

November 2005

Involuntary Hospitalization Laws (5585)

Presenter: Manny Robles, LCSW, Diane McDowell, Ph. D. Orange Co. Health Care Agency
Date/Time: **Nov. 1, 2005 9:00 a.m. - 12:00 p.m.**
Location: **CYS South 21632 Wesley Drive, Laguna Beach, 92651**

This **Mandatory** workshop for all **County** staff who have recently become certified to hospitalize patients without their consent or who will become certified in the next 3 months. The workshop will cover the 5585 laws, the latest CYS policies, and the clinical procedures for determining that a client is dangerous to themselves or to others.

Course objectives:

1. To be able to describe the clinical situations in which a person should be hospitalized against his or her will
2. To be able to describe the laws relating to involuntary hospitalization
3. To be able to identify the forms and procedures for carrying out an involuntary hospitalization

3 CE credits have been applied for: LCSW, MFT, MD's, and Psychologists.

Introduction to the WISC-IV for MH Clinicians

Presenter: Ernie Proud, Ph.D.
Date/Time: November 29, 2005, 9:00 a.m. – 1:00 p.m.
Location: **744 N. Eckhoff, Orange, CA (Auditorium)**

This workshop will introduce the recently released WISC-IV intelligence test and discuss how it differs from the WISC-III and what can be learned from the test about children with learning and behavioral problems. Ernie Proud, Ph.D. is a former CYS clinician and now a school psychologist.

Objectives: To be able to describe the kinds of information to be gained from a WISC-IV with children with learning and behavioral problems

Target audience: Psychologists and other mental health clinicians who wish to understand more about the use of intelligence tests with children with behavioral problems.

4 CE credits have been applied for: LCSW, MFT, and Psychologists

QRTips

This section provides monthly critical reminders in relation to documentation standards.

Billing for groups when there is more than one therapist.

1. The process of entering the group time on an ED is done the same way regardless of the number of therapists involved:
 - The group time, the number of therapists involved, and the total number of members in the group is entered on each ED.
2. When more than one therapist facilitates the group, typically the therapists have divided the notes and each written half of them. This works well following these simple rules:

- Each therapist puts himself/herself as the "Primary" on the notes s/he writes (each therapist will get full credit for the actual group time).

- As each therapist completes an ED s/he enters the documentation time for that particular note (s/he will get full credit for the time s/he spent documenting the note; the co-therapist, the one who does not write the note, does not get documentation credit.

3. When there is travel time involved

- Each therapist divides his/her travel time by the number of clients s/he is charting (**not** the total number in the group).

- Each therapist's divided travel time is entered on each ED completed by that therapist (after entering all of his/her EDs each therapist will have credit for his/her total travel time).

•**Example:** 2 therapist, 6 clients, 60 min group

oTherapist #1: doc times = 9 min, 6 min, & 11 min (for 3 clients).
Travel time = 30 min (i.e. 10 min/client)

oTherapist #1 will bill her first client entering 60 min for the session time (IRIS will break it out), 9 min. for doc time; & 10 min for travel time. The bill for second client is 60 min (service), 6 min (doc.), 10 min (travel); and the bill for third client is 60 min (service), 11 min (doc.), and 10 min (travel).

oTherapist #2: doc times = 10 min, 10 min, & 8 min (for 3 clients). Travel time = 60 min (i.e. 20 min/client)
oTherapist #2 will bill his first client entering the 60 min for the session time; 10 min for doc time; & 20 min for the travel time. The bill for second client is 60 min (service), 10 min (doc.), 20 min (travel); and the bill for third client is 60 min (service), 8 min (doc.), 20 min (travel).

More on Groups

- If two therapists run a group.....both therapists **must** sign the progress note.
- Only CYS registered clients can participate in groups.

**IF YOU WISH TO RECEIVE CE CREDIT
YOU **MUST** ARRIVE WITHIN 15 MINUTES!
THANK YOU**

Clinical Supervision: Beyond the Basics

Presenter: Steve Sultanoff, Ph.D.

Date/Time: November 18, 2005, 9:00 a.m.– 4:00 p.m.

Location: **405 W. 5th St. Ste. 433 Santa Ana, CA**

This program is designed to enhance and advance the supervision skills of participants who have previous knowledge and experience of the supervision process. The presentation (which will include lecture, small group interaction, video, activities, and magic) will include a review of the basic concepts in supervision including what is mental health supervision, who are the supervisees governed by the California boards, a model of case review, and theoretical approaches to supervision.

More complex topics such as risk management, dealing with problematic supervisees, experiential assessment and selection of supervisees, applying a theoretical model (dynamic, humanistic, gestalt, cognitive, behavioral, etc.) to the supervisee's process (rather than to the client's process) as well as other supervision topics will be examined. Participants will also receive an update on current regulations and realistic application of those regulations, as well as a review of the responsibilities and paperwork expected of clinical supervisors.

Target Audience: Licensed psychologist, social workers and MFTs who wish to supervise students, associates, interns and trainees

Objectives: Attendees will be able to:

1. Understand and differentiate supervision from other professional "supervisory" relationships
2. Clarify the types of supervisees governed by the Board of Psychology and Board of Behavioral Sciences
3. Understand the application of clinical theory to clinical supervision
4. Explore methods to address issues with difficult supervisees
5. Develop and effective selection/assessment process
6. Clarify rules and regulations for mental health supervision
7. Clarify practical application of regulations

6 CE credits have been applied for: LCSW, MFT, and Psychologists

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MUST ARRIVE WITHIN 15 MINUTES! THANK YOU**

The Impact of Mass Casualty Events on Children and Families

Presenter: Merritt Schreiber, Ph.D., Orange County Health Care Agency

Date/Time: November 22, 2005, 9:00 a.m. – 11:30 a.m.

Location: **744 N. Eckhoff, Orange, CA
(Auditorium)**

This training will present an overview of the issues related to the impact of mass casualty events on children and families. The unique issues triggered by large scale natural disasters and terrorism involving chemical, biological, radiological and nuclear agents will be presented along with results of several large scale terrorism exercises and experience in the field in the aftermath of Hurricane Katrina/Rita. A model of rapid behavioral triage, disaster systems of care and evidenced based interventions for children with traumatic loss will also be presented.

Dr. Merritt D. Schreiber, a psychologist with CYS, is also a reserve commissioned officer in the US Public Health Service attached to the National Disaster Medical System and is Southern California Disaster Response Network Coordinator for the California Psychological Association. He received a Presidential citation from the American Psychological Association for his work in the aftermath of the terrorist attacks on 9/11/01. He has made two trips to Louisiana to provide services in response to Hurricane Katrina.

Objectives: 1) To be able to describe the effects of mass casualty events on families and children
2) To be able to describe a model of response and intervention to events involving disaster and traumatic loss with children

Target Audience: Mental health professionals who work with children

2.5 CE credits have been applied for: LCSW, MFT, Psychologist

Introducing – The Quality Review and Training Team

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Your Culture and Mine

The family that eats together....

Child Trends Data Bank has just released the following information about family eating in America. To quote their report, "Like other forms of parental involvement, research shows a positive relationship between frequent family dinners and positive teen behavioral outcomes. Teens who regularly have meals with their family are less likely to get into fights, think about suicide, smoke, drink, use drugs, and are more likely to have later initiation of sexual activity, and better academic performance than teens who do not. Even after controlling for family connectedness, more frequent family meals have been found to be associated with less substance use, fewer depressive symptoms, and less suicide involvement, and with better grades."

In 2003, 42 percent of adolescents ages 12 to 17 ate a meal as a family six to seven days a week, 27 percent ate a meal as a family four to five days a week, and 31 percent ate meals as a family zero to three days a week. Hispanic adolescents ages 12 to 17 are more likely than non-Hispanic white and non-Hispanic black adolescents to eat meals six to seven days a week together with their families. In 2003, 54 percent of Hispanic adolescents ate meals six to seven days a week with their family, compared with 40 percent of non-Hispanic black adolescents and 39 percent of non-Hispanic white adolescents. Foreign-born adolescents are more likely than native born adolescents with native born parents to eat family meals together regularly."

In fact, there is a linear relationship between being either foreign born, having a foreign born parent or being native born with two native born parents and the likelihood of an adolescent eating with his or her family. Sixty-two percent of foreign born adolescents ate with their families compared to 47% of native born teens with a foreign born parent and 40% of native born teens with two native born parents. Additionally, being poor and having parents who are less educated are both predictive of being more likely to eat with the family.

The County of Orange Health Care Agency is an approved provider of continuing education credits for the California Board of Behavioral Sciences (provider no. PCE389), and is approved by the American Psychological Association to offer continuing education for psychologists. The Orange County Health Care Agency maintains responsibility for the programs.

Where indicated this is an activity offered by OC HCA, a CMAA-accredited provider. Physicians attending this course may report up to 3 hour(s) of Category 1 credit(s) toward the California Medical Association's Certificate in Continuing Medical Education and the American Medical Association's Physician's Recognition Award.



Show me the Evidence

Are atypical antipsychotics more typical than we think?

A recent study published in the *New England Journal of Medicine* (Lieberman et al. [2005]. Effectiveness of antipsychotic drugs in patients with chronic schizophrenia, 353, 1209-1223) has raised a question about just how much advantage newer, atypical antipsychotic medications have over the older, typical medications. The NIMH-sponsored, double-blind study had 1,493 patients at 57 U.S. sites randomly assigned to receive olanzapine (Zyprexa), perphenazine (Trilafon), quetiapine (Seroquel), risperidone (Respiridol), or ziprasidone (Geodon) for up to 18 months. Participants carried a diagnosis of schizophrenia but were neither first episode cases nor had they previously been treatment-resistant to medications. The primary outcome measure was discontinuation of medication treatment and additional outcomes included development of side effects, symptom reduction, and overall illness severity. Three quarters of the clients were male, were mostly white, and the mean age was 40 years.

Olanzapine (Zyprexa) was superior to the other medications, in terms of discontinuation for any reason, discontinuation at client's request, discontinuation for lack of efficacy, duration of successful treatment. Improvement was initially better with olanzapine, but over time there was no difference between medications. Fewer clients on olanzapine were hospitalized during the study. However, more clients on olanzapine discontinued treatment due to intolerable side effects (mostly weight gain and metabolic syndrome) and weight gain and metabolic symptoms were greater in the olanzapine group. Although there were no differences between medications in extrapyramidal symptoms, more clients on perphenazine (Trilafon) discontinued therapy due to intolerable extrapyramidal symptoms.

At least two findings from this study were startling: 1) In general the atypical antipsychotic medications, with the exception of olanzapine, were no more effective nor beneficial, nor less intolerable than the older, typical antipsychotic perphenazine and 2) Clients discontinued therapy at remarkably high rates and early in treatment. The discontinuation rates ranged from 64% with olanzapine to 82% with quetiapine, with a mean rate of 76%. Months to discontinuation range from 9.2 with olanzapine to 3.5 with ziprasidone, with a mean of 5.5 months. It should be noted that only about a third of clients discontinued at their request, another fourth because of judged ineffectiveness of the medication, and 10-20% because of a joint decision on intolerability of side effects. The average duration of successful treatment was a month or less with all medications, except olanzapine, which had an average duration of 3 months.

In most cases, the newer, atypical antipsychotics showed no advantage over the older medication, perphenazine, which was tolerated just as well as the other. Olanzapine, though causing more weight gain and metabolic symptoms, was modestly superior to other medications on most outcomes. It appears from this study that discontinuation of therapy, early in therapy, is the norm, rather than the exception for all antipsychotic medications at this time.