

## Medicaid in State Hospitals

*To the Editor:* In the article in the March issue on changing characteristics of schizophrenic patients admitted to state hospitals, the conclusions drawn by Thompson and associates (1) are weakened considerably by a significant oversight involving the funding of care in state psychiatric hospitals.

By law, Medicaid will not reimburse freestanding psychiatric hospitals for care provided to patients between the ages of 21 and 64. Therefore, the low percentages of state hospital care funded by Medicaid are not a result of a deteriorating economic situation for patients but rather reflect current constraints on reimbursement. Had this same patient population been treated in general-hospital-based psychiatric units that do receive Medicaid reimbursement for the 18-to-21 age group, the percentage of patients covered by Medicaid might be up to four times higher.

My conclusion is that rather than pour additional funding into antiquated institutions, we should promote downsizing of state facilities through the aggressive development of smaller community-based psychiatric units in local general hospitals. Such units can provide better-quality care, help keep the patient closer to home, and expand the use of partial hospitalization. They can improve the financial situation at the state level by reducing the cost of operating state hospitals while increasing the amount of federal Medicaid matching funds flowing into the state and to the general hospitals (2).

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## References

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2. Morrison WF, Prehn RA: A Win-Win Proposition: Rural Hospitals and Psychiatric Services. Raleigh, NC, North Carolina Hospital Association, Jan 1993

*In Reply:* In our article we used no-pay status as a proxy for medical indigence. No-pay status increased among both white and African American state hospital patients with a diagnosis of schizophrenia over the time period studied. Our conclusions are based in part on this information. The proportional use of Medicaid changed little, and Medicaid use was not the basis for any of our conclusions.

As for Dr. Prehn's conclusions, we have no problem with the use of general hospital units and day treatment facilities for the treatment of schizophrenia. Our point was that schizophrenic patients admitted to state hospitals are increasingly medically indigent. At the same time, indigent schizophrenic patients in other types of hospital are few in number. (Eighty-nine percent of no-pay schizophrenic patients are admitted to state hospitals.) When general hospitals are more willing to admit indigent schizophrenic patients, a discussion about further downsizing state hospitals might be appropriate. We also take exception to Dr. Prehn's assertion that the care in general hospitals has been shown to be of higher quality. Work demonstrating the accuracy of this statement has yet to be done.

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## Drug-Induced Mania

*To the Editor:* We were greatly interested in a report recently published elsewhere about drug-induced mania in obsessive-compulsive patients (1). During the last year we observed drug-induced mania in some patients treated with clomipramine, fluoxetine, and fluvoxamine in our Obsessive-Compulsive Disorder Center in Milan.

Comorbidity appears to be important in the development of this complication. The frequent co-occurrence of affective syndromes, of a positive family history for mood disorder, or both (2) suggests that these

are risk factors for developing manic or hypomanic symptoms.

Our observations indicate a definite temporal relationship between obsessive-compulsive and manic symptoms; the development of hypomanic or manic symptoms follows the progressive reduction of obsessive-compulsive symptoms. Moreover, the assessment of obsessive-compulsive patients for personality disorders revealed the presence of borderline personality disorder in 3.3 percent of such patients (3). When these patients were treated with proserotonergic antiobsessional drugs, they experienced reduced impulse control, dysphoria, and increased aggressiveness and reckless acts, symptoms similar to those found in mania.

In obsessive-compulsive patients with borderline personality disorder, psychomotor activation appears in the first weeks of treatment, before obsessive symptoms are reduced, and the clinical picture is characterized by expansive mood with claiming ideation, recurrent episodes of reduced impulse control, and loss of insight. Obsessions and compulsions remain unchanged, with a worsening of global functioning.

We agree with Stein and associates' suggestion (4) that the syndromes described are the phenomenological expression of a serotonergic dysfunction, even though data about biological and clinical correlates of serotonergic function deficit seem to be contradictory. Although reduced impulse control and aggressiveness have been explained as consequences of a serotonergic deficit, treatment with proserotonergic agents seems, in our clinical observation, to worsen these symptoms, at least in patients with obsessive-compulsive disorder.

Considering the clinical characteristics of the antidepressant-induced symptoms observed, we treat such symptoms with carbamazepine (5) or lithium. For patients who seem to be at risk of developing hypomanic or manic symptoms because of previous affective episodes or family history and personality profile, pharmacological management involves a slower increase of the dosage of proserotonergic antidepressants, combination of such drugs with stabilizing

agents from the beginning of treatment, or use of both approaches.

Systematic investigations are needed to confirm that the presence of borderline personality disorder in obsessive-compulsive patients predisposes such patients to antidepressant-induced side effects and to identify other factors.

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## Drug Use by Day Patients

**To the Editor:** The report by Cohen and Henkin (1) in the February issue on the prevalence of substance abuse by seriously mentally ill patients in a partial hospital program encouraged me to look at my own day treatment program at the Walter P. Carter Center, a small state hospital in inner-city Baltimore. The hospital serves a socially disadvantaged catchment area that appears to be similar to the one described by the authors in inner-city Philadelphia.

Out of a total of 42 active patients in the day treatment program, I reviewed the charts of 28 patients whom I had personally examined, or 66 percent. Fourteen of the 28 pa-

tients were men and 14 were women. They ranged in age from 24 to 63 years, with mean age of 39.4. Fifty-four percent were African American, 54 percent had completed the 12th grade, and 54 percent had been jailed at least once. All were unemployed. All had been hospitalized for psychiatric disorders, most within the last six months.

Twenty-four of the 28 patients, or 86 percent, had psychotic diagnoses based on DSM-III-R criteria. Of these patients, ten had a diagnosis of schizophrenia, eight of schizoaffective disorder, four of bipolar disorder, and one each of major depressive disorder with psychotic features and psychotic disorder not otherwise specified.

Four patients had nonpsychotic diagnoses; three had dysthymic disorder and one had multiple personality disorder with affective symptoms. Although none of the patients had a diagnosis of personality disorder alone, 13 had a personality disorder accompanied by another disorder, and in five patients personality disorder was very prominent.

Sixteen of the 28 patients, or 57 percent, were also substance abusers. Alcohol, by far the most common substance of abuse, was the preferred or only drug of 12 of the 16 patients. Six of the 16 patients used a variety of substances, including alcohol, marijuana, opiates, cocaine, and inhalants.

Cohen and Henkin (1) found that age and diagnosis were significant in differentiating substance users from nonusers. In this sample, which was older than theirs and had a higher proportion of women, gender and diagnosis predicted substance abuse. Thirteen of the 14 men were substance abusers, compared with three of the 14 women. Half of the 24 patients with psychotic diagnoses were substance abusers, as were six of the eight patients with mood disorder (bipolar, major depressive, or dysthymic disorders).

Ten of the 13 patients with any personality disorder, four of the five patients with very prominent personality disorder, and all four of the patients with nonpsychotic disorders were substance abusers. Therefore,

although substance abuse was prominent across diagnoses, these data corroborate Cohen and Henkin's findings that substance abusers tend to have diagnoses of either personality disorder or affective disorder.

These data also confirm Cohen and Henkin's findings that "a significant number of patients who attend partial hospitals in urban areas could also be abusing street drugs and alcohol." We have tried to meet this challenge by integrating the hospital's addictions services program into our day treatment program.

Our program is flexible enough that drug abusers can participate in substance abuse groups and in individual addictions counseling. They can also attend Alcoholics Anonymous and Narcotics Anonymous meetings in the building and the community. Breath analysis tests and urine drug screens are done routinely on some patients. Disulfiram is used selectively. Contacts with outside sources of information, such as family members or other care providers, are pursued. The patient government places sanctions on patients who attend the program when intoxicated. Problems certainly remain, such as the occasional need for acute detoxification and residential rehabilitation beds. It is difficult but clearly important to consider both the individual needs of certain patients and the needs of a program that serves a diverse group.

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## Reference

1. Cohen E, Henkin I: Prevalence of substance abuse by seriously mentally ill patients in a partial hospital program. *Hospital and Community Psychiatry* 44:178-180, 1993

## Hospitalphilia

**To the Editor:** Geller's approach (1) to the treatment of revolving-door patients with "hospitalphilia," described in the February issue, has much to offer. If we believe that patients can help themselves improve, why do we reject the notion that they