic properties, I may now instead first recommend a trial of an atypical antipsychotic drug before an antidepressant, especially because an antidepressant may precipitate cycling in patients with bipolar disorder. In addition, if the depressive symptoms turn out to be negative symptoms of psychosis, the atypical antipsychotic drug should help, as these agents have been found to be effective for negative symptoms. However, at present Sam is experiencing a mixed episode with psychotic features. My recommendations for the management of this phase of illness are described below.

The diagnosis of fibromyalgia or chronic fatigue syndrome is difficult to make in the presence of a major mental illness, especially when the patient continues to be quite symptomatic. My recommendation at this time would be first to treat his mood disorder.

The second area I address is the downhill course of Sam's illness. Kraepelin recognized the importance of the course of illness in diagnostic classification. Kraepelin (6) referred to dementia praecox, later known as schizophrenia, as an illness with a deteriorating course, in contrast with manic-depressive illness, which was episodic with full recovery between episodes and which was described as having a good prognosis. However, there is mounting evidence that recurrent mood disorders—once considered "good-prognosis diseases"—are, in fact, often very severe and life-threatening illnesses (7). For many patients, the long-term outcome is much less favorable than previously thought, with incomplete interepisode recovery and a progressive decline in overall functioning (7,8). Thus patients with bipolar disorder are likely to be exposed to multiple medications with an increased risk of side effects, and they may have a higher risk of suicide attempts and early mortality (9).

Sam not only has recurrent affective episodes that have not responded satisfactorily to his treatment plan, but he also appears to have experienced a significant deterioration in functioning. In my experience, this is not uncharacteristic; many patients with recurrent mood disorders may eventually develop significant impairment in their functioning even in the absence of major affective syndromes. Our group described this phenomenon among bipolar patients in a recent longitudinal study (7). The reason for impaired functioning even among euthymic bipolar patients is unclear. Some have suggested that it may be the result of residual symptoms or even impaired cognition (10).

There are several issues to address in the third area of my discussion—Sam's lack of response to treatment. Sam has failed to respond to many different medications in various combinations. There are multiple definitions of treatment refractoriness, and it is difficult to determine treatment refractoriness by taking a history. However, it is estimated that up to 60 percent of depressed patients who are referred for an evaluation for lack of response to treatment may have had inadequate trials of antidepressants (11). In my experience, a similarly high rate of patients with bipolar disorder who have been referred to me for consultation for resistance to treatment have not had truly adequate trials.

For example, I was recently asked to consult for a patient who had treatment-resistant bipolar disorder and who had failed to respond during the manic phase of illness to four different antipsychotic drugs—risperidone, olanzapine, quetiapine, and clozapine—as well as to gabapentin, lamotrigine, lithium, valproate, phenytoin, electroconvulsive therapy, and verapamil. It was reported that the patient could not tolerate the sedating effects of clozapine, and the clinician informed me that the clozapine trial was a failure. On closer observation, it soon became apparent that the "failed" clozapine trial was secondary to the sedation. The patient had been started during the manic phase on 50 mg of clozapine a day, instead of a starting dosage of 12.5 mg a day. The patient was also receiving six other medications, most of which were also central nervous system depressants—lithium, valproate, clonazepam, perphenazine, and gabapentin. Thus, depending on the circumstances, a medication regimen may have to be simplified in order to give a particular medication an adequate trial. Only after the regimen is simplified are we able to conclude that the trial was adequate.

It is important to identify and address the causes likely to be associated with lack of response to treatment. They include an incorrect diagnosis; a comorbid psychiatric diagnosis, such as panic disorder, obsessive-compulsive disorder, posttraumatic stress disorder, and substance abuse; a comorbid medical diagnosis; noncompliance; treatment-limiting side effects of medication; inadequate dosages of medications; psychosocial stressors; and the natural course of illness. Most of these issues have been addressed in this discussion.

Sam's diagnosis appears consistent with the case description; there also appears to be no evidence of comorbid psychiatric or medical conditions that would explain the refractory nature of Sam's illness. He has not reported side effects as a major problem. We are left with a few possibilities, namely, noncompliance, which is clearly the case (see below), incorrect dosages of medications, and the natural course of the illness. I have already provided examples of how incorrect dosages and inadequate trials can occur. I discuss this issue further in my treatment recommendations. Finally, it is possible, that Sam has a severe form of mood disorder that will continue to remain refractory to treatment interventions. However, I believe that we still have several options available.

Another point I wish to raise is the importance of recreating past pharmacological trials by way of the life chart methodology (12). Information gathered should include dosages and dura-

tion of the trials, combination treatments used, and responses to and side effects of the different medications. I believe that all patients with recurrent mood disorders should have their course of illness charted. Only then can we have a better understanding of how life events, psychotherapies, and somatic treatments positively or negatively affect the course of illness.

The fourth area I wish to discuss is noncompliance. The case summary indicates not only that Sam has had many different trials of medications in a series of different treatment settings but also that he has refused a majority of them and stopped taking his medications soon after discharge. The case summary provides little information about the trials in terms of dosage, duration, response, and side effects. It is also unclear why Sam refuses or stops taking medications. Is it because of ongoing persistent symptoms of his illness or because of other psychodynamic or psychosocial issues? It also appears that during hospitalizations Sam has experienced sufficient improvement to permit him to be discharged but that his response to treatment is short-lived. It is likely that his ongoing symptoms are partly responsible for his lack of insight, which has resulted in noncompliance.

Sam's lack of insight about his diagnosis and about his need for treatment has remained consistently poor since the onset of his illness. Lack of insight is a major problem; when it is present, clinicians hope that it will be limited to the extremes of a patient's affective episode and that insight will improve during the euthymic phase or when symptoms are mild. However, one study suggests that lack of insight among patients with bipolar disorder can be just as severe as among patients with schizophrenia (13). There is no indication that at any time during Sam's illness he has acknowledged that he has a mental illness or that he requires treatment. Unfortunately, if insight does not improve with treatment, Sam's prognosis remains guarded.

I have several recommendations for Sam's treatment. First I wish to comment on his psychosocial treatment. In a majority of cases that are referred to me because of lack of treatment response, it soon becomes clear that treatment efforts are disjointed. There is a rapid turnover of treating clinicians, who are sometimes involved with a patient for short periods and do not have a sound understanding of the treatment goals. Ideally, the same clinicians should be involved for long periods. They should communicate regularly with one another and develop a plan that coordinates all treatment efforts. Clearly, in Sam's case, the treatment efforts appear to be well coordinated, and the teamwork appears to have been a major reason for his continued ability to live outside a hospital.

I would also like to emphasize the importance of having a stable person (treater) in a patient's life, especially a patient with chronic mental illness. Having a stable treater for the long haul is just as important as having a good pharmacological regimen. The hope is that with time, this stable person will help the patient understand his or her diagnosis and need for treatment and provide support during difficult times. It is clear that there has been more than one stable treater in Sam's life.

I have two basic pharmacological treatment recommendations. It is essential to document Sam's previous medication trials with respect to his course of illness by using the life chart methodology (12). In addition, rather than recommending new and untested treatments, I would recommend retrials of previous medications to ensure the adequacy of these trials—unless a particular trial can be clearly documented as a failure.

First, I would recommend a retrial of clozapine. A growing number of open-label studies conducted over the past decade have shown the efficacy of clozapine for some patients with schizoaffective and bipolar disorder who responded inadequately to or were unable to tolerate mood stabilizers or conventional antipsychotic medications (14–16). The experts recommend clozapine as the first-line treatment in refractory mania (17).

To help Sam better tolerate this medication, I would recommend starting clozapine during the mixed or manic phase of the illness. Toleration seems to be better when clozapine is started at this phase than when it is started during the depressive phase (14). It may also be necessary to simplify Sam's medication regimen so that he is better able to tolerate the clozapine trial (18). I would recommend a trial of no less than six months, especially because reports indicate that improvement continues beyond the acute phase of treatment (14,19).

Even if Sam does not respond acutely to clozapine, it is possible that he may have less frequent and severe affective episodes in the long term; only by using the life chart methodology will the treating physician be able to recognize this response. It may be worth considering a trial of a depot neuroleptic in combination with clozapine, with the goal of enhancing compliance and preventing rapid decompensation if Sam abruptly discontinues clozapine.

If Sam continues to have recurrent manic episodes despite adequate dosages of clozapine (300 to 600 mg a day), the treating physician should consider combining clozapine with either lithium or divalproex. The latter is usually required if clozapine is prescribed at dosages of more than 550 mg a day because of an increased risk of seizures; clozapine may be prescribed at a dosage of up to 900 mg a day.

If Sam continues to experience recurrent major depressive episodes, a retrial of lamotrigine in combination with the medications suggested above may be useful. Recent data suggest that lithium is more effective in preventing recurrent manic episodes and that lamotrigine is more effective in preventing recurrent major depressive episodes.

Conducting these trials in a more structured and monitored setting to minimize the risk of noncompliance would be preferable. I would hope that a long trial of clozapine—six to 12 months—would help improve Sam's insight enough so that he would want to engage in treatment.

It is very likely that Sam's weight fluctuations over the course of his illness are secondary to his ongoing symptoms. His weight would probably stabilize as his affective and psychotic symptoms improved with the treatment that I have recommended.

A number of other treatment options may be considered. However, they should be used only if it can be established that other treatments have clearly been ineffective. Other med-

ications that have been reported to have thymoleptic properties from which Sam may benefit include ziprasidone (20) and risperidone (21, 22). Case reports and series and open-label studies suggest that topiramate, tiagabine, donepezil, nimodipine, and mexiletine are effective in treatment-resistant affective disorders (23–26).

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Psychiatric Medication: How Should Medications Be Administered?

Nazila K. Evans, D.N.Sc., R.N.

The problems presented by Sam's mental health history are challenging for any professional, and the psychiatric nurse is no exception. Sam is clearly a patient who has received a wide array of mental health services over a number of years. Initial questions that come to mind: What is the optimum level of functioning that Sam is capable of? What does Sam regard as his best and most desirable adjustment, and how does that compare with the ambitions his caregivers have for him?

It is reasonable to assume that Sam allows only selective intrusions of the outside world into his personal world, and therefore there is limited opportunity for reality testing. It is evident, however, that he does not have a favorable attitude toward psychiatric medications, because he denies having a psychiatric disorder and possibly because of the side effects of the many medications he has taken. It also seems reasonable to assume that Sam's care providers do not have a clear understanding of whether or not he has been consistently compliant with prescribed medications throughout his illness.

Certainly, nurses have participated in implementing Sam's treatment plan during his many inpatient stays. However, the case summary does not mention how nurses have been involved in Sam's care in community-based programs. Although this case presents many issues for discussion, from the psychiatric nurse's point of view the most pertinent considerations are medication compliance and the provision of a supportive and structured environment in which Sam can engage in reality-testing activities.

The proper administration of medication and compliance with the medication regimen are critical to the stabilization and rehabilitation of patients like Sam. However, it cannot be assumed that proper administration and compliance are occurring in Sam's case. Medication management for such patients can best be accomplished within a supportive and structured therapeutic relationship.

Careful tracking of medication ad-

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ministration and monitoring of compliance may alleviate the need for medication switches or increases in dosages that are based on the assumption that a certain medication is not working. It is important to deliberately incorporate the elements of medication management in the plan of care for all psychiatric patients who are on medication, and particularly for patients who have difficulty adhering to the prescribed medication regimen and who, like Sam, are poorly motivated, marginally compliant, in denial of illness, and cognitively impaired.

Medication management involves more than administering medication. It involves a set of activities beginning with assessment. The most important aspect of assessment in terms of medication management is evaluation of the patient's beliefs about his or her psychiatric illness and its severity and the patient's perception of the benefits and challenges of prescribed medications or other treatment regimens (1). Assessment also involves the investigation of gaps in the patient's knowledge and factual information. The information obtained from such assessments can be used in teaching the patient and clarifying misconceptions.

Other crucial steps in medication management for a patient with a psychiatric illness include administration of medication; monitoring of the physiological, psychological, behavioral, and social changes in response to medication; and documentation of the process and changes. In some community-based mental health settings, medication administration and monitoring activities are either nonexistent or are delegated to unlicensed health workers, which is likely in Sam's case. Assessing a medication's effects and teaching and monitoring the patient is a continual process, and it needs to be carried out by experienced and trained professionals. Medication management is a collaborative effort between the members of the health team, the patient, and the family.

Nurses are members of the interdisciplinary team in various psychiatric settings, including inpatient settings, partial hospital facilities, community mental health centers, and home-based care settings. By virtue of their biopsychosocial training and the amount of time they spend with the patient, nurses assume substantial responsibility in managing medication-taking behavior. Therefore, the role of the nurse in community-based mental health settings needs to be further clarified and developed.

Sam needs further functional assessment, medication management, and monitoring of the side effects of medication. He also needs more interpersonal contact in a structured environment. Thus Sam might benefit from a stay in a short-term, full-time partial hospital program—from four to six weeks, five days a week. Some investigators have suggested that the prescribed length of stay in a partial hospital program negatively influences attendance—that is, the longer the stay, the lower the rate of attendance (2,3). Studies also suggest that the number of prescribed days per week is positively related to attendance (2,4). A patient who attends on a full-time basis—that is, five days a week—and for a relatively short time may have a better attendance record.

To obtain the benefits of a partial hospital program, a patient must adhere to the prescribed schedule of attendance, which is based on the goals and objectives of the treatment plan. It is significant that Sam has refused to enroll in a partial hospital program, a clubhouse, or a vocational rehabilitation program. These programs tend to be more demanding and structured and require more interpersonal involvement. Therefore, if Sam's treatment plan were to involve partial hospitalization, the treatment team may be faced with an attendance problem.

In addition to Sam's denial of his psychiatric illness, other issues and concerns may influence his enrollment and regular attendance. For example, Sam's perception of barriers to attending the program may influence his enrollment and attendance. Previous studies have indicated that change of lifestyle, interpersonal involvement, daily structure, and practical inconveniences may be perceived barriers (2). Sam's perceptions of barriers to attending a partial hospital program must be addressed and incorporated in negotiations about enrollment.

Sam's enrollment in the partial hospital program should be considered as an initial phase in his long-term plan of care. Observations of his functional level in the program can help caregivers plan and organize a transition to vocational rehabilitation or other structured activities. Such observations are invaluable in ascertaining the best methods of enlisting Sam in a treatment plan that is realistic, that has achievable goals, and that takes into account his interests and his tolerance of stress.

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A Commissioner's Overview

Marylou Sudders, M.S.W., A.C.S.W.

Anyone reading this case study would agree that the community mental health system has failed Sam. Some may conclude that the only option is long-term hospitalization, but there we would differ. The real solution is to understand where the system has failed in Sam's case and to make it work. We can accomplish this quite simply by involving Sam in this process rather than treating him as an unfeeling object. In this way we can develop a workable treatment plan to replace the one that has not been effective.

Sam's clinical profile is not atypical for an adult served by a public mental health authority. The questions posed

are confronted regularly by inpatient and community practitioners, case managers, and policy makers. However, they are not the most germane to understanding Sam and to having a better picture of his clinical and rehabilitative needs. It is only by understanding Sam more clearly that we can determine the most appropriate setting to meet his needs.

From my experience as a social worker and policy maker, I know that psychosocial rehabilitation can be provided in a variety of contexts and that people want to participate in choosing the setting for their rehabilitation. Psychosocial rehabilitation is certainly not the sole domain of public psychiatric hospitals. In fact, inpatient facilities have only recently embraced the concepts of rehabilitation and recovery. If systems adhere to these concepts, then Sam must actively participate in his treatment.

In developing a clinical profile, recitation of a long list of services and medications without a fundamental reevaluation of a person's treatment goals is a common error made by practitioners. When goals are not incorporated into the context of service provision, the discussion often centers on placement rather than on the most appropriate setting to ensure success in meeting treatment goals. In addition, without Sam's participation in the establishment of goals and the creation of a therapeutic alliance, there is little likelihood of long-term success.

Before answering the question of "where," one must first gather some basic information about the "who," "what," and "why." Sam has maintained consistent long-term clinical relationships; however, has he benefited and is he currently benefiting from these relationships? What have these relationships meant to Sam? Does he feel that his own needs, strengths, and concerns have been heard and understood? Do staff convey a sense of hope to Sam?

Because of Sam's deterioration, staff likely feel helpless and hopeless. Viewing a change in setting from the community to a long-term hospitalization as the only available option is a natural consequence of hopelessness. Individuals like Sam challenge us as practitioners and policy makers to learn from our experience of helplessness and to use our network of supervisors and peers to plan a better course, not to act on our frustration. Developing a creative treatment vision that is uncomplicated by frustration or helplessness is a fundamental challenge to the clinical leadership of Sam's treatment team.

One strategy is to fundamentally resurvey the treatment landscape. Because practitioners often feel that they have "given their all" to an individual, an outside consultant may be able to highlight gains that these practitioners may not appreciate and may offer some objectivity in assessment. For instance, review of Sam's medication trials should include duration and dosage. The consultant does not need to be an expert in all areas. Provision of support for the team and reassessment of Sam's treatment plan are often meaningfully accomplished by a respected clinician.

This comprehensive assessment should provide the basis for a new treatment plan and a location for such treatment. However, before deciding on long-term hospitalization, I would investigate whether assertive community treatment might be an appropriate intervention. This program, as described by Dr. Munetz in his discussion of the case, carefully incorporates clinical, rehabilitative, and supportive services into a highly individualized plan.

Sam's difficult 20-year course of illness and the challenges he has presented emphasize the fact that changing policies and systems, such as developing assertive community treatment, and expanding rehabilitation options in the community are ultimately clinical interventions for individuals. As professionals in public mental health systems, we must always be aware of the person, who has hopes, dreams, and aspirations. We must not let the person be solely defined by his illness. It is therefore essential that Sam be empowered to participate in all discussions about his goals and to incorporate these goals into any revised treatment plan. Public mental health systems must be responsive to the needs of individuals and their families at all levels within the organization.

Yet the reality is that for the most part, the services of public mental health systems are not an entitlement in our country. Public services depend on budgetary priorities and appropriations. There are more needs than resources. Having stated the obvious, I will add that it is also incumbent on state mental health systems to ensure that clinical, not fiscal, decisions prevail in individual situations. It is essential that direct care staff and practitioners make sound clinical decisions, incorporating the client in the process. It never ceases to amaze me how creative direct care and clinical staff can be, even when resources are scarce, in mobilizing the resources necessary to meet the needs of a person like Sam.

Commissioners are accountable to the public to ensure that highly responsive mental health services are provided to individuals with serious mental illness in a cost-effective manner. A key task of a commissioner is to create and maintain a work environment that ensures that clinical decisions promoting the concepts of rehabilitation and recovery prevail throughout the system. It is the role of managers and policy makers to reconcile clinical needs with fiscal realities. Within such a context, the needs of an individual like Sam are occasionally brought to my attention. These situations provide me with firsthand information about individual needs and resource constraints. Often I or my leadership team can address an individual's immediate situation. Knowledge of the needs of a client like Sam is important to support future budget requests. My experiences listening to the life stories of people like Sam serve as a powerful reminder that a responsive mental health system is built on a positive alliance among staff and individuals with mental illness to achieve mutual treatment goals and better quality of life. ♦

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