# A Piece of Our Mind

COLORADO PSYCHIATRIC SOCIETY NEWSLETTER

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A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

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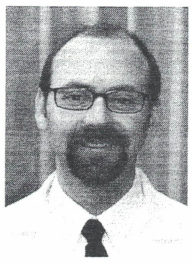
## 50TH ANNIVERSARY ISSUE



## President's message

### Looking In, Reaching Out, and Moving Forward

By David B. Arciniegas, M.D.

This year, 50th as a professional society, has been one of reflection regarding our mission as a society and the services we provide to our members. Our society serves as a forum for discussion of matters related to patient care, professional development, and public policy; a vehicle for political action on issues of relevance to the practice of psychiatry and the patients we serve; a source of continuing medical education activities; and a body through which to maintain professional and personal relationships with our colleagues. Although relatively equal weight is placed on these efforts at the organizational level, it is not clear to the Executive Council whether they reflect most accurately the interests and needs of CPS members. The last several years have seen declining attendance at CPS dinner meetings and educational programs, as well as waning participation by CPS members on the various committees of our organization. Concurrently, CPS has faced challenges in the development of funding required to maintain the breadth of activities in which our society is engaged - particularly our annual meetings and educational programs. Despite these changes, our society's commitment to advocacy and support of both professional and patient care issues remains strong. However, they have served as a prompt for the CPS Officers to review the real and perceived relevance, usefulness, and value of CPS' activities to you, its members.

In the course of this informal organizational self-study, the Officers and staff of CPS realized that more than ten years have passed since CPS last conducted a formal internal review and strategic planning session. With the support of the Executive Council, we began assessing CPS' allocation of effort and resources with respect to the concerns and priorities of our members. Laura Michaels, CPS Executive Director, subsequently authored a successful grant application to the APA to garner funding to support this project.

That project, which is already underway, includes both internal and external components. The internal component includes a survey of CPS' members, which you should expect to receive in the near future. The purpose of this survey is to solicit your guidance regarding the current and future goals of our organization. This survey is intended to help us learn which aspects of CPS current efforts you value most and areas in which you feel our emphasis might be re-focused or from which we should be re-directed. We also hope that it will provide an opportunity for you to offer ideas for future CPS projects or programs.

The external component of our review is based on a project developed by Tony Robucci, M.D., who will begin his term as CPS President later this year. This project is focused on the relationship between psychia-

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trists and other physicians in Colorado. As many of you may know, a study conducted by a coalition of eight non-profit foundations in Colorado reported in 2003 that 1 in 5 Coloradoans are in need of mental health services each year, but that less than one-third of individuals in need of such care receive it. Among the 640,000 Coloradoans with a diagnosable mental illness, only 25% receive services specifically for those conditions. When such services are provided, most (~70%) are delivered in primary care and non-mental health settings. The report also identified a relative shortage of psychiatrists in our state, and noted that consumers seeking psychiatric care often faced long waiting periods for appointments with psychiatrists. In light of the fact that such data might be used by some parties to argue for the development of alternative means by which patients might receive not only psychotherapeutic but also psychopharmacologic treatment, the CPS Executive Council decided that further assessment by our organization of the issues raised by this report was imperative.

With this background, Dr. Robucci initiated a survey of internal medicine, family practice, and pediatric physicians in Colorado. That survey sought to learn from them how CPS, and by extension its members, might engage most effectively in a collaborative effort to improve the coordination and delivery of mental health care in our state. The response to this survey was impressive both in terms of numbers of respondents and also the affect with which their comments were made. Many physicians expressed frustration with access to psychiatrists, a perceived necessity to practice outside their areas of comfort, and a lack of collegiality between psychiatrists and other physicians. Of course, response-bias needs to be considered in the analysis of such data: it is possible that a survey like this may prompt a response only from those with strong feelings on these matters. Nonetheless, the number of responses received suggests that our organization should consider developing efforts to facilitate improvement in the delivery of mental health care as it is delivered in the broader medical community.

The data yielded by our internal and external assessments will be reviewed during an organizational strategic planning retreat this spring. The CPS Executive Council engaged Mr. Bob Harris, who led the Leadership Training for APA District Branch Executives in November 2004, as a facilitator for this retreat. Based on the outcomes of that retreat, a strategic plan for CPS' continued development will be created. It is our hope that this effort will improve CPS' relevance and responsiveness to its members and effect positive changes in mental health care delivery in Colorado.

I hope that you will share my enthusiasm for this process: opportunities for organizational renewal are uncommon and those with funding to support them are rarer still. Even with this enthusiasm and support, our success in this endeavor depends upon you, the members of CPS, making known your views on the goals and activities of our society. Please feel free to contact our office by phone (303-692-8783) or e-mail (cps@nilenet.com) with your comments and ideas.

In closing, I offer you my thanks for allowing me the privilege of serving CPS over the last year and hope that you will join me in welcoming Dr. Tony Robucci as the new President of CPS.

*Dr. Arciniegas is the 2005-2006 CPS President. He is also Director, Neuro-psychiatry Service, and Assistant Professor of Psychiatry and Neurology at the University of Colorado Health Sciences Center, and Co-Medical Director, Brain Injury Rehabilitation Unit, Spalding Rehabilitation Hospital.*

# The Fifties: A Decade of Change and Innovation

By John Lightburn, M.D.

As we commemorate the 50th Birthday of CPS, I would like to revisit some of the history of the Society which might give us an appreciation of the revolutionary changes that have occurred in our profession. The 50's saw the beginning of exciting developments in psychopharmacology, psychotherapy, psychiatric education and the delivery of mental health services. In the space available, I can only present a general picture of what mental health care provided 50 years ago and the forces that started the dramatic developments that have occurred since then. I will not attempt to describe the important developments in psychopharmacology.

In 1950, psychiatric facilities in the state included three public hospitals: Colorado Psychopathic Hospital, Denver General Hospital, and the Colorado State Hospital in Pueblo. There were four private, for profit hospitals: Mount Airy Sanatarium, Porter Sanatarium in Denver, Emory John Brady hospital in Colorado Springs and Woodcroft Hospital in Pueblo. The very large Colorado State Hospital had over 5,000 patients. Therapy in hospitals was limited to electro-shock therapy for depression, insulin coma therapy for schizophrenia, hydro therapy for mania, and fever therapy for tertiary syphilis. Most of these therapies required fairly intensive physician and nursing care available only in Colorado Psychopathic Hospital, the private hospitals, and to a very limited extent at the State Hospital.

After several weeks of hospital care, those patients too ill to return home were referred to the courts and were scheduled for a hearing before the lunacy commission, comprised of two psychiatrists and an attorney who was the patient's guardian ad litem. The patient's physician presented a brief history and recommendations. The patient was given an opportunity to speak. The psychiatrists briefly consulted with each other and then told the patient he/she was committed to the state hospital. They were either incompetent to care for self, or dangerous to self or others, and were committed to the State Hospital in Pueblo.

In Denver county, Jane Woodhouse was the assistant city attorney responsible for recruiting and scheduling the work of the lunacy commission. Jane witnessed hundreds of patients being sent to an institution where the state provided inadequate funds for adequate psychiatric care. It was more like a warehouse to keep mentally ill patients out of sight and out of mind. She was deeply disturbed by this archaic process, and considered it cruel and inhumane.

Appalled by this situation, she joined with other concerned citizens to form the Colorado Association for Mental Health (CAMH). On August 21, 1953, Jane was elected first president of CAMH. Their efforts brought about the beginning of many exciting changes in the care for the mentally ill. The original Prospectus listed the following urgent needs: 1. Treatment facilities for psychotic children; 2. Community psychiatric outpatient facilities; 3. Professional psychiatric personnel in state institutions; and 4. Recruiting young people to enter the mental health field. CAMH let the public know about the plight of the mentally ill and in 1953 persuaded Governor Ed Johnson to appoint a special committee on Mental Health Services in Colorado made up of psychiatrists, social workers and other citizens. After two years of study, the committee issued a report entitled "What are Our Responsibilities in Mental Health?"

In 1958, Governor Steve McNichols requested two additional studies which laid the groundwork for reforms enacted by the Colorado Legislature. An additional report by the U.S. Public Health Service outlined extensive plans for the State Hospital and other institutions. For the first time since 1915, progressive laws were now governing the care of the mentally ill. Community Mental Health clinics were financed and established in many of the counties in the state. Now the state had commitment laws based on scientific definitions and procedures. We were on our way to a modern mental health care system.

In 1958 - 59, the legislature passed bills setting up an intensive treatment unit at Pueblo, and authorized Governor McNichols to obtain free land at Fort Logan for a psychiatric facility near Denver including $150,000 for maintenance and initial planning for the new Fort Logan Mental Health Center.

And there were big doings in other places beside the state house. At the School of Medicine, Frank Ebaugh had occupied the Chair of the Department of Psychiatry since 1902. In 1943, he stepped down and Herbert S. Gaskill left the chairmanship of the department at Indiana University to assume the chair vacated by Dr. Ehaugh. He had big plans for the department and the school. A new psychiatric clinic was built providing offices for residents, faculty and social workers. On the main floor was a lecture hall designed for viewing patient interviews. Dr. Gaskill recruited an outstanding faculty including such teachers as John Conger, Jim Dyde, Jim Galvin, Sydney and Gretl Margolin, Janice Norton, Rene Spitz, Brandt and Eleanor Steele. Not satisfied with a significant growth in the size and importance of the Department, he also had plans for establishing a psychoanalytic institute in Denver. Before Gaskill's arrival, there were two psychoanalysts in Denver: Jules Eisenbud and John Benjamin. With the plans for an institute in Denver, that number increased dramatically as psychoanalysis grew in popularity and influence.

That was what was going on when the Colorado District Branch became the Colorado Psychiatric Society with Clyde Stanfield as the first president. They were women and men with a mission, visionaries who made possible the system we have today. We are very grateful for the work of our colleagues and the members of the Mental Health Association. Let us hope it is not destroyed by the current drastic decline in state and federal funding.

(Author's Note: This article is an amplification of an article on the birth of the Colorado Psychiatric Society that appeared in the June 2005 edition of A Piece of Our Mind. There may be some factual errors because it is in part based on my recollections of that period.)

*Dr. Lightburn is a Past President of CPS (1967-1969).*

# A Glance Back: The Evolution of Psychiatry in Colorado

By Jerry Jacobson, M.D.

I came to Colorado in 1948, two years after the founding of the Colorado District Branch. With my arrival in Boulder the total number of Boulder psychiatrists skyrocketed up to three (the CPS Directory currently lists 31 of us). My comments will be in the context of the psychiatric climate I found in the Colorado of that time.

Herb Gaskill had come to Denver from the University of Indiana in 1943 to become Chair of Psychiatry. He brought with him John Conger, who chaired the Department's Psychology Section and later became Dean of the Medical School. Herb soon recruited Brandt and Eleanore Steele and Larry Hall to join the faculty and, along with Gretl Hitchman, Syd Margolin, Jim Dyde, Bill Shanahan, and Jule Eisenbud. They, and others, formed a Psychoanalytic Society and then an Institute.

Herb took over the Chairmanship from Franklin Ebaugh, who, as Department Chair, had in 1904 founded what was then called the Colorado Psychopathic Hospital. A student of Adolph Meyer at Johns Hopkins, Ebaugh's arrival in the 00's forged the transition from the Kraepelinian focus on presumed underlying organic brain diseases (handicapped by the shaky neurobiological understandings of the time) to the Meyerian concepts of psychobiological reaction patterns based on a multiplicity of biological and psychosocial environmental factors; i.e., a humanistic view of the patient as a whole person. The individual was studied by means of a meticulous chart of historical events, including the medical, psychological, and social events that together were thought to determine the individual's personality. Herb Gaskill's arrival in Colorado signaled the next shift, from psychobiological and psychosocial to psychodynamic (which in those days meant psychoanalytic) psychiatry.

Herb Gaskill was one of five analysts graduated from the Chicago Institute for Psychoanalysis in the early 1940's, a group which fanned out over mid-America to chair departments of psychiatry and establish Psychoanalytic Institutes in affiliation with them: Herb to Colorado, John

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Romano to Buffalo, Henry Brosin to Pittsburgh, Doug Bond to Western Reserve in Cleveland, and Maury Levine to Cincinnati. They called themselves the Stagecoach Group, so named after the classic John Ford/John Wayne movie of that title, which movie they watched as a group at each of their annual get-togethers, and which seemed to symbolize the romantic idealism with which they viewed their mission. This shift toward the psychoanalytic brought these communities in line with the broad movement across the country in which the psycho-biological approach of Adolph Meyer, which had dominated the psychiatric scene nationwide from the early 20th century until the mid-1940's, was supplanted by the psychodynamic and psychoanalytic approaches that had been influenced by experiences with combat neurosis during World War II. Other manifestations of this trend were evident in the psychodynamic emphasis in hospital treatment at such centers as the Menninger Clinic, Chestnut Lodge (staffed by Frieda Fromm-Reichman and other followers of Harry Stack Sullivan), Austen Riggs (where Erik Erikson and Robert Knight held sway), and Mt. Zion in San Francisco. Here in Denver, Mt. Airy Hospital, where John Lightburn was Medical Director, offered eclectic psychotherapeutic approaches along with what medications were available.

For a variety of reasons this was a time of over-idealization of the notion that psychodynamic understanding and treatment were adequate for every psychiatric condition, including those widely accepted today as requiring other modes of understanding and address. The powerful voices of psychoanalytic figures in academic and organizational psychiatry was certainly one factor in that. Another factor was the absence of viable and effective alternatives. The genetic and neurophysiological bases of some conditions were not yet known; Twelve-Step programs were not yet widely known; and cognitive-behavioral therapy was at its very beginnings. The eagerness with which dynamic approaches were turned to in mid-century had to do also with the meagerness of the biological treatments available at that time. Lobotomy and insulin- and metrazol-shock treatments had recently been discarded as disappointing, and the limitations of electro-shock were being recognized.

In the area of psychotropics, Thorazine and Reserpine, with their horrendous side effects, along with the adjunct barbiturates and chloral hydrate at night, pretty much constituted the medical armamentarium of psychiatry. Not much. MAO inhibitors and tricyclics did not make their first appearance until the late 1950's and early 60's. The tricyclics were originally formulated as anti-schizophrenia medications, for which they proved ineffective, and it was a later serendipitous finding that they were useful in depression. Ritalin became available for use in what was then called "Minimal Brain Dysfunction" in 1956, the same year as the Colorado District Branch was founded.

The psychodynamic toolkit of the time was also not an especially robust one by current standards. Psychoanalytic Ego Psychology held unquestioned supremacy in the world of psychodynamics. Kohut had yet to write even his initial article on empathy, and the beginnings of self-psychology were a decade or more in the future. Mahler's work on separation-individuation was only slowly becoming known and used. Her landmark book, The Psychological Birth of the Human Infant: Symbiosis and Individuation was not to appear until 1975. Winnicott's writings of the 40's and early 50's were only beginning to make the trip across the Atlantic, but were not yet generally well known to clinicians.

The psychoanalytic psychotherapy of the time did work satisfactorily primarily in dealing with clinical episodes that involved sexual and aggressive urges and the counterforces pitted against them by reality or moral considerations. Our results in working with issues of narcissistic grandiosity and idealization, and with schizoid issues, were quite variable, dependent on each clinician's capacity for empathic understanding and for following ego states and unconscious fantasies without the help of a theoretical map for them. In the absence of neurophysiological knowledge and more sophisticated clinical theories, each clinician had to rely more heavily on his or her own intuition and empathy than we do now. Many of us turned to the then-burgeoning field of ethology for clues in animal behavior that could be applied to understanding the neurobiological underpinnings of our patients' behavior. Konrad Lorenz, a pioneer ethologist who had friends in the

Department, was a frequent visitor to Denver. His presentations were well attended out of interest in gaining clues from the world of animal behavior that could be extrapolated to our patients.

As limited as our psychodynamic understandings were then relative to what we have today, much that was new and cutting edge in the 1950s is today so firmly embedded in current clinical (and popular) thinking as to seem always to have been there, unhesitatingly accepted by enthusiasts and skeptics of psychoanalysis alike. Even so commonplace a notion as the existence of powerful unconscious motives, often arising out of childhood experiences, affecting mood, perception and behavior was then a novel and enlightening concept. Likewise with such concepts as transference, repression, regression to a developmental fault line, and the somatic expression of emotional currents. It may be difficult to picture now just how dramatic it was then to grasp the therapeutic value for a patient of experiencing painful memories and affects in the presence of the psychiatrist, how it allowed a sense of mastery of emotions from which the patient had, at great cost, been running all his or her life. Also novel then was a grasp of the insistence of traumatic experiences on repeating themselves in dreams, fantasies, experience, and action, until they were mastered. Some of these understandings and techniques, part of the earliest psychoanalytic thinking, had gained added currency in the recent past from experiences with traumatic reactions during World War II and the early post-war years.

The therapeutic potency of simply listening, trying to understand patients, and trying then to impart those understandings to them, was also in itself new enough and unknown enough to create much interest among medical practitioners and the public. The Western Interstate Commission on Higher Education (known as WICHE) underwrote financing to send a number of us out in pairs to various communities to hold evening workshops with family practitioners and specialists on listening and understanding their patients' emotional lives. A colleague and I gave a series of 10 or 15 evening workshops for practitioners in Greeley, Fort Collins and Loveland. Workshops of this kind were eagerly received by physicians, whose medical school education in psychiatry had been quite meager, and for many of whom such an approach as we could offer was quite novel and helpful in their practice.

Colorado Psychopathic Hospital, as it was then called, was organized generally on dynamic lines, utilizing the milieu techniques then available, and with psychodynamic psychotherapy being offered in the child and adult clinics on a sliding scale of fees. The Children's Day Hospital was not yet in existence. Insurance in those days was not as commonly used as later came to be the case, but private fees for out-patient therapy ranged between $20 and $25 and the Psychiatric Clinic's sliding scale made treatment fairly widely accessible. The modesty of scale in that time can be illustrated by the fact that in 1957 a special State appropriation of $118,000 was adequate to seed new Community Clinics in Boulder, Denver, Colorado Springs, and several other communities on the plains and on the Western Slope in that year. Interest in supplying psychiatric services to our slimly populated state was evidenced also in a Montrose psychiatrist, Lyn Hopple, flying his own plane to Western Slope communities to do psychiatric consultations. Hans Marx of Denver did the same thing for the eastern part of the state. Public policy on mental health issues was also notably spirited in those days. One memorable evening in the late 1950's, Governor Steve McNichols met with the entire District Branch membership to brainstorm mental health needs in hospitals and communities around the state. On another occasion William Menninger was invited over from Topeka to work with the legislature on Colorado's mental health needs.

The Faculty of the Medical School were designated Geographical Full-Time Faculty, working full-time in their faculty offices but allowed to devote a percentage of their time to private practice. This system encouraged in Psychiatry, as in all Departments, a fluid intermingling of practitioners and academic psychiatrists.

At CPH, Brandt Steele headed the Psychiatric Liaison Division, teaching and supporting consultation to other Services on psychosomatic conditions and the emotional dimension of various illnesses and of medicine and surgery in general. PLD had been initiated here by Franklin Ebaugh in the spirit of his training under Adolph Meyer at Johns Hopkins School of Medicine. Interest in consulting with other departments and with psychosomatic medicine in general was a natural

outgrowth of Meyer's psychobiological approach. Rene Spitz bridged the Adolph Meyer era in encouraging students to utilize the Meyer life history schema with their patients. Our towering ignorance at that time of such factors as the immune system, neurophysiology, the bacterial component of gastric ulcer, the genetic contributants to various illnesses, etc., led to an exaggerated reliance on overly specific dynamic formulations that sometimes could approach the grotesque. Psychiatric and psychoanalytic centers around the world produced entire volumes ascribing specific dynamics to certain of the psychosomatic disorders, including some that we now know to have other determinants unknown to us at the time. To some extent this was yet another manifestation of the over-idealization of psychoanalysis. Nevertheless, the basic value of understanding the conflicts and predicaments of patients with somatic conditions has prevailed as a contribution of psychoanalytic psychiatry to medical understanding.

John MacDonald practiced and taught forensic psychiatry, mentoring residents in doing evaluations and testifying in psychiatric forensic cases. John Benjamin had been leading a child development research group in the Department for some time. The arrival of Rene Spitz in 1956 to pursue his groundbreaking studies of infancy here added depth and energy to the enterprise, which soon began attracting younger colleagues like Bob Emde, Ted Gaensbauer and others, to join and expand the effort further.

Brandt Steele and Henry Kempe initiated studies of abused infants and children in the late 1950's, culminating in their historic article in the Journal of the American Medical Association in 1962, on The Abused Child. It is difficult for us now to believe that for decades before that a child coming to an emergency room with bilateral long bone, skull, or rib fractures would be unquestioningly accepted as having suffered innocent household accidents. Their trail-breaking article, to be followed by many more articles and books on the subject, was honored in 1985 by inclusion in a Centennial volume entitled Landmark Articles in Medicine, as one of 50 articles representing the best of 100 years of JAMA articles in all fields of medicine.

All in all, in Colorado, as it was everywhere, those early years of the CPS were nodal times of transition, years of exciting change, discovery, maturation and development in psychiatry. Although the signs of ferment were evident, I don't know anyone who in 1956 would have predicted the availability fifty years hence of such developments as the sophisticated state of child research, the expanded range of psychoanalytic viewpoints, the variety of psychotherapeutic modalities, the nuanced array of psychotropic medications, or the technical advances such as real time functional brain-scanning that are matter-of-factly available to us in 2006.

*Dr. Jacobson is a CPS member with a psychoanalytic practice in Boulder.*

## The "Asylum"

By Irwin Levy, M.D.

The Colorado State Insane Asylum. That's what it was called back in 1879 when it first came into being. The name was finally changed in 1917 to the Colorado State Hospital. In 1991 it became the CMHIP (Colorado Mental Health Institute at Pueblo). I toured the Colorado State Hospital as a medical student in about 1959. Patients, or inmates, were used to visitors coming to look at them. I felt like a visitor at a zoo. Privacy? Where was HIPPA then?

My next encounter with the State Hospital occurred after my first year of residency when I went there to manage the ATC unit (Alcohol and Drug Treatment Program). That first day when I toured the unit was another history lesson for me because the ATC unit had formerly been the hydrotherapy unit and it was the first time I'd ever seen the water tubs.

Many of you have seen the old movie "The Snake Pit" with Olivia DeHavilland. It was an Academy Award winner, well worth viewing, showing the Asylums as they really were in those days. A more recent film, "One Flew Over the Cuckoos Nest" with Jack Nicholson, also shows the seamier side of state institutions. Now I'm not saying that our fine hospital in Pueblo was ever that bad; however, prior to 1962 the hospital operated, like most other state institutions, like a "holding facility" for the long term "treatment" of the mentally ill. It was centralized: patients would be brought into the hospital for an evaluation (the Front Wards), placed in a short term treatment unit, usually for ECT or Hydrotherapy (The Middle Wards), and then finally

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into the Back Wards where they could be housed for years or even life!

Then, in 1962, a major program change occurred. The Hospital geographically decentralized, reorganizing the patients within the hospital according to their county of residence. Staff was increased and was assigned to specific units for better continuity of care. To accomplish this monumental change, Leonardo Garcia Buenel was brought in from the Clarinda State Hospital in Kansas to be the assistant director. He had successfully accomplished the task of decentralization there, and it was called "The Clarinda Plan." Dr. Garcia, for you movie buffs, is the brother of the famous Spanish movie director Luis Buenel. The actual day that the move occurred, moving patients by buses from one unit to another, was a major undertaking as some of these patients had not left their wards for years! The residents of Pueblo were quite apprehensive as well, but the move went smoothly. Those changes, along with the advent of psychoactive drugs starting in 1950, specifically the phenothiazines and tricyclic antidepressants, allowed for many more patients to be adequately treated and ultimately moved back into the community.

In 1963, with the passage of the Community Mental Health Centers Act by Congress, federal funding began to pour into the states creating more community resources, which allowed more treatment in the local communities. In 1961, the State Hospital had reached an all time high of 6000 patients. The use of medications, the decentralization process, the creation of a second State Hospital facility on the grounds of Fort Logan, and, most significantly, the rise of treatment programs in the community, has dramatically reduced the census. Today, the average census at CMHI-P is 380 patients.

*Dr. Levy is a Past President of CPS (1982-1983).*

# The History of the Ethics Committee

By Joseph Jensen, M.D.

As we celebrate the 50th anniversary of CPS, Claire Zilber suggested an article on how the Ethics Committee came about. At this point in time it is hard to realize that for years we functioned without one. We were not able to come up with the answer locally as to what led up to my being appointed as the first Chair of the committee. Laura Michaels was able to obtain the answer from APA Headquarters. Dr. Walter Barton, Past President and Medical Director of APA wrote a book on The History and Influence of the APA. In the book he says:

"The agenda items on policy concerned with moral, and ethical conduct of members led to the recommendation that APA issue Ethical Guidelines and investigate complaints; a hearing was to be the responsibility of the local District Branch, with an appeal mechanism to a national Ethics Committee. The third Trustees Policy Meeting also reaffirmed APA adherence to the AMA Code of Ethics. The Principles of Medical Ethics, with Annotations Especially Applicable to Psychiatry, was issued by the APA in 1973. It detailed the procedures to be followed. The pamphlet was disseminated to the membership, to educate the field in using the mechanism when appropriate. Interest in ethical matters accelerated, as did the number of ethical complaints."

It thus seems that during the CPS Presidency of Dr. Charles Oppegard, who was President 1973-5, I was appointed the first Ethics Chair. Dr. Barton was right in saying that once the committee was appointed we were more aware of complaints and dealt with them. In the 1970s, Boards of Medical Examiners were not doing as good a job as they now are in dealing with ethical violations of its members. This meant many violators were not called to account for their behavior.

Committee chairs who followed me were: Dr. Jeremy Lazarus, then Dr. David Wahl, then Dr. Harriet Stern and at present, Dr. Claire Zilber. Drs. Lazarus, Wahl, and Stern have all served on the APA Ethics Committee.

The Ethics Column by Claire Zilber in the

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December issue of the CPS Newsletter describes how far our professional ethics committees have come. At the APA workshop in Washington they discussed the ethical issues in torture, the issues involved in "curing" homosexuals, and principles of confidentiality and consent to treatment for children and adolescents. These are great examples of the maturing of the Ethics Committee since its inception in 1973.

*Dr. Jensen is a former Chair of the Ethics Committee and currently Chair of the CPS History & Archives Committee. He is also a Past President of CPS (1966-1967).*

# A 35 Year History of Behavioral Health Services at Denver Health

By Edmund Casper, M.D.

When I joined the faculty at Denver Health in 1971, it was a time of great optimism. The Psychiatry Service was flourishing at that time. It was during the deinstitutionalization for the treatment of the chronic mentally ill, moving these patients from state hospitals to the community. After the passage of the Mental Health-Mental Retardation Bill under President Kennedy, Denver had been divided by the Federal Government into four geographic catchment areas. The planning at the Federal Government level was that there would be areas of a manageable size of 75,000 to 90,000 people, for whom there would be a Community Health Center to take care of mental illness. Denver Health was assigned to the northwest quadrant of Denver as a community health center, known as The Northwest Mental Health Center.

The Federal Mental Health Program provided for several different types of grants for the mentally ill. There were construction grants which provided funds to build Mental Health Centers, and Staffing Grants for funding staffing programs.

Denver Health received a grant which supported the construction of the 3rd, 4th, and 5th floors of the Denver Health Hospital, which opened in April of 1971. This space continues to be utilized for psychiatric services.

During this same time, Denver General was also awarded three staffing grants for the treatment of acute psychiatric emergencies, for outpatient mental health services, and drug and alcohol treatment including the treatment of heroin abusers with methadone.

At the time that I joined Denver Health in 1971, there was a small faculty of five psychiatrists, and Denver Health unfortunately had no relationship with the University of Colorado Health Sciences Center, Colorado Psychiatric Hospital, or the Department of Psychiatry in the University of Colorado Medical School. On my first day of work, the manager of Health and Hospitals was forced to resign.

I was hired at Denver Health as the team psychiatrist of an outpatient mental health clinic, located in the Westside Health Center, which is now the Sam Sandos Health Center. The team that I worked on had a psychiatrist, psychologist, mental health counselors, social workers, a child treatment team, and polysubstance treatment counselors. Unknown to me and prior to my employment, there was much turmoil in the Department of Psychiatry, which included Psychology, despite there being a large amount of resources. In the next six to eight months, both the Director of Psychiatry and the Director of the Mental Health Center were forced to resign. The jobs were combined and I was appointed as the Acting Director of both. There was a national search that was unsuccessful due to the instability of the department. When I was appointed the Director of Psychiatry in 1973, the two jobs were permanently combined.

Even then, Denver Health had an active Emergency Department with many psychiatric emergencies. A grant was awarded for Psychiatric Emergency Services, which was built around a core of psychiatric nurses. At that time recruiting experienced psychiatrists, or any psychiatrists, was difficult, so we had limited psychiatric attending time allowed to that service and most of the consultation by attendings was by phone. During the daytime hours if a psychiatrist was available, they would do face-to-face evaluations. The length of stay at that time on our inpatient service was seven days, with a quick transfer of our patients who needed treatment for psychosis or longer term treatment to Ft. Logan.

Denver Health had a Psychiatric Training Program for psychiatric interns, which was then six months of inpatient psychiatry, and six months of other medical rotations. It was very difficult to recruit psychiatrists to join the faculty. It was also

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difficult to have a training program without adequate attending staff.

The Medical Director of Denver Health, the Training Director of University of Colorado's Residency Training Program, and the training program at Ft. Logan entered into negotiations and meetings over training of psychiatric residents in the state of Colorado. The Governor had appointed a committee to study how psychiatrists should be trained in Colorado. The decision was made to combine all the residency treatment programs in Colorado into a single program with the VA, University of Colorado Department of Psychiatry, Denver Health Department of Psychiatry, and the training programs at both Ft. Logan and Pueblo. The first resident rotation at Denver Health was in 1975. This has grown into an active established training program with the three major rotations and partners continuing to be the Colorado Psychiatric Hospital, Denver Health and the VA, as well as the Colorado Mental Health Institutes of Pueblo and Ft Logan.

There have been major developments in the establishment of a Psychiatric Emergency Service with renovations of the Denver Health Emergency Departments and expansions through bond issues voted by the people. Through those monies there was an establishment of a specific geographic area within the emergency department for an emergency psychiatric service. This has grown, through multiple renovations, to be a locked, self contained unit with six observation beds. The emergency psychiatric volume has grown to 7,000 per year and includes provision of 1,500 Mental Health Hold evaluations per year. The service is now staffed with attending psychiatrists who are on duty from 7 am until 10 pm with the goal being either attending or senior resident coverage for the Psychiatric Emergency Department.

So the expansions of emergency inpatient training and outpatient facilities as well as drug and alcohol treatment programs were proceeding. There were mental health teams at the Westside Health Center, the Eastside Health Center, the northwest quadrant of Denver, Gilpin Street Clinic, as well as a large program on Broadway at the Broadway Center, which was a daycare program. Rehabilitation programs expanded rapidly with the decriminalization of public inebriation. A program was instituted for a non-hospital detoxification center, Denver CARES, which is a 100 bed detoxification center, in the heart of the Golden Triangle at 10th and Cherokee.

Funding for the national community health centers programs decreased under the new presidents in the 70's. Denver attempted to gain increased state funding, but was unsuccessful. Money going to Denver Health was reduced because of the fiscal crisis in the city. In 1981, there were major layoffs at Denver Health, particularly in outpatient mental health and the community programs, because the city felt that the state should be funding these programs as they were funding them throughout the state. There were major reductions in the mental health program in terms of two community mental health facilities and the daycare facility as well as the rehabilitation programs. There were also reductions in the methadone treatment programs, whose three clinics were reduced to one.

These reductions triggered a class action suit filed on behalf of the citizens, representing those with mental illness and addictions. The class action addiction lawsuit did not go far, but the mental health class action suit which is the now infamous Goebel lawsuit (named after a mentally ill woman who died homeless on the streets of Denver) proceeded. Several years later the first settlement of the lawsuit occurred and included an agreement that the Northwest mental health center would no longer be operated by Denver Health and instead would be taken over by a community group.

Shortly thereafter, a mental health task force, appointed by Mayor Pena, was funded by a Robert Wood Johnson Grant. This grant brought together a group of national experts who advised Denver on how to structure its community mental health programs. This resulted in the combination of the four Community Mental Health Centers into one organization that supplied services to the entire city, the Mental Health Corporation of Denver, now the Mental Health Center of Denver, which is governed and operated by a board appointed by the Mayor and independent of Denver Health and Hospital Authority.

The Behavioral Health Department of Denver Health then focused on the areas of emergency treatment of alcohol, drug and psychiatric patients, acute inpatient treatment of psychiatric and substance abuse patients, and the training of psychiatric residents and psychologists. As the training programs grew, Denver Health achieved an accredited Psychology Internship Program in 1984, which continues in the training of psychologists today. Denver Health played a prominent role in the continued training of psychiatric interns

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and residents. The inpatient service increased to thirty-eight acute inpatient psychiatric beds as well as eight medical detox and rehabilitation beds. The combined psychiatric training program achieved an approved psychiatric fellowship in addiction psychiatry under the program director at Denver Health. Denver Health established a twelve-bed inpatient adolescent unit for adolescents between the ages of ten and eighteen with a rotation for psychiatric child fellows.

The need for crisis intervention for acute psychiatric, drug and alcohol related problems continued to grow. There was a transition period where there was an acute crises unit which eventually became a part of a combined alcohol, drug, and psychiatric emergency service. The service continues to be located adjacent to and is part of the emergency department of Denver Health and Hospitals. The need for staffing emergency psychiatry continued to grow, and three attendings were hired to staff the Psychiatric Emergency Department.

The inpatient service continued to grow: there are now six full-time attendings on the inpatient psychiatric and addiction services. The outpatient community programs and consultation services continued to expand to meet the growing need for substance abuse treatment. The program continues to provide over 300 methadone treatment slots, and has just concluded a five-year grant to treat substance abuse with buprenorphine. The Outpatient Substance Abuse Treatment Program treats over 10,000 patients a year.

Denver Health Psychiatry expanded to a consultation program for the inpatients on the medical units, as well as an outpatient consultation at the Eastside and Westside Clinics. Denver Health's role in outpatient treatment of mentally ill patients is limited to the Denver Health Medical Plan patients, which is one of the plans available to city employees. Mental health outpatient visits increased to over 11,000 visits per year. The Child and Adolescent Outpatient Services continued to expand and accounts for the majority of the outpatient psychiatric visits. Over the last three years the training of psychiatric residents in the outpatient clinics was instituted, with now six residents being assigned to outpatient rotations. The number of psychiatrists has grown to seventeen full-time psychiatrists with the training Director of the Psychiatric Addiction Service being a faculty member of Denver Health. The number of attendings with postgraduate training in Addictions and Forensics has grown to six. The number of psychologists has grown to ten including a neuropsychologist.

In summary, the number of changes in the last thirty-five years is astounding given the role of Behavioral Health in emergency psychiatry, acute inpatient treatment, and the substance abuse programs, and given the decline in the number of psychiatric hospital beds and the decline of treatment of the mentally ill in the City and County of Denver. It has been my good fortune to have been able to be a part of the growth and the prominence of Behavioral Health and to have served the people of Denver for the past thirty-five years.

*Dr. Casper is a CPS member and recently retired from Denver Health Medical Center.*

## CPS Member Recognized as "Hero in the Fight"

At a special meeting in December, NAMI Colorado gave an award to **Richard Warner, M.D.** for his fight for treatment of people with severe and persistent mental illness. From the man who nominated him:

I speak…as the father of a son who was given back to his mother and me by Dr. Warner. The medical profession seemed to have given up on our son because of his physical and mental problems. He ultimately became bedridden with a gastric feeding tube. Today our son is employed and back in graduate school. Of course, others helped, but it was clearly Dr. Warner's understanding and leadership that produced what family and friends now refer to as a miracle.

Dr. Warner recently retired after 09 years as Medical Director of the Boulder County Mental Health Center. He set up the Iris Pharmacy, employing people with mental illness as pharmacy technicians, as well as other client employment programs including a property repair team. In addition, Dr. Warner was instrumental in the PACE Program, an innovative multi-agency jail-diversion program for people with mental illness. Several other successful programs were launched by Dr. Warner who also is the author of five books on schizophrenia and community psychiatric care which have been translated into seven languages. Congratulations to our colleague for this recognition.