

# Highlights of the 2001 Institute on Psychiatric Services

A month after the devastating terrorist attacks on the World Trade Center and the Pentagon, the 53rd Institute on Psychiatric Services was held as scheduled from October 10 to 14, 2001, in Orlando, Florida. About 1,500 participants attended more than 300 symposia, lectures, workshops, debates, and poster sessions. In the opening session, APA President Richard Harding, M.D., noted that the main theme of the institute—Multidisciplinary Roles in the 21st Century—could not be more appropriate and well timed.

Dr. Harding went on to say that high-quality care is almost always collaborative. Since the mental hygiene movement began in the early part of last century, mental health professionals have achieved quantum leaps in providing effective treatments and programs for persons with severe and persistent mental illness.

Although they share the goal of quality care, these professionals are not a homogeneous group. Practitioners in each mental health field are justifiably proud of their training and the experience they have to offer, but they are equally proud of the collaboration they have developed with other specialists for the greater good of their patients.

Dr. Harding then turned to recent APA accomplishments and activities. He cited the important role the association played in ensuring the establishment of sound privacy regulations, which had not been expected from the Bush administration. APA has sponsored national conferences on mental health in the workplace at the Carter Center in Atlanta and has been a driving force in the movement to improve workplace conditions and access to care for workers. Dr. Harding noted that APA is also pushing the political agenda for nondiscrimination for Medicare outpatients, which involves

ensuring parity in copayments for mental health care and pharmacy benefits should they become available.

The development of *DSM-V* is now in its early stages. Dr. Harding noted that although the work may not be completed until 2009, the decisions being made at this stage in the process will help form the basis for the next generation of diagnostic manuals.

Sadly, some of APA's proudest moments of late have related to the direct involvement of some of its members in responses to the September 11 attacks, said Dr. Harding. APA has also been a steady source of timely, reliable information—especially through its Web site—on dealing with both acute crises and the long-term consequences of the events and their aftermath. The site has logged hundreds of thousands of hits from journalists, professionals, patients, and the government.

Although few silver linings can be found in the wake of the disaster, Dr. Harding pointed out that we can turn the events into an opportunity to advance the cause of mental health. After September 11, millions of Americans will no longer view the symptoms of anxiety and depression as character weaknesses. People in the middle and higher socioeconomic groups will increasingly expect and demand services for themselves and their families. They will also begin to see that diagnostic labels lead to stigma and discrimination. They will demand change in the system, and APA should be there to help them get it.

Dr. Harding addressed the residents and other young people in the audience, telling them that they have been summoned by history to take a leadership role in helping the country recover from the traumatic events. In closing, he affirmed that the proud profession of psychiatry, in collabora-

tion with other mental health professions, would meet the challenge and deliver the best possible mental health care to all citizens.

In an unusual move that reflected the unusual times, Paula G. Panzer, M.D., vice-chair of the institute's scientific program committee, then initiated a brainstorming session to elicit participants' suggestions for impromptu sessions on the problems generated by the September 11 events.

## Disaster response

Among the changes to the program in response to the September 11 attacks, Carol A. Bernstein, M.D., changed the topic of her scheduled lecture to discuss disaster relief. She described her response to the terrorist attacks at the World Trade Center as director of the residency training program in the department of psychiatry at New York University Medical Center. One of the major challenges she faced was to convince her residents that everything they were doing after September 11 was important, that "we are all at Ground Zero."

Dr. Bernstein noted that all her residents showed up for work on September 12 despite the disruptions to the public transportation system. Many went out into the streets to try to help victims and their families. They found that people were looking for their loved ones, not for psychiatric help. Eventually the residents realized that the most useful thing they could do was pass out milk and cookies—but still they felt useless. They established a journal club to express their feelings, and Dr. Bernstein read extracts from their journal entries during her presentation. She also described patients' reactions to the terrorist attacks: some failed to show up for their appointments; others, such as

those with schizophrenia, seemed oblivious to what had happened.

Dr. Bernstein soon made the difficult decision not to allow her residents to go to Ground Zero without her approval. She noted that in the days immediately after September 11, people from all professions signed up to do things they were not qualified to do. Only after several days were mechanisms in place for assigning the right people to the right places. Dr. Bernstein pointed to the impossibility of channeling all the individual wishes to help—events such as the terrorist attacks usually cause chaos in existing systems.

In addition to the Red Cross, the Salvation Army, the New York Department of Mental Health, and many other organizations with mandates to provide assistance in emergencies, there are many mental health resources in New York City, Dr. Bernstein noted. After attending a disaster relief meeting of 60 psychiatrists on September 19, she decided to direct her residents to Disaster Psychiatry Outreach on Pier 94, which was designated by the New York Department of Mental Health as the primary mental health source for the September 11 disaster. There, her residents could benefit from the supervision of attending psychiatrists.

Dr. Bernstein expressed disappointment that future disaster response efforts are not likely to represent a coordinated approach. Although federal disaster relief funds are being made available to various mental health programs, each program seems to be applying for its own share.

Other sessions on disaster response, many of them informal discussions, were “Living Under Acute Levels of Stress: When Normal Isn’t Normal Anymore,” led by Mary Helen Davis, M.D.; “Oklahoma City: Lessons for Today,” by Kenneth Thompson, M.D.; “Working With the Chronically Mentally Ill After Disaster,” by Gloria Pitts; and “Working With Children and Adolescents After Disaster,” by Charles W. Huffine, Jr., M.D.

APA President Richard K. Harding, M.D., facilitated a discussion on addressing stigma in the context of the September 11 attacks. Participants discussed what psychiatrists can do to

help patients cope with the stigma associated with being—or appearing to be—Muslim or Middle Eastern. Psychiatrists from these ethnic groups may themselves be stigmatized, he noted, and may be torn between the need to help their patients deal with fear and the need to fight stigma.

Participants discussed the stigma associated with being a psychiatrist rather than a member of a profession that was able to be more directly involved in the initial emergency response. They also wondered whether the stigma of mental illness will be alleviated as a larger proportion of the population becomes affected by disorders such as anxiety and depression. One suggested that psychiatrists start conducting “September 11 screenings” to help establish a definition of a “normal” response. Participants acknowledged the importance of ensuring that ordinary people do not develop mental illnesses in the future as a consequence of dealing with these extraordinary events today. However, they expressed concern about the recent growth in prescriptions for anxiolytics and antidepressants, which could be a sign that people are trying to “medicate the problem away.”

### **Debate on federal funding of faith-based services**

The topic of one of two debates held during the institute was “Faith-Based Mental Health and Substance Abuse Services Should Have Liberalized Access to Federal Funding,” organized by the American Association of Community Psychiatrists. The debate was moderated by Andrés J. Pumariega, M.D., professor and chair of the department of psychiatry and behavioral science at East Tennessee State University, who noted that the topic stemmed from one of the early—and controversial—initiatives of the Bush administration. Although the legislative proposals of the White House Office of Faith-based and Community Initiatives have been stalled in Congress, the topic of the debate is still a timely one, Dr. Pumariega said, given the current interest in religion in the context of the events of September 11.

The affirmative case was argued by Anita S. Everett, M.D., inspector-

general for mental health in Virginia. David A. Pollack, M.D., associate director of the public psychiatry training program and associate professor of psychiatry at the Oregon Health Sciences University in Portland, argued the negative case.

Dr. Everett began by explaining that her argument would focus on three main points: that the provision of mental health and substance abuse services by faith-based groups is a good idea, that it is not a new idea, and that the problems cited by its critics are not insurmountable. She pointed out that current public mental health services are not fully meeting the needs of the people they were designed for. She believes that faith-based organizations are well placed to meet these needs and that cooperation between faith-based providers and other mental health services would open up more opportunities for people who need these services.

She gave the example of Catholic Charities, which is more than 100 years old and has four volunteers for every paid employee. This organization is 60 percent tax funded; only 12 percent of its budget comes from donations. She argued that the two central concerns of those who oppose federal funding of faith-based services—proselytization and employment discrimination—can be overcome. She suggested that regulations could be put in place, such as the law regarding prayer in schools. She also noted that, because of such requirements, some groups are not interested in federal funding. Dr. Everett also noted that Catholic Charities is an equal employment opportunity employer. She summarized by stating that the faith-based initiatives contain many sound ideas that are based on traditional American values.

Dr. Pollack opened his argument by pointing out that faith-based organizations are already providing mental health and substance use services and that some do receive federal funds. He reminded the audience that the topic of the debate was whether such funding should be liberalized and posed the question of why these groups should be treated differently than secular organizations—for example, why do they need

“institutional affirmative action”? He agreed with Dr. Everett about the success of Catholic Charities and other reputable operations that have clearly separated clinical and religious functions. However, he expressed concern that the groups that have been the most vocal in seeking liberalization of federal funding are those that have been denied funds for not complying with guidelines that other organizations have had to meet.

He acknowledged the importance of spirituality in mental health but asked whether it should be central to the treatment process and whether it should be incorporated against a patient's will. “Should the public accept practices that have not been validated?” he asked. He said that he believes that concerns about proselytization are in fact insurmountable. He pointed out that coercive measures that could be used by faith-based providers are contrary to principles of consumer choice and informed consent.

Dr. Pollack noted that although religious organizations have been allowed to violate equal employment opportunity laws in the interest of protecting their faith, they should not be allowed to do so with public funds. He believes that using religious rather than professional training standards to hire staff is unacceptable. In addition, it is difficult to imagine a process that could determine which groups deserve funds and which do not, he said.

In summarizing, Dr. Pollack said that there is no proof that faith-based groups will provide better care. He warned that the initiatives could produce a narrower, more fundamentalist approach to thinking, which, as the events of September 11 illustrate, can have tragic consequences.

In her rebuttal, Dr. Everett noted that the groups that would receive funding are, for the most part, well intentioned. Dr. Pollack replied that many fundamentalist groups are seeking federal funds and that psychiatrists and other health care professionals should not be so naive as to believe otherwise. He concluded by stating that religious beliefs can be honored, but not with federal funds, especially if the discriminatory provisions of the current initiative are not removed.

### **Mental illness in the developmentally disabled**

A symposium titled “Mental Illness in the Developmentally Disabled: A Multidisciplinary Approach” included presentations by Ramakrishnan S. Shenoy, M.D., and Bethany A. Marcus, Ph.D. Dr. Shenoy—a psychiatrist—and Dr. Marcus—a psychologist—are part of a multidisciplinary team at Central State Hospital in Petersburg, Virginia, that provides services for psychiatric patients with mental retardation and helps to ensure that these patients are placed in the least restrictive setting possible. The team also includes a registered nurse, an occupational therapist, a community outreach counselor, and a secretary.

Eighty cases were assigned to the team between February 2000 and May 2001. About 60 percent of the team's patients have a forensic history. Assessments involve confirming the diagnosis of mental retardation, identifying underlying medical problems, and determining compliance with medication regimens. Specific behaviors are targeted for increase or reduction—for example, behavior reduction might involve discouraging aggression or inappropriate toileting. Various interventions may be undertaken, such as medication adjustments and referrals to vocational programs. The team evaluates potential group homes and other residential settings in which patients may eventually be placed. It also provides emergency consultations after hours as well as ongoing support to the patients' families.

Dr. Shenoy described his role as the team's consulting psychiatrist. He noted that diagnosing psychiatric disorders among persons with mental retardation is complicated by factors such as speech difficulties and behavioral problems. The clinical interview is rarely diagnostic. Mood disorders are underdiagnosed among these individuals as a result of episodic presentation, medication masking, and the inaccurate belief among medical professionals and the general public that a person with mental retardation is not capable of experiencing depression or other mood disorders. Symptoms such as suicidal thoughts and feelings of worthlessness are often difficult to detect among these individuals.

In working with this patient population, Dr. Shenoy has become more aware of potential indicators of various disorders. For example, he has found that it is possible to detect bipolar disorder by observing episodic hyperactivity. Also, a positive response to a thymoleptic drug may indicate the presence of bipolar disorder. Methods such as biographical timelines, sleep charts, mood charts, adaptive skills analysis, behavioral incident charts, and monitoring of psychotropic drug profiles may also be useful for detecting psychiatric illness among persons with developmental disabilities. Nursing staff and other staff who see the patients daily play a critical role by noticing behavioral changes that might escape the attention of other members of the team.

One of the team's psychopharmacologic principles is “start low, go slow.” Dosages are maintained so as to minimize side effects. “Every case is an empirical trial of symptomatic psychopharmacology,” said Dr. Shenoy.

Dr. Shenoy noted that the multidisciplinary team has had an enormous impact in reducing institutionalization among its developmentally disabled patients, a population with an elevated risk of being institutionalized. Dr. Marcus described the team's success in moving three male patients from the hospital's maximum-security forensic unit to a civil psychiatric unit. All three men had serious psychiatric illnesses and had been civilly committed after being found incompetent to stand trial. They had spent an average of 21 years each in a maximum-security setting. Before the establishment of the multidisciplinary team in early 2000, no rehabilitative services had been available for these individuals. A systematic behavior program provided the necessary structure and oversight, and all three men made the transition successfully.

Dr. Marcus pointed out some of the obstacles to the success of the multidisciplinary team. For example, all staff members of the hospital, most of whom do not have experience with mental retardation, need to receive special training, which is labor-intensive. Dr. Marcus believes that it is crucial for the team to maintain the ongoing support of the hospital's ad-

ministration, to develop clear policies and procedures while remaining flexible, and to foster positive interactions between team members to ensure the team's ongoing success.

### **Barriers to help seeking and treatment for ADHD**

In an era in which many people think that attention-deficit hyperactivity disorder (ADHD) is vastly overdiagnosed, Regina Bussing, M.D., presented a lecture in which she argued that many children who truly have the disorder are not receiving the care they need. Dr. Bussing, who is director of the child and adolescent psychiatry division at the University of Florida College of Medicine in Gainesville, has identified several psychological and physical barriers that result in inequitable access to professional treatment for some groups of children with ADHD.

In a study that included all children in kindergarten through fifth grade in a public school system, Dr. Bussing identified children who were considered to be at high risk for ADHD. She then conducted interviews with these children and their parents to obtain information about the types of treatment that had been sought and also about existing barriers to getting treatment.

One notable result of the study was that girls were much less likely than boys to be evaluated and receive treatment for ADHD. Although no differences were found between girls and boys in the recognition of problematic behavior, only 20 percent of girls received an evaluation, compared with 57 percent of boys. Dr. Bussing also found that white children were nearly three times as likely as African-American children to be taken by parents for an evaluation.

Dr. Bussing's study identified several barriers to treatment for children who had a diagnosis of ADHD but were not receiving treatment. Two-thirds of the parents did not perceive a need for treatment. About half of the parents cited problems with the system, such as not knowing where to go for help, inconvenience in accessing services, and dissatisfaction with services that had been received. Forty-five percent had negative expectations of treatment. They were

afraid that the child might be taken away or hospitalized, or they believed that treatment would not be effective. African Americans were more likely than white individuals to have negative expectations. Almost 40 percent cited stigma in terms of objections by a family member and concerns about what other people would think.

Dr. Bussing noted that the results of the study emphasize the need for better public and professional education about ADHD, especially in regard to gender.

### **Developing a passion for public psychiatry**

Jacqueline M. Feldman, M.D., addressed barriers of another sort—those that keep mental health professionals from pursuing a career in public psychiatry. Dr. Feldman, director of the division of public psychiatry at the University of Alabama in Birmingham, suggested that people who will not even consider entering the field of community health are somewhat like the Dr. Seuss character who has decided he does not, and never will, like green eggs and ham—despite never having tasted them.

With enthusiasm, Dr. Feldman admitted that part of her mission in life is to convert “unbelievers” by helping them understand how rewarding a career in community and public psychiatry can be. It is “the most wonderful job in the world,” she said.

Dr. Feldman identified six areas of concern that help explain the reluctance of many providers to enter the field: patient characteristics, systems of care, systems of funding, stigma, role definition, and training. She then suggested strategies for overcoming these concerns.

Patients in public systems of care are often seen as just too challenging, Dr. Feldman observed. They often have very complicated diagnoses, including dual diagnoses; difficulties with compliance; and assorted medical, legal, financial, and relationship problems. Many are chronically ill, or their diseases do not respond to medication. Effective treatment must involve the whole person, and the patient's definition of successful treatment may be different from the provider's.

Yet despite—or perhaps because

of—their overwhelming problems, these patients deserve the best treatment possible. They often live under the worst of circumstances, yet they survive and persist. When clinicians reframe these patients' characteristics in the context of their daily lives, they cannot help but develop an admiration for them, Dr. Feldman said. Working with these patients requires intelligence, persistence, humor, and the ability to look beyond the individuals' life stressors to their inner strengths.

Dr. Feldman described the systems of care in public psychiatry as presenting another challenge. Patients are often treated in environments that providers find stressful, such as state and public hospitals, hospital emergency departments, jails, and homeless shelters. Many systems lack staff support or adequate physical facilities; sometimes they can appear overwhelming or dangerous. Peer support may be minimal or nonexistent. However, many system administrators are thrilled when public mental health care providers offer suggestions for improvements, Dr. Feldman noted. Providers have to be persistent, vocal, and assertive. The key is to demonstrate that a partnership will result in benefits for all concerned.

It is a fact of life that public psychiatry is chronically underfunded and that a lack of resources affects all aspects of practice and of program administration. Dr. Feldman pointed out that the problems of underfunding are especially challenging because they are largely out of the provider's control. But again, there are opportunities for action. Partnerships, especially with advocacy groups, can be very productive. Grants are available for some types of work. Creativity in seeking out funding can pay off.

Psychiatric patients in community and public health systems are acutely aware of the stigma attached to mental illness, as Dr. Feldman pointed out. Unfortunately, the stigma often extends to the providers who work with these patients, perhaps because it is assumed that this is the only type of work they can find. Rising above and beyond stigma is a lifelong challenge. Continuing to educate the public about mental illness is imperative. Partnerships with advocacy groups are



especially important in this endeavor.

Defining the role of the public health provider can be problematic. In some environments the psychiatrist may just write prescriptions; in others he or she may assume the role of medical director, clinician, mentor, educator, administrator, policy maker, or consultant. Another problem Dr. Feldman described is the therapeutic relationship. Some providers are trained to maintain distance and neutrality, while some feel solely responsible for their patients' treatment. When role definitions are expanded, new learning opportunities open up. Providers who can embrace the concept of treatment teams benefit from shared expertise.

Many providers may feel undertrained in community psychiatry and underexposed to the public sector. Although support for training in community psychiatry does exist, there are no uniform guidelines or prerequisites. Some programs require a few hours of training in off-site community health centers with no supervision. Others are embedded in academic psychiatry departments, where residents work full-time in public clinics for several months.

Dr. Feldman emphasized that improving training programs in public psychiatry is paramount. Centers of excellence must be identified. Multiple venues of training, on-site supervision, and longer rotations should be required. Students in any therapeutic profession can become involved in public psychiatry. Dr. Feldman promised that those who do will find rewards that few other careers can offer.

### **Public health care for women**

Nada L. Stotland, M.D., M.P.H., speaker of the APA Assembly, gave a lecture called "Women Patients, Public Mental Health Care: We Can Do Better." She explained that women constitute a patient population that deserves special attention because of differences in socioeconomic status between women and men, differences in physiology, and women's vulnerability to abuse. With this vulnerability comes a risk of comorbid conditions such as posttraumatic stress disorder, sexually transmitted diseases, and substance abuse.

Dr. Stotland sought to address several misconceptions surrounding health care for women. She pointed out that contrary to common belief, women of all socioeconomic backgrounds can be victims of violence. Women do not necessarily complain more at a given level of symptom severity than men do. Lung cancer is the most common malignancy among women, not breast cancer. Cardiovascular disease is also a major killer of women.

Dr. Stotland dedicated a segment of her presentation to schizophrenia, pointing out that while much has been said about women and depression—which is two to three times higher among women than men—schizophrenia is often absent from discussions about mental health care for women. In addition, people who have schizophrenia constitute a large proportion of the public health system's patients, because these individuals lack alternative sources of care.

Physical differences in the male and female brain have implications for the ways men and women experience schizophrenia, Dr. Stotland noted. Evidence suggests that ovarian hormones may protect the fetal brain from injury and the adult brain from the excessive dopamine activity associated with schizophrenia. Women tend to have a later onset of schizophrenia. The period between diagnosis of schizophrenia and prescription of a neuroleptic agent is shorter for women. Women receive 59 percent of all antipsychotic medications prescribed, and women over the age of 30 constitute the largest group of antipsychotic users. They experience fewer hospitalizations, shorter hospital stays, and lower relapse rates, but they have more dysphoria, irritability, and paranoia. Side effects such as weight gain have a different significance for women than for men, to the point that women may refuse to take their neuroleptic medications. Neuroleptics also have menstrual side effects and have been associated with cardiovascular problems and decreased bone density.

The sexual vulnerability of women with schizophrenia and other serious mental illnesses adds to the challenge

of treating these patients, observed Dr. Stotland. Who teaches them about contraception? Is it convenient for the patient to take an oral contraceptive every day? In addition, the patient may fear impairment of fertility. Does the caregiver recognize and respect the patient's concerns? (The fertility rate among persons with mental illness is similar to that of the general population.) If pregnancy occurs, will the patient get adequate prenatal care? What effect will the mental illness and prescribed medications have on the pregnancy, labor, delivery, and lactation?

Women with schizophrenia also risk losing custody of their children. Dr. Stotland believes that the public health system lacks supportive services for mothers with schizophrenia and other serious mental illnesses. The usual approach is either to take the child from the mother or to do nothing—when problems are not immediately obvious, the mother is left to cope alone.

Other health issues that are especially problematic for women with serious mental illness include dealing with menopause and reproductive malignancies. Pelvic examinations are often postponed because the patient is "too upset," and it is difficult to ensure that they are conducted later.

Dr. Stotland proposed a set of actions to help address these many problems. Providers must ask the relevant questions about gender-related effects when taking a history—questions about menstruation, sexual activity, contraception, pregnancy, hysterectomy, and menopause. Symptoms may vary with the stage of the menstrual cycle and whether the patient is in a postpartum period, and medication dosages may need to be adjusted accordingly. Caregivers must take an active role in screening and prevention—for example, there may be a way to avoid postponing a pelvic examination. At the same time, caregivers must be mindful of special considerations for persons with mental illness, such as the fact that many of these patients "live in a world of appointments but don't have watches."

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