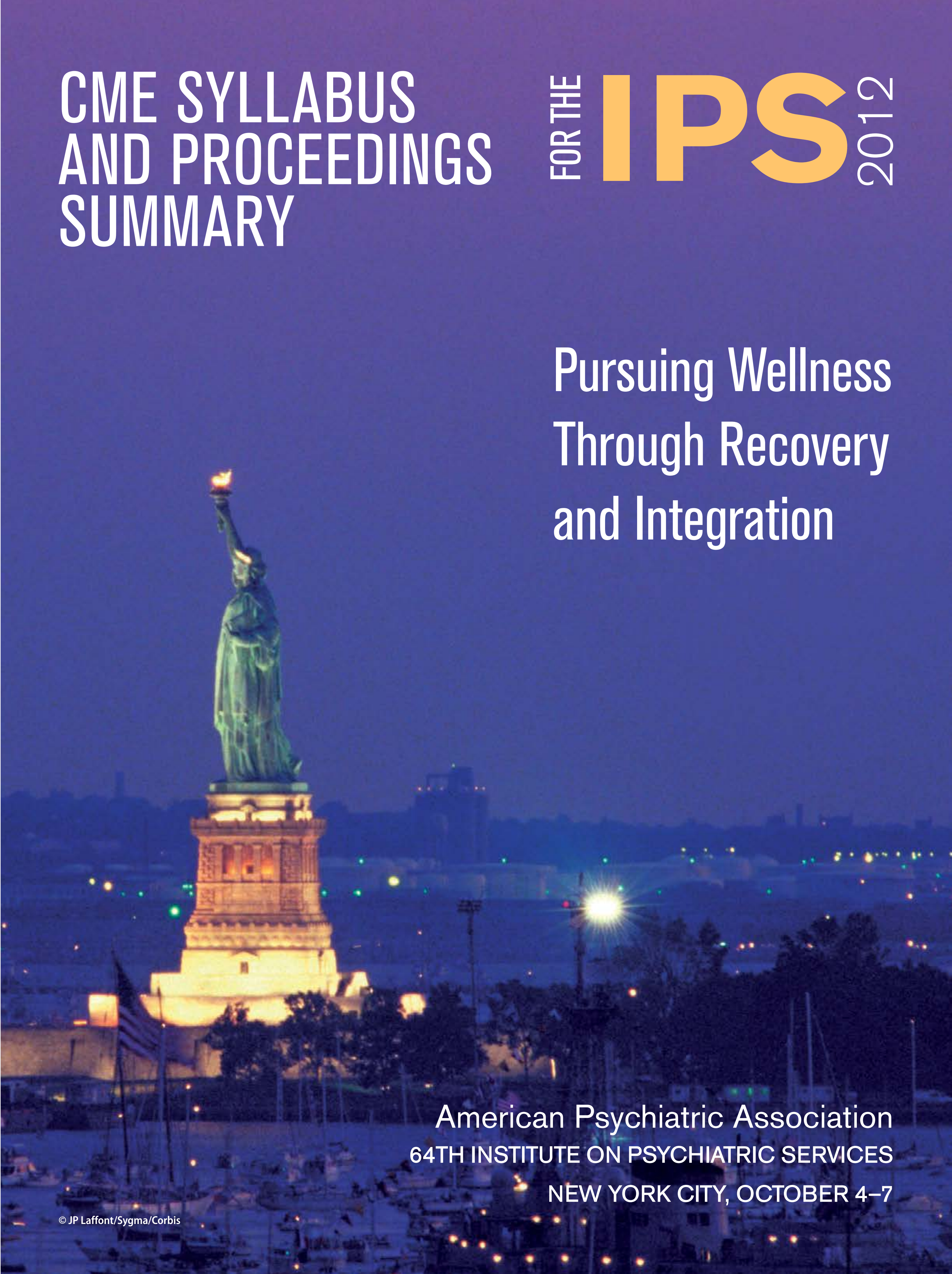
CME SYLLABUS AND PROCEEDINGS SUMMARY

FOR THE IPS 2012

Pursuing Wellness Through Recovery and Integration



American Psychiatric Association
64TH INSTITUTE ON PSYCHIATRIC SERVICES
NEW YORK CITY, OCTOBER 4–7

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CONTINUING MEDICAL EDUCATION

2011 CME Syllabus AND Proceedings Summary

FOR THE

64th Institute on Psychiatric Services

October 4–7, 2012
New York City

64th
Institute on
Psychiatric
Services

APA's Leading Educational
Conference on Public, Community,
and Clinical Psychiatry

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American Psychiatric Association
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64th Institute on Psychiatric Services

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64th Institute on Psychiatric Services
APA's Leading Educational Conference on Public, Community, and Clinical Psychiatry

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CE Credits for Other Disciplines

Conference Objectives

The conference objectives, of the **2012 Institute on Psychiatric Services**, are:

1.) To present the most current clinical information on severe mental illness - diagnosis and treatments;
2.) To identify and improve mental health disparities in the community;
3.) To demonstrate and apply new skills that will be useful in public psychiatry settings;
4.) To examine how the current health care system affects patient care;
5.) To learn about clinical innovations to improve patient care.

Target Audiences

Psychiatrists and Other Physicians; Administrators and Managers; Advocates and Policymakers; Addiction Counselors; Consumer and Family Members; Educators, Faculty, and Training Directors; Medical Students and Residents; Nurses; Planners, Researchers, and Evaluators; Psychologists; Counselors; and Social Workers.

Continuing Education Credits for Psychologists, Social Workers, Nurses, Counselors, Etc.

Accreditation Statement:

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Drexel University College of Medicine and the American Psychiatric Association. The Drexel University College of Medicine is accredited by the Accreditation Council for Continuing Education to provide continuing education for psychologists, social workers, nurses, counselors, and members of the International Association for Continuing Education and Training (IACET).

Please note that we are offering CE/CEU credits for only the following formats: Immersion Courses, Innovative Programs, Lectures, Symposia, and Workshops. If you are interested in earning CE credits for this conference, please go to the CME Certificate of Attendance booth located in Golden Gate, C1, Upper B2 Level to fill out evaluation forms or each session attended that offers CE/CEU credit (see list above). Attendees should only claim credit commensurate with the extent of their participation in the activity. Maximum CE credits allowed are 27 and 3.2 CEUs for IACET.

APA (Psychology):

Drexel University College of Medicine, Behavioral Healthcare Education, is approved by the American Psychological Association to offer continuing education for psychologists. Drexel University College of Medicine, Behavioral Healthcare Education maintains responsibility for this program. This program is being offered for up to 27 hours of continuing education.

ASWB (National Social Work):

Behavioral Healthcare Education, provider #1065, is approved as a provider for social work continuing education by the Association of Social Work Boards, www.aswb.org, phone: 1-800-225-6880, through the Approved Continuing Education (ACE) program. Behavioral Healthcare Education maintains responsibility for the program. Social workers will receive a maximum of 27 continuing education clock hours for participation in this course.

NAADC (National D&A):

This conference has been approved by the National Association of Alcoholism and Drug Abuse Counselors for a maximum of 27 educational hours. NAADAC Approved Provider #000125.

NBCC (National Counselors):

Drexel University College of Medicine is recognized by the National Board of Certified Counselors to offer continuing education for National Certified Counselors. We adhere to NBCC continuing education guidelines and can award a maximum of 27 hours of continuing education credit for this program.

PA Nurses:

Drexel University College of Medicine, Behavioral Healthcare Education is an approved provider of continuing nursing education by the PA State Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. Participants will be awarded a maximum of 27 contact hours for attending this program.

CEUs for all others:

Drexel University College of Medicine, Behavioral Healthcare Education has been approved as an Authorized Provider by the International Association for Continuing Education and Training (IACET), 8405 Greensboro Drive, Suite 800, McLean, VA 22102. In obtaining this approval, Drexel University College of Medicine, Behavioral Healthcare Education has demonstrated that it complies with the ANSI/IACET Standards which are widely recognized as standards of good practice internationally. As a result of their Authorized Provider membership status, Drexel University College of Medicine, Behavioral Healthcare Education is authorized to offer IACET CEUs for its programs that qualify under the ANSI/IACET Standards. Drexel University College of Medicine, Behavioral Healthcare Education is authorized by IACET to offer 3.2 CEUs for this program.

The American College of Nurse Practitioners (ACNP) and the American Academy of Physician Assistants (AAPA) accept AMA/PRA category 1 credit from other organizations accredited by the ACCME.

Disclosure Statement: All faculty and program planners participating in continuing education activities sponsored by the American Psychiatric Association and Drexel University College of Medicine are required to disclose to the audience whether they do or do not have any real or apparent conflict(s) of interest or other relationships related to the content of their presentation(s).

64th
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Conference on Public, Community,
and Clinical Psychiatry

Mission Statement

Vision, Mission, Values, And Goals
of the
Institute On Psychiatric Services

VISION

The Institute on Psychiatric Services (IPS) of the American Psychiatric Association is a yearly educational meeting which focuses on the needs of the most vulnerable, disenfranchised, and difficult-to-serve patients.

MISSION

The mission of the IPS is to train and support psychiatrists to provide quality care and leadership through study of the array of clinical innovations and services necessary to meet the needs of individuals who suffer from serious mental illness, substance abuse, or other assaults to their mental health due to trauma or adverse social circumstances, in order to assure optimal care and hope of recovery.

VALUES AND GOALS

To fulfill this mission, the IPS holds an annual meeting each fall that focuses on clinical and service programs, especially those that provide a complex array of services and clinical innovations to meet the needs of the most difficult-to-serve patients. Such programs constitute the continuum of care, from state and general hospitals to community-based drop-in centers, and attempt to meet the needs of persons living in rural communities, as well as the urban poor. The focus on more difficult-to-serve patients requires attention to the social and community contexts in which these patients are treated and reside. Contextual issues must be addressed because they operate as significant variables in the course of the psychiatric illnesses of certain patient populations such as those with severe and persistent mental illness, members of minority groups and those suffering economic hardships, most children and adolescents, the elderly, patients living in rural communities or in communities of immigrants, and patients treated in settings for physically or intellectually disabled individuals.

The IPS, therefore, fosters discussions of such issues as housing and vocational rehabilitation equally with innovative psychological treatments and pharmacotherapy. The clinical focus of the IPS is on innovations and adaptations of proven therapies as they are applied to the more difficult-to-serve populations. The IPS also serves as a forum for discussing systems of care, quality management, government policy, and social and economic factors as they have an impact on the most vulnerable patients.

The mission of the IPS is of particular significance to an important subset of APA members who are its prime constituents. This includes psychiatrists who identify themselves as in community practice, those involved in teaching community practice, those who serve in the public sector, such as staff working in state, community, and Veterans Affairs hospitals, community clinics, jails, or other community agencies, psychiatric administrators and those with a particular interest in the social issues that have an impact on patients. It is a goal of the IPS to provide a venue for relevant scientific programs that will retain such psychiatrists as valued members of the APA and attract colleagues who are not yet members. The IPS functions as a prime APA service to these important, devoted, and often isolated colleagues, many of whom are psychiatrists of color or international medical graduates. It is the goal of the IPS to reach out and encourage these psychiatrists to join the APA and attend this meeting. In turn, the APA will strive to ensure that the IPS serves as a professional home for these groups of colleagues.

Serving the populations that have been identified as the focus of the IPS involves collaboration with a wide variety of other professionals as well as with consumers, family members, and advocates. Therefore, an important part of the mission of the IPS is to encourage interdisciplinary and family member participation. Indeed, this mission has been an organizing principle of the IPS since its inception. Efforts will be made to further reach out to families, consumers, and allied professionals in the communities where meetings are held, and attention will be paid to ensuring their access to the IPS. The IPS is supportive of allied psychiatric organizations who share a similar vision and mission for which the IPS can serve as a scientific venue. It is part of the mission of the IPS to meet the needs of such allied groups for meeting times and space.

COURSES

COURSE 1

Thursday, October 4; 8:00 a.m.–12 Noon

Emergency Psychiatry: A Contemporary Paradigm From Theory to Practice

Faculty: Anthony Ng, M.D., Jon S. Berlin, M.D., Jodi S. Lofchy, M.D., Leslie Zun, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Identify the history of the development of Psychiatric Emergency Services (PES); 2) Recognize unique clinical needs to the care of psychiatric patients in the emergency setting; 3) Identify challenges to incorporating and integrating psychiatric care in the emergency setting; 4) Identify a paradigm to develop PES in collaboration with emergency medicine and 5) Incorporate identified strategies into the ongoing quality matrix.

Overall Summary: There has been an increase in the number of patients presenting to emergency rooms in recent years as community mental health resources have dwindled. Many of these patients present with self injurious behavior, anxiety, depression, substance abuse issues and behavioral disturbances. Additionally, many psychiatric patients also have significant medical co-morbidity. As a result, patients are facing increased wait time in the emergency rooms, overcrowding in the emergency room, risks of further decompensation, as well as overall care that can be compromised. A dedicated psychiatric emergency subspecialty has emerged to help address some of the unique clinical concerns regarding the care of psychiatric patients in crisis. In response to the increase in psychiatric demands in the emergency setting, Psychiatric Emergency Services (PES) have been developed to meet these demands. Psychiatric care in PES has shifted from a triage model to one of treatment. The goals of PES have included decreased wait times for emergency patients, less use of chemical restraint and decreased hospital admissions as well as improved consumer satisfaction. However, there are currently no standards or guidelines to how to create a PES that can address the needs of the patients.

In this course, using a didactic approach and audience participation, a diverse panel of PES and emergency medicine clinicians will provide a background to the development of emergency psychiatry as a field. Additionally, various types of services that should be part of a PES will be identified from triage to treatment. The panelists will use many of their experiences to identify some of the unique challenges as well as strategies to developing a PES in close collaboration with emergency medicine colleagues. Lastly, an example of a PES that was developed at Toronto University Health Network (UHN) will be highlighted to show how some of the principles strategies presented earlier in the course. Active and dynamic exchanges will be strongly encouraged throughout the course between the panelists and the attendees. The attendees will be strongly encouraged to share their experiences. At the end of the course, the attendees will recognize better some of the unique clinical needs and challenges that are confronting emergency psychiatric care in community mental health.

COURSE 2

Thursday, October 4; 1:00 p.m.–5:00 p.m.

Culturally Appropriate Assessment Revealed: The DSM-IV-TR Outline for Cultural Foundation Demonstrated With Videotaped Case Vignettes

Faculty: Russell F. Lim, M.D., Francis Lu, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Describe interviewing techniques to assess the various aspects of cultural identity after assessing their own, and viewing videotaped interviews using the DSM-IV-TR Outline for Cultural Formulation; 2) Describe methods to elicit the cultural explanation of the individual illness or explanatory model after a discussion of the different types of explanatory models and viewing a videotaped vignette; 3) Describe methods to elicit the stressors and supports of a patient by using a focused developmental and social history; 4) Discuss and identify ethnocultural transference and countertransference after discussing a journal article and viewing videotaped vignettes of patients and therapists experiencing both phenomenon and 5) Describe how to formulate a case with the differential diagnosis and how to negotiate a treatment plan with a patient after watching and discussing a videotaped vignette of a summarizing statement of an interview.

Overall Summary: Being able to perform a culturally competent assessment is a skill required by current RRC Accreditation Standards, including the ACGME core competencies for all graduating psychiatric residents. In addition, the U.S. Census Bureau has predicted that by 2025, Latinos will represent the majority population in California, Arizona, New Mexico and Texas and 33% of all U.S. children. In addition, the Institute of Medicine's report, "Unequal Treatment: What Health Care Providers Need to Know About Racial and Ethnic Disparities in Healthcare," showed that patients belonging to minority populations received a lower level of care than mainstream patients, when matched for insurance status. The Supplement to the Surgeon General's Report on Mental Health, entitled "Mental Health: Culture, Race and Ethnicity, "stated that "culture counts," and that patients belonging to minority populations had less access to care, Working with these patients requires clinicians to transform an awareness of the cultural differences between the clinician and patient into a cultural formulation that will allow both to understand each other better and to improve the patient's mental health care. The DSM-IV-TR Outline for Cultural Formulation (OCF) is an excellent tool for the assessment of culturally diverse individuals, broadly defined to include ethnicity, culture, race, gender, sexual orientation, religion and spirituality, socioeconomic status, and age, and has been included in the DSM-IV since 1994. In addition, the OCF was included in the 2006 APA Practice Guidelines on the Psychiatric Evaluation of Adults, Second edition. The course will also present Hay's ADDRESSING framework, used to assess cultural identity, Arthur Kleinman's eight questions to elicit an explanatory model, and the LEARN model to negotiate treatment with patients. Attendees of the course will learn how to assess their own and their patient's cultural identities, and how the ethnicity and culture of the clinician and patient affects transference and counter transference. Clinicians require culturally informed skills to accurately evaluate culturally diverse individuals so as to diagnose and treat them both appropriately and effectively. The course will teach clinicians specific skills for the assessment of culturally diverse patients. Participants will participate in a small group exercise on their own cultural identities, and then will view mini lectures on the five parts of the DSM-IV-TR Outline for Cultural Formulation, as well as instruction on interview skills, supplemented by the viewing of taped case examples. Discussion of the case vignettes will enable attendees to gain an understanding of the skills demonstrated in the videotaped vignettes. Participants will be encouraged to share their own approaches, and then modify their approaches based on material presented in the course.

COURSE 3

Friday, October 5; 8:00 a.m.–12 Noon

Primary Care Updates for Psychiatrists

Faculty: Lori Raney, M.D., Robert M. Schiller, M.D., Erik R. Vanderlip, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand the best practices for treating hypertension, diabetes and dyslipidemias; 2) Design treatment algorithms that may be useful in individual practice and 3) Comprehend limitations and liability concerns in providing treatment of chronic illnesses.

Overall Summary: Patients with serious mental illnesses have 25 years of reduced life expectancy due primarily to preventable causes that lead to cardiovascular disease. The top risk factors for this are: high cholesterol, hypertension, diabetes, obesity and smoking. It is well known that patients with SMI have difficulty accessing primary care services and even if available, often lack the perceived need to pursue care. It is also known they receive most of their care in CMHC settings were a level of trust is developed with both their psychiatrist and other treatment team members.

Models are developing to bring primary care services into mental health centers and to use primary care consultants to enhance care in "medical home" models. Community psychiatrists are beginning to find themselves in positions where they may be supervising PCPs, desiring to provide some primary care treatment themselves, reviewing data on medical outcomes other than mental health and other projects that may feel out of the scope of practice. To enhance these experiences, this Course aims to provide updates and treatment guidelines on the management of common medical problems including diabetes, hypertension and dyslipidemias in addition to other topics.

COURSE 4

Friday, October 5; 8:00 a.m.–5:00 p.m.

Buprenorphine and Office-Based Treatment of Opioid Dependence

Faculty: John Renner, Jr., M.D., Petros Levounis, M.D., Laura McNicholas, M.D., Ph.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Identify the clinically relevant pharmacological characteristics of buprenorphine; 2) Describe the resources needed to set up office-based treatment with buprenorphine for patients with opioid dependence and 3) List three factors to consider in determining if the patient is an appropriate candidate for office based treatment with buprenorphine.

Overall Summary: The purpose of the course is to provide information and training to participants interested in learning about the treatment of opioid dependence, and in particular physicians who wish to provide office based prescribing of the medication buprenorphine for the treatment of opioid dependence. Federal legislative changes allow office based treatment for opioid dependence with certain approved medications, and Food and Drug Administration (FDA) approved buprenorphine for this indication. The legislation requires a minimum of eight hours training such as the proposed course. After successfully completing the course, participants will have fulfilled the necessary training requirement and can qualify for application to utilize buprenorphine in office-based treatment of opioid dependence. Content of this course will include general aspects of opioid pharmacology, and specific aspects of the pharmacological characteristics of buprenorphine and its use for opioid dependence treatment. In addition, other areas pertinent to office based treatment of opioid dependence will be included in the course (e.g., non-pharmacological treatments for substance abuse disorders, different levels of treatment services, confidentiality). Finally, the course will utilize case-based, small group discussions to illustrate and elaborate upon points brought up in didactic presentations.

COURSES

COURSE 5

Friday, October 5; 8:00 a.m.–3:00 p.m.

Update on Psychopharmacology

Faculty: Jeffrey Lieberman, M.D., Franklin Schneier, M.D., Scott Stroup, M.D., M.P.H., David Kahn, M.D., Moira Rynn, M.D., Ted Huey, M.D., Frances Levin, M.D.

COURSE 6

Friday, October 5; 9:00 a.m.–4:00 p.m.

Impact of Psychiatric Disorders on HIV Management

Faculty: Marshall Forstein, M.D., Stephen J. Ferrando, M.D., Francine Cournos, M.D., Mary Ann Cohen, M.D., Kenneth Ashley, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Discuss the most common psychiatric disorders observed in HIV-infected patients; 2) Understand the increased risk of cognitive impairment among patients; 3) Describe the signs and symptoms of cognitive decline and 4) Recognize state-of-the-art approaches to HIV clinical management (including cognitive assessment).

Overall Summary: HIV affects both brain and mind function often impacting how patients cope with and manage the complex treatments that are currently available. Disorders of mood, cognition, personality and substance use may increase HIV risk in those uninfected, and increase secondary transmission in those already infected. HIV/AIDS may both cause and result from behavioral and psychiatric conditions. In addition, treatment of neuropsychiatric and psychiatric problems is becoming increasingly more sophisticated as the body of knowledge expands on pharmacological interventions and drug-drug interactions. This session will address these challenges by bringing practitioners up to date on the latest clinical treatment information, introducing practical approaches to case management, and discussing the vital role of mental health management in HIV patient care. Faculty will provide information on diagnosis and treatment of psychiatric disorders, and discuss the impact of cognitive impairment on HIV-infected individuals and their treatment, neuropathology of cognitive disorders, and specific clinical interventions including assessment of cognitive decline. Didactic and case presentations will provide the foundation for in-depth participant discussion. Participants will also be invited to share actual case scenarios and work through a guided, interactive process to evaluate individual cases, discuss potential diagnoses, and review recommended treatments and screening instruments.

COURSE 7

Friday, October 5; 1:00 p.m.–5:00 p.m.

Finding Your Ideal Job in Psychiatry

Faculty: Wesley E. Sowers, M.D., Robert S. Marin, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Identify core values and goals for personal and professional life; 2) Identify resources and limitations that will influence the ability to realize these goals; 3) Appreciate career opportunities in public service psychiatry and 4) Understand key strategies for seeking a job, evaluating job opportunities, and negotiating a desirable job contract.

Overall Summary: This course is intended for residents and early career psychiatrists interested in learning how to plan a satisfying career in psychiatry. It also will be of interest to psychiatrists wanting to increase their involvement with public sector psychiatry. The course will emphasize career opportunities in community psychiatry and publicly funded systems. However, the course is applicable to anyone contemplating a shift in the role or type of work they are doing. The program will begin with an overview of recovery principles and their implications for professional development. We will introduce participants to some of the ways recovery principles and a recovery oriented system of care create opportunities for a satisfying career. The discussion will emphasize the values, knowledge, skills and experience that will enable psychiatrists to define attractive job descriptions for themselves. It will also introduce professional development skills that enable mental health professionals to find and obtain the kinds of professional opportunities they are looking for. For examples, we will discuss such varied and important topics as: financial and non-financial sources of reward; job descriptions; leadership; networking; job contracts; loan repayment; advocacy; and balancing personal and professional goals. The middle part of the course will be devoted to self-assessment, interactive exercises in which participants will identify and evaluate some of the values, goals, strengths and limitations that they need to consider in their own career plans. The concluding section of the course will entail interactive discussion whose aims will be to acquaint participants with experiences (of faculty and participants) that enable us to: create individualized and rewarding job descriptions; learn how to approach job searches and job negotiation; acquire leadership skills and knowledge of systems of care; and cultivate a sense of professional identity as recovery oriented psychiatrists dedicated to the development of a recovery oriented, integrated system of care.

COURSE 8

Saturday, October 6; 8:00 a.m.–12 Noon

Geriatric Psychiatry: Update and Review

Faculty: Carl I. Cohen, M.D., Barry Gurland, M.D., Gary Kennedy, M.D., Barry Reisberg, M.D., Kimberly Williams, M.S.W.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Appropriately assess and treat delirium, dementia, mood disorders, and psychosis in older adults; 2) Identify potential points for intervention in the geriatric service system and 3) Identify appropriate community resources for older adults with mental illness.

Overall Summary: The aging population will double over the next 15 years, and most clinicians and treatment systems are ill-prepared to address the needs of this population. The aim of this course is to enable participants to successfully evaluate, diagnose, and treat older adults, and to utilize appropriate community resources. Moreover, participants working at the systems level will be better prepared to identify the needs of this population, and to develop potential solutions for improving their care. This course will provide an overview of the epidemiology of aging, and then review assessment methods and the latest strategies for the treatment of the principal clinical syndromes in geriatric psychiatry: dementia, delirium, mood disorders, schizophrenia and other psychoses. The course will conclude with a discussion of community resources and policy issues relevant to aging individuals.

COURSE 9

Saturday, October 6; 8:00 a.m.–12 Noon

Integrating Behavioral Health and Primary Care: Practical Skills for the Consultant Psychiatrist

Faculty: Lori Raney, M.D., John S. Kern, M.D., Jürgen Unützer, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand the importance of effective integration of mental health and addictions services and providers with primary care; 2) Identify various roles that would be appropriate for psychiatrists in these settings and 3) Identify and utilize sources of information and training to enhance psychiatrist skills in such settings/programs.

Overall Summary: Primary Care Behavioral Health (PCBH) Integration is an emerging research supported model for provision of mental health services. Based in a foundation of care management provided at the point of contact in primary care and supported by psychiatrists providing timely consultation to primary care providers, this model has caught the attention of healthcare reform proponents and others. Various models have been implemented around the country, engaging psychiatrists in unique and interesting ways. However, the training and preparation to work in these clinical settings has been lacking, with the exception of psychiatrists learning more by experience than by any formal didactic training or access to clinically relevant materials. This has led to a significant knowledge gap for psychiatrists who want to work in PCBH integrated care settings in informed and meaningful ways. This Symposium will address this knowledge deficit by presenting models of integration from around the country, focusing on the level of collaboration for each site, the make-up of the care team, the psychiatrist's role, primary care acceptance of the model and any outcome measures collected. Each of the speakers was selected to represent differing levels of PCBH integration as well as geographical variation in the models. These models will offer symposium participants detailed information on programs that could be replicated in other settings and resources to guide them through the process.

COURSE 10

Saturday, October 6; 9:00 a.m.–4:00 p.m.

Psychopharmacology for Primary Care Providers and Other Non-Psychiatrists

Faculty: Ronald J. Diamond, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand the major classes of psychiatric medication and how each can be used more effectively; 2) Develop target symptoms to follow the effectiveness of prescribed medication and 3) Balance risks and benefits and have a better understanding of how to optimize benefits while decreasing side effect burden.

Overall Summary: This course will present an overview of psychopharmacology for primary care physicians and non-psychiatric mental health professionals. Psychotropic medication is an increasingly important part of comprehensive mental health treatment. Most psychiatric medication is prescribed by primary care prescribers rather than by psychiatrists. Non-medical mental health professionals are often involved in medication decisions, even if they are not the actual medication prescribers. The session will present basic information so that primary care physicians and non-medical clinicians can work to optimize medication use for their patients. This overview will cover the major classes of psychotropic medication in common use, including indications for each, side effects, practical issues around use, and dangers. Ways of involving clients and teaching them about their medication will also be discussed.

COURSE 11

Saturday, October 6; 1:00 p.m.–5:00 p.m.

Clinical Approaches to Working With People Who Are Homeless and Have Mental Illnesses: Challenges and Rewards

Faculty: Stephen M. Goldfinger, M.D., Hunter L. McQuistion, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Demonstrate an understanding of the interactions and history of mental illness, poverty, substance abuse and homelessness; 2) Provide social, psychological and structural interventions to improve the lives and functioning of individuals who are homeless and mentally ill and entitlements and 3) Identify five ways to more successfully help individuals receive housing.

Overall Summary: This training course will bring together national leaders who provide mental health services or do services research with individuals who are homeless and have serious mental illnesses, as well as psychiatric residents who work with homeless people and a panel of local homeless individuals. We who are involved love this work, and our goal is to encourage more mental health professionals to work with people who are homeless with serious mental illnesses and with the organizations that provide services and support to this population. The format will include a combination of formal presentations, clinical consultations, and interactive panels; clinicians, academics, consumers, and residents. Participants will also have the opportunity to interact actively with the presenters to discuss strategies with their colleagues across disciplines and gain a deeper understanding of diverse approaches to dealing with people who are homeless and have mental illnesses.

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COURSE 12

Sunday, October 7; 8:00 a.m.–12 Noon

Addressing the Neurocognitive and Social Psychological Mechanisms Underlying Racist and Sexist Events in Our Daily Practice

Faculty: Donald H. Williams, M.D., Jimmie Harris, D.O., Lee June, Ph.D., Decolius Johnson, Ph.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand the relationships between the economic benefits of enslaving Africans and the social constructs of racism and sexism in the western hemisphere; 2) Understand the underlying neurocognitive and social psychological mechanisms of racism and sexism and 3) Practice identifying and using intervention strategies that address racist and sexist events in participants' work settings.

Overall Summary: The first portion of this course will briefly examine the underlying economic rationales and the current evolving scientific understanding of human populations as a base for the cognitive restructuring of our own racist and sexist beliefs and will include discussion of the economic rationale for the repeated enslavement of Americans of recent African descent and the concomitant development of racist and sexist constructs will be discussed. We will briefly review the current illusionary scientific understanding of genotypic and phenotypic variations in current human populations and J. Diamond's explanations for variations in wealth and technology of current population groups will be discussed. The second portion of the course will discuss C. Pierce's work linking racism and sexism to terrorism and torture, his view of racism as a delusional system, and his conception of "microaggressions." D.W. Sue's further work on microaggressions will also be noted. C.M. Steele's formulation of stereotype threat, psychological mechanisms involved in the stereotyping of the "Other" by race and sex, and the Implicit Association Test will be discussed. There will also be a review of intervention strategies to address these above mechanisms for maintaining racism and sexism. The final portion of the course will be devoted to participants practicing, identifying and utilizing intervention strategies to address racist and sexist events in their own work settings.

INNOVATIVE PROGRAM 1

Thursday, October 4; 1:30 p.m.–3:00 p.m.

Using Technology to Promote Consumer Engagement

1. Accessibility of a Computer-Based Shared Decision Making System (Mypsyckes) for Vulnerable Populations

Chair: Molly Finnerty, M.D.

Educational Objectives: At the end of the session, the participants should be able to describe how computer-based programs can promote shared decision-making and patient centered care, understand how computer-based clinical decision support systems can be designed to be an assistive technology for individuals with low literacy and recognize that consumers with schizophrenia spectrum and/or limited English proficiency are able to use MyPSYCKES, a computer-based decision support system.

Summary:
Objective: Computer-assisted Shared Decision-Making and wellness planning tools have the potential to promote patient centered care and quality improvement across medicine. However, concerns have been raised whether these technologies can reach those who may need these tools the most, those with more serious illnesses, socioeconomic disadvantages, and low English proficiency. We examine the engagement and use of MyPSYCKES in two diverse clinics serving individuals with SMI, multiple medical co-morbidities, and 30% mono-lingual Spanish speaking populations.

Methods: The participating clinics have a combined population of 523, with 52% male, 53% Caucasian, 16% African American, 46% Hispanic; 53% Medicaid enrollees. The total clinic population was compared to the population with schizophrenia for progress on MyPSYCKES engagement steps: 1) enroll as a user, 2) enter personal wellness strategies ("personal medicine"), 3) enter goal for treatment with psychiatrist ("power statement"), 4) enter early warning signs, 5) complete first CommonGround Report, 6) ongoing use of CommonGround reports. In addition we examined percent of users electing to use the Spanish version, and those who logged on outside the clinic. Findings: Engagement steps for the total clinic population and for the subset of individuals with schizophrenia were: 1) All individuals served at the participating clinics were enrolled in the program, 2) 78% vs 100% have identified Personal Medicine/Wellness activities, 2) 46% vs 82% have developed a Power Statement, 3) 30% vs. 71% have completed a first Common Ground report, and 4) 17% vs 58% have completed multiple Common Ground reports to date. The Spanish version was selected for 20% of users, and 10% accessed MyPSYCKES from outside the clinic.

Conclusion: MyPSYCKES can be used by individuals with serious mental illnesses. Schizophrenia is not a barrier to use and may be a positive predictor of engagement. Individuals with Spanish as a primary language can successfully use MyPSYCKES.

2. Impact of Four Types of State Incentives on Medicaid Mental Health Clinic Decision to Participate in a Large State CQI Initiative

Chair: Molly Finnerty, M.D.

Educational Objectives: At the end of the session, the participants should be able to identify different strategies for engaging mental health clinics in large scale quality improvement initiatives, understand the relationship between types of incentives and clinic leadership decision to participate in a large scale CQI initiative to improve prescribing practices and understand other predictors of clinic leadership decision to participate in a QI initiative at the client, physician, clinic, and regional levels.

Summary:
Objective: States often lead EBP implementation initiatives, and have the challenge of trying to bring these practices to scale. We examine the impact of different levels of State-sponsored incentives on clinic leadership decision to participate in a large CQI initiative to improve prescribing practices.

Methods: A total of 459 mental health clinic programs were offered the opportunity to participate in a PSYCKES CQI project in New York State over two years under four different incentive conditions: 1) technical assistance (TA) alone (n=86 clinics), 2) fiscal incentive (n=156 clinics), 3) fiscal incentives in the presence of additional LGU contract requirements to conduct a CQI project (n=153 clinics), and 4) required participation (n=64 clinics). All participating programs were offered TA and PSYCKES, a web-based application providing access to Medicaid data to support clinical decision making and quality improvement. The fiscal incentive was a 7% increase in clinic Medicaid payment. Logistic regression models were used to evaluate the likelihood of participation due to incentive type (compared to technical assistance alone). Clinic characteristics related to fit between the project and the clinic were also examined (whether clinic serves children, size and percent of Medicaid population, medical leadership, performance at baseline). Findings: Participation was 44.2% among clinics offered TA alone, followed in ascending order by clinics offered fiscal incentives (85.9% participated; OR 7.7, 95%CI:4.1–14.3,), clinics offered fiscal incentives with concurrent LGU CQI requirements (86.9% participated; OR: 8.4, 95%CI:4.4–15.8), and clinics where participation was required (98.4% participated; OR: 79.5, 95%CI:10.5-600.1). Other explanatory factors, like fit of the clinic program population to the initiative and leadership, will be discussed.

Conclusion: Type of state incentive offered influences participation decision for Medicaid providers, in a large scale quality improvement initiative. Funding: New York State Office of Mental Health.

3. Telepsychiatry: Conducting Direct Patient Interviews and Performing Mid-Level Provider Supervision

Chair: Joel Strauch, M.D.

Educational Objectives: At the end of the session, the participants should be able to understand the basics of telepsychiatry, ranging from telephone services to full duplex videoconferencing, articulate the advantages and limitations of telepsychiatry in terms of reaching underserved populations and understand how and when to consider the supervision of mid-level practitioners via teleconferencing.

Summary: This program will include a detailed summary of the state of telepsychiatry including how and where it is being utilized, the advantages and limitations to incorporating telepsychiatry into a clinical setting, and where telepsychiatry is headed. It will examine a brief history of telepsychiatry, look at current uses of the technology, and also discuss legal and logistic practice issues. It will also feature the presentation of a project that the three co-chairs implemented that involved a psychiatry resident supervising a nurse practitioner student via teleconference. The NP student was on her psychiatry nursing rotation in a small town 150 miles away and the four participants met weekly via teleconference to discuss cases and offer guidance. There will also be a discussion of ways to implement midlevel provider supervision or teleconference consults to physicians in other specialties into a current practice and how this can address the current shortfalls of telepsychiatry. Finally, there will be a block of time at the end for attendees to discuss their own experiences with telepsychiatry, either in terms of direct patient care or interacting with other providers.

INNOVATIVE PROGRAM 2

Thursday, October 4; 3:30 p.m.–5:00 p.m.

New Roles for Creative Arts Therapies

1. Recording for Recovery

Chair: David Ramsey, M.D.

Educational Objectives: At the end of the session, the participants should be able to describe the two-fold function for the recording for recovery process, namely, how patients articulate their personal goals for recovery, and how patients identify states of personal and social competency that support recovery goals, understand the positive effects of music therapy and the song writing process in assisting individuals in recovery and integration and understand how song-writing can facilitate: self-expression, imagined recovery from illness, and the importance of hope and gratitude.

Summary: Determining recovery goals is a key component of lifelong wellness for people with psychiatric illnesses. Engaging psychiatric patients in this process when acute symptoms are present is difficult to impossible; and often inappropriate. As symptoms are subsiding, music therapists utilize existing inclinations to pop music, tacit understanding of song composition and the power of group participation to facilitate sustained efforts aimed at elucidating aspects of personal recovery. The following presentation will describe the process of music therapy groups conducted in a professionally equipped recording studio on an in-patient psychiatric unit. It will detail the process of song writing and the dynamics involved in group collaboration when peers work together to complete a final music CD. Case studies will be presented that demonstrate processes that helped in-patient psychiatric patients determine recovery goals while at the same time provided experiences that embody states of wellness typically activated while fully engaged in the creative process with peers.

2. Therapeutic Applications of the Origami and the Creative Arts in the Treatment of Disaster Relief, Trauma and Severe Mental Illness

Chair: Tanya Azarani, M.D.

Educational Objectives: At the end of the session, the participants should be able to understand the use of the creative arts including Origami in the recovery from Trauma, understand the neurobiological bases of the healing process through the creative arts in the treatment of severe mental illness and disaster relief and understand different Origami techniques including a simple therapeutic model for their own clinical use.

Summary: Patients with severe mental illness, including Schizophrenia, often have histories of psychological and physical trauma, resulting in complex and challenging treatment dilemmas. The inner world of psychotic patients can be frightening, disorienting and isolating. Art therapy provides patients with a sense of autonomy and self-awareness through active engagement in a non-verbal means of emotional expression. Origami, the traditional Japanese art of paper folding, has great therapeutic potential in the treatment of trauma and severe mental illness. When combined with medication and psychotherapy, art therapy including Origami, can help psychotic patients work towards a more integrated sense of self. The Enrichment Origami Art Therapy model combines principles of art therapy, psychodynamic psychotherapy, and Asian philosophy emphasizing the importance of the individual mind-body connection. Origami requires a level of concentration that is integral to its success as a coping mechanism. The act of paper-folding helps focus patients' attention on the present moment, and away from psychotic symptoms or negative internal dialogue. The process of creation diffuses overwhelming thoughts or affects that often trigger impulsivity and self-injury. Origami provides a sense of control, confidence and personal satisfaction through the act of creating something beautiful. The collective group process helps in recovery from mental illness by creating a sense of safety and interpersonal connection. The presentation will include the historical basis of Origami and its healing properties. Applications of this model will be discussed in the treatment of elderly Japanese patients following the 2011 Great East Japan earthquake as well as other populations in conflict-ridden countries. There will also be a discussion of the use of this model in the treatment of patients with severe mental illness and trauma at a state psychiatric inpatient facility. A tool currently in development for a pilot study assessing outcome measures including motivation, cognition, and spatial awareness in origami folding will also be presented. In addition, individual case examples, images of patient work and special considerations for groups in this particular population will be explored. Lastly, an experiential exercise will teach participants about the use of Origami as a healing tool followed by discussion.

3. Cultivating the Language of Recovery Through the Creative Arts Therapies

Chair: Joseph Merlino, M.D., M.P.A.

Educational Objectives: At the end of the session, the participants should be able to understand the positive effects of creative arts therapy in assisting individuals in recovery and integration, demonstrate the ways that creative arts therapies interventions cultivate strengths and foster core recovery values, differentiate the use of creative art therapies from other therapeutic treatment and how they contribute to the support of the individuals working on recovery and experience the effects of creative arts therapy interventions.

Summary: This session will demonstrate how the creative arts therapy modalities utilize recovery principles, and how the use of creativity can foster choices, resiliency, agency and hope through the use of non-verbal and symbolic expression. Employing a multi-modal approach of presenting the work of creative arts therapists within Kings County Hospital, this program will provide the opportunity to view strength based, person centered approaches that focus on creative expression as a therapeutic goal. Creativity itself becomes the underpinning for individualized recovery choices, as it creates possibilities and emphasizes novelty, flexibility, and a support for nonlinear experience. Recognizing that wellness does not take a linear path, nonlexical means of expression are utilized as a means to offer support and cultivate strengths. Images, signs, shapes, sounds, gestures and other non-verbal symbolic expression are utilized as a bridge towards empowerment and an increase in a sense of agency. Utilizing performance, audio, and visual demonstrations, personal experiences with dance, music, drama and art therapy in an adult inpatient psychiatric setting will highlight how recovery is an individualized process that defies a measurement model. Rather, an arts oriented model will be employed, where the art itself will be utilized as the primary way of understanding and examining experience. Creating safety, building relationships and collaboration through creative arts modalities will be shown. Progression and enhancement of self-empowerment skills through creative expressions will be evaluated. Working with defenses and coping strategies through the creative process will be explored. Most importantly, the role of aesthetics as a tool for empowerment and integration will be demonstrated, and the possibilities of adding this to the language of recovery will be explored. Attendees will be offered an opportunity for interactive and experiential responses to the presentation.

INNOVATIVE PROGRAM 3

Thursday, October 4; 3:30 p.m.–5:00 p.m.

Innovations in Forensic Mental Health

1. Forensic Emergency Psychiatric Evaluation: Challenges in Providing Equitable Care for Inmate/Patients: An Interdisciplinary and Inter-Agency Approach

Chair: Kathryn Maloy, M.D.

Educational Objectives: At the end of the session, the participants should be able to understand the unique challenges of evaluating and treating a forensic population, including medical, psychiatric and psychosocial comorbidities, understand the collaborative administrative process of establishing and maintaining a novel emergency psychiatric service for inmate/patients, explore comparison between civilian and forensic New York City emergency psychiatric populations through case examples and service utilization data.

Summary: The incarcerated population has a higher prevalence of mental illness than the general population, and poses unique challenges to providing quality mental health care. Bellevue Hospital has two forensic male inpatient units that provide acute hospitalization and inpatient 730 (fitness to stand trial) evaluations for the male incarcerated population at Rikers Island that cannot be managed in an outpatient setting. Bellevue has provided this service since 1986, but the admission process was previously not comparable to civilian patients in terms of psychiatric staff monitoring and pre-admission medical clearance. In October 2011, the Bellevue Hospital Comprehensive Psychiatric Emergency Program opened a Forensic Evaluation Service where male inmate/patients are evaluated and observed throughout the evaluation by trained psychiatric technicians and nurses, are evaluated by attending psychiatrists and psychologists from the Bellevue civilian CPEP, and have full medical evaluation prior to arriving on the unit. This is a unique program that seeks to move towards more equitable and appropriate evaluation and treatment of inmate/patients. This session will first provide background about the current mental health treatment for incarcerated patients in the city of New York. We will then describe the process of developing the program, including our collaboration with city agencies, Department of Corrections and Prison Health Services.

We will next explain our approach to evaluating inmate/patients and navigating the co-morbid medical, legal and psychosocial issues. Finally we will report on our progress and challenges since opening the service, providing case examples and our initial data highlighting items such as the demographic and diagnostic profiles of inmate/patients, disposition, and a comparison with our civilian population.

2. Involuntary Commitment for Grave Substance Use Disorders: The Chronic Public Inebriate Initiative at Bellevue Hospital Center

Chair: Stephen Ross, M.D.

Educational Objectives: At the end of the session, the participants should be able to review modern history of civil commitment for substance use disorders in United States, adopt an operationalized definition of "grave substance use disorder, " understand how to initiate involuntary inpatient civil commitment for patients with SUDs and co-occurring psychiatric illness and identify legal and ethical questions affecting the use of commitment in patients with addictive spectrum illness.

Summary: The presenters introduce a pilot program involving civil commitment for high-utilizer patients gravely disabled by substance use disorders (SUDs) at Bellevue Hospital Center, New York City's flagship public hospital and the largest provider of inpatient addiction care in the United States. In the setting of several patient deaths following hundreds of emergency room visits and brief yet expensive and ineffective hospitalizations, an interdisciplinary (emergency medicine, psychiatry, internal medicine, hospital administration, legal counsel, and the New York City Department of Homeless Services) initiative began to better serve patients with multifaceted problems requiring extraordinarily complex treatment plans. A case series is presented of a dozen patients committed to inpatient dual diagnosis treatment including a detailed case report of a successful outcome of an early enrollee who was committed for inability to care for self due to severe psychiatric illness and grave alcohol dependence. The presenters discuss the use of involuntary inpatient commitment when appropriate as part of a comprehensive treatment plan to improve the standard of care for patients with grave SUDs and associated legal challenges, ethical considerations, and clinical realities.

3. Are We Doing Enough to Protect? Assessment of At-Risk Caregiving Attitudes and Parenting Behavior Among Parents With Mental Illness

Chair: Manisha Punwani, M.D.

Educational Objectives: At the end of the session, the participants should be able to understand that the assessment of at risk caregiving attitudes and parenting behaviors can be incorporated into the risk assessment protocol by inquiring from patients, who are parents, about their day to day stressors, the support systems in place, insight into their mental illness, the impact of mental illness on their parenting responsibilities and their understanding of how they can provide a safe environment for their children, formulate a plan to provide respite care if needed, refer for individual therapy, parent behavioral management training, support groups or group therapy, understand the different interventions and treatment options to address the at risk parenting behaviors so as to improve the global functioning of the patient and prevent bad outcomes.

Summary: Mental illness in parents has been implicated in many cases of Maltreatment and homicide cases towards their children. Yet there are many parents who suffer from mental illness and meet the demanding responsibilities of parenting and living with mental illness. Most of the literature focuses on mothers having mental illness and how this impacts their parenting, but we know from family systems theory as well as developmental perspectives that both parents play a crucial role in parenting and mental illness in either of the parent can impact children they care for. A typical risk assessment includes assessment of suicidal risk, homicidal risk, medical risk, ability to care for self and presence of psychosis. The authors of this session argue that risk assessment should include an assessment of at risk caregiving attitudes and parenting behaviors in our patients. The authors will explain in depth what at risk parenting behaviors use different assessment methods and how to address these. The program will also review literature to help participants understand the importance of assessing at risk parenting behaviors among parents with major mental illness. At SIU school of Medicine, the residents assess all patients for at risk parenting behaviors. We have found this allows us to address stigma, day to day stressors around parenting, patient's ability to manage their mental illness and provide a safe environment for their children. Assessment of at risk behaviors as an ongoing risk assessment will allow for early intervention and prevention when at risk parenting behaviors are identified. This will further allow us as providers to improve global functioning of our patients and prevent bad outcomes.

INNOVATIVE PROGRAM 4

Friday, October 5; 10:00 a.m.–11:30 a.m.

Psychosocial Issues in Recovery Oriented Practice

1. Psychosocial Approaches to Managing Bipolar Disorder

Chair: Lewis Mehl-Madrona, M.D., Ph.D.

Educational Objectives: At the end of the session, the participants should be able to list non-pharmacological therapies that have been used in the treatment of bipolar disorder, discuss what makes a person able to manage bipolar disorder without medication, list "red flag" situations in which failure of management without medication is highly probable, discuss the neurobiology behind a narrative CBT approach to hearing voices and having visions, list three techniques for reducing voices.

Summary: The goal of this presentation is to engage psychiatric practitioners in dialogue and discussion about non-pharmacological means to address serious mental health problems, focusing upon bipolar disorder and psychosis. We explore the life histories of over 200 patients who have successfully managed bipolar disorder without medication and a similar number from the presenter's practice who have tried to do and not been able. We look at the red flags for relapse, including using only one modality and being isolated; and at the requirements that appear to exist for successful management (physical methods such as exercise, yoga, biofeedback; psychotherapy; nutritional approaches; community; and early warning social systems with relapse action mandates). We look at psychotherapeutic approaches that appeared to benefit this group of patients. Then we turn our attention to non-pharmacological approaches to helping people manage their voices and visions. Many psychotic clients continue to have disturbing voices and distracting visions despite adequate medication and control of other symptoms. The dosages of medications to completely suppress voices and visions are often accompanied by objectionable side effects. Many patients (in our series) tell their providers that they are fine when they are not because they do not want their medication increased and their provider does not know how to talk to them about their voices other than to say that the voices are not real, which seems blatantly wrong to the client. We introduce a narrative CBT approach to voice management which is based on work successfully done in the Irish Advocacy Network and the Hearing Voices Network, both part of the National Health Service in the UK. We describe the techniques used to help patients learn to manage voices and some of the extra services from peers that are provided in the UK. This work with be discussed and then we hope for a lively interaction with the audience about the role and use of these approaches within psychiatry.

2. An Integrative/Functional Approach to Psychiatry and Sexual Health: A Model for Improving Recovery and Easing Social and Community Re-Integration

Chair: Barbara Bartlik, M.D.

Educational Objectives: At the end of the session, the participants should be able to recognize how unhealthy lifestyle practices contribute to chronic mental illness, understand the impact of micronutrient deficiencies on sexual and mental health and understand the terms "Integrative and Functional Medicine," and how these can be incorporated into traditional psychiatric treatment.

Summary: Too often, the general health, emotional well-being, and sexual health of people with psychiatric illness is put on the back burner, as professionals and the surrounding family and community focus on the management of psychiatric symptoms. Yet, in many cases, specific attention to increasing physical vitality and general health, and addressing sexual concerns, can help a person feel more normal and integrated into society, whether or not they are active in an intimate relationship. An integrative/functional medicine approach that emphasizes health-positive practices can help mitigate side effects of psychiatric medications, improve sense of self through greater vitality, and promote new learning that will continue to support better health in the future.

New health practices may be taught at a level that the individual is able to absorb. For example, some patients may begin by trying to eliminate high fructose corn syrup, sugar, and trans-fats from their diet, while taking additional vitamins, minerals, amino acids, and omega 3 fatty acids. Others might engage in meditation or vigorous physical exercise. Still others might benefit from minimizing their exposure to toxins in their water, food or environment. For each modality the health benefits and the potential effects on neuropsychiatric function will be described. Attention will be paid to the role of vitamin D in mental and sexual health. An integrative/functional approach is not just for the "worried well." Patients with significant psychiatric morbidity can benefit as well. Also, couching a discussion of sexuality in terms of health-promotion and the management of medication side-effects normalizes this topic therefore; patients are more likely to raise sexual concerns in treatment. If patients' concerns about sexual functioning are addressed, through psycho-education, pharmacologic management, and/or the administration of micronutrients that may be lacking, patients might be more willing to remain on the medications that they need for symptom control. Non-compliance often is due to sexual side-effects. In this session, Barbara Bartlik, MD, New York City psychiatrist and sex therapist, will present an integrative/functional medicine approach to the treatment of sexual and psychiatric disorders. She will discuss specific medications, integrative medicine strategies, therapeutic interventions, strategies for identifying and eliminating toxins, micro-nutrient evaluation and supplementation procedures, and macro-nutrient practices to encourage in patients, and why. Discussion of cases and practitioner resources will be included.

3. Translating Attachment Research into Prevention of Older Adult Suicides

Chair: Sheila Lobo Prabhu, M.D.

Educational Objectives: At the end of the session, the participants should be able to recognize Bartholomew and Horowitz's four attachment prototypes and their response to crisis or threat, describe the three working models of adult attachment and apply knowledge about attachment research to psychiatric care of the geriatric suicidal patient.

Summary: Examining interactions between working models of general attachment and relationship-specific attachment as they shape interpersonal experience allows clinicians to care for elderly patients with suicidal thoughts or behavior. The Independence model suggests that general and relationship-specific attachments function independently in determining relationship outcomes. Among the working models, a more hopeful approach is the Moderated model in which relationship-specific attributes can moderate general attachment schema, e.g., persons with insecure attachment can fare better in a relationship with a highly responsive partner or therapist. The Mediated model teaches patients that their general attachment models can shape relationships by causing certain behavior styles. A relationship-specific attachment-based approach helps the inpatient treatment team to understand the patient from the perspective of Bartholomew and Horowitz's four prototypes: secure, preoccupied, fearful-avoidant and dismissing-avoidant. Anxious (preoccupied) attachment, seen in borderline, histrionic, and dependent personality disorders, increases risk of both self-harm and suicide attempts. Persons with avoidant attachment (in narcissistic, avoidant, antisocial, and schizoid personality disorders) may be more likely to feel like a burden and to be socially isolated, which are both risk factors for completed suicide. Identifying attachment prototypes allows inpatient and outpatient teams to use specific targeted approaches to challenge cognitive schema, use behavior modification, and involve family and social supports to enhance treatment. Two cases of geriatric suicidal patients will illustrate successful treatment across the continuum of care. In these cases, attachment prototypes were identified in the inpatient psychiatric unit. The patients were educated about specific internal working models of attachment that usually accompany a prototype, and they examined how their relationship-specific behaviors moderated or mediated underlying general schema. Patients and families were encouraged to actively engage in comprehensive individual, group, and family treatment to prevent suicide.

INNOVATIVE PROGRAM 5

Friday, October 5; 1:30 p.m.–3:00 p.m.

Psychiatric Training And Recovery Practice

1. Public-Philanthropic Partnerships – The Connecticut Mental Health Center Experience

Chair: Michael J. Sernyak, M.D.

Educational Objectives: At the end of the session, the participants should be able to understand the potential relationships between public psychiatric institutions and non-profit entities, appreciate the benefits of these public/philanthropic partnerships and describe how such a relationship could be useful to their own situation.

Summary: This session will explore the nearly 20-year collaboration between the Connecticut Mental Health Center (a community mental health center administered by the Yale Department of Psychiatry for the state Department of Mental Health and Addiction Services) and the CMHC Foundation (a non-profit 501 (c)(3) organization).

We will discuss the larger community psychiatry context within which CMHC has functioned during its 45 years of existence, with a particular emphasis on the effect of changing reimbursement strategies have had on the ability of the center to support innovative programming. In addition, we will discuss the role of the Foundation in supporting initiatives that would otherwise have not occurred. Specific examples include the creation of a Farmers' Market on site, funding of small research projects proposed by center staff, support of arts and music programs, and other future projects. We will also discuss the role of a private non-profit in community engagement and other strategic goals.

2. Advancing Recovery in Psychiatric Education: The Project GREAT Experience

Chair: Gina Duncan, M.D.

Educational Objectives: At the end of the session, the participants should be able to understand the nature of the paradigm shift promoted by the recovery model of mental health care, understand programmatic strategies for bringing mental health professionals into the recovery model revolution, understand Project GREAT's educational initiative focused on providing recovery-based education and training and learn strategies for training in recovery and developing their own curriculum.

Summary: The training of doctoral-level professionals in knowledge, attitudes and skills relevant to practicing in recovery-oriented systems has hardly been a focus in curriculum development in training programs. Further, there have been no guidelines proposed regarding the transformation of an academic department of psychiatry into a recovery based system of care. Recognizing a glaring need in our own department – i.e., the need to foster recovery competencies among trainees in the department of psychiatry at Georgia

Health Sciences University, we collaborated with the Georgia State Department of Human Resources to develop Project GREAT (Georgia Recovery-based Educational Approach to Treatment), a peer-and-provider endeavor to champion the recovery model. The Project GREAT curriculum teaches the SAMHSA-defined principles of recovery and is now a regular part of the department curriculum. The Project GREAT strategy has been to incorporate Certified Peer Specialists as trainers and educators in our department as they teach and provide feedback to residents and other trainees in listening, collaborating, empowering, and fostering a partnership with consumers. As part of Project GREAT's educational strategy, CPSs are involved in (1) providing practitioners including trainees with routine exposure to recovery stories, (2) routinely interacting with practitioners outside the traditional patient role, (the interactions often include the usual clinical practice setting but just not the traditional patient role) and (3) providing ongoing feedback and education to trainees.

Project GREAT has since extended its educational efforts to mental healthcare service providers in the community including providing regular consultations to local hospitals. We have embarked on large–scale evaluations of the Project GREAT curriculum in an academic department and a state hospital system. Current data support the benefits of the curriculum at increasing provider knowledge and fostering attitudes and enthusiasm about recovery.

3. Is There a Role for GME in Healthcare Transformation? Building and Financing a Residency Program Within a Public/Private Venture

Chair: Kathleen Crapanzano, M.D.

Educational Objectives: At the end of the session, the participants should be able to understand one model of health care provision that incorporates GME needs, community access needs, and responsible funding mechanisms, have a working knowledge of the process to start a new psychiatric residency and understand challenges and potential solutions for faculty development in a community hospital setting.

Summary: Over the past two years, discussions have been underway between Louisiana State University (LSU), the operator of the State's public safety net health care system, and Our Lady of the Lake Regional Medical Center (OLOL), the Baton Rouge flagship hospital of Franciscan Missionaries of Our Lady Health System, a large faith-based health system, about the potential for creating a more rational approach to delivering the full spectrum of health care services to the under-served residents of the region. The result of these discussions is a unique and historic "Cooperative Endeavor Agreement," that binds the two systems together to implement, within three years of its execution, a new health care partnership that will reduce overall costs and redundancies while expanding access and promoting the centrality of prevention and primary care. Specifically, it will close the inpatient and Emergency Department services delivered today at LSU's Earl K. Long hospital, result in an increased inpatient capacity at Our Lady of the Lake, commit to an expansion of LSU's ambulatory care capacity (with a particular focus on building primary care medical homes), consolidate trauma services, and integrate LSU's training programs at OLOL while creating the opportunity to develop more residency programs. Further, the two systems have agreed to the implementation of one Electronic Medical Record (EMR) system to assure even greater collaboration and integration of effort. This agreement, endorsed by the Louisiana legislature, provides the framework for a new way to provide quality, accessible and cost-effective care to the indigent and Medicaid populations, as well as to serve as a model for care provided to an entire population, regardless of payers. This session will address the unique funding possibilities in this relationship, the impact of healthcare reform on GME in general, but on this unique collaborative specifically, and will use the experience of the new LSU-OLOL Psychiatry residency program as an illustration of the issues, benefits and unintended consequences of this arrangement. Changes to graduate medical education requirements in recent years will be discussed in the context of how education will be funded and delivered. Our experience with curriculum development and faculty recruitment as well as the issue of incorporating community physicians into this model will be discussed as well.

INNOVATIVE PROGRAM 6

Friday, October 5; 1:30 p.m.–3:00 p.m.

Practice Models For Primary Care/ Mental Health Integration

1. Engineering a New Practice Model: Real World Experience Integrating Primary Care at a Community Mental Health Center

Chair: Patrick S. Runnels, M.D.

Educational Objectives: At the end of the session, the participants should be able to describe barriers to establishing primary care at a community mental health center, discuss the limited scope of evidence and knowledge that is accessible regarding the practical implementation of an effective model of integrating care in a community mental health setting and describe one practical model for integrated care in a community mental health setting.

Summary: The Center for Families and Children is a large community mental health center in the Cleveland area, serving more than 6000 individuals annually. In partnership with The Cleveland Clinic, it was also one of the original 13 recipients of the SAMHSA grants for integrating primary care into a community mental health setting. Now entering the final year of this four-year grant, we have overcome a multitude of obstacles – both anticipated and unanticipated

– to develop a workable model for integration. This presentation will define the parameters of the grant, outline our approach, explore the most important challenges we faced, and finally, describe the model we ultimately designed and implemented that we believe provides a road map for integrating care in mental health centers across the nation.

2. Building Primary Care in a Community Mental Health Center

Chair: Marie Hobart, M.D.

Educational Objectives: At the end of the session, the participants should be able to understand health and wellness assessments and services integrated in a mental health and primary care community clinic, understand the experience of a primary care nurse practitioner working in a mental health and substance use treatment setting, list the essential infrastructure elements of implementing a primary care clinic and track quantitative and qualitative outcomes over time for wellness, mental health and primary care.

Summary: Access and ongoing provision of effective primary care for those with serious mental illness, addiction, homelessness and poverty is a major challenge for all of us in community mental health. Even in a state with near universal insurance it can be difficult for these individuals to find and maintain good primary care. In addition this population faces enormous challenges in lifestyle modification with regard to smoking, poor nutrition, limited opportunity for physical activity, as well as chronic stress. In 2010 Community Healthlink, an urban community mental health and substance use treatment center, was awarded a SAMHSA grant for Primary and Behavioral Health Care Integration. We have developed a system of care embedding two nurse care managers, a peer specialist, and a primary care nurse practitioner within the mental health and substance abuse clinic. This session will review the nuts and bolts of working with a primary care partner, setting up wellness services, and the infrastructure considerations necessary. Data will be shared on whom we are serving thus far, what types of services they are receiving, as well as outcomes thus far with regard to basic physical health indicators. We will review the culture change needed for integration, as well as descriptions of wellness services. Language and cultural considerations will also be reviewed.

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INNOVATIVE PROGRAM 7

Saturday, October 6; 8:00 a.m.–9:30 a.m.

Psychosomatic Treatment Innovations

1. Proactive Management of Psychiatric and Physical Conditions During Internal Medicine Hospitalizations

Chair: William H. Sledge, M.D.

Educational Objectives: At the end of the session, the participants should be able to understand the potential value of early recognition and treatment of co-morbid psychiatric and medical conditions, understand how to assess the economic value of hospital based psychiatric care, understand the value of multiple mental health specialties in providing psychiatric care to mentally ill medical inpatients, identify obstacles to the cost effective care within a medical setting for psychiatrically and medically ill patients.

Summary:
Introduction: Co-occurring mental (including substance abuse/use) and physical illnesses are associated with higher cost of care and service use. Other problems are the dissatisfaction and worry of the staff who frequently feel unprepared to deal with such patients. Consequently, these patients' problems may go un-addressed or ineffectively treated. This is a pilot study of a new approach to this problem. Program Description: We implemented a multidisciplinary (psychiatry, nursing and social work) approach to medical patient's care that entailed screening, evaluation, treatment and assisted disposition with concurrent advice and education to the physical care staff. The Behavioral Intervention Team (BIT) comprised of nursing, social work and psychiatric staff performed a 100% screening of admissions and identified those with co-morbid psychiatric conditions that might interfere with physical health care and treated these patients, concurrently collaborating with the medical team, advising and educating the nursing staff and the medical social workers.

Evaluation: The evaluation is a quasi-experimental before and after design comparing patients on the three medical units where the intervention was to be implemented for an 11 month (the comparison time) with a similar period of the following year (the experimental time) when the BIT was in place. Patients who had psychiatric consultations in the comparison time were compared to patients who had the intervention (BIT) along the dimensions of length of stay, the number of denied days, the sitter use related to psychiatric conditions, and the 30 day readmission rate. Results: Length of stay data demonstrates that BIT saved 1.34 days (Chi square=10.13, df=1, p<.002) per patient seen, sitter use reduced by 9% overall, denied days were eliminated, and 30 day readmission reduced by 2.7% (NS). Costs and financial benefits were analyzed from the perspective of the hospital and demonstrated expense reduction ($400 per saved day) and revenue enhancement

($992 per saved day assuming the day could be filled by a new patient). A rough estimate of a maximum financial (net of cost) benefit is $1,497 per patient consulted and a minimum cost of $84 per patient consulted. Staff were enthusiastic about the intervention.

2. Somatic Psychotherapy: Combining Osteopathy and Guided Imagery/Psychotherapy to Increase Effectiveness in Pain Management

Chair: Lewis Mehl-Madrona, M.D., Ph.D.

Educational Objectives: At the end of the session, the participants should be able to list three key elements of osteopathic manipulation for pain control, describe three ways in which narrative psychological methods can be used in conjunction with osteopathy and list three possible neurobiological mechanisms to explain how central pain perception can change as a result of treatment.

Summary: How to best treat pain is puzzling. Within the biomedical approach, the typical therapy is medication. However, the most effective medications are the narcotics, which are addicting. Patients are often referred to pain clinics when their doses of narcotics are quite high. A number of non-pharmacological methodologies are effective, including cognitive behavior therapy, osteopathic manipulation, guided imagery, and hypnosis. This presentation is about the integration of osteopathic manipulation with guided imagery and narrative psychotherapy in a family medicine context. The presenter is both a family physician and a psychiatrist working in pain management. The family medicine context provides a desirable venue within which to treat pain in a manner that integrates touch therapy with talking therapy since family physicians are able to both touch patients and talk to them. This approach to pain is centered around osteopathic manipulation for patient and physician. Within that context it is appropriate to talk, and the talk centers on developing a story for the pain. Pain becomes a character with intent, attitude, purpose, meaning, obstacles, goals, and audience. Through this discursive approach, the person becomes able to dialogue with pain in a manner in which the emotional factors involved in the origination and maintenance of pain syndromes can be expressed without the added difficulty of the perception of a psychiatric setting. This narrative approach can be supplemented with guided imagery and hypnosis to maximize the pain relieving effects of the intervention. The presentation reports on a series of 150 patients treated in this manner with significant reduction in narcotic use for all patients and elimination of narcotics for 59%. These patients had previously exhausted resources in a pain center. The presenter suggests that the combination of somatic/osteopathic treatment with a storied approach integrates emotion and cognition in an embodied manner and permits reshaping of synaptic connections for central pain perception. Patient visits lasted a minimum of one hour and occurred usually three times monthly at minimum for an average of 5 visits. The cost-effectiveness with conventional pain clinic visits is favorable.

INNOVATIVE PROGRAM 8

Saturday, October 6; 10:00 a.m.–11:30 a.m.

Primary Care Mental Health Integration

1. How to Successfully Embed Mental Health Services in Primary Care Settings: Lessons From a Working Model

Chair: Orit Avni-Barron, M.D.

Educational Objectives: At the end of the session, the participants should be able to demonstrate the skills and knowledge necessary to develop a successful mental health/primary care collaboration, troubleshoot system issues/obstacles, maintain a successful mental health service embedded in a primary care setting and inspire and train others to follow suit.

Summary: Up to 50% of patients seen in primary care have mental health problems. Combining physical and mental health care has long been recognized as a successful framework for improving outcomes and satisfaction among these patients and their providers. The embedded model, depicting co-location of mental health and primary care with significant interdisciplinary collaboration across people, functions, activities and sites over time, has been established as the most effective way to achieve these goals. However, learning to operate and function within a new system that combines two different, if somewhat overlapping, disciplines has been historically challenging. In this highly interactive session we will present a step-by-step guide to establishing an embedded care practice, based on our successful working model at the Gretchen S. and Edward A. Fish Center for Women's Health. We will present our identified elements of success and practical ways to use them in the development and maintenance of seamless service delivery in a primary care setting. Areas of focus include, but are not limited to: reducing resistance to collaboration, effective communication between medical and mental health staff, addressing and reducing stigma associated with mental health diagnosis and treatment (for both patients and providers), treating complex patients as a team, offering evidence based updates for mental health treatment, developing education initiatives aimed at empowering medical staff with knowledge needed for comprehensive treatment and more. Our ultimate objective for participants is to feel enthused, educated, able and inspired to increase collaboration among disciplines and to develop embedded practices of their own.

2. Collaborative Approach to Mental Health Care Delivery – The Toronto Experience

Chair: Diana Kljenak, M.D.

Educational Objectives: At the end of the session, the participants should be able to understand the concept and benefits of a collaborative care model, understand best practices for the successful implementation and ongoing service delivery of collaborative mental health care, reflect on how these can be adapted to improve access, decrease waiting times and improve continuity and coordination of mental health care.

Summary: A collaborative care model is generally utilized within a particular organization to foster collaborative work among multidisciplinary teams. This presentation will illustrate the benefits and promising practices of implementing such a model. The Toronto Urban Health Alliance (TUHA) is a collaborative partnership between six community health centres (CHC) and a hospital-based mental health program created to maximize limited resources. TUHA was developed to deliver patient centered, culturally sensitive and efficient mental health services through a collaborative care model. Goals included improving access to mental health services and to strengthen each CHC's capacity to meet the mental health needs of patients in the community.

The unique feature of TUHA is the partnership between six different community health centres and mental health specialists using a common set of principles and objectives to sustain and enhance the quality of service being offered in the community. Reflection on a multi-site partnership in the delivery of a collaborative model within a large urban centre creates a platform to determine the possibility of replicating a similar model in other communities. Outcome data will be presented.

3. The PEER (Prevention, Education, Evaluation, Rehabilitation) Program at St. Lukes-Roosevelt

Chair: Hunter McQuistion, M.D.

Educational Objectives: At the end of the session, the participants should be able to discuss the process of implementation of an early psychosis intervention service in a community hospital, present preliminary data on the progression of symptoms in a subset of patients in the early stages of psychosis and describe the progress of a group of adolescent patients through the PEER program.

Summary: The PEER (Prevention, Education, Evaluation, and Rehabilitation) Program is a subspecialty program within the Division of Psychiatry at St. Luke's-Roosevelt Hospital Center in New York City focused on the identification and treatment of teenagers and young adults in the early stages of psychosis. Our program currently serves 60 adolescents and young adults and our mission is to translate years of early intervention research into clinical practice. Our services include weekly individual therapy sessions, weekly group therapy sessions, psychopharmacology appointments and educational seminars for families. For the current proposal, we will present data on a subsection of our patients; these data include baseline and quarterly assessments in such domains as symptomology related to psychosis, cognitive functioning, depression, problem behaviors, treatment adherence, substance use and a number of other factors related to recovery. The purpose of the current study (N~25) is to track the progression of a community sample of patients in the very early stages of their illness. The information obtained during the current study will help to inform policies regarding implementation of programs that serve this high-risk population.

INNOVATIVE PROGRAM 9

Saturday, October 6; 3:30 p.m.–5:00 p.m.

Strategies for Serving Homeless Populations

1. From the Streets to Shelter to Housing: A Continuum of Integrated Services for Homeless Mentally Ill Persons

Chair: Richard C. Christensen, M.D.

Educational Objectives: At the end of the session, the participants should be able to understand the complex barriers faced by mentally ill, chronically unsheltered persons in accessing shelter, medical/behavioral health services and stable housing, appreciate the need for a continuum of integrated case management, primary care, behavioral health and housing services that foster recovery and inclusion for homeless, mentally ill persons and understand the need to develop recovery-oriented services for homeless individuals within the context of a trans-disciplinary treatment team.

Summary: Individuals who are mentally ill and chronically homeless (i.e., living on the streets continuously for a year or longer or experiencing multiple episodes of repeated homelessness over a 3 year period) face a number of formidable obstacles in moving from the streets to safe shelter and, ultimately, stable housing. For many, this pathway out of homelessness cannot be undertaken without the receipt of medical, psychiatric and addiction services. Access to desperately needed, and consistently provided, primary care and behavioral health services (e.g., psychiatric care, substance use treatment) are frequently outside the reach of most homeless persons who are chronically unsheltered. Mistrust of outreach workers, fear of shelters, as well as an inability to locate and negotiate primary care and psychiatric services can lead to prolonged homelessness and systems marginalization among individuals who are at particularly high risk of suffering from the trimorbid effects of serious mental illness, substance use disorders and life-threatening medical conditions. This Innovative Program will describe the evolution of a continuum of services that has resulted from an academic-public sector liaison in Jacksonville, Florida, based at a large urban center for homeless persons. The different components of this model of integrated care (e.g., psychiatric street outreach, shelter-based medical/social case management services, co-located primary care and behavioral services within a federally qualified health clinic, and assistance in obtaining transitional/permanent housing) are service adaptations that have been implemented over a ten year period to better meet the needs of this highly vulnerable population. This presentation will discuss how each of these components within the continuum of care, particularly street outreach and the integration of primary care and psychiatric services, is essential to promoting engagement, reconnection and recovery for chronically unsheltered persons suffering the effects of mental illness and substance use disorders. This integrated model has the potential of being replicated in other communities looking for ways to create a continuum of care for chronically homeless persons based upon supportive relationships between clients and providers.

2. Clinical Challenges Implementing Housing First Assertive Community Treatment Teams for People Who Experience Homelessness and Mental Illness in Canada

Chair: Kathleen A. McGarvey, M.D.

Educational Objectives: At the end of the session, the participants should be able to understand the challenges and benefits of working with people with addictions, mental health concerns and homelessness with a Housing First ACT Team, understand how offering a Housing First ACT program improves outcomes for people who are experiencing homelessness, addictions and mental health concerns (i.e., one year research data will be available), understand the unique challenges of being a clinical psychiatrist working within a national research project and learn successful strategies in engaging and retaining research subjects with complex needs, such as homelessness, substance abuse and mental health struggles.

Summary: The At Home/Chez Soi Research Demonstration Project is a multicenter longitudinal randomized controlled trial (RCT) funded by the Mental Health Commission of Canada One purpose of this project is to examine strategies for people with mental health challenges who were experiencing homelessness. Projects are underway in Toronto, Vancouver, Winnipeg, Montreal, and Moncton and as of November 2011 over 1030 participants now have homes. Based on the Housing First approach, the At Home/Chez Soi focuses on giving participants choice in scattered site apartment housing, no mandatory requirements for mental health/substance use treatment, rapid rehousing following eviction, and support services tailored to the individual needs of each consumer. Participants in all five study centers/cities were randomized to either one of several Housing First interventions (n=1255) or to treatment as usual (n=980), Assertive Community Treatment (ACT) being one of the Housing First interventions. In this framework, Housing First Assertive Community Treatment teams were implemented, receiving continuous training and fidelity support from "Pathways to Housing" (New York, USA). Evidence Based treatments of Illness Management and Recovery (IMR), Motivational Interviewing (MI), Integrated Dual Disorders Treatment (IDDT), and supported employment were used to support ACT-team clients. Due to the high social complexity of clients, ACT-team members had to utilize creative and new approaches to work collaboratively with clients towards their goals. Furthermore, innovative interventions such as peer support and recovery planning were integrated into all ACT teams. Researchers, who met with each study participant every 3 months over a 2-year period, to obtain longitudinal data, used unique strategizes to engage a complex population with high substance abuse and severe mental health challenges who were experiencing homelessness. The different study centers/cities varied in terms of the complexity of participants' needs and service delivery issues. In this symposium, we will review approaches that were used for engagement and retention of research participants as well as successful clinical strategies by psychiatrists and other clinicians from the ACT teams while working with a very complex and challenging population. Clinical staff from the Vancouver and Toronto ACT teams will discuss the unique challenges in both implementing and providing clinical care at the two study sites. Furthermore, staff from the Vancouver site will discuss successful strategizes of working with a population with very high stimulant use, as 80% of the Vancouver ACT-clients use stimulants and 50% use methamphetamine. Early research data will also be presented. The focus of the session overall will be on the specific clinical challenges presented with engaging and delivering services to a very complex population within a national research demonstration project.

3. Innovative Programming to Transition Psychiatric Patients Experiencing Discharge Challenges to Community-Based Services in Mississippi

Chair: Lydia Weisser, D.O.

Educational Objectives: At the end of the session, the participants should be able to discuss the development of the MSH-CIP, including organizational structure and curriculum topics, determine program curriculum and structural components that may be options for replication in existing programming within other agencies/organizations and identify programming strategies critical to working with an underserved population similar to the population served by the MSH-CIP.

Summary: Historically, Mississippi mental health services trends have been consistent with services described in the President's New Freedom Commission Report, including gaps in services available to individuals with psychiatric disabilities. Successful community inclusion and outpatient health care options have continued to present substantial challenges for two particular subsets of individuals with psychiatric disabilities: a) individuals who have been legally committed for psychiatric care three or more times within a twelve month period of time and b) individuals who have been in a psychiatric hospital more than 365 consecutive days. The Mississippi State Hospital Community Integration Program (MSH-CIP) incorporates a dramatic change in the organization, structure, and programmatic content of traditional services in Mississippi. This presentation includes information regarding program development, curriculum, staffing, and global organizational issues for implementing innovative mental health programming. The focus of program development was on strategies to overcome identified barriers while also emphasizing recovery and personal empowerment. Additionally, the program was established using strategies which resulted in minimal cost increases to the agency and more efficient utilization of resources. The MSH-CIP is one of several community-based programs offered by the MSH Community Services Division, which is Joint Commission accredited. The program includes the use of various evidence-based practices. A critical component of the program includes weekly opportunities for individuals who receive mental health services at a local community mental health center to voluntarily engage in discussions with MSH-CIP participants about various topics related to their personal experiences of transitioning to community life. Additional training content includes opportunities to engage in activities routine and necessary to caring for oneself and the home environment when living independently (i.e., medication self-administration, personal laundry and other personal hygiene activities, planning and preparing meals, other housekeeping activities, and a variety of prevocational activities). Tours of a local community psychosocial clubhouse are also incorporated into the training experience. Within the short time the program has been in operation, the MSH-CIP has been a successful addition to the continuum of care for individuals with psychiatric disabilities served by Mississippi State Hospital. It has been exciting to see the enthusiasm displayed by individuals participating in the program. For many program participants, they now view their options and future possibilities with hope and delight as they envision a life of recovery and meaningful community inclusion.

INNOVATIVE PROGRAM 10

Sunday, October 7; 8:00 a.m.–9:30 a.m.

Wellness and Self-Management

1. Supporting Wellness Self-Management and Graduation From Assertive Community Treatment

Chair: Molly Finnerty, M.D.

Educational Objectives: At the end of the session, the participants should be able to characterize reasons for discharge from ACT teams, describe barriers and strategies for transitioning ACT clients to lower intensity services and describe the impact of a model adapting Critical Time Intervention to the ACT discharge process.

Summary:

Objective: Assertive Community Treatment (ACT) is the most intensive and costly outpatient mental health service available for adults with severe mental illness. Originally conceptualized as a time-unlimited service, more recent findings suggest that some clients can successfully graduate from ACT. This study reports on the reasons for discharge from ACT, and the development and impact of a model applying Critical Time Intervention and Wellness Self Management to transition from ACT. Method: Reasons for discharge were extracted from CAIRS, the state outcome monitoring system, for all teams in NYS (n=79 teams). Regional focus groups were conducted to identify barriers and strategies to support successful transition. A workgroup of ACT staff, clients, researchers, and local and state mental health authority staff developed a program for supporting Transition from ACT by adapting Critical Time Intervention, a time limited case management model. A Wellness Self Management curriculum was adapted for ACT to support transition. The ACT Transition Program was implemented in 25 teams. We examined rates of successful discharge for participating and non-participating teams. Descriptive statistics and generalized linear multilevel mix-effects modeling (GLMM) were conducted to allow for multiple observations per client and nesting within team using SAS PROC GLIMMIX. Results: ACT clients are discharged from ACT for an array of reasons, with a minority of clients discharged due to graduation (22.6%). Participating teams had a significant increase in positive discharges (to 35.3%, X2(df=1) = 5.55, p<0.018). GLMM analysis showed that participating ACT teams were significantly more likely to evidence positive discharges compared with non participating teams (p<0.015). Analyses controlling for client demographic and diagnostic characteristics will be discussed.

Conclusion: Wellness Self Management and Critical Time Intervention strategies can be successfully adapted for ACT, and support increased graduation from ACT to lower levels of service. Funding: New York State Office of Mental Health and Bristol-Myers Squibb Foundation.

2. Treating Metabolic Syndrome in Patients on Assertive Community Treatment Teams: Preliminary Outcomes From an Integrated Care Project

Chair: David C. Lindy, M.D.

Educational Objectives: At the end of the session, the participants should be able to understand the diagnostic criteria and prognostic significance of metabolic syndrome, as well as results of metabolic syndrome treatment studies, understand the relationship between metabolic syndrome and serious mental illness, and its implications for patients on assertive community treatment teams in patients on assertive community treatment (ACT) teams and appreciate the alarmingly high rates of metabolic syndrome in patients on assertive community treatment (ACT) teams, the issues involved in attempting to treat metabolic syndrome in the ACT patients, and the importance of integrated care in accomplishing this goal.

Summary: It is well known that people with serious mental illness (SMI) die 25 years earlier than people from the general population and that the cause of death is typically medical, not psychiatric. Assertive Community Treatment (ACT) is an evidence-based treatment providing the most intensive level of out-patient care for SMI patients requiring more than standard care. ACT patients often have many unmet medical needs even when their mental health needs are met by the ACT team. ACT's capacity to successfully engage SMI patients suggests that the ACT model could be adapted to more effectively meet their medical needs. These adaptations could be designed to take advantage of local opportunities for better integration of medical and psychiatric care for ACT patients. The Visiting Nurse Service of New York (VNSNY) Community Mental Health Services operates three ACT teams in New York City, with a combined total of 200 patients. We have screened our ACT teams for metabolic syndrome, a cluster of symptoms associated with elevated risk of heart attack, stroke, and type 2 diabetes, as one way of assessing medical risk. We found metabolic syndrome prevalence rates of over 54% in the ACT patients, vs. 34% in the general population, plus high rates of either undiagnosed or inadequately treated hypertension, dyslipidemias, type 2 diabetes, pre-hypertension, and pre-diabetes. This session will present preliminary data from an integrated care treatment study of metabolic syndrome in ACT patients. We have designated one ACT team as the treatment cell, vs. the two other control teams which provide usual care. The treatment team will use a multilevel program to treat ACT patients with metabolic syndrome: 1) use of metformin and/or other appropriate oral hypoglycemic agents prescribed by the ACT psychiatrist, 2) a reward-based exercise program utilizing pedometers to measure patient steps per week, 3) care navigator services provided by a specially trained ACT nurse, and 4) the use of VNSNY nurses to provide medical home care to appropriate ACT patients. This session will facilitate discussion among audience members interested in treating metabolic syndrome in ACT patients, as well as the broader issues related to better integrated care.

3. Support Recovery by Flexible ACT: A Dutch Version of ACT

Chair: Michiel Bahler, M.S.C.

Educational Objectives: At the end of the session, the participants should be able to reflect on theory, implementation and practice on of FACT – the Dutch version of Assertive Community Treatment, describe four or more different activities of the multidisciplinary FACT-team that support recovery and describe how the digital FACT board support the multidisciplinary FACT-team in their actions.

Summary: Flexible Assertive Community Treatment is a Dutch version of ACT. The model is widely spread over the Netherlands and increasingly popular in their countries. FACT teams support all persons with a severe mental illness in their recovery process and inclusion. As ACT teams, FACT teams are multidisciplinary which enables the teams to integrate other Evidence Based Practices and make these interventions for all persons with an SMI. Because the FACT teams work in a restricted catchment area, there is a close collaboration with the community. FACT can be defined in 6 principles:1) support and treatment there where the client wants to succeed; 2) Support for community participation; 3) Continuity of care between Hospital and community 4) ACT, Flexible when needed; 5) Treatment by Guidelines and Evidence Based Practices 6) Support Recovery.

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INNOVATIVE PROGRAM 11

Sunday, October 7; 10:00 a.m.–11:30 a.m.

Workforce Innovations to Promote Care Integration

1. Establishing Psychiatric Services in a Primary Care Setting: A Private Practice Model

Chair: Albert J. Sayed, M.D.

Educational Objectives: At the end of the session, the participants should be able to understand the benefits to patients, primary care providers and the psychiatrist when providing psychiatric services in a primary care setting, understand how to: 1) initiate psychiatric services in a primary care setting, including recognition of the different roles of the psychiatrist; 2) choose a primary care group; 3) plan for the business and legal issues and understand some of the more common dilemmas that can arise when providing psychiatric services in a primary care setting and the various options for resolution.

Summary: There are many obstacles that patients face to obtain psychiatric care. The provision of psychiatric services in a primary care setting can reduce many of the obstacles. In addition to the benefit to the patients, the primary care physician and the consulting psychiatrist also benefit. The benefits to the psychiatrist can be professional and personal as well as economic. This model can be done in a private practice model without outside funding or support. The session will cover the initial considerations for the psychiatrist such as the different roles the psychiatrist may fill in a primary care setting. Business and legal consideration will be discussed. The management of various dilemmas that can arise over time will also be addressed. By the end of the session, the participant will be able to: 1) decide if this model of practice is something to pursue; 2) negotiate and structure a workable model to work in a primary care setting; and 3) manage important issues during the course of providing services in a primary care setting.

2. Innovative Peer Support Services for Individuals With SMI in an Academic, Community Mental Health Center

Chair: Thomas Styron, Ph.D.

Educational Objectives: At the end of the session, the participants should be able to demonstrate useful knowledge with regard to the development and implementation of peer programming for individuals with SMI in a community mental health center.

Summary: The importance and effectiveness of peer supports in the delivery of recovery-oriented care for those with serious mental illness has been well established over the last 15 years (Cook et al., 2009, Davidson et al., 2006). At the Connecticut Mental Health Center, a partnership of Yale University and the State of Connecticut, a variety of peer support-related initiatives have been developed and implemented. These initiatives include, but are not limited to: peer-staffed resource desks in the lobby and outpatient units; the presence of peers on the center's treatment teams and on the inpatient units; a peer-staffed mobile library focusing on recovery narratives; a centerwide peer-administered consumer satisfaction survey to provide systematic feedback to the center's leadership; the development of a peer advisory council which reports directly to the center's CEO; training, supervisory and support programs for peer employees. This presentation will provide its audience with details and outcomes with regard to these and other peer support initiatives.

3. Innovative Volunteer Services, Including a Full-Time Summer Internship for College Undergraduates, Within an Academic Community Mental Health Center Context

Chair: Thomas Styron, Ph.D.

Educational Objectives: At the end of the session, the participants should be able to demonstrate useful knowledge with regard to the development and implementation of innovative volunteer services, including a full-time summer internship for undergraduates, within an academic, community mental health center.

Summary: The importance of volunteer work, for both volunteers and recipients, has been well established (Weinstein & Ryan, 2010). Literature with regard to the role and experience of volunteers within mental health organizations is very limited; however, the presence and value of volunteers in the field is growing (Tsai et al., 2009). The Connecticut Mental Health Center, a partnership of Yale University and the State of Connecticut, has recently developed and implemented a variety of initiatives to increase the presence of volunteers at the center in an effort to enhance services, expose volunteers to the needs of individuals with SMI and behavioral healthcare and to increase the center's integration within its community. Volunteer-led initiatives include, but are not limited to, yoga and meditation, cooking, music, exercise, reading and gardening groups. Additionally, an intensive, full-time 8-week summer volunteer internship has been developed that offers the opportunity for college undergraduates who are interested in careers in behavioral health to be placed on treatment teams, participate in a series of special didactic seminars and to receive mentorship and supervision from senior staff at the center. This presentation will provide its audience with details regarding the development and implementation of these programs and some initial outcomes.

LECTURES

LECTURE 1

Thursday, October 4; 8:00 a.m.–9:30 a.m.

An Overview of Adults With Autism Spectrum Disorders

APA Frank J. Menolascino Award

Lecturer: L. Jarrett Barnhill, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Demonstrate a good working knowledge of the core features of autism and how these neurobehavioral symptoms impact social behavior and emotional relatedness; 2) Demonstrate an understanding of the relationship between brain development, neuroplasticity, gene-environment interactions and ASD as syndrome defined by behavioral observations; 3) Demonstrate an appreciation of the behavioral pharmacology of ASD, especially newer clinical research into the basic neuropharmacology of learning, extinction and behavioral regulation; 4) Demonstrate working knowledge of the problems associated with the differential diagnosis of co-occurring primary psychiatric disorders and 5) Understand the problems associated with our current approaches to the psychopharmacologic treatment.

Overall Summary: Autism spectrum disorders (ASD) are a group of complex neurodevelopmental disorders characterized by core impairments in social communication and repetitive restrictive cognitions and behaviors. This presentation focuses on the considerable genetic, neurobiological and social neuroscientific heterogeneity of this syndrome.

LECTURE 2

Thursday, October 4; 8:00 a.m.–9:30 a.m.

Successful Psychosocial Aging in Schizophrenia is Not an Oxymoron: Role of Behavioral Interventions

Lecturer: Dilip V. Jeste, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Demonstrate knowledge of the differences in trajectories of physical, cognitive, and psychosocial aging in people with schizophrenia; 2) Recognize predictors of successful vs. unsuccessful aging in people with schizophrenia; 3) Understand the use of behavioral and psychosocial interventions for older individuals with schizophrenia.

Overall Summary: Since Kraepelin described dementia praecox more than a century ago, schizophrenia has been considered a disorder with a progressively downhill (dementing) course. Yet, our studies over the past 25 years, as well as several other investigations in different countries, show that this concept is inaccurate. The course of chronic schizophrenia in later life is typically non-progressive. Contrary to expectation, aging of patients with schizophrenia is often associated with improvement in mental health-related quality of life even as physical health declines. A minority of older people with schizophrenia even have sustained remission of illness. Barriers to successful aging among people with schizophrenia include social stigma, biases on the part of care providers, physical comorbidity, and adverse effects of medications. While antipsychotic drugs constitute the mainstay of treatment of schizophrenia in adulthood, our group has demonstrated the efficacy of several manualized behavioral and psychosocial interventions in randomized controlled trials. Such interventions include: Cognitive Behavioral Social Skills Training, Functional Adaptation Skills Training, Diabetes Awareness and Rehabilitation Training, Work Rehabilitation, and an intervention specifically focused on Latino patients (Pedal). Successful psychosocial aging in people with schizophrenia is not a fantasy, but can be a reality if appropriate bio-psycho-social management is provided.

LECTURE 3

Thursday, October 4; 10:00 a.m.–11:30 a.m.

The Changing Face of Psychosis

Lecturer: David Healy, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand the importance of diagnosis in treating schizophreniform psychoses; 2) Understand the implications for both recovery models in those with psychoses but also for preventive approaches to reduce the incidence of psychosis; 3) Understand a simple clinical maneuver with significant cost benefit implications that could restore life expectancies in schizophrenia to those of the general population.

Overall Summary: Did schizophrenia only emerge in the 19th century? Could it disappear again? If schizophrenia were only of recent onset, what implications would this have for the management of psychosis?

Can social stresses precipitate schizophreniform psychoses? Is the natural course of these disorders the same as for schizophrenia? If not, what are the implications for treatment?

Using data from the 19th century asylum and from contemporary services in North Wales, this talk demonstrates significant changes in the incidence of schizophrenic psychoses. The time periods for these changes point to possible triggers. De novo onset postpartum psychoses have vanished. Catatonic states and hebephrenia are now rare. These changing incidences have implications for clinical management and service delivery and for the way in which we think about diseases and their histories. Finally we have outcome 5 and 10 year outcome data for schizophrenia that uniquely in medicine show an illness whose 21st century mortality rates demonstrate with no improvement on 19th century mortality rates and on certain features are worse.

LECTURE 4

Thursday, October 4; 10:00 a.m.–11:30 a.m.

The Fifth Cycle of Reform: Integration or Deinstitutionalization

Lecturer: Michael F. Hogan, Ph.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Demonstrate knowledge of the five cycles of reform in American mental health care; 2) Demonstrate knowledge of forces toward integration of care under health reform; 3) Demonstrate knowledge of strategies to promote integration of care while forestalling the disappearance of the public mental health system.

Overall Summary: This invited lecture will extend the framework ("Cycles of Reform") originally proposed by Morrissey and Goldman. I will demonstrate how the passage of parity legislation (MHE APA) and health reform (PPACA) set in place dynamics that can dramatically improve access to mental health care – and/or lead to the disappearance of the state managed public mental health system. I will discuss financing, advocacy, clinical and management strategies to cope with these trends and dynamics.

LECTURE 5

Thursday, October 4; 12 Noon–1:30 p.m.

The Center Cannot Hold: My Journey Through Madness

Opening Session Keynote Lecture

Lecturer: Elyn R. Saks, J.D., Ph.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Have inside view of psychosis – what it looks like, how it feels; 2) Better understand the impact of different interventions on one's illness; 3) Especially understand the impact of mechanical restraints; 4) Better understand the factors that lead to recovery.

Overall Summary: Saks will speak about her struggles with schizophrenia describing her experience of psychosis. She starts with her childhood and focuses on her life after her diagnosis. Given a "grave prognosis," she was expected to be unable to live independently, let alone to work. That is not how things worked out: she is a chaired professor with many friends and a beloved husband. Saks describes what has helped her, including good treatment, supportive friends and family, and an accommodating workplace. While Saks has always been committed to intensive psychoanalytic psychotherapy, coming to terms with needing medication was a long battle, fortunately now won. Saks will conclude the talk with some policy implications of her story, recognizing that she is an "n" of only one.

LECTURE 6

Thursday, October 4; 1:30 p.m.–3:00 p.m.

Mental Health Coverage and Mental Health Care in State Insurance Exchanges

Lecturer: Thomas McGuire, Ph.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Put current health insurance reforms for mental health care in the Affordable Care Act in the context of the policy history of mental health financing; 2) Understand the incentives to plans for underserving persons with mental and some other illnesses; 3) Appreciate the contribution and shortcoming of current policies in Exchanges to address the problem of incentives for underservice.

Overall Summary: The Affordable Care Act establishes state-level health insurance Exchanges through which millions of people in the U.S., many formerly uninsured, will purchase individual health insurance. Coverage under Exchange plans must include mental health at parity. However, equal coverage does not guarantee equal access to appropriate care. This presentation will relate current policy in Exchanges to the history of coverage of mental health care in private insurance markets, calling attention to reasons health plans have to discourage use of mental health care. Plan incentives associated with drawing an "adverse selection" of the risks from an insurance pool will be explained. Parity regulations address the problem of ensuring equal access, but these are only a partial solution. Managed care plans limit access through network design and utilization management. Using recent nationally representative data, the presentation then assesses how payment policies in Exchanges encourage/discourage plans in providing true parity: equal access to care for persons with mental and other chronic illnesses.

LECTURE 7

Thursday, October 4; 1:30 p.m.–3:00 p.m.

CMHC-Based Health Homes: A New Care Delivery Model

Lecturer: Joseph J. Parks, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Demonstrate knowledge of how the treatment, care coordination and disease management delivery model of a CMHC Healthcare Home, including (1) the services provided by the CMHC Healthcare Home, (2) the role of the Healthcare Home staff, and (3) data analytics used to support care coordination and disease management; 2) Demonstrate knowledge of how the specific functions of the CMHC Healthcare Home, including (1) the use of care coordination and disease management data analytic reports, (2) integrating the Healthcare Home team, treating primary care physicians, psychiatrists and medical specialists, and CMHC services, and (3) how to integrate physical healthcare needs and goals in treatment planning; 3) Demonstrate knowledge of how the efficacy of CMHC Health Homes in improving quality of care and cost containment.

Overall Summary: This lecture describes Missouri's action to reduce the high rates of morbidity and mortality of persons with serious mental illness (smi). A 2006 study by the National Association of State Mental Health Program Directors (NASMHPD) found that these high rates of morbidity and mortality lead to an average of 25 years loss of life for person with smi, which were largely caused by chronic health conditions, such as heart disease, diabetes and chronic respiratory diseases. The promotion of seamless, effective and coordinated healthcare services and supports for people with smi is fundamental in the recovery of life lost. As of October 2011, the Centers for Medicare and Medicaid Services (CMS) approved Missouri's state plan amendment to implement the first behavioral healthcare homes. Behavioral healthcare homes embody a holistic approach to the care and treatment of chronic behavioral and physical health conditions. Missouri's 27 behavioral healthcare homes coordinate and provide access to health services, preventive and health promotion services and mental health and substance abuse services. This lecture will present the structure, staffing, services, health information technology tools, and outcomes of CMHC health homes.

LECTURE 8

Thursday, October 4; 1:30 p.m.–3:00 p.m.

New Approaches to Social Integration

Psychiatric Services Editor's Choice Award

Lecturer: Robert Rosenheck, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Review recent research on social reintegration of seriously mentally ill and/or homeless adults in current progressive programs; 2) Present a new model for case management in supported housing that brings back some old ideas; 3) Review data suggesting improvements in social integration ratings and program efficiency and 4) Present alternative conceptual frames for addressing this challenge.

Overall Summary: Our ambitions for improving the lives of people with serious mental illness, addictions and homelessness have changed. Merely obtaining housing, preventing hospitalization, or linking clients to income supports, medications, or social services seem no longer to be sufficient. Yet recent research suggests that supported housing, while effective in helping people exit from homelessness does not lead to improvements in indicators of social integration. We have developed a new approach to supported housing: Group Intensive Peer-Support (GIPS) model of case management implemented in a VA supported housing program that combines Section 8 vouchers with case management for homeless veterans The fundamental shift in the model is that case manager-led group meetings are the default mode of case management support, and individual intensive case management is provided only when judged to be clinically necessary. GIPS implementation was associated with a greater increase in client social integration ratings and in the number of case manager services than at control sites, with no evidence of adverse effects on housing or clinical outcomes but with faster client acquisition of vouchers after program admission compared to other sites. This approach is consistent with an identity group support or enclave approach and suggests that some old ideas may be useful in addressing new challenges.

LECTURE 9

Thursday, October 4; 3:30 p.m.–5:00 p.m.

Taking Strengths Seriously

Lecturer: Mark Ragins, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand a set of four strengths based paradigms: (1) Social determinants of health, (2) Protective factors, (3) Self efficacy, and (4) Building resilience by finding strengths in struggles; 2) Identify how each of these strengths based paradigms can be translated into clinical practices they can use; 3) Apply these strengths based paradigms to understand how some people are living successfully with severe mental illnesses.

Overall Summary: One of the core recovery based principles is the transformation from "deficit based" services to "strength based" services. Taking strengths seriously means doing far more than listing a few things we like about our patients on the chart. It means changing our entire focus. Deficit based thinking – identifying and fixing what's wrong - is not only engrained into our professional medical training, it also comes naturally to most of us in our personal lives. Strengths based thinking, on the other hand, requires thoughtfulness and practice. This workshop will describe four different paradigms of strengths based thinking: 1) social determinants of health, 2) protective factors, 3) self-efficacy, and 4) building resilience by finding strengths in struggles. For each of these paradigms we will begin by discussing their theoretical background and then move on to concrete practice implications. The audience participants will be encouraged to describe specific ways they have incorporated each of these paradigms into their practice. There is an emerging "case study" literature of people who are living successfully with severe mental illnesses including schizophrenia. We will look at some of these examples from a strengths based perspective and encourage audience members to re-evaluate their own successes using these strengths based paradigms.

LECTURE 10

Friday, October 5; 8:00 a.m.–9:30 a.m.

Motivational Interviewing as Practical, Teachable and Quantifiable Method to Build Core Competencies in Recovery-Oriented Mental Health Care

Lecturer: Michael Flaum, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Describe the background and development of motivational interviewing as an evidence-based practice; 2) Identify and describe the three core components of the "spirit" of motivational interviewing; 3) Discuss at least two ways in which the spirit of motivational interviewing is consistent with the core concepts of mental health recovery; 4) Identify at least two training resources for Motivational Interviewing; 5) Identify at least one tool to rate fidelity of motivational interviewing skills.

Overall Summary: While there is now broad and increasing recognition that facilitating recovery is a key, if not the primary outcome that mental health professionals should strive to achieve, practical strategies to actually do so in real world clinical settings remain unclear to many providers. This presentation will attempt to demonstrate that the underlying spirit of Motivational Interviewing, an evidence-based practice initially developed for the treatment of substance abuse problems, is highly consistent with the core concepts of mental health recovery, and that a broader application of this practice in mental health settings may be a practical, teachable and quantifiable way for providers to enhance their capacity to facilitate recovery. It will be argued that as such, motivational interviewing should be a part of the core competencies for a wide variety of mental health trainees, including psychiatry residents. Resources for training and ratings of fidelity will be identified.

LECTURE 11

Friday, October 5; 10:00 a.m.–11:30 a.m.

Treatment of Schizophrenia: Current Limitations and Future Strategies

Lecturer: Jeffrey Lieberman, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand the effectiveness of current treatments for schizophrenia; 2) Demonstrate knowledge of the status of new research on experimental therapeutics for schizophrenia; 3) Understand future strategies for drug development and therapeutic interventions.

Overall Summary: The discovery of antipsychotic drugs was one of the great medical breakthroughs of the twentieth century. The first-generation antipsychotic drugs now called conventional antipsychotic drugs (CAPD), alleviated psychotic symptoms of schizophrenia and prevented recurrence. They did not improve other symptom dimensions and had high rates of neurologic side effects. Atypical antipsychotic drugs (AAPD) were a therapeutic advance. They presented fewer neurologic side effects and were though more effective at controlling aspects of the illness. Recent studies and clinical use have raised questions about their efficacy and safety. Many of the AAPDs have other side effects including weight gain and disturbances in glucose and lipid metabolism. Apart from clozapine and olanzapine, AAPDs show no clear, consistent efficacy advantages. Identifying new strategies for treatment development has proven challenging. Efforts have focused on three approaches. First is the development of novel agents with affinities for targets other than the D-2 receptor. This strategy has been unsuccessful to date, though there are a few theoretically promising targets (e.g. glutamate receptors, muscarinic receptors). The second strategy develops agents as adjunctive treatments to antipsychotic drugs targeting specific symptom domains of the illness (e.g. cognition, psychosis, negative symptoms). This strategy assumes that the various symptom dimensions of the illness may have different pathophysiological bases that no single agent could address. In this context the NIMH MATRICS and TURNS programs illustrate programmatic efforts to develop treatments for cognitive deficits in schizophrenia. These programs have generated promising results with selective DA-D1, GABA-A alpha 2, muscarinic1-4, Nicotinic alpha 7, 5-HT6 compounds.

The third strategy is exploratory, working towards building molecular libraries of neurobiologic targets through the identification of genes associated with schizophrenia, brain development and function, and the identification of candidate molecules. Once a "druggable" neurobiologic target is identified, the therapeutic molecule must be synthesized, formulated and tested in animal models before it is ready for human testing. New drug development in the 21st century for major mental disorders like schizophrenia must adhere to a rational process of drug discovery and development. This presentation will describe the current state of antipsychotic pharmacotherapy, adjunctive and polypharmacy, and innovative drug development.

LECTURE 12

Friday, October 5; 10:00 a.m.–11:30 a.m.

Inequality: The Enemy Between Us?

Lecturer: Richard Wilkinson, M.Med.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand the role of equality and inequality in a person's psychosocial well-being.

Overall Summary: Comparing life expectancy, mental health, levels of violence, teenage birth rates, drug abuse, child wellbeing, obesity rates, levels of trust, the educational performance of school children, or the strength of community life among rich countries, it is clear that societies which tend to do well on one of these measures tend to do well on all of them, and the ones which do badly, tend to do badly on all of them. What accounts for the difference? The key is the amount of inequality – measured by the size of the income gap between rich and poor – in each society. The picture is consistent whether we compare rich countries or the 50 states of the USA. The bigger the income differences in a society, the more ill health and social problems it has. Inequality has always been regarded as divisive and socially corrosive. The data show that even small differences in the amount of inequality matter. Material inequality serves as a determinant of the scale and importance of social stratification. It increases status insecurity and competition and the prevalence of all the problems associated with relative deprivation. Particularly important are effects mediated by social status, friendship and early childhood experience. However, although the amount of inequality has its greatest effect on rates of problems among the poor, its influence extends to almost all income groups: too much inequality reduces levels of well-being among the vast majority of the population.

LECTURE 13

Friday, October 5; 10:00 a.m.–11:30 a.m.

Non-Communicable Diseases (NCDS) and Integrated Care: Contemporary American & Global Challenges

Lecturer: Eliot Sorel, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Present current global burden of disease and disability evidence on non-communicable diseases' (NCDs) in the United States and globally; 2) Describe their impact on populations' health and health systems; 3) Define the challenges and opportunities for innovative health systems; 4) Present new health systems models of integrated care to meet the NCDs challenge; 5) Define the role psychiatry should play in primary care, mental health and public health integrated models, and identify the positive consequences of such models for training, services, research and policy.

Overall Summary: Non-communicable diseases (NCDs) lead in the global burden of disease in low-, middle- and high-income countries. Mental disorders lead among them representing 14% of the global burden of disease and between 30 to 45 % of the global burden of disability. A high level of comorbidity exists among NCDs including cardiovascular disorders, cancer, diabetes and depression. Early onset, late detection and interventions further augment severity of illness, refractoriness to treatments, increase the global burden of these diseases and health care costs. Contemporary American and global health systems are markedly fragmented, with a secondary and tertiary prevention, specialty focus, with little or no primary prevention and an insufficient populations' health focus. The consequence of such existing models are unsustainable health care and health systems' costs, rising burdens of diseases by NCDs and multiple comorbidities, chronicity, disability, insufficient access to care, premature death and dying. Solutions are beginning to emerge in response to contemporary and urgent American and global health challenges. Among them are the medical home, the medical neighborhood, and accountable care organizations. The author presents new models of health promotion, illness prevention and care that are integrated, team based, responsive, continuous, of quality, accessible and affordable. They are predicated on primary care, mental health and public health integration, the catalytic role that psychiatry should play in such models, and the positive consequences of such models for training, services, research and policy.

LECTURE 14

Friday, October 5; 10:00 a.m.–11:30 a.m.

Integrated Care: From Research to Practice

Lecturer: Jürgen Unützer, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Outline key arguments for integrating behavioral health and primary care services; 2) Provide an overview of the evidence-base for collaborative care programs at the interface of mental health and primary care; 3) Compare different psychiatric consultation models; 4) Help support the implementation of evidence-based integrated behavioral health care programs.

Overall Summary: This lecture will provide an overview of collaborative care and integrated behavioral health and primary care services. We will review the evidence-base for collaborative care and several examples of integrated care programs for diverse patient populations. We will also examine opportunities for psychiatrists to help implement evidence-based collaborative care programs to improve care and outcomes for individuals at the interface of mental health and primary care.

LECTURE 15

Friday, October 5; 1:30 p.m.–3:00 p.m.

Assisted Outpatient Commitment: The Data and The Controversy

Senior Scholar Health Services Research Award

Lecturer: Marvin Swartz, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Recognize the controversies about use of assisted outpatient treatment; 2) Discuss the results of empirical studies of assisted outpatient treatment; 3) Identify different forms of assisted outpatient treatment.

Overall Summary: Mandating adherence to mental health treatment in the community is among the most contested human rights issues in mental health law. While most American jurisdictions have statutes nominally authorizing involuntary outpatient commitment – a legal order to adhere to prescribed treatment in the community – until recently few states made substantial use of these laws. With the enactment of assisted outpatient treatment (AOT) in New York in 1999, in California in 2003, and in Florida, Michigan, and West Virginia in 2005, and the tragic deaths at Virginia Tech in the wake of a failed outpatient commitment order, policy interest in this topic has dramatically increased. AOT can best be understood in the context of a broad movement to apply available "leverage" to induce people with serious mental disorder to become engaged in treatment. This lecture will review the empirical literature on the effectiveness of the assisted outpatient treatment in the U.S., alongside the heated controversies about its use. We will also review recent research in New York to evaluate the effectiveness and cost impact of Kendra's Law, the largest and most intensively operationalized AOT program in the U.S.

LECTURE 16

Friday, October 5; 1:30 p.m.–3:00 p.m.

Trustin' Wise Ole' Owls: Racial Stress, Coping & Socialization in Black Families

Lecturer: Howard Stevenson, Ph.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand how racial stress and conflict is relevant to the experience of trauma; 2) Understand a theory that explains racial stress, coping, and socialization for youth and families; 3) Understand how racial stress and socialization are faced in family therapy with families of color; 4) Apply unconventional, culturally relevant, developmentally appropriate, gender-specific strategies with youth and families.

Overall Summary: Racial socialization is defined as the transmission and acquisition of intellectual, emotional, and behavioral skills to affirm and protect individual & collective racial self-efficacy for the reappraisal & negotiation (literacy) of racially stressful encounters. This workshop will discuss how this process is relevant to the theory and practice of novel culturally relevant therapy approaches to address trauma in Black youth and families. Recast theory is proposed as a model to reframe stress and trauma as workable realities during public interactions that take place in barbershops, basketball courts, school classrooms and therapy sessions.

LECTURE 17

Friday, October 5; 1:30 p.m.–3:00 p.m.

Cognitive Behavior Therapy for Personality Disorders

Lecturer: Judith Beck, Ph.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Use a cognitive conceptualization to guide treatment; 2) Conceptualize and solve therapeutic relationship problems; 3) Modify core beliefs.

Overall Summary: Patients with personality disorders frequently pose a special challenge in therapy, related, in part, to their very rigid, negative, overgeneralized beliefs about themselves, others, and their worlds and the coping strategies they have developed to get along in life. "Standard" cognitive behavior therapy often must be modified to forge a strong therapeutic alliance, to alleviate symptoms and help patients reach their goals. Therapy becomes especially difficult when patients' Axis II related beliefs become activated during treatment itself, leading these patients to employ their characteristic, dysfunctional coping strategies in the session. Through discussion and role play, I will demonstrate how to overcome difficulties in the therapeutic relationship, how to educate patients about their core beliefs, and how to modify core beliefs at an intellectual and an emotional level.

LECTURE 18

Friday, October 5; 1:30 p.m.–3:00 p.m.

Sex Offenders: Legal Responses to a Policy Dilemma

Lecturer: Paul Appelbaum, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand the dilemmas underlying recent legal approaches to sexual offenders; 2) Understand the impact of these developments on the mental health system; 3) Understand public safety implications of current approaches and possible alternatives.

Overall Summary: Until the late 20th century, sex offenders were commonly given indeterminate sentences, e.g., 10 years to life. There was some hope that such offenders could be rehabilitated, but in any case they would only be released from confinement when it was thought safe to do so. However, with changes in correctional fashions, including abandonment of the rehabilitative ideal and adoption of relatively inflexible determinate sentencing (e.g., fixed sentences of 10 years), the question of what to do with sex offenders whose prison terms were ending assumed new urgency. One response that continues to grow in popularity was the adoption of "sexually violent predator" statutes, allowing states to seek civil commitment of sex offenders after expiration of their prison sentences. The appropriateness of such statutes, the effectiveness of treatment provided, and the cost of the special facilities that have been built in many states all continue to be matters of intense debate. However, since only a small percentage of convicted sex offenders are subject to civil commitment, the majority reside in the community after completing their sentences. As this became clear, states and the federal government responded to intense political pressure by passing 3 types of statutes: sex offender registration laws, community notification laws, and restrictions on the location of residences and workplaces for sex offenders. These laws, however, are based on inaccurate premises about the likelihood of recidivism by sex offenders and the circumstances in which offenses occur; are expensive and difficult to enforce; tend to be deployed indiscriminately; and in the end are likely to be counterproductive. Adoption of more rational approaches to dealing with sex offenders is difficult in the charged environment that surrounds this issue, but is more likely to be protective of the public in the long run.

LECTURE 19

Friday, October 5; 1:30 p.m.–3:00 p.m.

Preparing for the New Healthcare Ecosystem: Integrating Behavioral & Physical Health

Lecturer: Linda Rosenberg, M.S.W.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand cost containment and quality improvement drivers of healthcare reform/change; 2) Learn about current integration models including state Medicaid health home option; 3) Explore applications and implications of health IT; and examine behavioral health workforce issues/potential solutions.

Overall Summary: The evidence is in and it is clear that we will not improve the health of our nation without addressing untreated behavioral health disorders. Improved mental health and addictions treatment is emerging as a priority in health reform, and community behavioral health organizations and practitioners are well-suited as key allies toward the triple aim of improved cost, quality and access. Following the Supreme Court ruling on the Accountable Care Act, both political and marketplace pressures to control costs continue to mount with focus on policy experimentation, service impact and the application of health information technologies. In this context, community behavioral health has key roles: as a collaborative resource to general healthcare; as a direct specialty health service provider; and as a community partner for innovation in improving the health of target populations. This session will describe, in practical terms, opportunities and challenges in this era of reform for practitioners, organizations, policy makers, health plans and consumers.

LECTURE 20

Friday, October 5; 3:30 p.m.–5:00 p.m.

Recovery Oriented Prescribing: Increasing the Effectiveness of Psychiatric Medications

Lecturer: Ronald Diamond, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Engage clients more in medication decisions; 2) Target medication towards client's own life goals; 3) Increase the effectiveness of prescribed medications.

Overall Summary: Medication is often considered the critical element of treatment, especially for people with serious mental illness. A person is typically labeled "treatment resistant" if he or she refuses to take medication, even if willing to participate in other forms of treatment. Too often there too little thought about the goals of taking the medication, the meaning of medication for the client, or how to balance risks and benefits. Medication is neither "good" nor "bad." Rather it is a tool that may, or may not, be useful. Medication can interfere with a person's sense of personal control. Medication can also increase personal empowerment. This lecture will discuss the social and psychological issues connected to the use of psychiatric medication, and suggest ways that medication can be used to help people be more effective in working towards their own goals. A medication trial starts with a clear understanding of the problem that is hoped might be helped by medication. It must include consideration of what else the person can do, besides taking medication, to impact this problem. And it must include a clear description of what getting better would mean.

LECTURE 21

Saturday, October 6; 10:00 a.m.–11:30 a.m.

Comparative Effectiveness of Collaborative Chronic Care Models for Mental Health Conditions Across Primary, Specialty and Behavioral Health Care Settings: Systematic Review and Meta-Analysis

American Journal of Psychiatry Editor's Choice Award

Lecturer: Mark Bauer, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Be able to identify the six elements of the Chronic Care Model; 2) Assess the strength of evidence regarding application of the Chronic Care Model to various mental health conditions; 3) Understand the relative advantages and limitations of meta-analysis and systematic review approaches to this issue.

Overall Summary:

Objective: Collaborative chronic care models (CCMs) improve outcome in chronic medical illnesses and depression treated in primary care. Impact across other treatment settings and mental health conditions has not been comprehensively assessed. We therefore utilized systematic review and meta-analysis to assess the comparative effectiveness of CCMs for mental health conditions across disorders and treatment settings.

Methods: Randomized controlled trials of CCMs vs. other care conditions published or in press through 8/15/11 were identified via literature search and contact with investigators. CCMs were defined a priori as interventions having >3 of 6 Improving Chronic Illness Care elements: patient self-management support, clinical information systems, delivery system redesign, decision support, organizational support, and community resource linkages. Articles were included that reported CCM impact on mental health symptoms or mental quality of life. Data extraction included analyses of these outcomes plus social role function, physical and overall quality of life, and costs. Meta-analyses included comparisons using unadjusted continuous measures.

Results: Seventy-eight articles yielded 161 analyses from 57 trials (depression n=40; bipolar disorders n=4; anxiety disorders n=3, mixed/other disorders n=10). Meta-analysis indicated significant effects across disorders and care settings in depression, mental and physical quality of life, and social role function (d=0.20-0.33). Total healthcare costs did not differ from controls. Systematic review largely confirmed and extended these findings across conditions and outcome domains.

Conclusions: CCMs can improve mental and physical outcome for individuals with mental disorders across a wide variety of care settings and provide a robust clinical and policy framework for care integration.

LECTURE 22

Saturday, October 6; 10:00 a.m.–11:30 a.m.

Community Health Centers – A Historical Perspective on CHCS and Behavioral Health

Lecturer: Maxine Golub, M.P.H.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand the history of the community health center movement; 2) Demonstrate knowledge of the goals and methods for integrating primary care and behavioral health; 3) Understand current challenges and lessons learned to date and goals for the future.

Overall Summary: This lecture will focus on history of the community health center movement, how and why it began, and where it has come in its 50 years. It will also look at the integration of primary care and mental health services, looking at challenges and lessons learned to date, including the impact of this integration on patients. Finally, it will explore our goals for the future.

LECTURE 23

Saturday, October 6; 10:00 a.m.–11:30 a.m.

Mental Diversity: 13 Practical Innovations to Improve Recovery Outcomes for Schizophrenia and Bipolar

Lecturer: Will Hall, M.A., DiplPW

Educational Objectives: At the conclusion of this session, the participant should be able to: 1 Understand the role of lived experience psychosis recovery for a "mental diversity" perspective in mental health; 2) Identify 13 promising practices in the standard of care, clinical practice, and agency policy that impact treatment and diagnosis for schizophrenia, bipolar and psychosis; 3) Demonstrate how these practices support improving recovery outcomes; 4) Identify potential obstacles to implementation of these practices.

Overall Summary: What can advocacy by people who have recovered from psychotic experiences teach us about improving mental health care treatment? Do existing standards of care for schizophrenia and bipolar truly realize positive recovery outcomes? What promising practices are emerging in clinical settings to improve these outcomes, and what does evidence based research have to say about these practices? What are the obstacles to their wide adoption? This session will outline the clinical and policy innovations being developed across the U.S. and around the world at the forefront of collaborations between peer recovery specialists, clinicians, researchers, and program administrators. We'll address promising practices in the areas of medication optimization, hospital diversion, early intervention, family member involvement, suicide response, police – community interactions, diagnosis, treatment non-compliance, multiculturalism, patient education, and more, drawing on lessons from U.S. peer recovery specialists, the international Hearing Voices Movement, and Finland's Open Dialogue.

LECTURE 24

Saturday, October 6; 1:30 p.m.–3:00 p.m.

Poverty as a Factor in Social Crisis and Human Disasters

APA Administrative Psychiatry Award

Lecturer: Pedro Ruiz, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand the relationship between poverty and mental illness; 2) Understand the role of disparities in the current health care system of the U.S.A.; 3) Identify the set of values that need to be implemented in the current health and mental health care system in the U.S.A.

Overall Summary: Now-a-days, it is clear that poverty plays a major role as a factor in social crisis and in human disasters. The impact of social class upon mental illness has been addressed and demonstrated by seminal studies during several decades. The studies conducted by E. Durkheim, R.E.L. Faris and H.W. Durham, M.H. Brenner, A.B. Hollingshead and F.C. Redlich, and many other scientists have without doubt clearly delineated the relationship between poverty, social class and mental illness. More recently, the relationship between economic factors, stress and health related outcomes have again pointed out the close relationship between these factors and conditions. Currently, we can anticipate and diagnose a series of illnesses, medically and psychiatrically, that are intrinsically connected to poverty and the stress generated by poverty. The populations of the United States clearly demonstrate and confirm these factors and conditions. It is therefore imperative that we address the disparities that evolved from discrimination and negative perceptions of these problems in healthcare. In this presentation, approaches to deal with these discriminatory practices in health and mental health care will be discussed and positively addressed. Appropriate solutions must be found and implemented.

LECTURE 25

Saturday, October 6; 1:30 p.m.–3:00 p.m.

CANCELLED

TBD

APA Alexander Gralnick Award

LECTURE 26

Saturday, October 6; 3:30 p.m.–5:00 p.m.

Unmasking Homophobia: Does Coming Out Still Matter?

APA John Fryer Award

Lecturer: Marjorie Hill, Ph.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Identify examples of coming out as a metaphor for change in adult development; 2) Describe the significance of advocacy and social change on enhancing both individual and LGBT community resiliency and positive outcomes; 3) Recognition of the challenges of internalized homophobia and transphobia as impediment to success; 4) Identify effective models of community engagement as coping skills in a myriad of LGBT and heterosexual environments.

Overall Summary: We have indeed come a long way since John Fryer's 1974 masked coming out at the 1974 American Psychiatric Association meeting. This post-Stonewall, pre-AIDS act of rebellion transformed history and shook the mental health field. The intervening 40 years have brought about innumerable legislative, cultural and communal LGBT victories. From removal of gay as a mental health disease to legal marriage in several states; from openly gay teachers to gays in the military; from to Will and Grace to Noah's Ark - the LGBT community's rise in visibility has been phenomenal. Yet sexual identity remains a too often stereotypically misunderstood or patently pre-judged lifestyle "choice." Anti-gay violence and bullying are on the rise. HIV/AIDS prevention and education efforts are stymied by stigma. Homophobia persists as a powerful influence on the day-to-day experiences of LGBT people. Does coming out still matter? Perhaps even more so, society at large needs to address understand and create a roadmap to understanding sexual orientation diversity. Anecdotal material needs to be supplanted by analytical data. Neither economic nor political success can replace the personal sharing and interpersonal knowing. We must identify the present day "masks" that challenges LGBT community success.

LECTURE 27

Saturday, October 6; 3:30 p.m.–5:00 p.m.

When Can and Will the Horrors of Physical Violence and Psychological Terrorism Be Greatly Lessened and Even Eliminated?

Lecturer: Leah J. Dickstein, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand, as physicians i.e., teachers, we must assume responsibility and make time as we can, to educate our colleagues in medicine and all patients and families/significant others, about the realities of terrorism in their lives and communities across the life cycle; 2) Understand, as physicians, we can use our earned professionalism to educate our community leaders and workers as to why and how they must choose to use their good power to identify terrorism and develop plans from day-one of life for children, parents, educators to change attitudes and consequent behaviors to focus on respect and cooperation to foster safe lives in homes and in communities, schools and on all streets; 3) As physicians, particularly psychiatrists, we are trained to understand and evaluate the genetics, physiology, psychiatric and other medical issues of potential good mental health and consequent behaviors and how to enable others to understand how behaviors and lives can be affected and improved with each person's ongoing commitment and efforts, including seeking help sooner than later or not at all.

Overall Summary: If too many believe we can't do anything about violence and its broader term, terrorism, which includes psychological factors, most of us will feel and remain fearful and powerless to effect positive changes in our and others' lives locally and worldwide. We must rethink the possible through the power of people, our most valuable asset, ready and willing to learn to assume some responsibility and appropriate planned good risks to improve the world toward goals of education, including respect for differences, fairness, ethics, understanding self and others, cooperation, teamwork, creativity and imagination. Nothing is unbelievable. Stereotypes about victimizers and victims and abuses of power by too many, while the majority remain fearful, and too often in denial until they are affected, solves nothing. This presentation will focus on the individual, community, national and international responsibilities of all people, women and men, of all ages, cultures, socioeconomic status, education, faith, health, sexual orientation, and good powers, willing to assume, at various levels and times, responsibilities to slowly, steadily and effectively plan forward to change: awareness, understanding, attitudes, consequent behaviors, including repercussions and rewards for actions and inactions from birth to death and treatment or mistreatment.

LECTURE 28

Sunday, October 7; 8:00 a.m.–9:30 a.m.

How Is Religion Relevant to Psychiatry?: Research and Applications

APA Oskar Pfister Award

Lecturer: Harold Koenig, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) To understand the historical relationship between religion and psychiatry; 2) To learn about the role of religion in coping with stress, loss, and physical illness; 3) To become aware of the research on religion and mental health, and the findings; 4) To understand how religion may influence mental health or disorder and 5) To learn how to apply these research findings to clinical practice.

Overall Summary: Dr. Koenig will provide a brief history of the relationship between religion and psychiatry, will examine the use of religion to cope with stress and trauma, and will review quantitative research examining relationships between religious involvement and positive emotions, human virtues, social functioning, negative emotions, mental and substance abuse disorders. He will then develop a theoretical model to try to explain and understand these relationships. He will also address applications to clinical practice, including a brief discussion of an ongoing randomized clinical trial examining the effects of religious vs. conventional CBT in major depression.

LECTURE 29

Sunday, October 7; 8:00 a.m.–9:30 a.m.

Research on Socially Assigned Race, Health and Mental Health

Lecturer: Camara Jones, M.D., M.P.H., Ph.D.

LECTURE 30

Sunday, October 7; 10:00 a.m.–11:30 a.m.

Early Intervention and Youth Mental Health Models of Care: 21st Century Solutions to Strengthen Mental Health Care and Modern Society

Lecturer: Patrick McGorry, M.D., A.O., Ph.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand how recent research has improved the prospects for understanding complex disorders like schizophrenia; 2) Understand how the developmental needs of adolescents and emerging adults are not met by current conceptual models; 3) Understand the need for international structural research reform and innovation in this area.

Overall Summary: Mental and substance use disorders are among the most important health issues facing society. They are by far the key health issue for young people in the teenage years and early twenties, and if they persist, they constrain, distress and disable for decades. Epidemiological data indicate that 75% of people suffering from an adult-type psychiatric disorder have an age of onset by 24 years of age, with the onset for most of these disorders – notably psychotic, mood, personality, eating and substance use disorders – mainly falling into a relatively discrete time band from the early teens up until the mid-20s, reaching a peak in the early twenties. While we have been preoccupied with health spending at the other end of the lifespan, young people have the greatest capacity to benefit from stepwise evidence-based treatments and better health care delivery. In recent years, a worldwide focus on the early stages of schizophrenia and other psychotic disorders has improved the prospects for understanding these complex illnesses and improving their short term and longer term outcomes. This reform paradigm has also illustrated how a clinical staging model may assist in interpreting and utilising biological data and refining diagnosis and treatment selection. There are crucial lessons for psychiatric research and treatment, particularly in the fields of mood and substance use disorders. Furthermore, the critical developmental needs of adolescents and emerging adults are poorly met by existing conceptual approaches and service models. The paediatric-adult structure of general health care, adopted with little reflection by psychiatry, turns out to be a poor fit for mental health care since the age pattern of morbidity of the latter is the inverse of the former. Youth culture demands that young people are offered a different style and content of service provision in order to engage with and benefit from interventions. The need for international structural reform and an innovative research agenda represents one of our greatest opportunities and challenges in the field of psychiatry.

POSTER SESSION 1

Thursday, October 4; 8:30 a.m.–10 a.m.

PS1-01

Gabapentin: An Adjunctive Therapy in Treating Anxiety Disorders

Yakir Vaks, M.D., Sree Latha Krishna Jadapalle, M.D., Amel Badr, M.D.

Abstract:

Background: Anxiety disorders are common and very disruptive to patient's personal and social life. SSRIs are the current gold standard medications. However, they are effective in approximately 50% to 60% of patients. It is important to explore new areas of research in psychopharmacology of anxiety. Gabapentin is used as an add-on treatment in different anxiety disorders such as panic disorder, obsessive-compulsive and post-traumatic stress disorder. The mechanism of action of Gabapentin is alteration of L-amino acid transport system and modulation of L, N, and P/Q type of voltage dependent calcium channels. The available research shows conflicting evidence of gabapentin being effective in the treatment of severe and moderate anxiety, there is little evidence of it being effective in treating mild anxiety.

Objective: To determine the effectiveness of Gabapentin as an adjunctive therapy in patients with anxiety disorders.

Methods: We conducted a retrospective study to collect and analyze the data of 44 patients from the community hospital outpatient clinic who had DSM-IV diagnoses for anxiety disorders and were prescribed gabapentin in a daily range of 300-1800 mg to control their symptoms of anxiety. HAM-A scale is used to assess the anxiety and according to the score patients were grouped as having severe [25-30], moderate [18-24], mild [14-17] anxiety, or normal [<14]. We assessed the baseline Ham-A score and recorded their follow-up HAM-A scores every 3 months, over a period of one year. Our inclusion criteria include patients with Generalized Anxiety disorder, Social Anxiety disorder, Obsessive-Compulsive disorder, Post Traumatic Stress disorder and Panic disorder. To control for substance abuse or dependence associated anxiety, our study excluded patients with co-morbid substance abuse or dependence.

Results: Among the total 44 patients with anxiety disorder, 18 were females and 26 males. The baseline HAM-A scales showed 63.63% [n=28] patients with moderate anxiety, 22.72% [n=10] with severe, and 13.63% [n=6] with mild anxiety. Tukey's test (ttest) results on the severe, moderate and mild anxiety data are as follows: [1] Severe Anxiety: HAM-A 2nd, HAM-A 3rd and HAM-A 4th are significantly different from HAM-A baseline with a P-value of <0.01.[2] Moderate Anxiety: HAM-A 2nd, HAM-A 3rd and HAM-A 4th are significantly different from HAM-A baseline with a P-value of <0.01. [3] Mild Anxiety: HAM-A 2nd, HAM-A 3rd is significantly different from HAM-A baseline with a P-value of <0.05 while HAM-A 4th is significantly different from HAM-A baseline with a P-value of <0.01.

Conclusions: Based on the results of our study, the effectiveness of Gabapentin as an adjunctive medication choice to manage anxiety spectrum illness is clearly supported for all ranges of illness severity.

PS1-02

A Case of He Chewed His Fingers Off

Carmen Casasnovas, M.D., Aracelis Johanna Lu, M.D.; Melissa Begolli, M.D.; Raj Addepalli, M.D.

Abstract:

Introduction: A 66 year old Hispanic man came to the ED for a wound check of his left hand. The patient stated he did not know how he sustained the injury. Documents from the EMR showed a history of self-mutilation. He later admitted to biting the fingers and nails of his left hand when he felt worried. The patient had nibbled his left 5th digit down to the DCP joint and caused injury to his 1st and 3rd finger on the same hand. He reported that he had not bitten his hands in "months" as he had them wrapped in bandages, so he supplanted the finger biting tendencies by biting his shirt collar when worried. Per chart, the patient had reported that he bit his fingers because he was having obsessive thoughts and once he bit his fingers, the anxiety and obsessive thoughts resolved. While being evaluated in the ED, he bit off the tip of his finger and was admitted to the inpatient medical floor as he was found to have a MRSA infection. He recalls his behavior began after his friend had passed away from AIDs related complications. He also endorsed that he had a congenital disorder of his left hand that left it insensate and resulted in a surgery he described as "taking nerves from one part of the arm and putting them on the other." The patient reported a history of anxiety that was treated for a while with a "little yellow pill." The Consult Liaison Service diagnosed him with obsessive-compulsive disorder (OCD). Review of his medical record revealed that he had been diagnosed 5 years prior with mild dementia treated with Aricept 10mg at bedtime but complete dementia workup was not found and subsequent visits did not document dementia.

Discussion: Self-mutilation is often associated with intrusive thoughts, impulses or obsessions that may fall within the category of the OCD spectrum. Our patient does not meet criteria for OCD and did not rate significantly on the Dimensional Obsessive-Compulsive Scale. His history of uncontrolled diabetes may lead us to consider peripheral neuropathy causing his fingers to be less sensitive to pain and enabling a person prone to anxiety and fingernail biting to take this action a step further if tolerance for pain was no longer an obstacle in the path of self-gratification. Data indicates that patients with dementia may at times be at increased risk of self-injurious behavior, unfortunately

his history of dementia was not followed up. We suspect the finger biting is the result of a multi-factorial etiology involving anxiety, obsessions, the need for immediate self-gratification, as well as a biologic component brought upon by his possible peripheral neuropathy. This is where the importance of an adequate follow up comes to play in order to monitor the patient's progress, gain tight control of his diabetes, decrease infections and provide counseling and support to reduce psychogenic factors that increase the risk of self-mutilation.

PS1-03

Web-Based Depression Screening and Psychiatric Consultation for College Students: A Feasibility and Acceptability Study

Aya Inamori, B.A., Rachel LaRocca, B.A., Trina Chang, M.D., MPH, Nhi-Ha Trinh, M.D., MPH, Maurizio Fava, M.D., Albert Yeung, M.D., ScD

Abstract: Major depressive disorder (MDD) is a highly prevalent illness. College students are at particular risk for depression due to developmental transitions, academic pressure and increasing financial strains. Campus-based services are struggling to provide for an increasing number of students seeking mental health services. Previous literature has shown that online depression screening is a cost-effective method of identifying college students with depression. This study investigates the feasibility and acceptability of web-based psychiatric consultation for college students using personal computers, webcam, and Skype, a free video-conferencing software. Students were invited to complete a mental health survey via Facebook, craigslist, e-mails and flyers. The online survey included demographic data, history of depression and treatment, and the 9-item Patient Health Questionnaire (PHQ-9) for depression screening. All students received online psycho-education material at the conclusion of the survey. Students who screened positive (PHQ-9=10) or endorsed any level of suicidal ideation were offered a Skype-based psychiatric consultation with a licensed psychiatrist free of charge. After the consultation, students filled out 7-item satisfaction questionnaire. 972 students currently attending a university in Massachusetts consented to the depression screening survey. 262 students (30.4%) screened positive for MDD or showed some levels of suicidal ideation and were offered a psychiatric consultation using Skype-based videoconferencing. 69 students (26.3%) consented to participate and 17 students (24.6%) successfully scheduled and completed the consultation. 14 students (87.5%) reported that sound quality was clear and 13 students (81.3%) reported that visual quality was clear. 13 students (81.3%) found the interview useful in helping them understand their depression. 15 students (93.8%) considered that psychologists and psychiatrists can successfully see patients via video-conferencing. The current study shows that online screening survey followed by psychiatric consultation using personal computer, webcam, and Skype is a feasible and acceptable means of recognizing and treating depression among college students. Students rated the experience highly. This web-based model may provide a promising service to recognizing and treating college students with depression.

Audience: Psychiatrists, psychologists, social workers, mental health clinicians, students and trainees.

PS1-04

Long-Term Safety and Tolerability of Once Monthly Aripiprazole-Intramuscular-Depot for Maintenance Treatment in Schizophrenia

Ross Baker, Ph.D., Wolfgang Fleischhacker, M.D., Raymond Sanchez, M.D., Pamela Perry, M.S., Na Jin, M.S., Brian Johnson, M.S., Robert A. Forbes, Ph.D., Robert D. McQuade, Ph.D., William H. Carson, M.D., John Kane, M.D.

Abstract:

Objective: To understand the safety and tolerability profile of aripiprazole-intramuscular-depot (ARI-IM-depot) during maintenance treatment of schizophrenia.

Methods: Subjects requiring chronic treatment with an antipsychotic were eligible. Subjects not already on aripiprazole monotherapy were cross-titrated during weekly visits from other antipsychotic(s) to oral aripiprazole monotherapy during the 4–6 weeks oral conversion phase (Phase 1). All subjects requiring chronic treatment with an antipsychotic entered a 4–12-week oral stabilization phase (Phase 2) and received oral aripiprazole (10–30 mg/day). Subjects meeting stability criteria for 4 weeks then entered an IM-depot stabilization phase (Phase 3), wherein they received ARI-IM-depot injections every 4 weeks (400 mg, single decrease to 300 mg permitted) with co-administration of aripiprazole oral tablets in the first 2 weeks. Subjects meeting stability criteria for 12 consecutive weeks were randomized to ARI-IM-depot or placebo, during a 52-week, double-blind maintenance phase (Phase 4). Safety of treatment was assessed across the study phases by time of first onset of adverse events (AEs), changes in movement disorder rating scales and changes in weight and metabolic parameters

Results: The study was stopped early because efficacy was demonstrated by the pre-planned interim analysis (conducted after 64 relapses). ARI-IM-depot was well tolerated with similar rates of AEs across all phases. Discontinuations due to treatment-emergent AEs were: Phase 1, 3.8% (n=24/632); Phase 2, 3.0% (n=21/709); Phase 3, 4.9% (n=28/576); Phase 4, 7.1% (n=19/269). Most AEs were mild or moderate; severe AEs were rare (<5.0% incidence in all phases). AEs >5% incidence in any phase were: insomnia (all phases); headache (Phases 1, 3 and 4); anxiety, akathisia, weight increase (Phase 3 and 4); injection-site pain (Phase 3); and tremor (Phase 4). The majority of AEs (headache, somnolence, nausea) had a peak first onset within the first 4 weeks of treatment. The incidence of treatment-emergent extrapyramidal symptoms (EPSs) was similar in all phases (Phase 4 ARI-IM-depot, 14.9% vs. placebo, 9.7%). Mean baseline weight in each phase was similar (range 80.4–84.8 kg). Mean changes in weight from baseline were Phase 1, –0.2 kg; Phase 2, 0.1 kg; Phase 3, –0.2 kg; and Phase 4, –0.2 vs. –0.4 kg (ARI-IM-depot vs. placebo, respectively). There were no unusual shifts in laboratory values or fasting metabolic parameters across all study phases. Shifts from normal to high metabolic values occurred at similar low rates between ARI-IM-depot and placebo in the double-blind phase.

Discussion: No unexpected AEs emerged during the transition to IM-depot, or with long-term ARI-IM-depot. Rates of AEs in Phase 1 were no different than rates in Phase 2, suggesting that the study switch strategy was useful. These data suggest that ARI-IM-depot offers a new option with a different risk–benefit profile than currently available treatments.

PS1-05

Lurasidone Adjunctive to Lithium or Valproate for the Treatment of Bipolar I Depression: Results of a 6-Week, Double-Blind, Placebo-Controlled Study

Antony Loebel, M.D., Josephine Cucchiaro, Ph.D., Robert Silva, Ph.D., Jay Hsu, Ph.D., Kaushik Sarma, M.D., Gary Sachs, M.D., Joseph R. Calabrese, M.D.

Abstract:

Objective: To evaluate the efficacy and safety of lurasidone, adjunctive to lithium or valproate, in patients with bipolar I depression, without psychotic features.

Methods: Subjects meeting DSM-IV-TR criteria for bipolar I depression with a Montgomery Asberg Depression Rating Scale (MADRS) score =20, were randomized to 6 weeks of double-blind (DB) treatment with either lurasidone 20-120 mg/day (LUR) or placebo (PBO), both adjunctive to either lithium (Li) or valproate (VPA). Therapeutic blood levels of Li or VPA had to be maintained for = 28 days prior to randomization. Changes from DB baseline (DB BL) in MADRS (primary endpoint), and secondary efficacy outcomes were analyzed using either mixed model repeated measures (MMRM) or analysis of covariance, last observation carried forward (ANCOVA-LOCF), or logistic regression.

Results: Overall, 78% of LUR – (143/183) and 83% of PBO-treated subjects (136/163) completed the study. Mean MADRS scores at DB BL were similar for LUR (30.6) and PBO (30.8), indicative of moderate-to-severe depression. At Week 6 study endpoint, LUR was associated with a significantly greater MADRS reduction vs. PBO (-17.1 vs. -13.5; $p < 0.01$; MMRM). Similarly, LUR treatment reduced CGI-bipolar severity (CGI-BP-S) depression ratings by -2.0 vs. -1.5 for PBO ($p < 0.01$; MMRM), and improved Sheehan Disability Scale (SDS) scores by -9.5 vs. -7.0 for PBO ($p < 0.05$; ANCOVA-LOCF). Significant improvements vs. PBO were also observed for anxiety symptoms, assessed by the HAM-A total score (-8.0 vs. -6.0; $p < 0.01$; ANCOVA-LOCF), and in quality of life, assessed by the Quality of Life, Enjoyment and Satisfaction Questionnaire (Q-LES-Q-SF; +22.2 vs. +15.9; $p<0.01$; ANCOVA-LOCF). Responder rates (reduction in MADRS =50%) were significantly higher for the LUR (57%) than for the PBO group (42%, Logistic Regression $p<0.01$). Discontinuation rates due to adverse events were 6% for LUR and 8% for PBO. Most frequently reported adverse events were nausea (17.5% vs. 11.0%), headache (10.4% vs. 12.3%), and somnolence (8.7% vs. 4.3%) for LUR vs. PBO, respectively.

Conclusion: In this study, adjunctive use of LUR compared to placebo significantly reduced depressive symptoms in patients with bipolar I depression who had inadequate response to either Li or VPA alone. LUR treatment also significantly improved measures of social and occupational function as well as quality of life. The tolerability and safety profile of LUR observed in this study was consistent with that reported in previous studies in schizophrenia. The following information concerns a use of lurasidone that has not been approved by the U.S. Food and Drug Administration. Trial registration: clinicaltrials.gov identifier: NCT00868452 Sponsored by Sunovion Pharmaceuticals Inc.

PS1-06

Lurasidone Monotherapy for the Treatment of Bipolar I Depression: Results of a 6-Week, Double-Blind, Placebo-Controlled Study

Antony Loebel, M.D., Josephine Cucchiaro, Ph.D., Robert Silva, Ph.D., Kaushik Sarma, M.D., Ph.D., Hans Kroger, MS, Joseph Calabrese, M.D., Gary Sachs, M.D.

Abstract:

Objective: To evaluate the efficacy and safety of lurasidone, flexibly dosed at 20-60 mg/day or 80-120 mg/day, in the treatment of major depressive episodes in patients with bipolar I depression without psychotic features.

Methods: Subjects meeting DSM-IV-TR criteria for bipolar I depression, with or without rapid cycling, with a Montgomery Asberg Depression Rating Scale (MADRS) score =20 and a Young Mania Rating Scale score =12, were randomized to 6 weeks of once-daily, double-blind treatment with either lurasidone 20-60 mg (LUR20-60), lurasidone 80-120 mg (LUR80-120) or placebo (PBO). Primary and key secondary endpoints were change from baseline to week 6 endpoint in MADRS and CGI-bipolar severity (CGI-BP-S) depression scores, respectively, analyzed using mixed model repeated measures (MMRM).

Additional secondary outcome measures were analyzed using analysis of covariance, last observation carried forward (ANCOVA-LOCF), or logistic regression.

Results: Study completion rates were 74.1% in the LUR20-60 group (n/N=123/166; mean modal dose, 34.9 mg/d), 73.4% in the LUR80-120 group (n/N=124/169; mean modal dose, 92.3 mg/d) and 74.7% in the PBO group (n/N=127/170). Lurasidone treatment resulted in significantly greater MADRS score reduction at Week 6 endpoint for both the LUR20-60 group (-15.4; p<0.001; effect size=0.51) and the LUR80-120 group (-15.4; p<0.001, effect size=0.51) vs. PBO (-10.7). Both LUR groups separated significantly from PBO from week 2 onward. Lurasidone treatment resulted in significantly greater endpoint reduction in CGI-BP-S depression scores for both the LUR20-60 group (-1.8; p<0.001) and the LUR80-120 group (-1.7; p<0.001) compared with PBO (-1.1). Responder rates (reduction in MADRS =50%) were significantly higher for LUR20-60 (53%) and LUR80-120 (51%) compared with PBO (30%; p<0.001 for both comparisons). Both LUR20-60 and LUR 80-120 groups showed significant improvement vs. PBO on the Hamilton Anxiety Rating scale (p=0.05), the Sheehan Disability Scale (p=0.01), the self-rated Quick Inventory of Depressive Symptomatology (p=0.01), and the Quality of Life, Enjoyment and Satisfaction Questionnaire (p=0.01). Discontinuation rates due to adverse events for LUR20-60 (7%) and LUR80-120 (6%) were similar to PBO (6%). For LUR20-60, LUR80-120, and PBO, respectively, the most frequently reported adverse events were nausea (10.4%, 17.4%, 7.7%), headache (14.0%, 9.0%, 11.9%), and akathisia (7.9%, 10.8%, 2.4%). Minimal changes in weight, lipids and measures of glycemic control were observed.

Conclusion: In this study, monotherapy with lurasidone, flexibly dosed at 20-60 mg/day or 80-120 mg/day, significantly reduced depressive symptoms in patients with bipolar I depression compared to placebo. Tolerability and safety of lurasidone was consistent with results of previous studies in schizophrenia. The following concerns a use of lurasidone not approved by the FDA Sponsored by Sunovion Pharmaceuticals Inc.

PS1-07

Evaluation of the Prevalence and Severity of Depression in Patients With Obsessive-Compulsive Disorder (OCD)

Rupal Patel, M.D.; Dr. Himanshu Tyagi, MRCPsych, Dr. Lynne Drummond, MRCP, MRCPsych

Summary: Current research evidence suggests that comorbid depression with OCD leads to poorer treatment outcomes. As depression frequently accompanies OCD, it can be one of the most important factors in producing refractoriness for OCD treatment. Our study investigated all patients with a primary diagnosis of treatment refractory OCD who were accepted for outpatient treatment at a specialist OCD service in London between 1st January 2008 and 30th June 2010. We explored the relationship between OCD, depression and treatment outcomes. Standardised measures for assessment of the severity of OCD and depression were completed at assessment, mid-treatment, discharge and follow-up reviews up to 1 year after completion of treatment. Yale Brown Obsessive Compulsive Scale (Y-BOCS) was used to assess the severity of OCD. To assess the symptoms and severity of co-morbid depression, self-rated Beck Depression Inventory (BDI) and clinician rated Montgomery Asberg Depression Rating Scale (MADRS) were used. PADUA inventory was used to assess the symptoms of OCD. Routinely collected social and demographic data were also used to understand the role of any additional factors in treatment outcomes. Preliminary results indicate that greater than two-thirds of treatment-refractory patients in our sample (n=158) were depressed. Differences in symptom severity and treatment response between depressed and non-depressed OCD patients were found and their statistical and clinical significance is being analysed.

PS1-08

Hyponatremia Induced Psychosis in a 38-Year-Old Male on Citalopram

Jamsheed Khan, M.D.; Jessica M. Cunningham, MSIII; Ayme Frometa, M.D.; Amel Bader, M.D.

Summary: The patient is a 38 year old Indian male, unemployed with a 6 month psychiatric history of Anxiety Disorder NOS and Major Depressive Disorder. He has been following up with his psychiatrist. Began experiencing symptoms of anxiety and depression, and thus sought treatment. At that time his psychiatrist started him on Citalopram 20mg PO daily and Klonopin 0.5mg PO BID. Despite compliance with his medication and weekly therapy sessions, the patient experienced increased anhedonia, sleep disturbances, intense guilt, and weight loss of 35 pounds over the course of six months. Eventually, the Celexa was increased to 40 mg. Presented with disheveled appearance, internal preoccupation, disorganized behavior and persecutory delusions for 1 day. Additionally, the patient had been non compliant with his medication for past 4 days, he was also experiencing auditory hallucinations telling him that he had done wrong and deserved to be punished. On admission, urine tox screen and BAL were negative. The only abnormality was hyponatremia, with Na+ of 125mmol/l. His urine osmolarity was within normal limits at 503 mOsm/L. Although polydipsia, intermittent hyponatremia, and psychosis (PIP syndrome) is a documented phenomenon associated with schizophrenia6, the patient's urine osmolarity rules out water intoxication or SIADH5. Psychosis and depression can also be the presenting symptoms of an Addisonian crisis7, but with a normal cortisol level of 10.1μg/dL, this differential diagnosis was also excluded. His TSH was 4.94 mIU/L, with T4 within normal limits, indicating subclinical hypothyroidism. A head CT did not reveal any acute pathology. All other lab work was within normal limits. Based on his lab work and clinical presentation it was determined that the patient's psychosis was induced by his hyponatremia. The patient was restarted on Celexa 40mg PO daily and Klonopin 0.5mg PO BID. Additionally, he was started on Risperdal 2mg BID to manage his psychotic symptoms, and placed in group and individual therapy sessions. After four days, his Risperdal was increased to 3 mg BID and Cogentin was added. On the sixth day of admission, Risperdal was discontinued and Perphenazine was given to reduce extrapyramidal symptoms that the patient had been experiencing. Nothing was done to correct the sodium levels other than nutritional support, by day seven his Na+ as 136 mmol/l and his feelings of guilt and persecutory delusions had lessened significantly.

Discussion: It seemed most probably that the patient's poor nutritional status, which had resulted in a 35 pound weight loss, was responsible for the disturbance in his sodium level6.

Conclusion: When patients report loss of weight or when the physician notices a decrease in the patient's weight, instead of changing the antidepressants physicians should also include the factors like less fluid intake as a possible cause of electrolyte imbalance and therefore electrolyte panels should be obtained at regular intervals.

PS1-09

An Uncommon Cause for Serotonin Syndrome With a Common Medication Combination

Nicole Guanci, M.D.

Abstract:

Background: Serotonin syndrome is a well-known syndrome that develops with an overdose or combination of serotonergic pharmacologic agents. However, other potential causes include drug-drug interactions involving pharmacokinetic properties of medications, specifically interactions at the cytochrome enzyme system. We report a case involving a patient who developed serotonin syndrome on two commonly used medications – haloperidol and sertraline.

Case Report: We present a case of a 19 year old man with Major Depressive Disorder with psychotic features on haloperidol 5mg PO daily, benztropine 2mg PO daily, and sertraline 100mg PO daily. He presented to the Emergency Department 12 hours after ingesting 2 extra doses of haloperidol 5mg, with tremors, rigidity, nausea, and vomiting. Physical exam showed increased lower extremity muscle tone, bilateral upper extremity fine tremors, 4 + reflexes bilaterally, 3 beats of clonus in the left ankle, and sustained clonus in the right ankle. Blood pressure was 136/69, heart rate was 89, temperature was 36.6 °C, and respiratory rate was 18. The remainder of the physical exam was within normal limits. Laboratory studies revealed a creatinine kinase (CK) level of 1074. On admission, he was started on IV hydration and lorazepam 2mg IV every 2 hours prn for a suspected diagnosis of serotonin syndrome. Mental status exam showed underproductive speech, "ok" mood, and flat affect. He denied suicidal ideation, homicidal ideations, auditory or visual hallucinations. Over 48 hours of admission, symptoms gradually improved. No sources of infection were found. His CK trended down and vital signs remained stable. He was then discharged without psychotropic medications until re-evaluated by his outpatient psychiatrist.

Discussion: Our patient's symptoms in the context of sertraline use were considered consistent with Serotonin syndrome. In this case, the interaction of haloperidol and sertraline involving the cytochrome 2D6 system was the suspected etiology. The potential for serotonin syndrome exists because reduced haloperidol, a metabolite of haloperidol, acts as a potent inhibitor on cytochrome 2D6. Since sertraline is a substrate of this cytochrome enzyme, haloperidol's inhibition raises serotonin levels, causing an increased serotonergic state.2

Conclusion: Although serotonin syndrome is a well-known phenomenon, our case highlights the importance of monitoring for milder cases, particularly in the context of commonly used regimens. Further, vigilance is important for the consult-liaison psychiatrist, in addition to the outpatient clinician, to monitor for drug-drug interactions at the cytochrome enzyme system, considering that even minor contributions of substrate metabolism may lead to serotonin syndrome.

PS1-10

Exacerbation of Preexisting Actinic Keratosis During Repetitive Transcranial Magnetic Stimulation Treatment: A Case Report

Ye-Ming Sun, M.D., Ph.D., T. Khurshid, M.D., F. Limson, G. Caracci, M.D.

Abstract: Transcranial Magnetic Treatment (TMS) has been used effectively for treating depression with minor side effects, such as local skin irritation, which are usually mild and tolerable. However, the effect of TMS on pre-existing skin conditions has not been well addressed in the literature. We here report a case in which TMS worsened actinic keratosis. Mr. B is an 85-year old male with a longstanding history of recurrent severe major depressive disorder who was referred for TMS. Mr. B also has actinic keratosis on his scalp. His dermatologist was consulted during the initial medical clearance evaluation and she endorsed using TMS for Mr. B's depression. rTMS was applied using the standard NeuroStar system with additional medical cotton cheese cloths between the scalp and the coil pad during treatments. After 15 sessions of repetitive TMS (rTMS) treatment, patient's HAMD score dropped from 36 to 3. However, the keratosis lesions under the stimulation coil

had increased in number. With dermatological treatment, Mr. B's skin lesions have been under control since he finished all his rTMS treatment sessions. This case shows that rTMS can cause exacerbation of pre-existing skin condition, such as actinic keratosis.

PS1-11

Can Major Depressive Disorder Predispose the Development of Fibromyalgia?

Carolina Mercader D.O., Sarah Sheikh, M.D.

Abstract:

Objective: To find a more clear physiological association between Fibromyalgia and Major Depressive Disorder. We present a case of a patient with Fibromyalgia and Major Depressive Disorder whom developed FMS several years after being diagnosed with Major Depressive Disorder.

Introduction: Fibromyalgia (FMS) is characterized by chronic widespread musculoskeletal pain and stiffness in association with fatigue and poor sleep. It includes the presence of pain in all four body quadrants in combination with excess tenderness to palpation in at least 11 of 18 muscle tendon sites, in the absence of clinically demonstrable peripheral nociceptive causes. Patients with FMS also frequently suffer from emotional distress and/or psychiatric disorders. The prevalence of Major Depressive Disorder (MDD) appears to be higher in FMS patients.

Case Report: This patient is a 58-year-old caucasian female with a psychiatric history of MDD for the past 25 years and FMS for the past 20 years. For treatment of both her depression and FMS, she was started on Duloxetine 2 years ago which has significantly improved her depressive symptoms but has not further improved her pain and limitations due to FMS. We bring this case to the surface because it does not appear to be a typical case. In most cases, the pain and limitations produced by FMS will cause depression. Our patient, however, developed MDD atleast 5 years before developing FMS. This raises the question of the real association between MDD and FMS. It also raises the question whether MDD can predispose a patient to FMS.

Discussion: The pathophysiology of pain in FMS remains unclear, complex and the cure is not known. FMS is a chronic pain syndrome, however, recent functional neuroimaging studies have shown alterations in sensory and affective brain processing of body information. FMS is suggested to be a manifestation of depression or affective spectrum disorder. It has also been demonstrated that FMS may be associated with gray matter dysfunction in brain regions such as parahippocampal gyrus, insular, and medial prefrontal cortices. More studies need to be conducted to find the connection between the somatic symptoms of FMS and MDD, with the hope of finding a more individualized treatment for these patients.

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PS1-12

Use of the Columbia Suicide Severity Rating Scale for Depressed Patients in Primary Care

Kimberly Nordstrom, M.D., Robert Keeley, M.D., MPH, Matthew Engel, MPH, and Michael H. Allen, M.D.

Abstract:

Background: Common screens for suicide risk in primary care may not detect the risk associated with a prior suicidal behavior. We used the Columbia Suicide Severity Rating Scale (C-SSRS) to further explore suicide risk in a primary care population initially assessed with the Patient Health Questionnaire-9 (PHQ-9)and the MacArthur Foundation protocol.

Methods: We analyzed 216 subjects screening positive for probable major depression (PHQ-9 score >=10) in a trial testing Motivational Interviewing. Suicidal ideation was assessed with the PHQ-9/MacArthur Foundation protocol. Prevalence of various forms of ideation and attempts were examined, using the C-SSRS, in those reporting versus denying SI on the PHQ-9. General linear models will be used to examine the relationship of prior suicidal behavior, diagnosis, substance use and demographic variables to current suicidal ideation.

Results: 150 subjects (68.5% of the total sample) denied suicidal ideation in the previous 2 weeks on the PHQ-9. However, 17 of these (11.3% of 150) reported a history of active ideation (n=9) and/or a previous attempt (n=13). Of the 66 subjects reporting ideation in the past 2 weeks on the PHQ-9, 21 (31.8% of 66) reported a lifetime history of active ideation (n=9) and/or previous attempt (n= 15) on the C-SSRS. Significantly more of those with current SI reported a prior attempt (8.7% vs. 22.7%, p=.009) but none of these were deemed high risk by the MacArthur protocol.

Conclusions: This is the first study we are aware of to implement the C-SSRS in primary care. A substantial proportion of those with and without current SI carried the risk of a previous attempt. The C-SSRS may augment the PHQ-9 for characterizing subjects at risk for suicide in primary care. Supported by NIMH K23MH082997 (Keeley)

Reference:

Posner K, Brown GK, Stanley B, et al. The Columbia-Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. Am J Psychiatry. 2011 Dec 1; 168(12):1266-77.

PS1-13

Risk of Development of Osteoporosis Due to Depression in the Elderly Individuals: A Literature Review

Umesh Vyas, M.D.

Summary:

Educational Objectives: At the conclusion of this presentation, the participants will be able to understand, 1) The risk of development of osteoporosis, 2) Need for close monitoring and early assessment of risk, 3) Need for prophylactic treatment to avoid complications due to development of osteoporosis.

Introduction and Hypothesis: Fifteen percent of elderly individuals report clinically significant depression due to variety of reasons. Osteoporosis is a disorder of bone metabolism which can be caused by multiple factors. The elder population has multiple risk factors for development of low Bone Mineral Density (BM.D.). Data supports that SSRI causes low BM.D. There are numerous mediating processes, factors and causes that may contribute to relationship between depression and low BM.D., therefore it has been suggested that depression may be an unrecognized risk factor for development of osteoporosis in this patient population. Low BM.D. is a common condition among the elder population; prevalence of osteopenia and osteoporosis is expected to increase due to increasing elder population. Low BM.D. is associated with increased risk for debilitating fractures, particularly in hip, vertebrae and distal forearm. There is a growing body of evidence that depression impact the risk for fractures in the older population. Most studies support that depression is associated with increased risk for both low BM.D. and fractures. There are many risk factors for low BM.D., but some are unalterable. Therefore it is crucial to identify modifiable risk factors to reduce the public health burden of osteopenia, osteoporosis and fractures, and complications associated with them.

Objective: A literature review was performed to extract evidence and to evaluate risk of Osteoporosis in depression.

Method: Pubmed.gov was searched by using pre determined key word: "Depression AND Osteoporosis."

Results: Current available evidence supports that there is a definite increase of development of osteoporosis due to various factors, pathways and medications used in treatment of depression.

Conclusion: Evidence exists that patients with depression are at an increased risk of development of low BM.D. due to various factors, and hence increased risk for development of Osteoporosis. These patients may benefit from close monitoring, early assessment of risk, and preventive measures such as prophylactic treatment to avoid complications.

PS1-14

Clozapine and Lithium Combination Leading to Lithium Toxicity: A Case Report and Literature Review

Naveen Yarasi, M.D.

Summary:

Introduction: Combining neuroleptic drugs with lithium can offer a valuable therapeutic contribution to the treatment of schizophrenia and schizoaffective disorder despite the potentially increased risk of side effects. (Cohen and Cohen 1974). Literature shows vast majority (75 90%) of patients receiving lithium monotherapy become intoxicated at some point during the course of therapy and that more than 50% of the patients on lithium treatment received at least one concomitant antipsychotic medication during the course of their treatment. The neurotoxic reaction between lithium and any antipsychotic drugs is a rare and mostly reversible event. Although adverse reactions with lithium and haldol predominate, other antipsychotic drugs has been implicated in increased lithium toxicity, including thioridazine, fluphenazine, chlorpromazine, clozapine, and risperidone. Several case reports described neurotoxic side effects in the course of combined clozapine and lithium treatment without an apparent effect on the pharmacokinetic disposition of lithium. However we report a case where lithium and clozapine combination have increased serum lithium levels resulting in neurotoxicity.

Case Presentation: Patient is a 23 year old female with Paranoid Schizophrenia, who was initially treated with lithium carbonate 900mg/day with a lithium level of 0.6mEq/liter. Clozapine was started at 25mg qhs after a trial of risperidone and aripiprazole and was gradually increased to 200mg by seven days. On day 8 of combined lithium and clozapine treatment, she developed tremor, nausea, vomiting, myoclonic jerks, shuffling, stumbling gait, confusion, drooling, perioral dyskinesia, and dysarthric speech. She also had muscle stiffness and some signs of cog wheeling & rigidity, which were resolved with a shot of benztropine. Vital signs were normal except for tachycardia. Stat EKG showed sinus tachycardia. CBC and CMP were unremarkable. Lithium level was interestingly high at 1.5mEq/l. No other medication changes were made apart from addition of clozapine. No signs of dehydration were present. The neurologic symptoms completely resolved after the discontinuation of lithium.

Discussion: Literature shows that some drugs, such as antidepressant and neuroleptic agents, increase lithium toxicity without changing renal clearance, presumably by increasing intracellular concentrations. But our patient interestingly had increased serum lithium level and the mechanism of which was unknown. Although the development of neurologic symptoms in our patient can be explained by the lithium toxicity, the possible explanation for increased serum lithium level could not be found As a conclusion since there is a possibility of a rare but serious interaction with lithium and clozapine, clinicians should be aware of the risk of concomitant administration of lithium and clozapine. So we suggest the need for close and regular clinical observations and serum concentration monitoring to avoid any unexpected complications.

PS1-15

Long Term Improvement in Self Injurious Behavior and Continual Stabilization of Mood Symptoms Over Three Years of Maintenance ECT in an Autistic Child

Katherine Lubarsky; George P. Tatmo, BS; Susan Zafarlotfi, Ph.D.; Giovanni Caracci, M.D.; Ye-Ming Sun, M.D., Ph.D.

Summary:

Introduction: Self injurious behavior (SIB) occurs regularly in children with autism and other developmental disabilities. Severe cases of self injury pose a significant clinical challenge, as they are often refractory to pharmacological and behavioral interventions. The literature has shown that acute ECT treatment is effective in decreasing rates of self injury, but there is scarce data on the long term outcome of these patients or follow up after maintenance ECT.

Case Report: We report the long term improvement in self injurious behavior in a 12 year old autistic child receiving ECT treatment. A profound and consistent reduction in rates of self injurious behaviors has occurred over a 3 year time period of weekly (6 month) and twice monthly (2.5 years) maintenance ECT, with continual stabilization of mood symptoms. The self injury rate was not only maintained at the low level attributed to an initial acute ECT treatment course (previously reported in the literature), but further reduced by an additional 66% during maintenance treatment course. Over this time period, no brain structural changes are evident on CT.

Conclusion: This case provides further support for using ECT as safe and effective long term management of severe and refractory self injury behavior in autism.

PS1-16

Home Treatment for the Acutely Mentally Ill in Rural Southern Germany as an Alternative to Inpatient Treatment – An Economic Analysis

Karel Frasch, M.D.; Miriam Ott, Henriette Jahn, M.D., Annett Rauscher, Markus Jaeger, M.D., Isolde Munz, Thomas Becker, M.D., Reinhold Kilian, Ph.D.

Summary:

Objective: Home Treatment (HT), a home based multiprofessional psychiatric service for the acutely mentally ill which is still in its infancy in Germany, is hypothesized to be equally effective to traditional inpatient treatment (TAU). Our study compared HT (n=60) to TAU (n=58) in two patient groups (studied consecutively, similar diagnostic distribution: schizophrenia n=25 HT, n=21 TAU ; affective disorders n=26 in both groups) with regard to clinical effectiveness (HoNOS, PANSS, HAM.D.-21 at admission vs. discharge). We found HT to be equally effective with regard to HoNOS and PANSS scores; as to HAM.D.-21 scores, HT patients improved significantly more than the TAU group. This study aimed to analyse the cost-effectiveness of HT in comparison to TAU.

Method: Statistical analysis of treatment effects was performed by mixed effects regression models with random time effects and a fixed treatment x time interaction. Selection bias was controlled by the propensity score method. For economic analysis, total direct costs have been adjusted for propensity scores. Incremental cost effectiveness ratios (ICER) have been conducted for adjusted outcome variables and adjusted costs. Nonparametric bootstrapping has been applied for estimating ICER variance. Cost effectiveness acceptance curves CEAC have been computed for the interpretation of CEA results.

Results: Regression coefficients for time x treatment interaction effects revealed a greater improvement in depressive symptoms for patients in the HT group (b -5.71; p <0.001). Total adjusted treatment costs did not significantly differ between treatment groups. ICER for the improvement of depressive symptoms indicates a saving of 314,3 € with each increase of the treatment effect by one unit of the HAM.D.-21. CEAC reveals a 82,5 % probability of HT to be cost-effective in comparison to TAU at a maximum willingness to pay of 500 € for an improvement of the HAM.D.-21 by one unit.

Conclusions: In our patient sample, HT turned out to be a feasible and clinically effective intervention across diagnostic groups with an emphasis on schizophrenia and affective disorders, especially with regard to depressive symptoms (superior improvement in the HT group). As to economic issues, we found a trend towards cost-effectiveness with regard to depressive symptoms in comparison with TAU which may be due to small sample size and high variance on the one hand and to the course of the willingness to pay curve on the other. Further controlled studies with larger patient groups and longer observation periods are required to find out about cost-effectiveness of HT vs. TAU, especially with regard to long term course.

Educational Objectives: At the conclusion of the session, the participant should be able to 1) recognize HT as a feasible and at least equally effective treatment option compared with inpatient treatment 2) name the results of our study and discuss its limitations/implications for further research.

PS1-17

Selegiline Transdermal in the Treatment of Borderline Personality Disorder: An Open Label Trial in 58 Patients

Paul Markovitz, M.D., Ariel D. Stern, BA, MS

Abstract:

Objective: Borderline Personality Disorder (BPD) is a common illness affecting at least 2% of the population. Treatment options for BPD are poorly studied for such a common illness. We report on an open label trial of transdermal selegiline in the treatment of patients with BPD.

Method: 58 patients were treated with 12 mg/day transdermal selegiline after failing treatment with published effective BPD dosages of SSRIs (93%), SNRIs (100%), antipsychotics (71%), other agents (90%) and anticonvulsants (53%). Outcome was measured by the Hopkins Symptoms Checklist 90 Revised Scale (SCL).

Results: Regression analysis showed SCL total score for the group as a whole was significantly reduced (p = .01), as well as depression and anxiety subscales (p=.05). For the top quintile of responders (top 20%), total score (p=.001), and all subscales including depression (p=.001), anxiety (p=.001), hostility (p=.05), psychoticism (p=.001), somatization (p=.05) and interpersonal sensitivity (p=.001) showed statistically relevant decreases. A time-series analysis of patient progression over the period of observation indicates a downward trend over time in all 58 patient scores and subsclaes (p=.001) pointing to ongoing efficacy and improvement. The magnitude of improvement was five-fold higher in the top quintile of patients.

Conclusions: These results suggest a therapeutic role of transdermal selegiline in treating patients with BPD, with a particularly high therapeutic value for the most responsive patients.

PS1-18

Efficacy and Effectiveness of Depot Versus Oral Antipsychotics in Schizophrenia: Synthesizing Results Across Different Research Designs

Bruce Wong, M.D.; Sander Yermakov, MS; Wayne Huang, MPP; Thomas Samuelson, BA; Steve Offord, Ph.D.; Paul E. Greenberg, MS

Summary:

Background: Depot formulations of antipsychotic agents are often used in clinical practice to address compliance issues in the management of schizophrenia. However, randomized controlled trials (RCTs), observational studies, and various meta analyses have yielded inconsistent findings regarding their comparative effectiveness across the different study designs. This raises important practical questions of therapy in managing schizophrenia, but also of how study design should be viewed in comparative effectiveness research and the possible tension between efficacy and effectiveness of medications. In order to reconcile these inconsistencies in results, this study implements a novel approach to systematically account for the effect of study design on the relative efficacy of antipsychotic formulations.

Methods: A PubMed literature review targeted English language articles published since 2000, with efficacy information for depot and oral antipsychotic treatment arms in schizophrenia, and which reported relapse, hospitalization or all cause discontinuation as endpoints. Data reported in the studies were used to calculate risk ratios (RR) [depot/oral; RR<1 favors depot]. Where available, average baseline characteristics were used to adjust endpoints for age and gender within each treatment arm, using marginal effects reported in the literature. Adjusted RR were pooled by study design (RCT, prospective observational, and retrospective observational), corresponding to qualitative differences in the level of researcher control over patient treatment. Within each study design grouping, meta analysis with random effects was used to estimate the pooled RR and 95% confidence interval (CI) of all endpoints combined. In turn, average conversion factors between study designs were calculated as the ratios of pooled RR.

Results: Preliminary literature search criteria resulted in 389 studies. Further refinement and systematic review of full text versions yielded 13 relevant studies (5 RCTs, 4 prospective, 4 retrospective), including information on 19 depot oral comparisons. Meta analysis of adjusted endpoints resulted in RR [CI, p value] of 0.88 [0.64 1.20, p=0.416] for RCTs. In contrast, there was a significant advantage for depot formulations in both prospective (RR=0.62 [0.48 0.81, p<0.001]) and retrospective (RR=0.56 [0.44 0.71, p<0.001]) studies. These imply conversion factors of 1.41 and 1.57 between RCTs and prospective and retrospective designs, respectively.

Conclusions: In tightly controlled RCTs, the benefits of depot antipsychotics were not significantly superior to oral formulations. In contrast, as study design shifts towards prospective and retrospective studies in real world clinical settings, depot formulations display significant advantage. Furthermore, the estimated conversion factors quantify the average effect of study design on comparative effectiveness and facilitate meaningful comparison across studies.

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POSTER SESSION 2

Thursday, October 4; 3:00 p.m.–4:30 p.m.

PS2-01

Prescription Opioid Addiction: Trends From 1998 to Present Day and Availability of Treatment Options

Stephanie Rolin, M.P.H.

Abstract: Prescription opioid addiction has become an increasing problem in the United States. As sales of legal opioid pain relievers quadrupled between 1999 and 2011, the number of Americans illicitly using these drugs more than doubled. In 2006, 2.2 million Americans illicitly used opioid pain relievers for the first time, surpassing new users of marijuana for the first time. Today, opioid pain relievers are abused more than any other illicit or prescription drug. This is important as yearly mortality associated with illicit opioid use is 2%. A concerning aspect of the increase in opioid prescription drug abuse is that the majority of illicitly used opioids are acquired from a single physician. In fact, few people obtain prescription opioids from more than one physician (1.6%), from a drug dealer (3.9%) or on the internet (0.1%). Although opioid dependence and abuse is associated with overall higher morbidity and mortality, several treatment options exist for addicted individuals. Specifically, buprenorphine has emerged as a desirable alternative to methadone. However, availability of buprenorphine is limited as physicians must receive a special license to prescribe buprenorphine and they can only prescribe to a maximum of 100 patients at any time. This limits the availability of buprenorphine, especially in rural areas, where there are fewer overall providers to begin with. For example, in NH, a total of 42 physicians are certified to prescribe buprenorphine, equal to about 1% of practicing physicians. This presentation will review the increase in prescribing patterns from 1998 to present day, demographics of addiction, and focus on available treatment options, such as buprenorphine. There will be a special focus on the geographical availability of buprenorphine, using ArcGIS to map available providers in the Northeast compared to population density.

PS2-02

The Chicken or the Egg? Clarifying Diagnostic Dilemmas in a Patient With Multiple Medical Comorbidities

Frank Clark, M.D., Emile Barrouk, M.D.

Abstract: Psychiatric diagnoses are often complicated by a patient's medical history. This case study explores the process of choosing a diagnosis in a 19 year old female patient with no prior psychiatric history. She presented with severe mood and anxiety symptoms, including social isolation and panic attacks, in the setting of multiple medical comorbidities, which included hypothyroidism, dermatomyositis, interstitial lung disease, and anti-synthetase syndrome. She had also been treated with high dose steroids and immunosuppressant medicines, both of which can cause mood symptoms. Her family history is significant for multiple psychiatric illnesses as well as autoimmune disease. The patient was evaluated at our university psychiatry clinic and was started on medicine and therapy. Prognosis is good based on her response to this treatment. This case illustrates the importance of recognizing all of the patient's biological-psychological-social factors in formulating a proper diagnosis and treatment plan.

PS2-03

Perspectives on Housing and Recovery: Engaging Young Adult Mental Health Service Users Through a Community-Based Participatory Research Initiative

Ryan Borg, M.P.H., Amy Manion, Neena Schultz, Jonathan Delman, Alisa Lincoln

Abstract: At the conclusion of this session, the participant should be able to: 1) describe the design, conduct, and main conclusions of a Community-based Participatory Research (CBPR) study that explored the role of housing in the lives and recovery of young adults with mental illness in Boston; 2) understand the unique contribution of a CBPR approach in mental health services research. Young adults with mental illness, also known as "transition age youth" (TAY), struggle with economic, social and housing instability, and are consequently at increased risk for poor health outcomes as they transition from adolescence into adulthood. Despite this heightened vulnerability, a significant number of TAY lack access to appropriate services and support systems. To better understand the lives of TAY in Boston, a CBPR study was undertaken. Community-based Participatory Research (CBPR) is a collaborative approach that provides a mechanism for community members affected by issues under study to fully participate in all aspects of the research process. CBPR has been used with young adults to study issues of concern to them, but rarely with young adults with mental illnesses. In 2007, a Boston-based research collaborative made up of mental health service users, family members and academic based researchers, identified housing as a critical area of attention for TAY and recognized that using CBPR as a tool to examine the role of housing in the lives of TAY represented an exceptional opportunity to create a meaningful understanding of this group's unique life and health circumstances. A CBPR model was used to design and conduct a pilot study that explored the relationship between housing and health for young adults with mental illness. Young adult service users from the local community were enlisted and trained as research associates to participate in the design and conduct of the study. The specific aims of the study are to gain the perspectives of young adults with mental illness around their housing needs and the role of housing in their recovery and well-being, to learn about the role of racial and ethnic diversity, age and gender in the housing needs of young adults with mental illness, and to increase our understanding of factors that promote stable housing and system characteristics that support young adults in their recovery. Twenty-nine TAY (ages 19-25) were recruited from diverse housing settings in Boston. Semi-structured interviews were conducted by community research associates. Interviews were transcribed and coded using a rigorous and iterative process. A group analyses process was undertaken in keeping with the CBPR model. Preliminary results of the study will be presented along with implications for the improvement of existing services and the development of new methods of service delivery and programs that better meet the needs of TAY in Boston.

PS2-04

The Impact of Trauma History on Course of Hospitalization for Clients With Severe Mental Illness

Kun Tang, M.D., Gerard Gallucci, M.D., M.H.S., Imran Trimzi, M.D., Daniel Grimes, M.D., Jack Samuels, Ph.D., Susanna Kramer, M.A.

Abstract:

Background: In the past decade, numerous studies have shown an association between trauma history and psychotic disorder and psychiatric symptoms. A case control study conducted by Heins M et al. focused on the relationship between trauma and psychosis. Ramsay CE and his team examined the correlations between variable childhood trauma and social factors, substance abuse, and psychotic symptoms. They found trauma variables were associated with differential psychotic symptoms, educational level and certain psychosocial factors. Intelligence deficits and cognitive impairment were also found to be related to a history of trauma. The adverse childhood experiences (ACE) study showed a strong relationship between the childhood abuse and many of the leading causes of death in adults including the medical diseases such as ischemic heart disease, cancer, chronic lung disease, etc. However, very few studies have investigated how the history of trauma affects the course of hospitalization and the outcomes of the treatment during psychiatric hospitalization.

Methods: Delaware Psychiatric Center clients in acute units, who were admitted after (and including) May 1st, 2012 and discharged before (and including) August 31, 2012 will be included. The trauma scale (Trauma Assessment for Adults-brief revised version), a questionnaire about variable types of stressful or difficult life events, will be administered at time of admission. The charts will be reviewed by the psychiatric resident and all of the information including the trauma assessment, age, gender, race, education background, PROFOKS scale(a brief intelligence screen), MMSE (Mini Mental State Examination), AXIS I II and III diagnosis, substance history, previous psychiatric hospitalization history, history of suicide attempts, current hospitalization duration (days), aggressive behaviors, use of seclusion/restraint, use of psychotropic PRN medications during hospitalization will be recorded into a database. For those clients with more than one hospitalization during this period of May 01, 2012 to August 31, 2012, only the first hospitalization will be reviewed. The statistical correlation analysis will be performed by a well-trained statistician.

Anticipated Results: In this project, we would like to find any potential correlations between the variables of trauma history and the course of hospitalization and the outcome of hospitalization treatment for clients with severe mental illness. We would also like to examine the potential links among the variables of trauma, cognitive status, co-occurring substance addiction, suicide attempts and previous psychiatric history. It will help us to understand the impact of trauma history on the assessment, diagnosis, symptoms, treatment progress and outcomes of mental disorders, which will help to inform future treatment, discharge and follow up planning for residents at DPC and other State Psychiatric Hospitals.

PS2-05

Improving Engagement in Mental Health Services for Older Persons With Depression: Current Needs and Intervention

Jo Anne Sirey, Ph.D., Patricia Marino, Ph.D.; Alexandra Greenfield, BA; Dorothy Tagarelli, MSW; Debra D'Angelo, BA, Carla Gabris, BS; Sharon McKenzie, Ph.D.; Martha Bruce, Ph.D., MPH

Abstract:

Objective: Despite increased detection of depression and availability of effective treatments for major depression, most older adults referred for care do not engage in services. The Open Door intervention is a brief, individualized intervention to identify barriers to mental health care among older persons whose depression is detected in non-medical, non-mental health treatment settings. In this presentation we describe the Open Door intervention and the demographic and clinical characteristics of the target population.

Method: Eligible subjects are adults age>60 receiving home delivered meals and 'identified' as depressed. Randomized participants receive an in-home visit for a diagnostic (SCID) and suicide risk assessment, and to evaluate depression severity and functioning. Attitudes towards depression and its treatment are assessed as well. Participants then receive either the Open Door intervention or a control intervention matched for time.

Results: The 137 participants are mostly (72%) female, non-Hispanic (92%), 69% White, and 31% Black. The mean age is 78.0 with 12.2 years of education. Most (65%) subjects live alone. Most (63%) met SCID criteria for either minor (13%) or major depression (51%). Rates of major depression were comparable for older adults of African descent and Caucasians. Almost one third (29%) of participants endorse suicidal ideation that prompted a suicide risk assessment. Within the group of participants with suicidal ideation, 3/4 had mild risk and 1/4 had intermediate risk. Almost all of the participants viewed depression as a common illness that could affect anyone (98%) with an understanding that it could reoccur (67%). Only a small portion (16%) of believed that depression "will eventually go away by itself." Less than half felt they "had enough information to deal with depression" (49%) or knew "what to expect regarding treatment of depression" (44%). Almost half (49%) still view depression as a normal part of aging; and most (80%) view depression as a natural reaction to loss.

Conclusion: In this vulnerable group of older adults, screening is useful to identify depression, suicide risk, and begin a link to mental health care. While there is an increasing acceptance of depression as treatable, lack of knowledge prevails and ageist misconceptions remain. Individual perceptions of mental health care can continue to be barriers to engagement in care in addition to limited Medicare mental health resources. Optimistically, older adults have been receptive to the Open Door intervention and have completed the study intervention sessions with a very low rate of study attrition due to refusal. Research supported by NIMH funding (R01 MH07926).

PS2-06

Clonidine Withdrawal in a Patient Suspected to Suffer From Lorazepam Abuse

Muhammad Zafar, M.D., Bryan Chambliss, M.D., Muhammad H. Majeed, M.D., Uzma Beg, Branden Youngman, M.D.

Abstract: Patients suffering from benzodiazepine abuse and withdrawal often present in the Emergency Room. However it is also important to be mindful of what suffering could be caused by other medications and their withdrawal. It can present a diagnostic challenge to be able to identify the medication responsible for causing the particular symptom.

PS2-07

Healthcare Decision-Making as a Potential Source of Psychological Distress

Samuel Weber, M.D., Kenneth I. Pargament, Ph.D., Mark E. Kunik, M.D., M.P.H., James W. Lomax II, M.D., Melinda A. Stanley, Ph.D.

Abstract:

Objective: As research into religion and health has received increased attention in recent years, greater numbers of studies have examined the link between religious belief and psychological well-being. Despite this increased attention, many such studies overlook the psychological health of nonbelievers (i.e. atheists and agnostics). In a recent review, we found that various forms of psychological distress are experienced by nonbelievers and that greater certainty in one's belief system is associated with greater psychological health. One primary source of distress for nonbelievers involves the negative perceptions of atheists and agnostics by others. Research has shown that medical appointments and decisions regarding healthcare can also be sources of psychological distress. This distress is especially pronounced in settings where poor communication and understanding are present. Religious nonbelievers are a minority group in the United States, and their preferences may be less well understood by healthcare professionals. This difference in worldview can result in distress for the nonbelieving patient. The objective of this study is to examine healthcare decision-making as a potential source of distress for nonbelievers.

Method: A systematic literature review was conducted with PsycINFO using the following search terms: "atheis*," "agnosti*," "apostasy," "apostate," and "deconversion." The search was limited to articles published between January 1980 and April 2011. 4 articles were identified for inclusion in the present review.

Results: All four studies focused on healthcare decision-making among nonbelievers. Nonbelievers demonstrate a general avoidance of religious forms of treatment and support, preferring to rely on family and friends in times of crisis. Nonbelievers are also less likely to participate in Alcoholics Anonymous. Many atheists have clear preferences regarding end-of-life care, and express concern that healthcare workers may attempt to proselytize them prior to death. Despite these differences, nonbelievers are no different from believers in their perceptions regarding the efficacy of secular treatments for depression, and nonbelievers who do participate in AA derive benefits comparable to believers.

Conclusions: There is a growing interest in the relationship between religion and mental health. One limitation to the existing literature is the lack of attention to nonbelievers. We have identified healthcare decision-making as a potential source of psychological distress among religious nonbelievers, but further research is necessary to determine

how healthcare providers can most effectively minimize distress among their nonbelieving patients.

PS2-08

Obsessive Compulsive Disorder: Increase of Total White Matter and White Matter Tissue Within the Left External Capsule: Voxel-Based Morphomet

Thomas Sobanski, M.D., Gerd Wagner, Ph.D., Gregor Peikert, Ph.D., Uwe Gruhn, M.D., Heinrich Sauer, M.D., Ralf Schlösser, M.D.

Abstract:
Objective: abnormalities in obsessive-compulsive disorder (OCD), e.g. increase or decrease of total white matter (WM) volume, increase of left frontal lobe WM, and reduction of WM volume in prefrontal and right parietal areas. As regards gray matter (GM) a reduction in parieto-frontal cortical regions as well as an increase in the basal ganglia have been reported. With regard to the inconsistency of prior results we performed an MRI study employing a most recent VBM method. The main focus of the study was to investigate WM alterations in patients with OCD.

Methods: Fourteen patients with obsessive-compulsive disorder (OCD) and fourteen healthy control subjects (HC) matched for age and gender were enrolled in the study. One patient had to be excluded due to imperfect segmentation. All patients (9 women, 4 men) were treated in our psychotherapy ward. MRI volumes were analyzed with the VBM toolbox using the unified tissue segmentation approach as implemented in SPM8. Voxel-by-voxel one-way ANOVA was performed to test for differences between controls (HC) and patients with OCD regarding regional WM and GM volume. All statistical images were thresholded at voxel-level $p<0.001$ (uncorrected for multiple comparisons).

Results: Total WM volume was increased in patients with OCD ($p<0.021$). By means of VBM we could observe a significantly increased WM volume within the left external capsule (EC) ($x = -21$, $y = 17$, $z = 11$, cluster size $=225$, $p<0.001$). In regard to total and regional GM volumes there were no significant differences between groups. None of the results was correlated to age of onset or duration of the disease.

Conclusions: Earlier results of increased total WM volume in patients suffering from OCD are confirmed by our study and extended by the new finding of increased WM volume in the EC. Thus, the observed abnormalities of WM tissue provide further evidence for a disorganization of neuroanatomical connectivity in OCD.

PS2-09

Love in the Time of Dementia: Sexuality, Intimacy and Dementia, a Case-Control Survey

Shilpa Srinivasan, M.D., Laurie Harden, M.D., Carol Waters, LISW-CP, Rebecca Boland, MA, Michele Neese, RN, Kara Sieverdes, M.D., Andres Leone, M.D., Claire Presswood, MS

Abstract: Sexuality and intimacy are normal and integral aspects of older adulthood with 80% of adults age 60 or older continuing to be sexually active. Despite age-related changes in psychologic and physiologic aspects of sexuality, in the absence of disease or medication interactions, such changes rarely cause sexual problems. Majority of older adults view a satisfying sexual relationship as important to overall quality of life. Sexuality can be significantly affected by cognitive decline. As cognitive disorders occur on a spectrum, intimacy and sexuality problems are impacted by increasing severity of illness. A higher degree of caregiver burden has been correlated with less frequent sexual intercourse and lower levels of affective and sexual marital satisfaction. We conducted a pilot survey to investigate attitudes about sexuality and intimacy, comparing partners with and without a spouse who suffers from cognitive impairment. Community-dwelling older adults age =65, were recruited from an out-patient practice. The control group consisted of cognitively intact couples. The "dementia" group consisted of the cognitively intact partner of a person with a dementia diagnosis. The survey instrument was constructed to collect information on the following areas: Sexual Activities, Physical Problems, Sexual Depression, and Illness Outcome, measured using a 5-point Likert scale. Descriptive statistics including frequencies, means, cross tabulations and independent samples t tests were used to analyze survey results using SAS 9.2. 78 participants were screened and 20 completed the survey (11 dementia group vs. 9 controls). Average age was 77 years. 52% of control group respondents indicated they "never" have sex vs. 82% in the dementia group. Higher frequency of sexual activities overall was reported by the control vs. the dementia group ($p=.0068$). Preliminary results indicate differences in intimacy, sexual expression and sexual satisfaction in couples with and without a spouse with dementia. Larger sample sizes and further studies may provide more significant distinctions between the two populations in an effort to facilitate discussions about intimacy and sexuality which are often under-addressed in the clinical setting, particularly with older adults. Additional research in this area is needed to comprehensively address patient care for this growing population.

PS2-10

Evaluation of Cognitive Behavioral Therapy & Motivational Interviewing Treating Gambling Behavior in Problem & Pathologic Gamblers: A Systematic Review

Lori Schwartz, M.D., Steven E. Hutchens, M.D., Seth Himelhoch, M.D., M.P.H.

Abstract:

Context: It is estimated that 5 to 15 million people in the United States are affected by problem or pathologic gambling. This number is very high, especially when one considers the impact on gamblers' lives, close relationships, employment, finances, and increased criminal activity.

Objective: This meta-analysis compares the effectiveness of motivational interviewing (MI) versus control and cognitive behavioral therapy (CBT) versus control for decreasing gambling behavior in adult men and women diagnosed with problem or pathologic gambling disorder.

Data Sources: Randomized control trials (RCTs) were identified in PubMed and PsycInfo databases from January 1980 through August 2011.

Study Selection: RCTs comparing MI or CBT to a control group for the treatment of pathological gambling were chosen. Ninety-three articles were identified from ther database searches with 5 studies meeting eligibility criteria for detailed review.

Data Extraction: Two reviewers performed data extraction independently with a kappa statistic calculated as 0.80, which is considered high inter-rater agreement. Effect sizes (ES) were represented by standardized mean differences (SMD), for which 95% Confidence Intervals (CI) were calculated.

Results: Overall ES for decreased gambling behavior was 1.13 (CI 0.32, 1.95), with significant heterogeneity (I2 = 92.7%). Stratification was used to reduce heterogeneity. When stratified by intervention type, ES for CBT was significant (2.57, CI 1.99, 3.14) while ES for MI was not significant (0.32, CI -0.03, 0.67). Stratification yielded a homogenous tracing in participants receiving CBT (I2 = 0%) and less homogenous tracing in participants receiving MI (I2 = 59.7%).

Conclusions: Criteria-based problem and pathological gambling shows a significant response to CBT as opposed to a minimal response to brief MI.

PS2-11

Autonomic Dysfunction in Autistic Population

Cecilia Belardinelli, M.D.

Abstract:

Objective: Evaluation of autonomic dysfunction symptoms in Autism Spectrum disorder (ASD) population. The goal of this work is to present data of medical symptoms related with autonomic dysfunction in a population of children diagnosed with autism spectrum disorder.

Background: Besides the core symptoms of Autism regarding impaired socialization, language and restrictive patterns of behavior, there is also a common finding of affected sensory processing symptoms as well as somatic complaints related with autonomic dysfunction. There are multiple studies that demonstrate autonomic dysfunction expressed in reduced vagal tone that may be part of the underlying physiology of different autistic symptoms such as the difficulty to get a calm state necessary for a social interaction as well as the need to develop repetitive behavior as a way to cope with increase sympathetic reactions unopposed by vagal response. Symptoms related with autonomic dysfunction can be found in a chemical level as it is described increase level of neurotransmitters, at behavior level while processing visual information, performing mental task or stress response and symptoms at somatic level. Sleep problems, unexplained constipation or diarrhea, cold extremities, and urinary retention are associated symptoms that suggest underlying autonomic dysfunction. Gastrointestinal symptoms have been reported more frequently in children with autism compared with siblings.

Methodology: All participants were children with diagnosis of Autism Spectrum disorders (ASD) evaluated by the pediatric neurologist (XM) at the Autism Center, UMDNJ-New Jersey Medical School. The information was obtained by chart review of parent Initial Interview form and first clinical evaluation. The diagnosis of ASD (autism, PDD-NOS or Asperger 'syndrome) was based on DSM-IV criteria. Children with Rett's syndrome or Disintegrative disorders were excluded.

Results: the studied population has a total number of 127 patients with ASD: 58 (45.6%) patients have Autistic Disorder, 59 (46.4%) PDD NOS and 10 (7.8%) Asperger Syndrome. Median age was 6 years old (range: 2-18 yo). Gender (M/F): 107 (84.2%)/20 (15.7%).The most frequent autonomic symptoms observed were: emotional liability 93 (73.2%), anxiety 92(72.4%), gastrointestinal symptoms 58 (59.8%) and sleep problems 55(56.1%). Others symptoms reported in more than 20 % of the population were flushing, abnormal sweating, cold/heat intolerance and dry skin. Most of patients complaint of coexistence of multiple symptoms, 65 (51.1%) patients reported = 3 symptoms.

Conclusion: Autonomic dysfunction symptoms are prevalent in ASD population in this cohort, and it is consistent with reports in literature.

PS2-12

Incidence of Seizures and Concomitant Pseudoseizures in the Epilepsy Monitoring Unit

Diana Mungall, B.S., Batool F. Kirmani, M.D.

Abstract:

Rationale: Patients are often referred to epilepsy monitoring unit for evaluation of spells of unclear etiology. Recent studies show that up to 9-15% of patients with diagnosed epilepsy have concurrent pseudoseizures. The diagnostic dilemma arises when patients with epilepsy develop concomitant pseudoseizures. Pseudoseizures is a conversion disorder which need to be managed by a psychiatrist. The gold standard for diagnosis is prolonged close captioned video EEG monitoring in the Epilepsy Monitoring Unit (EMU) for adequate diagnosis.

Methods: A retrospective chart review was conducted on epilepsy patients admitted to the Scott & White Hospital Epilepsy Monitoring Unit from 2008 to 2011. Data collected included seizure history and type, EEG findings, current AEDs, failed AEDs, VNS surgery, frequency, history of psychiatric illness, history of other neurologic disorders. Subject data were acquired from electronic medical records. Approval for this retrospective analysis of patient records was given by the hospital's Institutional Review Board.

Results: We retrospectively analyzed 14 patients with chronic epilepsy who developed increased frequency of spells different from their typical seizures. The study population consisted of 14 patients (mean age: 43 years, range: 21 – 67 years). 12 of 14 patients had concurrent psychological disorders including depression (64%), anxiety (50%), and physical or sexual abuse (29%). Study patients suffered from an average of 2.8 psychological disorders (range of 1-5). Study patients had a history of use of tobacco, alcohol, and illicit drugs of 35%, 21%, and 7% respectively. The study patients were on an average of 2.6 (range 1-5) AEDs, had failed an average of 2.1 (range 0-9) AEDs, and 2 patients (14%) had VNS stimulators. The occurrence of increased frequency from the baseline associated with change in semiology of the seizures despite therapeutic anticonvulsant levels prompted the need for 5-day intensive video EEG monitoring. Pseudoseizures were documented in all patients.

Conclusions: Our data analysis showed that the gold standard for diagnosis is prolonged close captioned video EEG monitoring for adequate diagnosis. The treatment of patients with dual diagnosis requires a multidisciplinary approach between psychiatrists, epileptologists, and psychologists.

PS2-13

ADHD and Neurofibromatosis, 1 Treatment Challenge: A Case Report

Sree Latha Krishna Jadapalle, M.D., Amel Badr, M.D.

Summary: NF-1 is a common AD genetic disorder with an incidence of 1 in 3500. According to Ferner 1994, approximately 40 to 60% of NF-1 individuals show specific learning disabilities consistent with the definition of the United States' National Joint Committee on Learning Disabilities. Literature so far indicates that there were a higher percentage of ADHD diagnoses among the children with NF-1 in contrast to both their unaffected- NF-1 siblings and their parents. In the brain scans using MRI, they found the appearance of unidentified bright signals, or UBS especially in the basal ganglia, thalamus, cerebellum, and brainstem which are known to be part of the frontal-striatal system. Studies suggest that abnormalities in this brain system gives rise to core behaviors associated with ADHD. Regarding the patho physiology of cognitive deficits in NF-1 population some preliminary studies suggested that loss of neurofibromin in NF-1 affects the cell growth and differentiation causing aberrant myelination and plays a significant role in cognitive development. There is only one prospective studies (Mautner et al in 2002) done regarding the treatment of ADHD children with NF-1. Further clinical trials are underway testing targeted pharmacologic agents for ADHD and so far literature recommends same treatment at this time as for individuals without NF1. We report a case of a seven-year old African-American male, first grade student, living with mother and occasionally with father, with no prior psychiatric hospitalizations, currently in special education with IOP and child study team, with diagnoses of attention deficit hyperactivity disorder combined type for more than 3 years, oppositional defiant disorder for more than one and half year and Neurofibromatosis stage I. He was brought by the parents into the emergency room due to history of assaultive behavior and worsening of destructive behavior for the past one week. The patient initially showed improvement with Dexmethylphenidate of total 20mg and also with addition of abilify but his aggressive behavior relapsed after few weeks. A combination of Dextroamphetamine and Amphetamine XR 20 mg was started and patient showed good improvement in his impulsive behavior with no relapse. There is lack of literature available regarding the studies done about the pharmacological treatment of ADHD in children with NF-1. Through our case report and literature review we strongly recommend further controlled studies on the pharmacological agents used for treating ADHD in NF-1 children.

PS2-14

Riluzole for Impulsive Aggression in Autistic Disorder: A Case Report

Gleydys Salgado, M.D., Charles N. Cartwright, M.D., Fauzia Syed, M.D., Aasiya Haroon, Nwayieze Ndukwe, M.D., Edward Hall, M.D., Tolga Taneli, M.D.

Abstract: Riluzole is the only U.S. FDA approved drug shown to slow the progression of amyotrophic lateral sclerosis. Riluzole has demonstrated efficacy in open-label trials of adult depression, anxiety disorder, and obsessive-compulsive disorder. Riluzole has also been used off-label in controlling impulsivity and aggression in autistic patients, when other treatment options have been exhausted [1]. This case study examines the use of Riluzole in targeting impulsive aggression and obsessive-compulsive symptoms in autism. A 17 year-old adolescent Caucasian male was referred to the emergency department by his outpatient physician for thoughts of self-mutilation and homicidal ideation. The patient has a history of Autistic Disorder, Bipolar Disorder, Attention-Deficit/Hyperactivity Disorder, Obsessive-Compulsive Disorder, Anxiety Disorder, and intellectual disability. The patient has had multiple psychiatric admissions due to behavioral decompensation. At the time of admission, the patient was found with a knife in his hand with a plan to amputate his arms and legs. Upon evaluation, the patient reported his mood as anxious and depressed with disturbances in sleep, increased appetite with weight gain, low self-esteem, irritability, and the compulsion to harm others. The patient was admitted to the hospital and continued on his current regimen: Lithium ER 750 mg twice daily, topiramate 100 mg twice daily, risperidone 1 mg in the morning and 2 mg at bedtime, quetiapine 200 mg three times daily, escitalopram 20 mg daily, lorazepam 1 mg every 6 hrs as needed, benztropine mesylate 0.5 mg twice daily. Glyburide 500 mg was prescribed to prevent metabolic syndrome. Laboratory studies including for liver functions tests were unremarkable. During the first week in treatment, repetitive speech and impulsive aggression persisted. Increasing risperidone failed to elicit improvement. The patient was started on riluzole 50 mg at bedtime. By the end of the first week of treatment with riluzole, no side effects and no new episodes of agitation were observed. The patient was discharged from the hospital and followed for several months. Within the first month of treatment, the patient demonstrated a reduction in impulsive aggression and self-mutilation; however, in the second month, he started to decompensate and became aggressive. Riluzole dose was increased to 100 mg twice daily, but the patient failed to improve. This case illustrates the potential efficacy of Riluzole in controlling impulsive aggression in autism refractory to other treatments. The decompensation following early improvement may represent an opportunity for further investigation.

Reference:

1. Wink LK, Erickson CA, Stigler KA, McDougle CJ. Riluzole in autistic disorder. J Child Adolesc Psychopharmacol. 2011;21(4):375-9.

PS2-15

A 15 Year Old Patient With an Atypical Neuropsychiatric Presentation of Lyme Disease (OCD)

Carolina Mercader D.O.; Amel Badr, M.D.

Summary:

Intro: Lyme disease is a multi-systemic illness that can cause neurologic and psychiatric symptoms. We present a case of Lyme Disease in a 15-year-old female who manifests behavioral disturbance and symptoms of Obsessive Compulsive Disorder.

Case: This is a case presentation of a 15 year old Caucasian female, living in central New Jersey, with history of Lyme Disease for 6 months, history of Obsessive Compulsive Disorder for 9 months, two inpatient psychiatric hospitalizations, follow ups with Lyme Disease specialist and therapist both last seen one week before our evaluation, history of noncompliance with treatment as she completed antibiotic treatment but has been noncompliant with psychotropic medication. Patient was escorted to the Emergency Room by parents due to worsening agitation and assaultiveness towards them for one week. After being diagnosed with Obsessive Compulsive Disorder, her behavior has recurred with symptoms lasting 2 consecutive weeks, then partially resolving for one month. Over the course of one week prior to evaluation, patient became involved in nightly rituals including having her parents do her homework for her, remove her earrings, and brush her teeth. On day of evaluation patient became agitated after her parents refused to do her homework and she made a hole in a wall by kicking it with her foot; parents called police and patient was taken to ER for psychiatric evaluation. Patient was admitted to Child/Adolescent Psychiatry unit. On the unit, she was calm with less anxiety. A family meeting was held after 3 days on the unit and a conclusion was made that she would consult with her specialist and comply with medical treatment first, to then be started on psychiatric treatment.

Discussion: Patient's first ELISA test was found to be negative. This test as well as other currently available serological tests can be unreliable, with both false positive and false negative results. Clinicians need to consider clinical factors that would aid in the diagnosis of Lyme disease. These include a history of an erythema migrans rash, and exposure to a Lyme endemic area. Other key parts of the evaluation include CSF studies, structural and functional imaging, as well as tests for cognitive dysfunction including tests of memory, attention, processing speed, and verbal fluency. In addition to clinical factors, neuropsychiatric symptoms such as forms of psychosis, agitation, anxiety and behavioral disturbance could also be a manifestation of the infectious disease caused by the spirochete Borrelia burgdorferi. Even before official diagnosis of Lyme Disease, patients should be educated about neuropsychiatric symptomatology and should be aware of any behavioral changes. It is also very important for the clinician him or herself to always consider Lyme disease as a rule out diagnosis with new onset neuropsychiatric presentations, especially when the patient is exposed to endemic areas.

PS2-16

Two Cases of Urophagia in a Psychiatric Unit: Is it Pathological?

Raj Addepalli, M.D., Jaimini Chauhan-James, M.D., Bedford Taylor, M.D., Pronoy Roy, M.D.

Abstract: Urophagia, or, the consumption of urine, is not accepted as a safe or healthy practice; however there is a subculture where in people drink their own urine. We present two cases where in patients with psychiatric illness have reported their practice of drinking their own urine.

Case 1: Patient V is a 29 year old man with a history of alcohol Dependence and schizoaffective disorder bipolar type, came into the ED brought in by his older brother for erratic and aggressive behavior. In the ED, the patient was aggressive, exposing himself and even attacked a police officer. He was admitted to the inpatient unit for stabilization. Collateral information from his family indicated that, among the deteriorating behavior included drinking saved urine from bottles. The brother of the patient stated that outside the bathroom were several plastic water bottles filled with what looked to be urine that had been saved for days. On subsequent interviews, he admitted to urinating in the bottles and saving them to consume at a later date with a caveat that the urine had "an expiry date of a few days, and that if you drank the urine past a few days it would not only taste terrible but it would cause you to become sick. "…In the initial days of admission, he was forthcoming in discussing his practice of drinking urine but as he improved he was more reticent in discussing it.

Case 2: This patient is a 57 year old African American homeless man with a psychiatric history of chronic paranoid schizophrenia who presented to the emergency department after being found in the street yelling and creating a public disturbance. He was subsequently admitted for inpatient stabilization. While on the inpatient psychiatric unit Mr. T was found to be consuming his own urine. In the initial days of admission, he continued to drink his urine from cups in public but as he psychiatrically improved, he was more discreet in drinking it in the privacy of his room.

Discussion: The practice of drinking one's own urine has been described in ancient hindu texts called the Damaara Tantra, under the heading of 'Shivaambu kalpa vidhi' and is known to contain 107 stanzas on the virtues of urine as a medicament. In Rome, urine was recommended for the treatment of ulcers by wetting the body of patients with their own urine. Using the search term " urine therapy" on popular search engines reveal hundreds of websites which extol the virtue of drinking one's own urine as a cure for various ailments from flu to pneumonia, to Parkinson's disease and maintaining dental health. Our patients were initially open in either discussing or continuing to practice drinking urine but as they became less psychotic they were more aware that this practice was not universally acceptable. They were more cognizant of social mores as they improved.

PS2-17

Hyponatremia Directly Caused by Atypical Antipsychotics: A Retrospective Study and Literature Review for Quality Improvement

Mehnaz Waseem, M.D.; Carolina Mercader, D.O.; Marek Belz, M.D.; *Medical students:* Erin Livingston, Thao Tong; Amel Badr, M.D.

Summary:

Background: Hyponatremia is seen in about 4% of patients with chronic Schizophrenia and occasionally in patients with Bipolar Disorder, Depression, and Mental Retardation. Hyponatremia is a state of imbalance in water electrolyte homeostasis, generally defined as a lowered serum sodium level of <136 mmol/L. Case reports of drug induced Hyponatremia suggest that atypical antipsychotics can induce hyponatremia.

Methods: We conducted both a retrospective study and a literature review. For the retrospective study, we analyzed serum sodium lab values of 72 patients in our outpatient clinic between ages 18 65 with Psychotic Disorders who were taking atypical antipsychotics. Patients with Axis III comorbidity were excluded from this study. We also conducted a literature review of cases of Hyponatremia caused by atypical antipsychotics.

Results: In our retrospective study, of the 72 patients analyzed, 5 patients had abnormal serum sodium levels below 136 mEq/L. Of those 5 patients, 3 patients were taking Risperidone, 1 patient was taking Paliperidone, and 1 was taking Olanzapine. In our literature review, we obtained findings that suggest Hyponatremia can be directly due to several commonly used atypical antipsychotic including Olanzapine, Risperidone, Aripiprazole, and Ziprasidone. One 34 year old patient with Schizophrenia was found to have developed Hyponatremia 8 weeks after initiation of Olanzapine 20 mg PO daily (115 mmol/l). One 32yo Schizophrenic male patient started on Ziprasidone therapy was admitted into the ER with Hyponatremia (122 mEq/L) 20 days after initiation with Ziprasidone. Another case involved a 60 Schizophrenic male who was started on Aripiprazole, and after 2 weeks had a decrease in serum sodium from baseline of 142 mEq/L to 120mEq/L.

Another case of Hyponatremia also occurred in a 48yo Schizophrenic male taking Risperidone, whom was initially stable on Risperidone with baseline sodium 136 mEq/L but two weeks after initiation presented to ER with generalized seizure and was later diagnosed with Hyponatremia with a serum sodium 110mEq/L.

Conclusion: Though our own retrospective study does not show statistically significant results, we found incidences of Hyponatremia in patients on atypical antipsychotics. Our literature study indicates that Hyponatremia can be caused by several commonly used atypical antipsychotics including Aripiprazole, Ziprasidone, as well as Olanzapine, and Risperidone. These results suggest the importance of Panel 14 laboratory workups. Even if a patient's initial workup is unremarkable, consecutive workups should be done as development of Hyponatremia can vary anywhere between 1 to 8 weeks. We suggest routine workups of patients every 2 weeks in order to closely monitor serum sodium level. More frequent monitoring will help the clinician prevent the development of electrolyte imbalance and will thus help improve patient quality of care.

PS2-18

The Ohio Army National Guard Mental Health Initiative: Prevalence of DSM IV Disorders

Marijo Tamburrino, M.D.; Philip Chan, M.S., Marta Prescott, M.P.H., Joseph Calabrese, M.D., Israel Liberzon, M.D., Renee Slembarski, M.B.A., Emily Goldmann, M.P.H., Edwin Shirley, Ph.D., Thomas Fine, M.A., Toyomi Goto, M.A., Kimberly Wilson, M.S.W., Stephen Ganocy, Ph.D., Alphonse Derus, B.S., Mary Beth Serrano, M.A., James Sizemore, M.Div., Sandro Galea, M.D.

Summary:
Objective: To explore the lifetime and current prevalence of DSM IV Axis I disorders among a subsample of the Ohio Army National Guard (OHARNG).

Method: 1052 (40.2%) of 2616 OHARNG soldiers who completed a telephone survey were randomly invited to participate in the in depth clinical cohort assessments using the Clinician Administered PTSD Scale and the Structured Clinical Interview for DSM IV TR. Of those invited, 11.9% (n=125) declined. Of the remaining 952, 21 (2.3%) did not attend their scheduled interview, and the goal of 500 was met before the remaining 406 (43.7%) were contacted. Interviews occurred in neutral settings such as private library rooms, between November 2008 and December 2009.

Results: The prevalence of at least one DSM IV disorder was 66.4% (332); substance use disorders were the most prevalent (52.2%), followed by mood disorders (30.0%) and anxiety disorders (22.0%). The prevalence of at least one current disorder was 25.0% (n=83); alcohol abuse (28.2%), M.D.D (22.4%) and alcohol dependence (20.4%) were the most common. Deployed soldiers had a higher lifetime prevalence of alcohol use disorders (53.0% vs. 39.5%, p=0.0049) and PTSD (6.8% vs. 2.5%, p=0.0447) compared to those never deployed. Women were more likely than men to have any mood disorder history (43.3% vs. 28.2%, p=0.0163).

Conclusions: Alcohol abuse and M.D.D were the two most common lifetime disorders, similar to findings in the general population. However, the prevalence of alcohol abuse in the OHARNG was twice the rate in the general population. The fourth most common disorder in this study was drug use compared to specific or social phobia in the general population. Women were more likely to have mood disorder history, as expected from other general and military study populations. However, we did not find the expected lower prevalence of substance abuse in women. Clinicians should ask patients about military service, and carefully screen for substance abuse.

PS2-19

Neuropsychiatric Manifestation of SLE: Its Correlation With Anti-Ribosomal P Antibody and Its Implication on Treatment Guidelines

Mahreen Raza, M.B.B.S.

Abstract: Psychosis and other neuropsychiatric manifestations of SLE can lead to diagnostic and therapeutic challenges and early diagnosis and treatment can lead to a favorable response. The reported prevalence of antiribosomal P antibody in the SLE population ranges from 6% to 46%; it is higher in Asian patients and at a relatively lower presentation in blacks and Caucasians. Interest in these autoantibodies mainly derives from the finding by Bonfa et al. of an association between anti-P antibodies and NPSLE. However, inconsistencies in their prevalence and clinical correlations have become an obstacle to their use as a diagnostic marker of the disease. I am describing my case of 28 year old Guatemalan female with SLE who presented with full blown psychosis of being pregnant with 12 babies and abnormal perception of auditory & visual hallucination during flare of SLE. Blood was drawn for autoantibodies during the flare when patient was acutely psychotic. Anti-Ribosomal P antibodies titers was high when she was in the flare of disease and it came down with remission of Psychosis. Aggressive treatment with steroid (Prednisone >60mg/day) and low dose psychotropics was suggested by C/L Psychiatrist. Psychosis improved with the treatment. The presence of rising antiribosomal P antibody conferred a markedly increased risk of psychosis (odd ratio 4.4) and depression (Odd ration 10.5). As psychosis remits the antiribosomal P titers decline suggesting that this antibody may have pathogenic significance (although the effect of corticosteroid could not be excluded). The goal of my case

report is to show the positive correlation of elevated titer of Anti-ribosomal P antibody with emergence of psychosis and decreasing titer leading to resolution. My research question is that should Ribosomal antibodies be included in inclusion criteria for the classification of SLE as it is involved with the disease activity with special correlation with Psychosis and other Neuropsychiatric symptoms and its implication in changes in treatment guidelines.

PS2-20

Bath Salt Intoxication: A Literature Review of the Clinical Signs, Symptoms, Physiology, and Current Treatment Recommendations

Scott Yoho, D.O.; Curtis McKnight, M.D.; David Kasick, M.D.; Anne-Marie Duchemin, M.D.

Summary:

Introduction: "Bath Salts" are increasingly popular drugs. They contain mephedrone and other synthetic cathinones and are sold legally in many countries including the United States. As a consequence, psychiatrists are more and more often faced with a potential diagnosis of bath salt intoxication when treating patients using these designer drugs.

Objective: To review the current literature on clinical signs and symptoms of bath salt intoxication, the physiological effects of bath salt ingestion, and the current recommendations for treatment of acute bath salt intoxication.

Method: This study consists of a literature review performed by searching PubMed using keywords: Bath Salt, Mephedrone, Cathinone, Methylenedioxypyrovalerone, MDPV, and "meow meow." Search for these terms resulted in 589 articles, ranging in publication date from 1927 to the present. Articles were reviewed based on relevance, content, and online availability.

Results: Bath salts are still considered by many to be "legal highs" despite the recent legislation passed to help curb the distribution and use of these increasingly popular drugs. Bath salt intoxication has profound psychiatric effects which can present with symptoms of agitation, paranoia, and hallucinations, among others. Bath salts also have far reaching effects on other major systems of the body including cardiac, neurologic, gastrointestinal, pulmonary, and ear, nose and throat symptomology. Other symptoms are also prominent such as fever, diaphoresis, hyponatremia, and rash. The physiology of bath salts is not fully understood and varies in each specific synthetic compound but they appear to have aM.P.H.etamine like effects. At this time, a cost effective, widespread method of screening for bath salt use does not exist. Bath salts do not register on routine urine or serum drug toxicology screens and present physicians across treatment settings with the dilemma of how to effectively determine what is causing the patient's symptoms when presenting with suspected toxidromes. Treatment is mostly supportive and involves treating the patient's symptoms in most cases.

Conclusions: Understanding the clinical signs, symptoms, and physiology of bath salt intoxication can be valuable due to the lack of effective screening tests for these drugs. While more research is needed on bath salts and their effects on the body, there is data available to assist health care providers with diagnosis and treatment of patients with bath salt intoxication. A history of bath salt use should be investigated in patients presenting with possible symptoms of bath salt intoxication.

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POSTER SESSION 3

Friday, October 5; 8:30 a.m.–10:00 a.m.

PS3-01

Mental Health Screening at a Student-Run Free Clinic

Travis Ladner, B.A., India A. Reddy, BA, Robert F. Miller, M.D., Michael J. Fowler, M.D.

Abstract:

Background: Mental health screening is an important challenge for student-run free clinics, which typically serve troubled, indigent patient populations. These clinics have the opportunity to connect at-risk patients with community mental health resources for additional psychiatric care. The Shade Tree Clinic is a student-run, physician-supervised free clinic started by Vanderbilt University School of Medicine students that serves uninsured patients in northeast Nashville. Since August 2011, through the American Psychiatric Association's Helping Hands Grants Program, the Shade Tree Clinic has endeavored to increase community awareness of mental health issues as well as the utilization of community mental health resources for high-risk patients. Shade Tree patients were screened for depression and alcohol abuse through the Patient Health Questionnaire (PHQ-9) and Alcohol Use Disorders Identification Test (AUDIT), respectively. These surveys were administered to patients by students during regular in-clinic appointments. Patients scoring above threshold for either PHQ-9 (score >14 out of 30) or AUDIT (score >7 out of 40) were referred to a student social worker for additional counseling and referral to community mental health resources. Patients were also invited to a monthly Psychiatry Night led by Shade Tree physician volunteers.

Methods: This present study is a retrospective chart review of patients screened for mental health disorders at Shade Tree between August 2011 and April 2012. PHQ-9 and AUDIT survey results were collected from each patient. Documentation of meetings with social work and psychiatric referrals were assessed in the electronic medical records for patients above threshold (PHQ9 >14 and/or AUDIT >7).

Results: 272 unique patients were seen at Shade Tree between August 2011 and April 2012. 61.0% were women. 29.3% did not speak English, with 24.5% of patients speaking Spanish. 247 patients (90.8%) had a documented completed PHQ-9 or AUDIT survey. The mean PHQ-9 score was 6.12 (SD: 6.33; 95% CI: 5.31, 6.93). 27 patients (9.9%) scored above the threshold for moderate depression. Of these patients, 21 (77.8%) met with a social worker; 12 (44.4%) were referred for additional psychiatric services. The mean AUDIT score was 1.6 (SD: 3.84, 95% CI: 1.06, 2.13). 11 patients (4.5%) scored above the threshold for hazardous alcohol use. Of these patients, 7 (63.6%) had a documented encounter with a social worker; 3 (27.3%) were referred for additional psychiatric services.

Conclusion: Shade Tree serves a patient population with diverse mental health needs and has been able to integrate mental health screening into the standard primary care setting. The social work program at Shade Tree represents a model for mental health screening and referral for other student-run free clinics.

PS3-02

Impact of Community Treatment Orders on Hospital Admissions

Kate Wood, M.B.B.S., Dr. Sowmya Krishna, MBBS, MRCPsych, Dr. Ashish Kumar, MBBS, MRCPsych

Abstract: Psychiatric illnesses are complex and prognosis depends on various factors. There is a cohort of "revolving door" patients who become non concordant with medications and disengage from services soon after discharge from hospital. This results in worsening mental health and they get re-admitted. Compulsory treatment in the community has been tried in various countries to improve outcomes in this patient group. In the UK, Community Treatment Orders(CTO) were introduced in 2008 to break the pattern of poor concordance.

Aim: Our study looked at the impact of CTO's on hospitalisation.

Method: The study sample included all the patients under the Liverpool Assertive Outreach Team (AOT), who had been placed under CTO between November 2008 and July 2011. Data collected included age, sex, diagnosis, medication, number and nature of hospital admissions after CTO was initiated.

Results: 36 patients were placed on CTO over the 21-month period. 69% of them were males; mostly White British in origin. 78% had a diagnosis of Schizophrenia. 56% were on depot medication and 22% on a combination of depot and oral antipsychotics. 64% (n=23) were never recalled to hospital; 17 were on depot antipsychotics. 36% (n=13) were recalled; 77% (n=10) had formal admissions with 50% having being detained more than twice and 33% (n=3) were discharged within 72 hours. 36% were discharged from CTO during the study period.

Discussion: Our study shows that CTO can significantly reduce the number of admissions to hospital when used in combination with depot medication. These were patients that received assertive community treatment, which in itself could have had an impact on the engagement and concordance. This is a sample from an inner city area and results need to be applied cautiously. There is a need for more experimental studies in this field.

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PS3-03

No More Psychiatric Patients in Police Cells: Ten Years of Experience With the Psychiatric Emergency Unit in Amsterdam, Netherlands

Jeroen Zoeteman, M.D.

Abstract: After the turn of the century the disturbances in the cooperation between police and mental health institutes in Amsterdam, the capitol of the Netherlands, escalated to scandals in the newspapers, legal conflicts and formal questions in the Dutch parliament. Psychiatric patients had to be held for a long time in police stations after they were brought in by police because of dangerous behavior or public nuisance. It took many hours before they could be assessed and treated by psychiatric services. All this turmoil resulted in an unique alliance between police, the municipal health service and the mental health institutes. In 2003 the mental health institutes formed one Psychiatric Emergency Service Amsterdam (PESA) and a Psychiatric Emergency Unit (SPOR). The PESA offers immediate help to young people and adults in severe and acute mental distress in the community, the cause varying from psychosocial crises to severe mental illness, 24 hours a day, 7 days a week. Every year approximately 6000 consultations take place, one third leading to admissions in psychiatric hospitals and half of which involve coercive measures. After a short screening the police now can bring psychiatric patients immediately to the SPOR for psychiatric evaluation. Ten years after the start, more than 10.000 patients have been brought to the SPOR. By concentrating this specific population to one location, the staff got more experienced. It was possible to cause a strong decline in the use of coercion (14% to 1%) and to improve the quality of care and the response time of the service.

PS3-04

A First Case Report of Brugada Syndrome Unmasked by Prescribed Dosage of Amitriptyline

Gurpreet Sandhu, M.D., Cheryl Kennedy, M.D., Jagdeesh Batana, M.D., M. Tariq, M.D., Amanpreet Brar, M.D.

Abstract:

Method: 58 y/o AAF with PPH of MDD recurrent severe without psychotic features was admitted to the cardiology for syncopal episode. Patient was Amitriptyline 200 mg bedtime, Buproipon 300 mg Daily,Citalopram 60 mg daily and hydroxyzine 50 mg BID for Depression from Psychiatrist. She was attending day program 3 times per week.EKG done on patient revealed typical Brugada syndrome changes. Patient has Echo and Stress test, Heart was normal in structure. All the medications was stopped and Patient was started on Remeron 20 mg at bedtime. EKG was normalized after stopping the above medications. Patient received Implantable Cardioverter Defibrillator.Patients with a spontaneously appearing Brugada ECG have a high risk for sudden arrhythmic death secondary to ventricular tachycardia/fibrillation. The ECG manifestations of Brugada syndrome are often dynamic or concealed and may be unmasked or modulated by sodium channel blockers, a febrile state, vagotonic agents, -adrenergic agonists, -adrenergic blockers, tricyclic or tetracyclic antidepressants,lithium, perphenazine, a combination of glucose and insulin, hypo- and hyperkalemia, hypercalcemia, and alcohol and cocaine toxicity.

Results: First we as a Psychiatrist must be Familiar with this arrhythmia syndrome that can result is sudden death in patient. It is also very important to ask for sudden death history in family during psychiatric interview as this disease has genetic component and screening of family members is recommended. We encounter with patients use who use alcohol, cocaine and psychotropics that are very much responsible for unmasking Brugada Sundrome.

PS3-05

We Are the 99%: Building a Mental Health Intervention From the Ground-Up Within the Occupy Movement

Hetty Eisenberg, M.D., Flavio Casoy, M.D.

Abstract: It became clear to those of us spending time in the Occupy San Francisco encampment that there was a significant mental health problem. We observed a visible number of camp residents exhibit a range of mental health needs. The needs we observed included: stress and burnout; trauma from police threats and other conflicts; chronic severe mental illness; substance dependency; anger problems; and chronic homelessness. We witnessed conflicts escalate to verbal and physical violence on a number of occasions. Despite best efforts, occupiers often lacked the tools to de-escalate these conflicts. Many of the activists in camp were becoming frustrated with the presence of the mentally ill participants. Meanwhile, we heard troubling reports from other occupations around the country that tensions between some activists and the mentally ill or homeless populations were causing irreparable divisions that threatened to undermine the movement. Some activists were moving out and abandoning their encampments because of the presence of the mentally ill and homeless populations. We believed that one of the most powerful messages of the Occupy movement is its radical inclusion. The Occupy movement brings together factions across a wide range of interests and backgrounds. In this light, the 99% necessarily includes all individuals, particularly those amongst us who are most marginalized. Moreover, we felt that the public health hazard blamed on the encampment shined a light on our city's pre-existing public health problem – one that is worsened by deep budget cuts in public mental health services. For these reasons, we decided that offering some kind of mental health support within the Occupy San Francisco encampment could help to sustain the movement. This poster presents the efforts of two UCSF psychiatry residents to bring together a group of San Francisco public service groups, mental health training programs, and private mental health practitioners to establish an Emotional First Aid tent at Occupy San Francisco. The Emotional First Aid Tent at Occupy San Francisco took off quickly and existed for over one month. It was an exciting model for emergency mental health relief work. In addition to detailing the establishment of the Emotional First Aid tent, the poster will present some of the challenges the project encountered: recruitment of volunteers and counselor burnout; complex ethical and medical-legal considerations; inspiration from mental health efforts at other Occupy encampments; working in a uniquely egalitarian context; anti-psychiatry voices; the impact of economic oppression on mental health; interfacing with public mental health institutions in SF; how to relate with police in a setting in which police were feared; and physical/space issues."Psychiatrists Occupy Place in Protest Movement." Psychiatric News. January 20, 2012. Volume 27, Number 2, page 1-31. http://psychnews.psychiatryonline.org/newsArticle.aspx?articleid=334875

PS3-06

Capacity Building in Alzheimer's Disease: Lessons Learned From a Pilot Study in 6 Distinct Areas in Lebanon in Summer 2011

Lama Bazzi, M.D., Christina Borba, Ph.D., MPH, Julia Carney, Zeina Chemali, M.D., MPH

Abstract:

Introduction: Advances in health care came with an exponential growth in world's elderly population, and accompanying illnesses, including Alzheimer's disease (AD). The Arab world is no exception. The authors report on a 6-day Capacity Building Workshop on AD throughout Lebanon, directed and conducted in collaboration with the Lebanese Ministry of Social Affairs (MoSA) and the AD Lebanon foundation.

Methods: Informed consent was obtained to collect demographic data and administer pre and post-tests gauging knowledge on AD. A Likert scale assessed reasons for participation and interests, and a semi-structured questionnaire evaluated strengths and weaknesses of the workshop.

Results: 94% of the participants were women, 36% between 31-40 years old. 80% were social workers or nurses and 65% were government employees. Highest Likert ratings for participating in the workshop were the desire to mentor others (71%), improve communication with elders in the community (69%), and improve care of the elderly (61%). Participants felt they learned most about: aging sensitivity training (74.4%), positive behavioral support (60%), and dealing with difficult behavior (55.6%). MoSA was viewed as playing a primordial role in educational workshops and community training. Incomplete evaluations, participant ignorance in monitoring methods, and workshop fatigue impacted negatively on data outcomes.

Conclusions: Cross-cultural work in AD is most important especially when focusing on the needs of the population studied. A large number of community workers were sensitized to AD. Participants reported being empowered in advancing elders' quality of care in their respective communities. Challenges related to the group heterogeneous backgrounds, a lack of prior education into evaluation methods and the fasting period of Ramadan. Lessons learned from Summer 2011 governed planning for the following summers' community follow up.

PS3-07

Impact of Break-Up on Facebook for an Adolescent Girl: A Case Report

Salman Majeed, M.D., Karriem Salaam, M.D.; Rabia Salman; Muhammad Khalid Zafar, M.D.; Uzma Beg

Abstract: Breaking up on social networks such as Facebook has been increasing over the last few years. It is easier for the initiator as it allows distancing and protects against painful emotions. But it is inhumane and unkind for many reasons. It disrupts the process of mourning. The pain perceived by the recipient is not limited to losing the intimate relationship. Instead, it adds public humiliation, worthlessness and marked sense of rejection. Here, we discuss the case of a 16 year old girl who was shocked to learn about her break up from the status update of her boyfriend. Not being able to tolerate the intense pain and humility, she impulsively overdosed on full bottle of Tylenol in an attempt to kill herself.

PS3-08

Organization-Wide Processes for Implementation of Psychiatric Advance Directives Policy

Rachel Zinns, M.D., David Miller, Ph.D., Tatyana Poblaguyev, M.D., Michele Kerner, ACSW, LCSW, Kishor Malavade, M.D., Scot McAfee, M.D.

Abstract:

Background: In recent years, there have been numerous reports of consumer and clinician attitudes regarding psychiatric advance directives (PAD), content of PAD documents, and factors relating to their completion process. Yet little has been written about the implementation of PAD at the organizational level, especially with regard to dissemination and access to documents and the honoring of PAD. Despite many reports of supposed benefits of PAD, and national policy oversight moving towards a standardization of PAD, their use has not been widespread. Indeed, our preliminary survey revealed that, mimicking the national trend, few if any New York City hospitals have an official policy – implemented or otherwise – regarding the use of PAD.

Objective: To describe the process of implementing an institutional policy on PAD, with emphasis on monitoring access to and honoring of PAD. This project represents a system-wide, coordinated effort including consumer education, staff training, and incorporation into residency training curriculum.

Methods: A planning committee was formed to create and implement an institutional PAD policy. A literature review was conducted to research examples of PAD documents, opinions of consumers and providers regarding benefits and barriers to PAD interventions, as well as strategies for consumer and provider training. A phone survey of other area hospitals was conducted to determine whether a similar process had occurred elsewhere. Educating providers about PAD and obtaining feedback from them regarding implementation strategies are ongoing. Development of guidelines for monitoring the dissemination of and access to PAD throughout our facilities is underway. In collaboration with Primary Care and Palliative Medicine teams, services are being organized to offer Psychiatry clinic patients both education and facilitation with medical advance directives in addition to PAD. Development of a residency training curriculum on medical and psychiatric advance directives, competency assessment, and integrated care is underway.

Results: We report on the process of creating and implementing a PAD policy, highlighting strategies which were most helpful as well as obstacles/resistance frequently encountered. Early results of monitoring how PAD are accessed and honored, as well as feedback from consumers and providers regarding implementation strategies will be shared.

Conclusion: Despite many proposed clinical and organizational benefits of PAD, their use has not been widely implemented nationally or locally. We hope to present a model of integrated PAD policy implementation which addresses real-time barriers and provides recommendations for successfully implementing PAD policy across a spectrum of community health organizations.

PS3-09

CBASP for Co-Occurring Chronic Depression and Alcoholism: Initial Findings

Jennifer Kim Penberthy, Ph.D., Christopher Gioia, Ph.D.; Andrea Konig, Ph.D.

Abstract: Alcoholism and chronic depression frequently co-occur and make effective treatment more complex and challenging. Chronically depressed alcohol dependent individuals possess unique characteristics that make effective treatment more challenging. For instance, they have a higher likelihood of psychological abuse and trauma history, specific cognitive/learning deficiencies, a more chronic and severe course of depression, including an earlier age of onset, increased number of co-morbidities, and a more complex and risky prognosis. Depressed alcoholic individuals typically report a lifelong history of intrapersonal and interpersonal failure and demonstrate interpersonal avoidance and detachment as frequently manifested in their maladaptive drinking escape behavior. As such, the use of CBASP with this population presents some unique challenges. We will present an augmented CBASP approach for treating chronically depressed alcoholics and discuss the challenges and potential solutions for working successfully with this population to reduce both depressive symptoms as well as alcohol intake. We will review additional issues and skills to consider as well as common pitfalls and interpersonal challenges and strategies to address these. Initial findings from our clinical research will be presented along with additional potential applications.

PS3-10

Benzodiazepine Use Misreport: A Potentially Lethal Complication of Benzodiazepine Dependence, Two Case Reports

Maria del Pilar Trelles Thorne, M.D., Susana Sanchez, M.D.; Danijela Ivelja, M.D.

Abstract:
Introduction: Benzodiazepine withdrawal syndrome is a serious complication of benzodiazepine dependence. Presenting symptoms vary widely from tachycardia and anxiety to perceptual disturbances, seizures and even death. We report two cases of benzodiazepine withdrawal initially presenting solely with behavioral symptoms and where benzodiazepine use was underreported, delaying adequate management.

Methods and Results: Case 1: 33 year-old man with a history of opioid dependence and MDD presented to the emergency room with insomnia, delusions of grandeur and erratic behavior. He denied any recent substance use. His vital signs were within normal limits. Urine toxicology was negative. Upon admission to psychiatric unit for management of psychosis, risperidone 1mg by mouth twice a day was started without improvement. After 48 hours of hospitalization, heart rate was noted to be in the 100's and blood pressure was elevated. Lorazepam 2mg by mouth every six hours was started under suspicion of substance withdrawal. After improvement of symptoms, patient reported five-month history of daily alprazolam use which he discontinued abruptly four days prior to admission. Symptoms completely resolved. One month after discharge he remained asymptomatic. Case 2: 34yo man with opioid dependence presented to the hospital with the complaint of severe anxiety, depressed mood and auditory hallucinations. He reported daily use of alprazolam, up to two milligrams, for one month which he discontinued abruptly four days prior to admission. Initially his heart rate was 106 beats per minute, but repeat was 72. Urine toxicology was negative. Psychiatry was consulted for management of psychosis. He was diagnosed with acute benzodiazepine withdrawal and started on lorazepam 2mg by mouth every six hours. His symptoms rapidly progressed and he developed severe autonomic instability, requiring 50mg of lorazepam intravenously in the first 24 hrs. His mental status improved completely after two days. He admitted the underreporting of alprazolam use.

Conclusions: It is important to consider withdrawal from a potentially dangerous substance in the differential diagnosis of new onset psychosis in patients with history of substance abuse. Both cases presented with delirium without changes in vital signs. Underreport of benzodiazepine use is not uncommon, and in these two cases was potentially lethal.

PS3-11

Correlation Between Tobacco Smoking and Mental Disorders Including Suicidal Tendencies

Meang Je Cho, M.D., Sohn Jee Hoon, M.D., Ryu Ji Min, M.D.

Abstract:
Object: In Korea, there is limited information on nicotine dependence and its correlation with psychiatric disorders. Based on the Korean national psychiatric epidemiologic survey in 2006, we examined the relationship between the severity of tobacco smoking and mental disorders, with specific attention to suicidal tendencies.

Methods: Total of 6,510 adults underwent face-to-face interviews. The Korean version of the Composite International Diagnostic Interview (K-CIDI) was used to evaluate lifetime prevalence and correlates of mental disorders. According to the severity of tobacco smoking, participants were grouped into never-smokers, ever-smokers, and nicotine dependence(ND). The frequencies of mental disorders and suicidal tendencies were analyzed among Nicotine dependence/ever-smokers. Multivariate logistic regression analysis was used to predict the odds ratios and significance levels among groups.

Results: Associations of nicotine dependence with alcohol use disorder, mood disorder, anxiety disorder, pathological gambling, and suicidal tendencies were significant, even after controlling for demographic characteristics. Associations of most psychiatric disorders with smoking were stronger in females than in males.

Conclusion: ND is highly associated with alcohol use disorder, mood and anxiety disorders, pathological gambling, and suicidal tendencies. Interventions are needed in order to prevent the development of nicotine dependence from regular smoking.

PS3-12

Synthetic Cannabinoids and the Onset of Psychosis in Youths: A Case Report

Anita Jothy, M.D., Joshua Felsenfeld, MSIII, and Shoaib Khalid, MSIII

Abstract: Cannabis, also more familiarly known as marijuana, is predominantly used as a psychoactive drug but we also know of its medicinal qualities. Fifty years ago synthetic cannabinoids were developed to further study the clinical benefits of cannabis. For the past few years these synthetic derivatives, now more commonly known as "Spice" and "K2" are being sold in particular shops and on the internet as herbal incenses, which are legal when not consumed. Knowledge of this legal, inexpensive, and easily accessible

substance has spread widely, especially within the teenage population. Their effects are similar to cannabis including euphoric and sedative effects, and also including altered thought process and psychotic states. We present a case of A.C., a fifteen year-old boy, who had been diagnosed with major depressive disorder and discovered Spice and subsequently led to having new onset psychotic episodes. Clinicians should be wary of the growing popularity of synthetic cannabinoids particularly when encountering teenagers with new onset of psychosis. And especially take note that synthetic cannabinoids are undetectable in standard urine toxicology testing. It has been found that Spice can lead to more potent and prolonged psychotic episodes than its counterpart cannabis. We will discuss in more detail the consequences of use of synthetic cannabinoids.

PS3-13

Association Between Substance Abuse Treatment Referral and Depression Outcomes Among Safety-Net Patients Served in an Integrated Care Program

Ya-Fen Chan, Ph.D., Hsiang Huang, M.D., MPH, Jürgen Unützer, M.D., MPH, MA

Abstract:

Objective: The study aim is to examine the association between substance abuse treatment referrals and depression outcomes in an integrated mental health program.

Methods: A total of 2402 individuals with concurrent substance use and depressive disorders enrolled in the program between 2008 and 2010 were included. Three groups of treatment referral status were identified: accessed treatment referral (n=816), declined treatment referral (n=316) and no treatment referral (n=1270). The primary outcome is improvement in depressive symptoms (Patient Health Questionnaire 9 (PHQ-9) score<10 or = 50% reduction in PHQ-9 score) during treatment.

Results: Using propensity score adjustments, patients who accessed substance abuse treatment were significantly more likely to achieve depression improvement than those who declined referral services (hazard ratio (HR)=1.47, 95% confidence interval (CI): 1.08-1.99, p=0.013). Each one month delay in substance abuse treatment referral after program enrollment was associated with a decreased likelihood of depression improvement (HR=0.96, 95% CI: 0.94-0.99, p=0.02). Propensity score quintile stratification and regression adjustments yielded similar magnitude and direction of the reported associations.

Conclusions: Effective referral to substance abuse treatment services and early initiation of treatment referral are associated with better depression outcomes among safety-net patients seeking mental health services in primary care.

PS3-14

Benefits of Somatic Pain Screening and Processing in Autism Spectrum Disorders Adult Not Saying Patients

Christine Palix, M.Psy., Albert Boxus, Psychiatrist, Rossi Pierre, Psychiatrist, Nouar Kheira, Psychiatrist

Abstract: Benefits of somatic pain screening and processing in autism spectrum disorders (ASD) adult not saying patients.

Background: For some rare patients, ASD come along with an intense autistic withdrawal reducing the oral communication and the social interactions. How to detect a somatic pain and how to take care of it in that situation. The aim of this study was to investigate the evolution of the SGA and anxiolytics prescriptions of SGA versus antalgics in ASD adult not communicant patients using pain scales.

Methods: 37 individuals (29 males and 8 female; mean age 47 years) meeting CIM 10 criteria for ASD were included in the study. We realized 237 scales of pain during 3 years every time they arrived in the ASD department for adults, every time their behavior modified and every time they could feel a pain. We compared the prescriptions of second generation antipsychotic drug (SGA), anxiolytics versus antalgics at 3 periods: 2009, 2010 and 2012.

Results: SGA prescriptions decrease since 2010 and 2011, anxiolytics prescriptions decrease during 2009, 2010 and 2011 and we observe an increase of antalgics prescription during 2009, 2010 and 2011.

Conclusion: Detecting and searching somatic pain for ASD adult not saying patients could avoided unsuitable prescriptions of SGA and anxiolytics versus antalgics.

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PS3-15

Psychiatric Disorders and Psychotropics in 100 Terminal Cancer Patients

Pierre Gagnon, M.D., Pascale Arsenault, B. Pharm.; François Tardif, MSc; Joanie Le Moignan, MSc.; Mélanie Simard, M.Sc.

Abstract:

Background: Psychiatric disorders, including delirium, are described as very prevalent in terminal cancer patients. However, few studies analyzed the actual prevalence of psychiatric disorders and the use of psychotropics in this population. Psychiatric disorders have a major impact on quality of death. This study describes the prevalence of psychiatric disorders and the use of psychotropics in a cohort of terminal cancer patients.

Objective: To describe the prevalence of psychiatric disorders and the use of psychotropics in a cohort of terminal cancer patients.

Methods: 100 patients admitted in a 15-bed hospice in Canada, during a 5-month period (May to September 2008), were reviewed from admission until death (average survival= 14 days; average age= 68.7 years) for the presence of psychiatric disorders and prescription of psychotropics. Doses of benzodiazepines and antipsychotics were converted into equivalent units (mg of lorazepam and haloperidol). The Nursing Delirium Screening Scale (Nu-DESC) was used for delirium assessment.

Results: Seventy-six percent of patients developed significant delirium symptoms during stay (as measured by a Nu-DESC score of 2 or higher), whereas anxiety disorders and major depression were diagnosed in 17 % and 4 % of patients respectively. From admission until death, 94%, 84%, and 17% of patients used, respectively, at least one antipsychotic, one benzodiazepine, or one antidepressant. Haloperidol (average dosage= 2 mg) and methotrimeprazine (average dosage= 12.5 mg) were the most frequently used antipsychotics (60 and 33 % in patients-days respectively) whereas lorazepam (average dosage= 1 mg) and midazolam (average dosage= 7.5 mg) were the most frequently used benzodiazepines (74 and 30% of patients-days respectively). Lung and liver metastases were respectively associated with a higher and a lower dosage of benzodiazepines ($p<0.05$).

Conclusions: Delirium was the most frequent diagnosis, with significant symptoms in three-forth of patients, whereas major depression was lower than the prevalence reported previously. Benzodiazepines and antipsychotics, mainly haloperidol, were the most prescribed antipsychotics, in dosage usually recommended in this population. Research and clinical implications: At the conclusion of this session, the participant should be able to:

Clinical implications:

- Describe the prevalence of psychiatric disorders and the use of psychotropics in terminal cancer patients
- Discuss the role of psychiatrist in end-of-life care, especially as a specialist in psychopharmacology.

Research implications:

- Understand the most important psychiatric disorders to design research projects in terminal cancer;
- Consider the prevalence of psychiatric disorders and use of psychotropics while studying psychosocial issues in end-of-life care.

PS3-16

SSRI Cutaneous Adverse Reactions: A Side Effect Not Well Known

Sadeq Al-Sarraf, M.D., Rashi Aggarwal, M.D., Christopher Montes, M.D.

Abstract: Selective Serotonin Reuptake Inhibitors (SSRIs) are one of the most frequently prescribed classes of drugs (1) Cutaneous adverse reactions induced by SSRIs are common in psychiatric pharmacotherapy, easily noticed but are less well known (2). These side effects can be life threatening and might need urgent medical care. After encountering patients with rashes in our clinical practice and realizing the need to increase recognition on this topic we reviewed data available in the literature regarding SSRIs adverse cutaneous reactions to improve recognition of these important adverse reactions and understand different ways to manage these reactions when they occur. Adverse cutaneous reactions have been reported with all classes of psychotropic drugs, including antipsychotics, anticonvulsants, anxiolytics, and antidepressants. These reactions are potentially harmful and might be life threatening. Increased index of suspicion is warranted for patients who develop a skin rash during treatment with an SSRI. Papular skin rash constituted the majority of the recorded adverse skin reactions. These cutaneous adverse reactions might be class related as they occurred on rechallenge with the same medication or by different medication from the same class; this might require substitution with an antidepressant medication from a different class. Severe systemic symptoms (fever or general malaise) and the need of systemic treatment should prompt immediate drug discontinuation. Using antihistamines or steroids might be beneficial in treating these adverse reactions, severe cases might need transfer to a medical monitoring or intensive care unit.

PS3-17

Characteristics of the Homeless Under the Criminal Justice System

Rachel Pope, M.D., C. Brendan Clark, Ph.D.; Karen L. Cropsey, Psy.D.

Abstract:

Intro: According to the federal definition, homelessness is defined as "an individual who lacks a fixed, regular, and adequate nighttime residence and an individual who has a primary nighttime residence that is a supervised publicly or privately operated shelter…, an institution that provides a temporary residence for individuals intended to be institutionalized, or a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (U.S. Housing and Urban Development, 2011)." According to the National Coalition for the Homeless (NCH, 2009), homelessness has been on the rise in the last years and certain demographics appear to be overrepresented. For example, among the homeless, 38% are alcohol dependent and 26% are dependent on various other substances (NCH, 2009). African-Americans, men and members of the criminal justice system are all over represented (NCH, 2009). Of note, homelessness among inmates currently in jail was 7.5-11.3 times the rate in the general population (Greenberg, 2008). However, little is known about the characteristics of individuals who are under criminal justice supervision in the community who may also be homeless and this was the purpose of the present study.

Methods: Self-report data was collected from approximately 25,000 individuals under community corrections supervision for substance related offenses from 2003-2007 via semi-structured interviews at program entry. There were 1034 (4%) who were classified as homeless. In addition, demographics, substance use, criminal justice history, and other psychosocial variables were collected. Univariate and multivariate analyses were used to determine characteristics associated with homelessness for individuals under criminal justice supervision.

Results: The results of the multivariate analyses indicated that the homeless were more likely to be older, female, unmarried, unemployed, without insurance, and self-report a drug of choice. They were more likely to report a history of: suicide attempts or ideation, mental health treatment, physical or sexual abuse, trading sex for drugs, and committing property or court-related offenses.

Discussion: As expected the homeless participants were much less stable than the other participants, with higher levels of unemployment, abuse, mental health issues, and legal problems. It was unexpected that a higher percentage of women would be homeless; typically men comprise a higher percentage of the homeless population (NCH, 2009). This higher level of homeless women may reflect a unique gap in the local safety-net. Overall, this population is faced with a number of obstacles that will likely impede their ability to comply with the legal system and to make progress in their recovery from substance abuse. More intensive interventions are likely needed to ensure lasting sobriety and reduce recidivism.

PS3-18

Integration of Mental Health and Primary Care in Screening and Treatment of Postraumatic Stress Disorder in the VA Clinical Setting

Elliot Lee, M.D.; Rachel Molander, M.D.; Rachael Pluim-Bergmann; Eileen Ahearn, M.D., Ph.D.; Dean Krahn, M.D., MS

Summary: In an effort to create seamless, population-based, veteran-focused care, the Veterans Administration has integrated mental health care into the primary care setting. The integrated model depends on PTSD screening for all primary care patients, followed by further evaluation by primary care physicians for positive screens. In this model, psychiatrists are embedded in primary care and serve as consultants to primary care physicians. Subsequent mental health care delivery can occur in the primary care setting for uncomplicated cases or may subsequently occur in specialty mental health clinics. The integrated care approach has been studied in the treatment of depressed primary care patients, but less is known about the successful level of referral and engagement of this approach for Posttraumatic Stress Disorder (PTSD). In this study, we describe the care management of veterans who screened positive for PTSD in various VA primary care clinics. During the 1 year period of September 2009-2010, 804 veterans in primary care screened positive for PTSD using the 4 question PC-PTSD screen. One hundred and ten of the veteran were already enrolled patients in the mental health clinic. Sixty eight percent of the remaining 694 veterans had an integrated care evaluation by mental health staff in the primary care setting and 32% were diagnosed with PTSD. The use of telemental health allowed veterans at both rural and urban clinics to receive integrated care evaluation with equal likelihood in either setting. We analyzed the OIF/OEF veteran population separately to better understand the referral process for our newest veterans. Of the 305 OEF/OIF veterans who screened positive, 71.8% had an integrated care assessment and 67% of these veterans were subsequently referred to the mental health clinic. Ninety eight percent of veterans had documented assessment of a positive screen, with documented follow up from primary clinic or integrated care regarding treatment of their mental health symptoms. This high rate of follow up of mental health symptoms is indicative of the success of screening and the integrated care approach in the primary care setting for OEF/OIF veterans with PTSD symptoms.

PS3-19

An Experiment in Integrated Care Education

Sosunmolu Shoyinka, M.D.; Rubin Moore, M.D.

Summary: With the current critical shortage of mental health care professionals (1)Integrated Care is poised to become a key model of mental health care delivery in the United States. There is evidence that up to 70% of mental health care is delivered in primary care settings while no show rates for specialty mental health care are high. Integrating Behavioral Health into Primary Care offers expanded access, reduced stigma and population-based psychiatric care. While the concept of Integrated care is rapidly gaining grounds in the mental health services arena, less attention is being paid to training the next generation of psychiatrists in delivering care within this model. The University of Missouri Community Psychiatry program offers a newly developed elective for senior residents in Integrated Care. This elective was developed specifically to expose residents in their 4th year to clinical experiences in delivering psychiatric care in an Integrated system. The Family Health Center in Columbia, Mo is a Federally Qualified Health Center that has recently partnered with the Burrell Behavioral Health system, a private, not for profit organization that provides a wide range of mental health services for individuals and families, under the auspices of a Missouri State grant, to develop integrated services. FHC serves 3 counties in Missouri, with a potential population of over 50,0000 individuals. This population has a high prevalence of mental health needs, yet it's psychiatric services are limited to one psychiatrist half a day per week, a mental health nurse, and a counselor. Beginning in July 2011, in partnership with the university of Missouri dept. of psychiatry, a yearlong half-day per week elective rotation was developed that enables a 4th year psychiatry resident to collaborate with Behavioral Health Consultants (master's level SW) to provide real-time consults to primary Care providers and thus both increase access as well as decreasing wait times to see the psychiatrist and APRN. The residents have access to attending supervision at all times but are encouraged be flexible and use their initiative in solving problems, using an outpatient consultation-liaison model. The elective also offers valuable experience in treating co-occurring disorders. Initial feedback has been strongly positive both from the clinic staff and the trainee.

PS3-20

A Case of Grave's Disease Treated by a Psychiatric ACT Team

Mary Woesner, M.D.; Jeremy Marsh, MS4; J. Daniel Kanofsky, M.D., M.P.H.

Summary:
Introduction: Physical diseases are difficult to treat in psychiatric patients, whether they are co morbid disorders or mental disorders due to a general medical condition. The psychiatric symptoms are difficult to treat on a medical ward or clinic and the physical symptoms are difficult to treat on a psychiatric ward or clinic. For this reason, medical psychiatric units have been developed. However, these are uncommon. It has been suggested that psychiatric Assertive Community Treatment (ACT) Teams are a place to integrate medical and psychiatric treatments.

Methods: The medical and psychiatric records of an Assertive Community Treatment (ACT) Team patient with a seven year history of Grave's disease/hyperthyroidism were reviewed. The patient was followed at home by members of the ACT Team.

Results: We review the case of a woman with psychiatric symptoms caused by untreated Grave's disease. Her Grave's disease remained untreated due to non compliance with medications and due to severe symptoms of irritability, aggression, and mood variability which were not manageable by the medical teams. The patient improved through the interventions of the psychiatric ACT Team.

Conclusions: We make a case for the use of the psychiatric ACT Team in the treatment of patients with mental disorders due to a general medical condition, when the psychiatric manifestations are severe and cannot be managed on a medical ward or in a medical clinic. We suggest the concept of the "medical psychiatric ACT Team" as a corollary to the medical psychiatric inpatient unit.

PS3-21

Antipsychotic Dose Escalation Prior To The Development of Neuroleptic Malignant Syndrome (NMS)

Julie Langan; Dr. Daniel Martin, MBChB, BMSC (Hons); Dr. Polash Shajahan, MBChB, M.P.H.il, MRCP(UK,) FRCPsych

Summary:
Background: "Neuroleptic malignant syndrome" (NMS) which derives from the French "syndrome malin des neuroleptiques" was first described in 1960 by Delay and colleagues in association with haloperidol. It is a potentially fatal idiosyncratic reaction to antipsychotics. Pathophysiology remains enigmatic. Mortality rates may be as high as 55%. Rapid alteration and escalation of anti psychotic dose is thought to be an important risk factor. "Rapid escalation of dose" as a phenomenon has been difficult to define.

Aims: To identify cases of NMS, review risk factors and focus on changes in antipsychotic dose in the 30 days prior to NMS onset. We also attempt to scientifically define "rapid escalation of antipsychotic dose."

Methodology: Retrospective analysis to identify NMS cases using DSM IV criteria within NHS Lanarkshire, Scotland was undertaken. Once identified, demographics, risk factors for NMS and the episode were described by 2 independent psychiatrists. A 30 day antipsychotic dose trajectory prior to NMS onset was recorded. Cumulative antipsychotic dose was calculated using chlorpromazine equivalence to allow comparison of total cumulative dose of different anti psychotics. In the UK the British National Formulary (BNF) contains information regarding maximum licensed doses of antipsychotic medication. Cumulative antipsychotic dose as a percentage of total maximum BNF dose was also calculated. Dose trajectories were compared to inpatient and outpatient clozapine titration schedules.

Results: 12 cases were identified. Sex distribution was equal. Average age was 47.8 years. The most common diagnosis was Schizophrenia (295){50%, (n=6)}, followed by Mood (Affective) Disorders (296){25% (n=3)}. 33.3% (n= 4) received parenteral antipsychotics within 30 days of NMS onset. Antipsychotic polypharmacy rates were high 41.7% (n=5). Individual 30 day dose trajectories prior to NMS onset were plotted and means obtained. Mean dose trajectory was compared to standard clozapine inpatient and outpatient titration regimens. NMS patients had higher total daily chlorpromazine dose and more rapid dose escalation, particularly in the 10 days prior to NMS onset, compared to individuals titrated on clozapine. Differences in cumulative dose and dose escalation using percentage maximum BNF were less marked.

Discussion: It would appear that using higher doses and titrating anti psychotics faster than standard clozapine titration schedules may be associated with the development of NMS. Converting antipsychotic medication received to a cumulative chlorpromazine equivalent and monitoring this over time may be useful in early detection and prevention of NMS. Chlorpromazine equivalence as a measure of total anti psychotic dose received may better predict NMS compared to percentage BNF.

PS3-22

Dose Related Effect of Acculturation on Suicidal Ideation and Attempts Among Hispanics Living in the U.S.

M. Mercedes Perez Rodriguez, M.D.; Enrique Baca Garcia, M.D., Ph.D.; Maria A. Oquendo, M.D.; Shuai Wang, Ph.D.; Carlos Blanco, M.D., Ph.D.

Summary:

Background: Acculturation is a multi dimensional construct. Measuring different facets of acculturation may yield better results than a single measure. Only one nationally representative survey has examined the effect of acculturation on suicidal ideation and attempts among Hispanics in the U.S., and found that different facets of acculturation increased lifetime suicidal ideation and attempts. We aimed to examine the impact of five complementary measures of acculturation (age at migration, time in the U.S., language preference, social network composition, race/ethnic orientation) on suicidal ideation and attempts among Hispanics in the U.S. We aimed to extend prior findings by demonstrating a linear, dose related effect of acculturation on suicidal ideation and attempts.

Method: *Subjects:* Hispanics living in the U.S. (N=6,359) from wave 2 of the National Epidemiologic Survey of Alcohol and Related Conditions (n=34,653, 2004 2005). We used descriptive statistics, linear chi square tests and multinomial regression logistic models to analyze the effect of acculturation on risk of lifetime suicidal ideation and attempts.

Results: The older the age at the time of migration, the lower the lifetime risk for suicidal ideation and attempts compared to those younger at the time of migration or U.S. born. Lifetime suicidal ideation increased with time spent in the U.S. As the degree of English language orientation increased, there was a dose related increase in the risk for suicidal ideation and attempts. As the Hispanic/Latino social network and Hispanic/Latino race ethnic identification decreased, risk for suicidal ideation and attempts increased.

Conclusions: Acculturation is a multi dimensional construct. Multiple facets of acculturation were significant correlates of lifetime suicidal ideation/attempts, with a linear, dose related effect (i.e., higher levels of acculturation were correlated with increased risk for suicidal ideation and attempts). Hispanics living in the U.S. are diverse in terms of level of acculturation. This is a key factor for tailoring interventions and providing personalized mental health care.

PS3-23

Cultural Mistrust and Psychopathology in African Americans

William Lawson, M.D.; Michael A. Gara, Ph.D., William A. Vega, Ph.D., Stephan Arndt, Ph.D., Michael Escamilla, M.D., David E. Fleck, Ph.D., Ira Lesser, M.D., Harold W. Neighbors, Ph.D., Daniel R. Wilson, M.D., Ph.D., Stephen M. Strakowski, M.D.

Summary: Rates of clinical diagnoses of schizophrenia in African Americans are uniquely elevated among major U.S. ethnic groups and contradict population rates derived from epidemiologic surveys. A 6 site study of comparing ethnicity-blinded and unblinded diagnostic ratings of African American to White and Latino subjects with severe affective disorder using a sequential assessment design showed that African Americans according to the consensus of blinded expert raters, had higher and putatively misdiagnosed rates of schizophrenia spectrum diagnoses than did non-Latino White subjects. A key contributor in several studies have been higher reported rates of psychotic symptoms in African Americans. However African

Americans also show higher rates of cultural mistrust: the degree to which African Americans distrusted white society. We sought to determine from this carefully diagnosed and blinded rater study if mistrust contributed to reported psychosis. The relationship between the cultural mistrust inventory and psychopathology as measured by the SAPS, MADRS and YMRS was examined in the 244 African American patients with severe affective disorders. 104 male and 144 female (age range 18-43) from the 6 regional site study were included. We found that the cultural mistrust inventory is significantly related to total psychosis(r=.15) hallucinations/delusions(r=.14) and depression (r=.20), (p<.05), but not mania or bizarre behavior, when controlling for demographics. Cultural mistrust is presumed to be the result of negative racial experiences or awareness of historical antecedents. These findings provide limited support to a cultural basis for the greater risk of psychosis in African Americans, which may account for the overdiagnosis of schizophrenia. Additional research is necessary to better understand socio-cultural factors such as cultural mistrust and psychopathology.

PS3-24

Treatment of Depression in Latino Women: Relevance of Activation and Self Management Training

Laura Safar, M.D.; M. Alegria

Summary:

Background: Depression is highly prevalent and a significant source of morbidity and disability in the United States. Latinos comprise a growing percentage of the U.S. population. The lifetime prevalence of Major Depressive Disorder is 10 25% for women and 5 12 % for men. Less power and learned helplessness are some of the psychosocial factors which may explain this gender difference. Practice guidelines recommend both pharmacological and psychological interventions for the treatment of depressive disorders. There are very limited quantitative data supporting guidelines for the treatment of depression in Latino Women. Cultural factors and the influence of vegetative symptoms and negative cognitions characteristic of depression may contribute to perpetuate low levels of activation and self management in Latinas. Activation and Empowerment training may help depressed Latinas develop a more collaborative relationship with their mental health provider and participate more effectively in their mental health care.

Objective: To examine if the DECIDE intervention, which teaches patients a set of skills which may facilitate a more active role in the mental health encounter and in the individual self management, and a more collaborative provider patient relationship, provides benefits in the treatment of depressed Latino Women.

Method: A total of 225 depressed and 76 non depressed Latino women were enrolled in a multisite random controlled trial examining a patient activation and self management intervention. Measurements of activation (Patient Activation Scale PAS) and of Self-Management (Perceived Efficacy in Patient Provider interactions and Self Management PEPPI) were administered at baseline, 45 days, and 90 days. Demographic characteristics across control and intervention groups are comparable, which indicated successful randomization.

Preliminary Results: There was an increase in activation in both intervention groups, but only in the non depressed group there was a significant difference between intervention and control subjects. There was an increase in Self Management scores in both intervention groups, but only in the subgroup of depressed subjects the difference was significant between intervention and control subjects. We discuss these findings and the influence of depressive disorders in subjects' activation and self management.

PS3-25

Homelessness and Recovery From the Perspectives of People With Dual Diagnosis

Maria Mananita Hipolito, M.D.; Elizabeth Carpenter Song, Ph.D.; Rob Whitley, Ph.D.

Summary: Mental health services have come to view stable housing as critical to the continued recovery of people living with psychiatric disabilities. According to the Substance Abuse and Mental Health Services Administration, half of the mentally ill homeless population in the United States also suffers from substance abuse and dependence. Minorities, especially African Americans, are over represented in this group. The present study examines the experiences of people with co occurring disorders of mental illness and addiction that are formerly homeless and now living in intentional recovery communities (RCs) provided by a core service agency in Washington, D.C. First person narratives collected in the context of a longitudinal qualitative study titled, Creating Communities were examined to determine the influence of the evolution of housing for these individuals from “having no place to stay” to living in a stable place of their own. The authors explore the importance of stable, supportive housing for individuals recovering from mental illness and addiction through the ontological security of having a place to call “home” and a place of physical, psychological and social safety. Three domains strongly emerged in which residents convey the impact of transitioning from being homeless to being housed in a stable housing units with supportive environment. Residents felt that living in a supportive housing improved their sense of security, imparted a favorable effect in their sense of independence, and encouraged social and community participation. ‘Creating Communities’ is being conducted in the context of an ongoing collaboration between Dartmouth

Psychiatric Research Center and Howard University. This five year research and training center grant focuses on the recovery and rehabilitation of African Americans with severe mental illness funded by National Institute on Disability and Rehabilitation Research.

PS3-26

Is Internet Addiction a Psychiatric Illness or an Emerging Social Phenomenon?

Shaneel Shah, M.D., Jeffrey Hamblin, M.D.

Abstract: Internet is rapidly becoming entwined in our daily lives and now forms an essential part of many activities. Ivan Goldberg coined the term 'Internet Addiction Disorder' in 1995. Seventeen years later, Internet Addiction is now seen as a worldwide problem and estimates of prevalence vary from 2-35%. DSM-5 work group has made proposal to include 'Internet Use Disorder' in section III, under conditions that require further research. Is Internet Addiction a separate disorder? Will it be wise to consider something this essential and pervasive as Internet a pathological entity rather than an emerging social phenomenon that deserves attention as a normative behavior? An attempt is made here to discuss and evaluate this dispute along with the critical appraisal of literature.

PS3-27

Drug Addiction in Sickle Cell Disease

Adekola Alao, M.D.; Jennifer Selvarajah, M.D.

Summary: Sickle Cell Disease (SCD) is a genetic disorder of the blood that most often affects people of African, Middle Eastern, Mediterranean, and Asian ancestry. In individuals homozygous for this trait, over 50% of the hemoglobin is hemoglobin S. Approximately one out of 600 African-Americans has SCD. This report will describe the case of a 27 year old African American who expressed suicidal ideation after his pain was not adequately controlled in the emergency room. While this behavior from patients should not be encouraged, patients with documented SCD in bone pain crisis should be adequately treated. In persons with SCD, hemoglobin S predominates. Unlike normal hemoglobin (hemoglobin A), hemoglobin S forms polymers when the oxygen supply is reduced in any way. The rapidity of polymerization depends on the concentration of hemoglobin S, which explains why heterozygous carriers are essentially asymptomatic. Affected erythrocytes are rigid, crescent (or sickle) shaped, and fragile; they are also more adhesive than normal. By blocking small blood vessels, these abnormal cells compromise blood supply to tissues and bones, leading to vaso-occlusive crises. There has been widespread speculation that patients with SCD may become drug dependent if their painful crisis is treated with narcotics. However, there has been no scientific evidence to support this assertion. Paradoxically, individuals suffering from sickle cell disease who are not adequately treated may develop an addiction to narcotics due to self-medication to treat their pain.

Conclusion: patients with documented SCD in bone pain crisis should be treated aggressively. It is better to error on the side of treatment than risk negligence and sub-standard care.

PS3-28

Antipsychotic Use and Inpatient Admissions at One VA: What is the Relationship?

Abigail Dwiggins, M.D., Stephanie Peglow, DO, Martin Cruz, Ph.D., Gregory Briscoe, M.D., Kathleen Stack, M.D.

Abstract:

Objective: The electronic records (CPRS) of patients discharged from Hampton VAMC inpatient psychiatric ward in 2008 were reviewed. Those prescribed antipsychotics were examined for variables which might be related to treatment outcomes.

Method: After IRB approval, gender, race, period of service, diagnostic category and tobacco use was recorded. Outcomes were measured by time to re-hospitalization, unscheduled and planned outpatient visits. The length of index hospitalization, subsequent hospitalizations, homeless, co-occurring substance use disorders (SUD) were recorded as these variables may impact service use and treatment compliance.

Results: One hundred seventy-three of 364 (48%) were prescribed antipsychotics. Of these, 35% were homeless, 68% were Black and 29% White. Ninety-one percent were male, 97% were admitted voluntarily. Forty-three percent were Vietnam Era, 22% Post-Vietnam Era and 31% were Persian Gulf War and 53% had PTSD. The primary discharge diagnosis was a psychotic illness 38%, mood disorder 30%, and anxiety disorder 17%. Atypical antipsychotics were used in 99% of patients with typicals almost exclusively used as in dual-therapy. Most frequently prescribed was quetiapine (40%), aripiprazole (26%) and then risperidone (16%). Those prescribed quetiapine had the longest time to re-admission, 112 days, with aripiprazole 83 days to re-admission. Length of stay did not vary by type of antipsychotic. Twenty-two of 24 (91%) on dual-antipsychotic therapy had a schizophrenia diagnosis which was associated with longer length of stay and shorter time to readmission. SUD was present in 74% of veterans on antipsychotics yet this was not associated with time to readmission. However as the number of substances used increased, the length of in-hospital stay decreased as did attendance at outpatient appointments. Nicotine dependence was associated with a longer length of stay (14 and 10 days respectively) and shorter time to readmission (78 and 100 days respectively).

Conclusion: Most veterans that were prescribed antipsychotic medication had a diagnosis of a psychotic disorder. Quetiapine was the most frequently prescribed antipsychotic and was associated with longer time to readmission. Typical antipsychotics were primarily used in combination with atypical and in those who had schizophrenia, a longer length of stay and shorter time to readmission. Lastly, this data suggests patients on antipsychotics that smoke are higher users of inpatient services.

PS3-29

A Case of Supratherapeutic Clozapine Levels in a Carrier of an Ultra Rapid CYP2A1F Allele

Carmen Casasnovas, M.D., Yusef Canaan, M.D.; Kambiz Kamrani, MS; Raj Addepalli, M.D.

Abstract:

Introduction: Supratherapeutic clozapine levels are seen in a patient with a carrier of a normal to ultrarapid allele of a CYP1A2 genotype. We suggest epigenetic and posttranscriptional modifications as an explanation to the high clozapine levels in this individual.

Case Report: 54 year old Puerto Rican woman with a history of schizoaffective disorder was admitted to our service on clozapine 550mg/day. Initial clozapine blood level was 1700ng/ml and norclozapine 775ng/ml. Clozapine was decreased to 450mg/day. Repeat levels in 5 days showed clozapine at 1408ng/ml and norclozapine at 646ng/ml, haloperidol 5mg daily was added as the patient was titrated off clozapine to 400mg/day. Five days later, clozapine was at 1700ng/ml, norclozapine at 482ng/ml. Haloperidol was increased to 15mg daily and clozapine decreased to 200mg q HS. Sodium valproate was added at 750mg twice daily. Patient tolerated medication changes well, denied side effects, though symptoms did not improve. After 14 days, clozapine levels were at 1827ng/ml and norclozapine at 580ng/ml. Medical records from 2 years prior indicated clozapine levels of 1330ng/ml followed by 1646ng/ml a week later, 759ng/ml 4 days later and 883ng/ml a month later. Blood samples were sent to the laboratory for PCR analysis of 13 well documented CYP4501A2 alleles (Unit Code 89401): CYP1A2*1C,CYP1A2*1D,CYP1A2*1F,CYP1A2*1K,CYP1A2*3 CYP1A2*4 CYP1A2*5,CYP1A2*6,CYP1A2*7,CYP1A2*8,CYP1A2*11,CYP1A2*15,CYP1A2*16. Disscusion The patient was found to have the CYP1A2*1F allele. CYP1A2 has a role in N-demethylation and CYP3A4 in N-oxide biotransformation in the metabolism of clozapine. CYP1A2*1F confers with normal metabolism and if induced to normal and extensive N-demethylation of clozapine into norclozapine. Some studies suggest that allelic variants like CYP1A2*1F do not affect clozapine clearance. Jiang et al. demonstrated no relationship between CYP1A2 genotypic and metabolic phenotype of clozapine and suggested that epigenetic and posttranscriptional factors are a more dominant influence on metabolism. Our patient displays 2 years of supratherapeutic clozapine with no signs of cholinergic or agranulocytic toxicity. An explanation for the high clozapine level despite the patient's genotype is epigenetic modification of the cytochrome genes. Two inheritable possibilities are DNA methylation and chromatin remodeling, in which the DNA is unable to be unwound for transcription, leading to less cytochrome production. Furthermore, posttranscriptional processing of cytochrome mRNAs or posttranslational modification of the protein products can alter the phenotype. Due to limited alleles tested, absence of a detectable mutation does not rule out the possibility that the patient has a metabolizer status other than the ones predicted and tested. Further tests need to be conducted to investigate alternative CYP450 alleles as well as quantitative PCR to assess the amount of gene product transcribed.

PS3-30

Adolescents' Beliefs About Medication, Family Beliefs, and Therapeutic Alliance With Their Doctors: Predictors of Adherence to Prescribed Psychiatric

Fayez El Gabalawi, M.D.; Mark A. Novitsky, Jr., M.D.; Anil Meesala, M.D.; Kanthi Varagani, MBBS; Abel Bumgarner, MSIV; Benjamin E. Leiby, Ph.D.; Matthew B. Wintersteen, Ph.D.; James Luebbert, M.D.

Summary:

Purpose: Examine the relationships between adolescent/family beliefs about psychiatric medications, therapeutic alliance between adolescents and doctors, and medication adherence.

Method: 81 inpatient adolescents and their families completed questionnaires that included Morisky 8 item medication Adherence Scale (MMAS 8), Beliefs about Medicines Questionnaire (BMQ), Working Alliance Inventory short form (WAI S), and inventory of reasons for non adherence. Questionnaires were given upon admission, discharge, and at one month follow up. Due to non normality, medians and inter quartile range (IQR) are reported for variables of interest. The Wilcoxon Signed Rank test was used to test for any change in belief over time, and the Wilcoxon Rank Sum test was used to compare adherence groups with respect to adolescent or family beliefs. High adherence was defined as MMAS score greater than or equal to 6. Correlation was calculated using Spearman correlation.

Results: 71% of adolescents reported lower adherence (MMAS < 6) at one month follow up. Frequently cited reasons for non adherence included: difficulty remembering to take medication, family not in agreement with patient taking medication, and issues related to filling prescriptions. Adolescent general beliefs about medication showed a small improvement from admission to discharge

(Median change of 1 unit; p=0.01) but did not change from discharge to follow up. There was no evidence of change in adolescent specific beliefs about medication over time. Adolescent beliefs at admission were not associated with adherence before admission. There was some evidence that admission general beliefs and follow up general and specific beliefs were associated with follow up adherence with high adherence patients having (more positive) beliefs (p=0.08, p<0.01, and p=0.09, respectively). Family beliefs were marginally associated with adherence at discharge (p=0.08). Family beliefs were positively correlated with adolescent general beliefs at discharge (r=0.28, p=0.01) and follow up (r=0.27, p=0.02). Therapeutic alliance was not associated with adherence.

Conclusion: Most inpatient adolescents (71%) showed low adherence to medication at one month follow up. Adolescent and family beliefs about medication were positively correlated, and were associated with follow up adherence. Thus, attention to adolescent and family beliefs about medication during hospitalization may serve as a viable clinical tool to improve follow up adherence. More research is needed in this area.

PS3-31

Effects of Antipsychotics on Sodium Channels: A Case Report on Cystic Fibrosis

Ferhana Nadeem, M.D.; Mallik Patel, BSc; Rumana Rahmani, BSc; Aditi Shah, BSc

Summary:

Introduction: Cystic fibrosis (CF) is a recessive multi system genetic disease with an abnormal transport of chloride and sodium across epithelium, leading to viscous secretions in the lungs, pancreas, liver, and intestine. CF is caused by a mutation in the gene of proteins, cystic fibrosis transmembrane conductance regulator (CFTR). This channel is responsible for controlling the movement of halogens from inside to outside of the cell. Hence, chloride and thiocyanate are trapped inside the cells in the airway and in the skin. Chloride is negatively charged, this creates a difference in the electrical potential inside and outside the cell causing cations to cross into the cell. Sodium is the most common cation in the extracellular space and the combination of sodium and chloride creates the salt, which is lost in high amounts in the sweat of individuals with CF.

Objective: Our goal is to determine effects of antipsychotics on sodium channel which adversely affect patients with electrolyte abnormalities, cystic fibrosis.

Method: This is a case report of SB, 27y/o AAF with a diagnosis of Schizophrenia paranoid type continuous and history of Cystic Fibrosis as an infant transferred to BRMC from another healthcare system. Two weeks prior to this admission, the patient was non compliant with her medications and was decompensating. She was not sleeping, nor eating and was internally preoccupied, talking to herself. She became increasingly paranoid that her family was after her and on the day of admission became combative, aggressive and physically assaultive to her family. After admission to the inpatient unit SB was started on Quetiapine 50mg orally, twice daily, which was increased gradually. She improved and was discharged.

Discussion: Severe hyponatremia results in neurological symptoms – such as headache, muscle cramps, confusion, delirium and agitation – it mimics symptoms of psychotic illnesses, making it difficult to recognize hyponatremia as an adverse drug reaction. Some theories state that antipsychotics cause SIADH. Antipsychotics stimulate the release by acting as a non osmolar stimulus and enhance the activity of ADH on the kidney. Atypical agents such as risperidone can induce excessive water intake and on aripiprazole.; Authors have suggested that antipsychotic induced hyponatraemia may be serotonin mediated through increased ADH release, augmentation of the effects of endogenous ADH on the kidney and lowering of the threshold for ADH release by influencing the osmostat. Even though the mechanism through which antipsychotic drugs causes disturbance in Na+ concentration remains unclear, there have been numerous theories to explain the electrolyte imbalance. Further studies need to be done to find relationship of the sodium channel with use of antipsychotics and exacerbation of symptoms that may worsen medical conditions.

References:

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PS3-32

Stress Indicators in the Skeletal Remains of a Late Post Classic Mexica Population

Jacqueline Cortes, M.D.; Gerhard Heinze Martin, M.D. and Arturo Jorge Ramirez Padilla, M.D.

Summary:

Introduction: Mexicans lived under great pressure; their daily life had high emotional tension. They had nervous, neurotic personalities with constant fear, apprehension, and angst.

Hypothesis: Various stress indicators were found in the skeletal remains of this Mexican population.

Objective: Describe the stress indicators found in these skeletal remains.

Methodology: one hundred and twenty (120) skeletons were classified by sex and age from a total of 124 Macehual skeletons, a late Post Classic Mexican population between 1300 and 1521, in San Gregorio Atlapulco, Xochimilco de la Cuenca de Mexico, Residential Platform "El Japon," belonging to the Osteology Laboratory in the Physical Anthropology Department of the National School of Anthropology and History. To be able to perform the necessary tests to describe stress indicators, those with most teeth were chosen.

Results: The stress indicators found were: occlusal wear, caries secondary to occlusal wear, enamel hypoplasia, porous Hyperostosis in the frontal and parietal bones, porous superior orbital cribrum secondary to cortical wear, dental paradontosis, facial asymmetry, and dental calculus. Markers of occupational stress were also found, bone degeneration was found in upper extremities as they worked cultivating vegetables, they rowed for prolonged periods of time.

Conclusion: according to the previously mentioned indicators, the Mexicans in general were subjected to stress due to theirs beliefs and lifestyle, but the Macehuales were subjected to even greater stress as they belonged to the lowest social sphere.

PS3-33

The Benefits of a Cambodian Health Promotion Program

Sarah Berkson B.A., Shin Daimyo, M.P.H.

Summary: Cambodian refugees suffer from an increased burden of preventable diseases. For example, according to Massachusetts mortality data, Cambodians are dying from diabetes at a rate 6 times higher than the general population, and from stroke at a rate 2.5 times higher. In response to this health crisis, the Harvard Program in Refugee Trauma developed the Cambodian Health Promotion Program over a decade ago and continues to enroll participants. Participants have been primary or secondary Cambodian survivors of torture recruited from the patient population at Lynn Community Health Center and the Cambodian Mutual Assistance Association, and from the local community in Lynn and Lowell, Massachusetts. In the current curriculum, participants attend five 90-minute classes covering (1) health promotion, (2) exercise, (3) nutrition, (4) stress management and sleep hygiene, and (5) the patient-provider relationship. An English-speaking behavioral healthcare provider and a Khmer-speaking Cambodian health educator co-teach the culturally adapted curriculum through a combination of didactics, activities, video presentations and discussion in a small classroom setting. In order to evaluate the program, the Cambodian health educator verbally administers a questionnaire individually to each participant before and after each health promotion class. Here, we present the questionnaire data of 162 participants from 2007 to 2011. Our analysis using paired samples t-tests shows significant ($p<0.05$) improvements in depression symptoms, hours of sleep per night, frequency of nightmares, number of minutes spent exercising per week, health, energy, body pain, social functioning, confidence that health can improve, confidence in understanding causes of illnesses, and confidence in communicating with the doctor. Our results suggest that the Cambodian Health Promotion Program offers significant benefits for its participants and that health education can play a powerful role in promoting health and quality of life in survivors of torture.

PS3-34

A Case of Visual Distortion Caused by Zolpidem in a Patient With Schizoaffective Disorder: A New Learning Curve

Mahreen Raza, M.B.B.S.

Abstract:

Objective: To describe a patient who developed visual distortion secondary to zolpidem while undergoing treatment for exacerbation of schizoaffective disorder.

Case Abstract: A 40 year old female from Portugal with Shizoaffective disorder presented to the emergency department with complaint of suicidal ideation, depressed mood, insomnia, and negative symptoms such as slow movement, flat affect, and underproductive speech. The patient also reported fear of deteriorating vision secondary to the presence of intermittent shadows and recurring movement of the ceiling and wall towards her. These symptoms of visual distortion are uncommon in schizophrenia. The patient reported that the visual distortions coincided with the start of zolpidem 10 mg by mouth at bedtime two months prior; this medication was specifically sent to her from Portugal by her mother. Of note, once the zolpidem was discontinued, the patient's visual distortions resolved within a day. Other medications the patient was taking included lithium 150 mg by mouth three times daily, haldol 5 mg by mouth twice daily, and klonopin 0.25 mg by mouth at bedtime; these medications were provided to her by her outpatient psychiatrist in the U.S.

Discussion: There have been 22 case reports of zolpidem related psychotic symptoms. However, the exact mechanism by which zolpidem may cause visual perception changes is undetermined. Many factors have been correlated with zolpidem induced visual distortions, such as pharmacokinetic factors, gender, age and hypoalbuminemia.

Conclusion: It is of great import that patients with mental illnesses involving psychosis have causes unrelated to their primary disorder explored as potential etiologies of their symptomatology. In this case, an objective causality assessment revealed that the visual perception distortion in this patient was likely secondary to zolpidem, not the schizoaffective disorder which was a confounding factor.

POSTER SESSION 4

Friday, October 5; 3:00 p.m.–4:30 p.m.

PS4-01

WITHDRAWN

PS4-02

Factors Associated With Parental Satisfaction With a Pediatric Psychiatric Crisis Consultation Service

Jonathan Lee, M.D., Dr. Daphne Korczak

Abstract:

Background: One emergency child psychiatric service model consists of outpatient psychiatric consultation within 48-72 hours of presentation to the Emergency Department. Parental satisfaction with this model of service delivery, which delays psychiatric assessment, is unknown. Parental perception of this model is important as these experiences have the potential to influence their children's views of mental health services.

Aims: 1) to determine the degree of parental satisfaction with the crisis consultation model and 2) to examine potential predictors of parental satisfaction.

Methods: Parental satisfaction was ascertained by a structured telephone interview following crisis consultation at the pediatric crisis clinic (PCC) of an academic, tertiary care centre. Parents of patients were asked to rate their satisfaction and overall helpfulness of the consultation using a five point Likert scale.

Results: Parents of seventy-one percent (n = 124) of 181 pediatric patients seen in the PCC from 2007-2008 participated in the post-consultation interview. Parental satisfaction with the outcome of the consultation was 3.4 (±1.5). Mean rating of helpfulness of PCC consultation was 3.7 (±1.5). Perceived helpfulness of crisis consultation was most highly correlated with amount of discussion, amount learned, and amount of information provided (r = 0.50, 0.61, and 0.62 respectively). Parental satisfaction was most highly correlated with amount of discussion, amount of information provided, and greater knowledge gained, (r = 0.54, 0.67, and 0.68 respectively).

Discussion: Perceived helpfulness and satisfaction with consultation outcome were highly correlated with the amount of post-consultation discussion, amount of information provided, and degree to which parents felt they learned from the consultation. These results highlight the importance of incorporating a psychoeducational component to the emergency child and adolescent psychiatric assessment.

PS4-03

Schizencephaly Associated With Anxiety Disorder

Neha Kansara, M.D.

Abstract:

Background: A 38-year-old female with congenital partial complex seizures and generalized tonic clonic seizures with no past psychiatric history presented with a single episode of depressive symptoms associated with uncontrolled anxiety following a recent seizure activity. Computed tomography and Magnetic resonance imaging of the brain showed Dysplastic left cerebral hemisphere with abnormal sulci and gyri formation with malformed left lateral ventricle and a posterior fossa cyst.

Method: Patient was seen and evaluated at an adult outpatient psychiatric clinic after being referred from the Psychiatric emergency services. Collateral information along with the MRI and CT scan were then obtained and reviewed.

Result: She significantly improved on Citalopram 40 mg/day in two weeks without any untoward side effects.

Conclusion: Although uncommon, Schizencephaly with congenital seizures and/or borderline intellectual functioning may be considered as one of the differentials for Anxiety disorders. Furthermore, neuroimaging should be done to confirm the diagnosis.

Keywords: Anxiety disorder, schizencephaly, seizure.

PS4-04

Do Weight Gain and Metabolic Side Effects Differ in Children and Adults Prescribed Aripiprazole, Quetiapine, or Risperidone?: A Systematic Review

Steven Powell, M.D., Sheila Chang, MPH; Peter Maro, M.D.; Ali Peterson, MPH

Abstract:

Background: Adult and pediatric patients treated with atypical antipsychotics often experience excessive weight gain, hypertension, hyperglycemia, and hyperlipidemia. Understanding whether side effect profiles differ between the most commonly prescribed agents could greatly inform prescribing decisions.

Objectives: To quantify differences in weight gain and metabolic side effects between aripiprazole, quetiapine, and risperidone in adults and children.

Search Methods: Medline, PsycINFO, and The Cochrane Library; all last accessed October 2010. Reviewed reference lists and contacted experts. No constraints on language or publication status.

Selection Criteria: Randomized controlled trials that compared at least two of the three atypical antipsychotics of interest and reported change in weight. All dosing ranges were included and there were no age or diagnosis restrictions.

Data Collection and Analysis: Two blinded clinicians independently completed data extraction with a piloted, standardized data collection form. Study quality was assessed through the Cochrane risk of bias tool. Investigators were contacted to obtain missing information. We calculated weighted mean differences (WMD) and 95% confidence intervals (CI) using random effects models.

Main Results: Of 95 studies identified through our search, 15 published trials involving 8,923 study participants met our full inclusion criteria. Quetiapine resulted in more weight gain than risperidone (WMD 1.29 kg, 95% CI 1.10-1.49, p<.001, 7 trials) and risperidone resulted in more weight gain than aripiprazole (WMD 0.56 kg, 95% CI 0.39-1.52, p=0.25, 2 trials). No trials directly compared aripiprazole to quetiapine, but an indirect method of comparison demonstrated that quetiapine causes more weight gain than aripiprazole. Similarly, quetiapine led to a greater increase in glucose levels (WMD 0.10 mmol/L, 95% CI -0.44-0.25, p=0.58, 6 trials), a greater increase in blood pressure (WMD 0.57 mmHg, 95% CI -2.33-3.46, p=0.70, 2 trials), and a greater increase in total cholesterol (WMD 7.40 mg/dl, 95% CI 7.10-7.71, p<.001, 5 trials) than risperidone.

Conclusions: Quetiapine causes more weight gain than risperidone and also leads to a greater increase in total cholesterol levels. Furthermore, both quetiapine and risperidone cause more weight gain than aripiprazole. There is insufficient evidence reflecting differences in glucose levels and blood pressure to draw a comparative conclusion.

PS4-05

Anxietas Tibiarum, a Case-Based Review: The Challenge of Antidepressant Therapy in Primary Restless Legs Syndrome

L. Tynes, M.D.

Abstract: Restless Legs Syndrome (RLS) is a common neurologic disorder – occurring in 10% of the population – impacting quality of life as severely as other chronic medical illnesses (Phillips et al, 2000; Earley & Silber, 2010). In 1861, Wittmaack first described RLS with comorbid depression and anxiety, calling it “anxietas tibiarum” and considered it a form of “neurasthenia” (Winkelmann et al 2005). Depression is common in RLS. The average patient HAM-D score is 9.27 (vs controls = 5.88; p<0.001), with over twice the odds of meeting DSM-IV major depression criteria as other medically ill patients (Sevim et al 2004; Winkelmann et al 2005). Ms A was seen in consultation on the inpatient Neurology service: “Patient with RLS on SSRI and TCA which aggravates RLS, need another antidepressant.” Ms. A, a 52 y/o female with known RLS, presented to the ED after a business trip. Bilateral leg pain began in flight and kept her up pacing all night. ED evaluation was negative. Ms. A reported symptomatic depression despite taking citalopram and amitriptyline. Other medications included: BCPs, hydroxyzine, and ropinirole. MSE was consistent with depression. Abnormal labs: Albumin 2.8 gm/dL, Ferritin 30.9 ng/ml. Diagnosing RLS: an urge to move the legs; worsening at rest, relief with movement, and worse in the evening (Allen et al., 2003). RLS may be due to dysfunction of dopamine signaling in the brain, iron metabolism, opioid system, or a combination; both CNS and spinal cord may be involved (Allen et al 2001, Chaudhuri et al 2004). There may be a strong genetic component, as more than 50% of idiopathic RLS cases have a family history of RLS; 19.9% of first degree relatives may be affected; 1st and 2nd degree relatives have a significantly higher risk of RLS than controls. Transmission is most likely autosomal dominant (Winkelmann et al 2005; Winkelmann 2002; Allen et al 2002). Secondary causes include iron deficiency, ESRD/hemodialysis, pregnancy, neuropathy, Parkinson’s disease, diabetes, and others. Work-up includes: ferritin, serum glucose, renal function, pregnancy test. Best practice approach to intervention: (1) Iron repletion when indicated; (2) Dopaminergics such as pramipexole (0.125-0.75mg) or ropinirole (0.25-4.0mg) 90-120 minutes before typical symptom onset; (3) eliminate common aggravators: serotonergic antidepressants, antidopaminergic medications (antiemetics, antipsychotics), anti-histamines; caffeine and alcohol; and (4) literature review reveals little guidance for treatment of depression in RLS. Case reports suggest bupropion, with its predominantly noradrenergic and dopaminergic mechanism of action, may be effective for lone RLS and depressed RLS pts (Kim et al, 2005; Lee et al, 2009). RCTs with bupropion SR (Bayard et al, 2011) and ropinorole (Benes et al, 2011) show promise. Research is needed to improve treatment options.

PS4-06

Community Psychiatry Tracks for Residents: A Review of Four Programs

Elliot Lee, M.D., Claudia L. Reardon, M.D., Robert M. Factor, M.D., Ph.D., Carolyn J. Brenner, M.D., Prameet Singh, M.D., Joyce A. Spurgeon, M.D.

Abstract:

Objective: Many psychiatry residency graduates end up practicing at least in part in community settings. However, declining funding and other issues prevent many residency programs from offering robust community psychiatry training to all of their residents. To provide such training to residents most interested in this type of work, some residency programs have developed Community Psychiatry Tracks, with the goal of developing future leaders in public sector psychiatry. None of these tracks have as of yet been described in the literature.

Methods: We cataloged those U.S. psychiatry residency programs that offer Community Psychiatry Tracks by surveying training directors and members of the American Association of Community Psychiatrists. The four programs actively offering such tracks participated as co-authors in this manuscript in describing their track curricula, from which common and variable elements were elucidated.

Results: Common elements across the four Community Psychiatry Tracks include application processes, mentorship, scholarly projects, participation in organizations, and minimal protected time. Variable elements include teaching opportunities, didactics, resident evaluation, and funding.

Conclusions: Recommendations for programs wishing to start a Community Psychiatry Track include garnering of departmental and faculty support and taking a scholarly approach to design of track curricula. A Community Psychiatry Track preliminarily appears to be a well-received way to offer enhanced Community Psychiatry training to interested residents, to recruit medical students to residency programs, to offer opportunities for collaboration between residents and faculty members, and to expand opportunities for scholarly work by residents.

PS4-07

Effective Communication Strategies for Treating Difficult Patients

Victoria Pham, D.O., David Rubin, M.D.

Abstract: Psychiatrists often have uneasy interactions with their patients. Factors that influence these challenging encounters include: (1) Personality and related disorders in patients. (2) Poor communication skills in physicians. (3) The fragmentation of visits in response to systemic changes in health care financing. (4) Availability of outside information sources that challenge physician authority. Recognizing difficult patients allows for psychiatrists to formulate effective communicative strategies. The followings are proposed solutions to enhance communication with difficult patients:

1) Increased frequency of visits with clearly articulated limits.
2) Redirection of patient entitlement towards the acknowledgement of their rights to good health care.
3) Enhanced physician insight into the extent to which their feelings and behaviors influence doctor-patient interactions.
4) The CALMER model
5) Fostering of increased physician empathy. Physician skill training in expressing negative emotions
6) Increased patient access to community resources

PS4-08

Patterns and Trajectories of Suicide Attempters and Suicide Completers in Terms of Utilization of Health Care Services

Renaud Johanne, M.D., Monique Séguin, Ph.D.; Alain Lesage, M.D., MPhil; Jean-Jacques Breton, M.D.; Sophia Rinaldis, MSc; Gustavo Turecki, M.D., Ph.D.

Abstract: In Quebec, suicide represents the second leading cause of death in the 15-24 age group. It is documented that approximately 90% of youth suicide completers suffered from one or more major mental health disorders (Brent et al., 1993; Renaud et al., 2008). Despite this statistic, a significant proportion of them were left without appropriate health care support in the period preceding their death (Luoma et al., 2002). This study aimed to explore patterns and trajectories of health care service utilization in youths in order to establish a well-organized service plan to aid in preventing suicide.

Methods: Participants: A total of 67 consecutive youth suicide completers were recruited through the Quebec Coroner's Office. As comparison, a group of 45 consecutive youth suicide attempters and a group of 56 living controls also participated. Instruments: Psychiatric diagnoses were evaluated using the psychological autopsy method. Trained clinicians administered the SCID for axis I and II diagnosis. The Suicide History Scale and Suicide Intent Scale were used to detail suicide attempts. All available case notes and records of utilization of services as well as peer and/or family involvement were examined using a heuristics matrix model (Thornicroft & Tansella, 1999). A panel of experts then reviewed all the information and identified the needs for care and services at the individual, local, regional and provincial level. Finally, the panel determined whether or not the needs were met with regard to the presented problem.

Results: Psychiatric morbidity was higher among suicide completers and attempters, in comparison to living controls. Unmet health care needs were highest among suicide completers and lowest among living controls. More specifically, 52 of 67 suicide completers and 26 of 45 suicide attempters had unfulfilled needs. The needs that were higher for suicide completers, when compared to suicide attempters, were detection/training (67.3% vs 11.5%; X2=21.578; df=1; p ? 0.001) and coordination/continuity of care (75.0% vs. 50.0%; X2=4.875; df=1; p ? 0.02). In terms of governance, proportions were similar for both completers and attempters (32.7% vs. 32.4.6%; p=NS). Uniquely among suicide attempters, the needs were highest for coordination and continuity of care.

Conclusion: Our findings suggest that important clinical, research and public health actions are urgently needed. This will allow for knowledge transfer from policy makers to social and health care professionals in order to provide better care for users.

Acknowledgments: Standard Life Centre for Breakthroughs in Teen Depression and Suicide Prevention, NARSAD, FRSQ

PS4-09

Patient and Provider Self-Reported Identification of and Attitudes Toward Treatment From the World Trade Center Mental Health Treatment Program

John Leikauf, M.D., Clyde Schechter, Ph.D., Alison Rapoport, M.D., Fatih Ozbay, M.D., Vansh Sharma, M.D., Craig Katz, M.D.

Abstract:

Objective: The World Trade Center Mental Health Treatment Program (MHTP) at Mount Sinai is a clinical service that treats patients with mental health problems associated with their work in the rescue and recovery efforts at and around the World Trade Center site following the 9/11 terrorist attacks. The mental health conditions being treated at this time are now chronic or refractory in nature. The purpose of this study was to examine prevalence of primary psychiatric disorders and treatment modalities, to assess patient and provider attitudes about treatment effectiveness, and to calculate agreement between provider and patient reports.

Methods: Cross-sectional survey of 234 outpatients treated at the MHTP for no less than 3 months prior to survey administration in 2010, with additional cross-sectional survey of these patients' providers. We derived patient demographics, frequencies of patient- and clinician-reported diagnoses, treatment types, and satisfaction with treatment types. To investigate agreement between patient- and clinician-reported treatment frequencies, we calculated both kappa statistics and sensitivity/specificity.

Results: The most common reported primary diagnoses were PTSD (42.31%), MDD (42.74%), alcohol dependence/abuse (0.85%), and other (14.53%). The most common treatment modalities reported were medication management (65.5% providers/81% patients), supportive (55%providers/68% patients) and CBT (50% providers/61% patients). The modalities rated as most effective were wide-ranging, but with medication management chosen by a plurality (14% providers/17% patients). While patients and providers identified specific treatments as being used or being most helpful at similar rates overall, there was little individual patient-provider agreement about which treatments were being used or were most helpful. There was a non-significant trend toward patients identifying their treatments as being more helpful overall than providers.

Conclusions: Providers and patients identified eclectic treatment modalities as being used in an outpatient clinic that serves patients with primary diagnoses of MDD, PTSD and other diagnoses subsequent to trauma exposure. The patients and providers identified similar proportions of treatment types being provided and most helpful, but there was low agreement between individual patients and their respective providers regarding the type or value of treatments being provided. These results suggest that patients and clinicians in our trauma-exposed sample value treatments as being broadly helpful at similar rates, with a non-significant trend toward patients valuing their treatment more highly than clinicians, but that individual patient-provider pairs perceive the type and value of specific treatment interventions quite differently. Our results have implications for understanding mental health literacy and perceptions of and satisfaction with care in practices treating trauma-exposed individuals.

PS4-10

Considerations on Morgellons Disease From the Psychiatrist's Perspective

Aikaterini Fineti, M.D., Daniel Almeida, M.D., Mary Colavita, M.S.

Abstract:

Introduction: Morgellons Disease (MD) is a lay term used to describe a broad constellation of symptoms, mainly comprising: non-healing skin lesions, emergence of fibers or solid material from the skin, and pruritus or other disturbing cutaneous sensations. Despite the latest CDC report published January 2012, stating that no common underlying medical condition or infectious source was identified, but rather, that it is similar to more commonly recognized conditions such as delusional infestation, there is still no consensus among physicians. We report a case of a patient with self-diagnosed MD, whose private psychiatrist recognizes patient's symptoms as organic in nature.

Case Report: Patient is a 38 year-old woman with psychiatric history of PTSD, Bipolar Disorder, ADD, Eating Disorder NOS, Alcohol abuse, Methamphetamine Abuse, and Borderline Personality Disorder who was admitted to the ICU due to suicide attempt via overdose on acetaminophen. Patient reported complaints of "crawling" sensations under the skin and spontaneous production of "fibers and foosballs coming out of the skin," associated with infestation by an undetermined infectious agent. Patient self-diagnosed MD and felt hopeless and desperate due to the "uncertainty" of her medical condition and the "skepticism and sarcasm" from medical community. She noted that her "only hope" was a private psychiatrist who believed that her condition had an infectious etiology and was helping her investigate the cause of her symptoms.

Discussion: Morgellons Research Foundation describes MD as a newly defined illness first noted in 2002, when a lay person designated this name to her son's illness. Information about MD can be found online, and almost the entirety of the patients is self-diagnosed after Internet research. Despite the lack of evidence that MD is a new disease, psychiatrists still struggle to find the perfect approach when treating patients with MD. Instead of validating or dismissing the patient's symptoms or beliefs as nonexistent or delusional respectively, we recommend a multidimensional approach: provide maximum empathy, focus on relieving patient's distress, and the part of MD symptoms that is psychiatric, address psychiatric co-morbidities, acknowledge that MD is not fully understood at present but must be considered delusional until evidence suggests otherwise. Daniel Almeida, M.D., Mary Colavita, M.S.

PS4-11

Screening for Caregiver Depression in a Pediatric Specialty Mental Health Clinic

Holly Swartz, M.D., Doug J. Henry, Ph.D., Joshua E. Hefferen, M.S.W., David F. Rowe, B.S., Martin M. Lubetsky, M.D., Shoshona Shear, M.D., Carol Van Zile, M.S.W.

Abstract:

Introduction: Many children receiving services for psychiatric disorders are in double jeopardy: not only do they struggle with their own mental health challenges but, in addition, one third has a parent who also suffers from depression. Studies have shown that parental psychopathology moderates child treatment outcomes such that offspring of depressed children are less likely to respond to mental health treatment and to preventive interventions. Further, having a depressed parent is associated with more severe psychopathology in offspring in both childhood and in adulthood. Fortunately, successful treatment of parental depression is associated with improved child outcomes as well. Although the goal of specialty pediatric mental health treatment is to help children, some consideration must be given to the mental health needs of their caregiver as well. Health care systems, however, have traditionally separated adult and child services making it challenging to address the needs of the entire family. We therefore sought to initiate routine caregiver depression screening and referral in a specialty pediatric mental health clinic.

Methods: Caregivers of children brought to a large, urban, outpatient specialty pediatric mental health clinic who were seeking a new mental health evaluation were screened for depression using the 9-item Patient Health Questionnaire (PHQ-9). Caregivers who scored =8 on the PHQ-9 were offered a referral to an on-site adult mental health clinician for a discussion of options for further evaluation and treatment.

Results: Between July, 2010 and October, 2011, 600 parents and guardians were screened. Of these, 235 (39%) scored = 8. Of those with an elevated PHQ-9 score, 51% (119/235) accepted a referral to the on-site adult mental health clinician; 12% (27/235) declined a referral indicating that they were already receiving psychiatric treatment. Of the caregivers with elevated depression scores, 62% (146/235) accepted a referral for evaluation and/or treatment. The remaining 38% (89/235) declined. Many expressed appreciation for a more holistic approach to families' needs.

Conclusions: Screening for caregiver depression in a large, urban pediatric mental health clinic is feasible and acceptable to families participating in services. A substantial minority of parents and guardians who seek psychiatric treatment for their children are in need of similar services themselves. Caregivers were likely to accept treatment referrals when an "in person" adult clinician was available for facilitating referral to care. Future studies will examine the impact of this initiative on child outcomes.

PS4-12

Application of Mindfulness in Children and Adolescent Psychiatry: A Literature Review

Aderezza Ferrer, M.D., Sree Latha Krishna Jadapalle, M.D., Amel Badr, M.D.

Abstract:

Background: Mindfulness is a type of meditative technique that accentuates an observant and non-reactive stance toward one's thoughts, emotions, and body states. Mindfulness meditation involves empirical learning through silent periods of sitting meditation or slow walking and purposeful attention to daily activities (for example, mindfulness of eating). In addition to relaxation, the main activity involved in mindfulness is a cognitive and intention-based process characterized by self-regulation of attention to the present moment with an open and accepting orientation toward one's experiences. Amalgamation of mindfulness with other methods like cognitive–behavioral therapy, has led to the development of a number of mindfulness-based treatments especially for stress, depression relapse, borderline personality disorder, ADHD, anxiety disorders, and substance abuse. Mindfulness techniques are known to significantly enhance the self-awareness, increased impulse control and decreased emotional reactivity to difficult events. Evidence of mindfulness practice in adults recommended that these effects can be achieved in the long term and particularly applicable to those with chronic conditions, or for children and adolescents who have numerous developmental challenges. The research on mindfulness in children and adolescents is very minimal.

Objective: To do a literature review of peer reviewed journal articles pertaining to the effectiveness of mindfulness in treating the psychiatric conditions in children and adolescents.

Methods: We reviewed literature on the neurobiology and clinical effectiveness of mindfulness in treating psychiatric disorders in children and adolescents by performing a comprehensive search using Pubmed and other journal databases. We analyzed 20 peer reviewed journals from 2001-2011 on the topic and highlighted the relevant information.

Conclusion: There have been increasing applications of mindfulness in the field of child and adolescent psychiatry, after seeing effectiveness in adults. So far, very few controlled studies were done using different mindfulness techniques in pediatric population with psychiatric disorders like ADHD, learning disabilities, depression, anxiety, substance abuse, impulse control disorders, emotional problems in HIV youth and improvements have been noticed in all these patients.

PS4-13

Correlation Between Holt-Oram Syndrome and Bipolar Disorder

Asim Rizvi, M.D., Aasiya Haroon, M.D., Sonia Voiculescu, MS, Amel Badr, M.D.

Abstract:

Background: Hand-Heart syndrome was first reported in a case presentation by two physicians from King's County Hospital in 1959, Mary Holt and Samuel Oram. They reported on a family in which members of four generations were affected by both congenital heart disease and skeletal anomalies, specifically in the upper limbs and radial digits. The syndrome is inherited as an autosomal dominant trait that is completely penetrant. The disease is due to mutations in the transcription factor TBX5, which is important in the development of both the heart and upper limbs. The pathophysiologic sequels are a direct result of malformations of the heart and upper limbs. No contributory environmental factors are yet known.

Case Report: This case is of a 13 year old girl born with a heart murmur, incomplete growth of clavicle and problems with shoulder, elbow and wrist joints, along with radial digit malformations. She was diagnosed with Holt-Oram Syndrome after her first psychiatric hospitalization at our hospital in 12/31/2006. The patient follows up with a cardiologist, pediatrician, and psychiatrist for all of her medical care.

Conclusion: Reviewing the psychiatric sequel of Holt-Oram syndrome, even though it is not a direct pathologic manifestation of the disease, plays a great role in understanding and preventing its occurrence. Children which exhibit physical/deforming pathologies to a disease often times are exposed to verbal and physical abuse from strangers, peers, and even family, which can predispose them to developing mental health illnesses in adolescence and adulthood.

PS4-14

Balancing Civil Liberties With Clinical Care: Does Lengthening Initial Involuntary Admission Affect Long-Term Commitment Rate?

Alexander de Nesnera, M.D., Paul Shagoury, Ph.D., Elizabeth Howell Woodbury, PSY. D, David G. Folks, M.D.

Abstract: In New Hampshire, persons hospitalized involuntarily due to being a danger to themselves or to others as a result of mental illness have two court hearings if they need longer-term hospitalization to treat their mental illness symptoms. The first hearing determines if there is probable cause for the initial admission. The second hearing is held to establish if a longer-term hospitalization is warranted. A new law passed in 2010 extended the initial duration of involuntary emergency admissions after the first hearing, if probable cause was found for the initial admission, from ten days to a potential total of fourteen days. All involuntary emergency admissions sent to two adult admission units at New Hampshire Hospital over an one-year period from the start date of the new law were followed to determine whether the number of longer-term commitment petitions filed by the treating psychiatrists changed after the implementation of the new law. The average length of stay prior to and after the implementation of the new law was also assessed. There was a 45% decrease in the number of long-term commitment petitions filed by treating psychiatrists after the implementation of the new law. There was no change in the average length of stay one year prior to and one year after the implementation of the new law. Lengthening the initial involuntary admission time leads to a decrease in the rate of longer-term commitments and does not lead to a change in the average length of hospital stay. Decreasing the rate of longer-term commitments may also decrease the number of petitions for emergency involuntary treatment and guardianship applications.

PS4-15

Health Needs of Justice-Involved Persons With Mental Illness and Substance Abuse Returning to the Community From Incarceration

Merrill Rotter, M.D., Ryna Dery, B.A., Alexandra LaMantia, M.A.

Abstract: For individuals involved with the criminal justice system, good health maximizes the potential for participation in treatment, prevents domestic violence, reduces recidivism and lowers health costs. The U.S. Department of Justice reports that approximately 25% of incarcerated individuals in the U.S. have a medical problem and just under 25% report a permanent medical impairment including impairments to speech, hearing, vision, or mental capacity. Additional studies have shown that individuals released from correctional facilities had been diagnosed with chronic medical conditions such as asthma, diabetes, hepatitis or HIV/AIDS at rates three to six times higher than the general population. When cross-referenced with alcohol dependence or drug use, prevalence increases dramatically with 44% occurrence of medical conditions and 39% occurrence of impairments. Many chronic medical disorders including HIV, hepatitis B and C infections; cardiovascular, gastrointestinal and neurological disorders are common for individuals with substance abuse disorders. In this poster we present a cross-sectional study of medical conditions in a population of 577 clients with substance abuse and/or co-occurring mental illness who have been placed in a NYC-based alternative to incarceration program. Demographic and diagnostic data were collected and all clients were screened for medical conditions and treatment histories. Consistent with previous studies, the overwhelming majority (69%) have at least one serious medical disorder (e.g. high blood pressure, asthma, diabetes, HIV+) and the prevalence of medical conditions among individuals with co-occurring mental illness was even greater (84%). These findings will be broken further with reference to specific conditions, and will be analyzed and discussed in terms of the re-entry and treatment planning needs of clients returning to the community from incarceration.

PS4-16

A Case of a Transgender Delusional State With Treatment Recommendations

Raj Addepalli, M.D., Molly Kilpatrick, MS; David Hauser, M.D., Pronoy Roy, M.D.

Abstract:

Introduction: Studies estimate that between 20-30% of psychotic patients may manifest the delusion of sex change. Clear recommendations for management of this particular delusion are lacking.

Case: V.R., a 66-year-old man with a history of schizoaffective disorder remained stable until the age of 63, when his father passed away. Two years following his father's death he began dressing and claiming to be female. He was admitted to the hospital for suicidal ideations during an exacerbation of his schizoaffective disorder. He introduced himself as female, used a female name and wore makeup. He expressed delusions regarding his genitalia during the admission claiming to have internal female organs but external male genitalia and to have been born female. V.R responded to a specific course of antipsychotic medication, returned to baseline, and was discharged on Navane and Olanzapine with outpatient clinic appointments. One year later, V.R. was readmitted after a violent outburst at home. His transgender delusion persisted along with paranoia, insomnia, irritability and agitation. VR refused to take Navane but was compliant with Olanzapine, Prolixin, Trileptal and Clonazepam. Patient remained psychotic and was subsequently transferred to a state hospital. Discussion Studies suggest that repeated exacerbations of psychotic symptoms are associated with more severe and treatment nonresponsive symptoms. Even in pharmacologic compliant patients, 30-40% will have only a partial response and 20% will show treatment resistance. Strategies to address medication non-responsive delusions may include confrontation techniques, principally with falsifiable delusions, and the use of cognitive behavioral therapy to treat residual delusions wherein one does not challenge. If the patient is unable to return to baseline and the delusion of sex change persists, ethical recommendations for treating transgender patients should be considered. Meta-analysis data suggests that cognitive behavioral therapy in either individual or group format can improve overall outcomes in patients with residual symptoms. The Harry Benjamin International Gender Association states that the "goals of therapy are to help the person to live more comfortably within a gender identity and to deal effectively with non-gender issues" and recommend psychotherapy as a tool in developing self-comfort in patients.

Conclusion: This case required the incorporation of recommendations for the gender identity disorder to fully address the patients' healthcare needs. In addition to treatment with antipsychotics and therapy, staff training on confidentiality, sensitivity and addressing the patient by the preferred name is of importance. The building of an open relationship will optimize healthcare services. Until there is further research in this area, it may be necessary to marry multiple care plans in order to achieve increased compliance and patient satisfaction.

PS4-17

Gender Related Considerations of Parenthood During Residency: A Review

Maria del Pilar Trelles Thorne, M.D., Rashi Aggarwal, M.D.

Abstract:

Introduction: There is a growing number of physicians starting a family during residency training. Parenthood during residency represents a unique challenge with on call responsibilities, occupational exposures, a demanding day-to-day schedule, need for continuity of care and of the pregnant resident and breastfeeding. Our review summarizes the literature available and makes suggestions for further research.

Method: A literature search was conducted using Pubmed and Ovid-medline. The following MESH terms were used: residency training, resident, pregnancy, woman physician, women in medicine, childbearing, parenthood and family leave of absence. We also did cross-checks of reference list cited in existing articles.

Results: Although there are various articles on pregnancy during residency, there is minimal literature pertaining to gender related issues of parenthood. Pregnancy during residency has been associated with preterm labor, pre-eclampsia, intrauterine growth retardation, low birth weight and voluntary abortions. There is a tendency for women physicians, as opposed to their male counterparts, to delay childbearing due to perceived career threats. It has been reported that almost double the number of male residents, compared to female residents, have children during residency. There are multiple reports of female residents finishing breastfeeding early; however this has not been compared to results from spouses of male residents. The length of leave of absence after birth of a child is directly related to satisfaction of parenthood during residency; however, these vary widely among programs. There is a surprising lack of literature and recommendations for occupational exposures for the pregnant resident. We couldn't identify any articles relating to special considerations for gay/lesbian residents wanting to adopt during residency.

Conclusions: As we expected, there are unique challenges faced by female residents becoming parents during residency. Formal policies for all programs regarding leave of absence after birth, childcare services and breastfeeding rooms are needed. Further research is required analyzing gender differences in how residents approach parenthood during residency. Finally we need focused research in areas of occupational exposures and considerations for gay/lesbian residents.

PS4-19

Brief Mindfulness Strategies for Clinical Applications and Personal Stress Management

Panakkal David, M.D., Deborah Schoeberlein, B.A.

Abstract: This poster illustrates BRIEF unique techniques that require significantly less training time than the Mindfulness Based Stress Reduction model. Poster displays two basic techniques to improve attention and emotional resilience as well as to promote physical relaxation and sleep. The presentation focuses on a mindfulness model that utilizes regular repetition of extremely brief, secular mental techniques tailored to suit the busy lifestyles of both clinicians and clients. This model was piloted in 2011 & 2012 at multiple U.S. Embassies and U.S. Consulates with populations including Foreign Service officers, Medical Providers, Marine Security Guards, Regional Security Officers, and affiliated Special Agents. Anecdotal evidence suggests that this model is applicable and efficacious among these populations.

Educational Objectives: At the conclusion of this session, the participants should be able to: 1) Demonstrate familiarity with existing research on mindfulness-based interventions. 2) Describe the theory of mindfulness and learn two basic mindfulness techniques as a personal stress management strategy. 3) Identify applications for patients with varied clinical conditions and for personal use of mindfulness techniques to reduce compassion fatigue.

Literature References:

Journal Article: Krasner S: Association of an Educational Program in Mindful Communication with Burnout, Empathy, and Attitudes among Primary Care Physicians JAMA.2009; 302(12):1284-1293

Book: Schoeberlein D: Teaching Mindfulness: A Guide for Anyone who Teaches Anything: Wisdom Publications, 2009.

PS4-20

Apathetic Thyroid Storm Diagnosed in a Hispanic Elderly Woman With Past Psychiatric History of Depression

Daniel Almeida, M.D., Rashi Aggarwal, M.D.

Abstract:

Introduction: Thyroid storm is a rare, life-threatening syndrome characterized by extremely exaggerated signs of hyperthyroidism. It most commonly includes insomnia, irritability, psychomotor agitation, and mood lability. Apathetic thyrotoxicosis is a rare presentation of thyroid storm (6). It presents with symptoms of depression, apathy, somnolence or pseudo-dementia in the absence of the usual symptoms and signs of hyperthyroidism. Apathetic hyperthyroidism is often missed or attributed to other psychiatric problem. We report a case of patient admitted to Thyroid Storm who presented with Apathetic features which were initially attributed to her past psychiatric history of Depression.

Case Report: Ms. M. is a 65 years old woman with history of HTN, Hyperlipidemia, Hyperthyroidism and Depression who presented to the Emergency Room (ER) with complaints of fevers, abdominal pain, nausea, vomiting, diarrhea, palpitations and hair loss. Patient also reported extreme weakness, staying in bed all day. She appeared blunted and amotivated. Patient was also tearful at times and verbalized hopeless and anhedonia. Patient was febrile, tachycardic and had elevated blood pressure. Thyroid Function Tests confirmed diagnosis of Thyroid Storm. Patient was admitted and given IV Dexamethasone, Methimazole and Propranolol. Psychiatric was initially consulted to treat her 'comorbid depression'. No anti-depressant medication was given. Patient's thyroid function stabilized and patient was discharged home after 7 days without symptoms of depression.

Discussion: Depression is usually linked to hypothyroidism, not to hyperthyroidism (4). Prolonged hyperthyroidism might exhaust noradrenergic transmission and thus contribute to depression. In 1931, Frank Lahey M.D. termed such thyrotoxicosis “apathetic hyperthyroidism.” He warned that this group “of quiet, disinterested, apathetic patients, although not giving the appearance of extreme illness, when subjected to undue stress quietly and peacefully sink into coma and die an absolutely relaxed death without activation.”

Conclusion: Internists and Psychiatrist should be aware of this uncommon presentation of Hyperthyroidism, especially in patients with co-morbid psychiatric illness. In this patient, the symptoms of apathy were initially attributed to her past psychiatric history of depression, which was a major confounder in her case.

PS4-21

Depression Mediates the Association Between Somatization-Like Illness and PTSD in Primary Care

Jagdeesh Batana, M.D., Samir Qasim, M.D., Giovanni Caracci, M.D., Donald S. Ciccone, Ph.D.

Abstract:

Background: Recent studies suggest that somatization and PTSD are prevalent among patients seeking primary medical care. According to one estimate patients with PTSD report almost twice as many nonspecific physical symptoms as those without the disorder. The reason for the increase in symptom reporting, however, is not well understood. The present study was designed to examine the possibility that depression may mediate the association between somatization-like illness and PTSD in primary care. In addition, we sought to determine whether the relationship between somatization and PTSD differs for males versus females since females are more likely than males to report nonspecific, physical symptoms.

Method: A consecutive series of 363 adult, English speaking patients attending a large ambulatory care clinic at the New Jersey Medical School volunteered to participate in the study. PTSD symptoms were assessed using the Posttraumatic Stress Disorder Checklist while somatization-like symptoms (nonspecific physical complaints) and symptoms of depression were assessed using the Patient Health Questionnaire.

Results: Patients screening positive for a somatization-like illness (N = 94; 25.9%) reported significantly more PTSD symptoms ($p<.001$) as well as significantly more depressive symptoms ($p<.001$). In an uncontrolled analysis, a continuous measure of PTSD symptoms accounted for 35.9% of the variance in somatization. When the influence of depression was controlled using forced-entry hierarchical regression, however, the unique variance in somatization attributable to PTSD was reduced to 3.8%. This amount was further reduced to just 2.2% when frequency of trauma exposure was taken into account. The pattern of mediation was similar for males and females except that in females the unique variance explained by PTSD symptoms (after controlling for trauma exposure and depression) was reduced to zero while in males PTSD continued to explain 6.2% of the variance ($p<.01$).

Discussion: The present study was able to replicate the association between somatization-like illness and PTSD and found that it was at least partially mediated by symptoms of concurrent depression. An uncontrolled analysis showed that PTSD accounted for substantial variance in somatization but this effect was all but eliminated in females when depression was taken into account. PTSD continued to account for a modest amount of unique variance in males. These results suggest that many symptoms of somatization-like illness in primary care may be attributed to comorbid depression. Psychiatric screening in primary care may not only identify individuals with untreated mental illness but may reduce unnecessary medical care for patients reporting nonspecific, physical ailments.

PS4-22

Neuropsychiatric Manifestations in Pediatric Patients With Lyme Disease: A Case Series

Fauzia Syed, M.D., Carolina Mercader, D.O.; Colin Kanach, MS

Abstract:

Objective: The purpose of this case series is to demonstrate that neuropsychiatric manifestations of Lyme Disease can vary significantly. We focus on the child and adolescent population by showing the psychiatric symptomatology in two children diagnosed with Lyme Disease. Our purpose is to also suggest the importance of LYD as a differential diagnosis in patients with acute behavioral changes.

Introduction: Lyme disease (LYD) is a multisystemic disease caused by Borrelia burgdorferi (Bb), a tick-born spirochete. Complications of hematogenous dissemination of spirochetes include dermatologic, cardiac, and arthritic, however, there has been much debate over neuropsychiatric complications associated with LYD. Behavioral and mood disturbances are the second most common reported psychiatric symptom in children. Increasing severity of the symptoms, such as new anxiety disorders, irritability, and oppositional behavior, may interfere with academia and lead to additional problems and stressors in the child.

Case Reports: Case 1 – This patient is an 11-year-old Caucasian male, with no prior psychiatric history, who presented to the Psychiatric ER with violent behavioral changes and for making homicidal statements towards family for several weeks. He had been diagnosed with late stage LYD at age 5. Case 2 – This case involves a 15 year-old Caucasian female diagnosed with LYD after two

ELISA tests as her first test result was negative. Six months prior to the diagnosis patient began displaying obsessive compulsive traits which developed into rituals. After almost a year of increasing symptoms, patient presented to the Psychiatric ER for worsening obsessive compulsive behavior and assaultive behavior at home.

Discussion: Mood and behavioral changes have been reported in many studies. Sometimes these changes can be so severe that it can later be reported as a complete personality change. Fallon et al. went on to describe these changes, as they would pertain to pediatric patients. Irritability, oppositional behavior, and anxiety disorders were the most common symptoms reported in minors. Case 1 emphasizes that behavioral changes can manifest in late stages of LYD. Case 2 suggests that clinicians should not rely heavily on tests, as the initial Elisa Test performed on the patient was negative. It is very important for the clinician to always consider LYD as a rule out diagnosis with new onset neuropsychiatric presentations, especially when the patient is exposed to endemic areas. Even before official diagnosis of LYD, patients' parents, teachers and community members should be educated about neuropsychiatric symptomatology and to be aware of behavioral changes.

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PS4-23

Impact Plus: An Integrated Complex Care Clinic for Medical-Psychiatric Co-Morbidity in Primary Care

Nadiya Sunderji, M.D., Pauline Pariser, M.D.

Abstract: Patients with chronic co-morbid medical conditions represent 1-4% of the patient population but account for 30-60% of health care costs. Psychiatric-medical co-morbidity rates are high, and are associated with increased symptom burden, functional impairment, health care costs and mortality, as well as decreased quality of life. These complex patients are typically managed by serial consultations among multiple disconnected providers applying single disease management models, inadequate in addressing mutually reinforcing medical conditions, as well as concurrent psychiatric disorders. We describe a novel approach to management of patients with multiple chronic medical and psychiatric conditions, which is a team model of simultaneous interprofessional treatment planning that brings together patients, caregivers, the primary care team (including pharmacists, social workers, nurse and nurse practitioners, dieticians and family physicians), and, secondary consultants (psychiatrists, general internists, and senior psychiatry residents) in real-time at the primary care site. The goals of the clinic are to increase patient and provider satisfaction, optimize health care service use, and create opportunities for transfer of skills amongst providers from diverse disciplines. We describe the inception of the clinic, its format, conditions that enhanced its success, and challenges that we faced in implementation. We illustrate the potential benefits of this treatment approach through case examples, and interviews with patients and providers.

PS4-24

Meta-Analytic Support for Antipsychotic Prophylaxis of Post-Operative Delirium in the Elderly

Christopher Wilk, M.D., Polina Teslyar, M.D., Veronika M. Stock, M.D., Ulas Camsari, M.D., Mark Ehrenreich, M.D., Seth Himelhoch, M.D., MPH

Abstract:

Context: Delirium is common in hospitalized elderly patients and results in increased morbidity and mortality, prolonged hospitalization, and increased health care costs. Although there is a considerable evidence available for the treatment of delirium, the evidence supporting pharmacologic prevention of delirium in a high risk elderly patient population is limited.

Objective: This meta-analysis aims to determine whether delirium in at risk elderly patients can be prevented with antipsychotic medications in the inpatient setting when compared with a placebo control.

Methods: A systematic literature review of articles from January 1950 to March 2012 was conducted in Pubmed, PsychInfo, and the Cochrane Controlled Trials and Database. Only randomized controlled trials of typical or atypical antipsychotic medication used to prevent the onset of delirium were included for analysis. Key words used in the search were: "delirium," "encephalopathy," "ICU psychosis," "prevention," and "prophylaxis." Five studies (total n=1443) met these inclusion criteria and evaluated haloperidol (n=3), risperidone (n=1), and olanzapine (n=1). All five studies examined elderly surgical patients, spanning five different countries. Data analysis was performed using the "metan" command in STATA (StataCorp LP, Texas).

Results: Four of five studies showed a significant decrease in the relative risk of developing delirium. The overall treatment effect size was 0.53 (95% CI 0.32- 0.89) suggesting a significant protective effect of antipsychotic prophylaxis. Analysis for heterogeneity (I2) showed that 79.5% of total variation is due to between-study variance.

Conclusions: Although few studies have examined the impact of the prophylactic use of antipsychotic medications, this analysis suggests that either pre or peri-operative use of prophylactic antipsychotics may be an effective strategy

to reduce the overall risk of post-operative delirium in high risk elderly patients.

PS4-25

Excess Frequent Insufficient Sleep in American Indians/Alaska Natives

Daniel P. Chapman, Ph.D., Janet B. Croft, Ph.D., Yong Liu, M.D., M.S., Geraldine S. Perry, Dr.PH, Anne G. Wheaton, Ph.D., Letitia R. Presley-Cantrell, Ph.D., Earl S. Ford, M.D.

Abstract: A growing body of evidence indicates that frequent insufficient sleep (FIS), defined as 14 or more days/past 30 days in which an adult reported not getting enough rest or sleep, is associated with adverse mental and physical outcomes. Little is known about the prevalence of FIS among American Indians/Alaska Natives (AI/AN). We assessed racial/ethnic differences in the prevalence of FIS from the combined 2009-2010 Behavioral Risk Factor Surveillance Survey, a telephone household survey of U.S. civilian, non-institutionalized adults among 810,168 respondents who self-identified as non-Hispanic white (NHW, n=671,448), non-Hispanic black (NHB, n=67,685), Hispanic (n=59,528) or AI/AN (n=11,507). Prevalence (%), prevalence ratios (PR), and 95% confidence intervals (CI) assessing racial/ethnic differences in FIS were obtained from descriptive and multivariate logistic regression analyses that included race/ethnicity, age, sex, education, employment, smoking, physical inactivity, binge drinking, obesity, and frequent mental distress (FMD, 14 or more days/ past 30 days when the respondent reported their mental health was not good). We used SAS-callable SUDAAN software to account for the complex sampling design. We found significantly higher unadjusted prevalences [95% CI] of FIS among AI/AN (34.2% [32.1-36.4]) and NHB (29.4% [28.6-30.1]) and a significantly lower prevalence among Hispanics (25.4% [24.7-26.1]) compared to NHW (27.4% [27.1-27.6]). However, the significant age-adjusted excess prevalence of FIS in AI/AN compared to NHW (PR=1.20; 95% CI: 1.12-1.27) was weakened by the addition of sex, education, and employment status (PR=1.04; 95% CI=1.04-1.19); this latter relationship was further attenuated by the separate additions of obesity (PR=1.10; 95% CI:1.03-1.18), lifestyle indicators (PR=1.08; 95% CI: 1.01-1.16) and FMD (PR=1.05; 95% CI:0.99-1.13). After age adjustment, the disparity between NHW and NHB (PR=1.02; 95% CI:0.99-1.04 was no longer significant. The significantly lower age-adjusted prevalence of FIS in Hispanics (PR=0.84; 95% CI:0.81-0.86) compared to NHW could not be explained further by controlling for sociodemographic characteristics, adverse behaviors, and FMD (PR=0.84; 95% CI: 0.81-0.86). This is the first report of a high prevalence of FIS among AI/AN. These results suggest that the investigation of sleep health interventions addressing obesity and FMD may benefit AI/AN populations in addition to public health messages about the adverse roles of physical inactivity, smoking, and alcohol use.

PS4-26

Tinnitus and Insomnia: A Significant Relationship With Psychological Consequence

Kiran Majeed, M.D., Gregory Asnis, M.D., Margaret Henderson, M.D., Manju Thomas, M.D., Clewert Sylvester, M.D., Richard De La Garza, II, Ph.D.

Abstract:

Objective: Tinnitus is a highly prevalent medical disorder occurring in approximately 15-20% of the population. Unfortunately, this condition can become chronic and severe leading to significant impairment in quality of life. Tinnitus has been reported to be associated with insomnia with rates ranging from 14-75%. It was our hypothesis that the presence of insomnia may be the cofactor that leads to compromised functioning in tinnitus patients. Insomnia by itself is well-known to lead to compromised daily functioning and predisposes people to develop anxiety and depressive disorders. Since most studies evaluating insomnia in tinnitus patients have relied on retrospective chart reviews or questionnaires asking a single question regarding sleep function, our project was to clarify some detailed aspects of sleep to more fully assess sleep problems and to evaluate other functions of daily-life such as energy and concentration.

Method: We screened 72 prospective patients that were responding to an advertisement, recruiting for a tinnitus treatment study. Subjects were initially interviewed over the telephone using a structured questionnaire. The latter addressed issues of tinnitus (e.g., constant vs intermittent), sleep functioning (total sleep time, sleep onset, awakenings, and awakening time as compared to prior to tinnitus), energy, concentration, etc.

Results: The tinnitus sample (49 males and 23 females) had a mean age of 57.3 years (range 29-78 years). 70.8% of the sample endorsed some form of insomnia developing after the onset of their tinnitus; most had difficulties falling asleep (55.5%) or increased night awakenings (51.3%) whereas a minority (18%) of the insomniacs had early morning awakening. Approximately 60% had a DSM-IV-TR diagnosis of insomnia secondary to tinnitus(at least one sleep disturbance plus dysfunction in daytime functioning).

Conclusion: Our data confirms that tinnitus is frequently co-morbid with insomnia as a symptom and as a diagnosis. Although prior studies have suggested this association, our study is the first to fully evaluate sleep disturbances identifying insomnia as a symptom as well as a diagnosis. Since insomnia is so highly prevalent; early identification and treatment of it should lead to better daytime functioning and tolerability of a patient to his/her tinnitus. Interestingly, insomnia was rarely treated in our sample.

PS4-27

Determining an Optimal Cut Off Score for the WFIRS P Using ROC Curve Analysis

Trevor Thompson, Ph.D.; Vanja Sikirica Phar, M.D., M.P.H., Andrew Lloyd, DPhil, Juliana Setyawan, Phar M.D., MSl, Margaret Weiss, M.D., Ph.D.; M. Haim Erder, Ph.D.; Paul Hodgkins, Ph.D., MSc

Summary:

Objectives: The current study employed Receiver Operating Characteristics (ROC) analysis to (i) evaluate the ability of the Weiss Functional Impairment Rating Scale Parent Form (WFIRS P) to discriminate ADHD and non ADHD individuals, and (ii) identify a WFIRS P cut off score that optimizes correct classification.

Methods: The WFIRS P was completed by the parents/ guardians of 678 children (476 physician defined ADHD cases and 202 non ADHD controls) with a mean age of 11.5 (SD=3.4; range=5 19). The WFIRS P provides an overall rating of degree of impairment of an individual's behaviour or emotional problems on clinically relevant domains of functioning using a 4 point Likert scale (0=never or not at all, 3=very often or very much). Although the WFIRS P can be scored on several domains, a single mean WFIRS P was employed for maximum parsimony. Non parametric ROC analysis resulting from 2000 stratified bootstrap replicates was used to examine the classification performance of the overall WFIRS P mean score and to estimate an optimal classification cut off score.

Results: Area Under the ROC Curve was 0.91 (95% CI=0.88 0.93) suggesting the WFIRS P exhibits an excellent basis for accurate discrimination of ADHD and non ADHD. Youden's J index revealed that sensitivity (0.83) and specificity (0.85) was maximal for an overall mean WFIRS P score of 0.65.

Conclusions: When assessing function, the WFIRS P appears to provide a simple and effective basis for differentiating between ADHD and non ADHD diagnostic classification.

PS4-28

Anxiety and Depression Among Parents of Children With Mental Retardation

Muhammad Waqar Azeem, M.D.; Imtiaz Ahmad Dogar, MBBS; Snehal Shah, M.D.; Mohsin Ali Cheema, MBBS; Alia Asmat, MSc; Madeeha Akbar, MSc; Sumira Kousar, MSc

Summary:

Background: Studies have shown an association between parental anxiety and depression, and caretaking of children with developmental cognitive delays. There is little data in developing countries, such as Pakistan, concerning the impact of raising children with Mental Retardation, upon the quality of parent functioning and risk for psychopathology.

Objective: To evaluate for anxiety and depression among parents of children with Mental Retardation (MR).

Methods: This was a prospective study conducted at a tertiary care hospital in Pakistan. Participants were 198 parents (99 fathers/99 mothers) of 100 children with the diagnosis of MR. The parents were assess for anxiety and depression using DSM IV criteria. Informed consent was obtained. The study was approved by the Institutional Research Committee.

Results: Mean age for mothers was 40.2 years and for fathers was 42.9 years. 19% of mothers and 10% of fathers were illiterate. The mean age of the children was 10.5 years (range: 2-25 years), with 30% females and 70% males. The degree of severity of Mental Retardation of this group was: 25 % mild MR, 42% moderate MR, 20% severe MR and 13% with profound MR. Comorbid diagnosis included: cerebral palsy 22%, epilepsy 34%, and autistic disorder 11%. 82% of the cases of MR were congenital. 79% of the children have various behavioral difficulties, including aggression. Among mothers, 89% have anxiety, depression or both anxiety and depression as compared with fathers, 77% has anxiety, depression, or both. Among mothers, 35% met criteria for anxiety, 40% for depression and 13% for both anxiety and depression. Among fathers 42% had anxiety, 31% depression and 3% both anxiety and depression. There was association between mothers anxiety and depression and degree of mental retardation among children, with depression being highest in mothers of children with moderate MR (57%) and anxiety being highest (50%) among mothers of children with profound MR and both anxiety& depression together being highest among mothers of children with profound MR. There was no significant association among father's anxiety, depression or both and degree of MR in the children.

Conclusions: 1. Parents of children with MR are at higher risk for anxiety, depression or both, needing mental health assessment. 2. There was correlation between mother's anxiety, depression or both and level of MR among children. 3. Limitations include lack of comparison group and small sample size.

PS4-29

Children's Psychiatric Hospital Initiatives in Reducing Restraints and Providing Trauma Informed Care

Muhammad Waqar Azeem, M.D.; Debra Anderson, MS; Michelle Sarofin, LCSW; Linda Carabetta, RN; Treena Mazotta, MSW; Lisa Hayden, Ph.D.; Jennifer Avenia, LCSW, JD; Akash Aujla, M.D.; Marianne Wudarsky, M.D., Ph.D.; Mark Root, RN

Summary:

Background: Restraints are usually utilized in child and adolescent programs such as inpatient psychiatric units, residential programs, schools and juvenile justice settings as means of managing aggressive and self injurious behaviors. These procedures can be considered by patients as aversive and traumatizing, and in worse case scenarios deaths have been reported. There are limited studies looking at various programs in reducing restraints in inpatient child and adolescent settings. This study was conducted at 78 bed state run inpatient child and adolescent psychiatric hospital.

Objective: To determine the effectiveness of Children's Psychiatric Hospital initiatives based on strategies developed by National Association of State Mental Health Program Directors (NASMHPD) in reducing restraints among youth during inpatient psychiatric hospitalization. These strategies are based on trauma informed and strength based care, and rooted in primary prevention principles.

Methods: This study was conducted between January 2005 and December 2010, over five years. Data was collected regarding youth involved in various types of restraints including mechanical and physical restraints, as well as admission data. Data was collected through an electronic database system and a quantitative analysis was completed. Empirical analysis was completed through observation and direct interviews. The strategies which were implemented at the facility to reduce restraints included 1) Leadership toward organizational change 2) Use of data to inform practice 3) Workforce development 4) Use of restraint reduction tools 5) Improve consumers role in inpatient setting 6) Vigorous debriefing techniques.

Results: In 2005, the total number of admissions to the hospital were 178 (51% Males, 49% females) including 38% Caucasians, 34 % African Americans, 27 % Hispanics and 1 % others. In 2010, the total number of admissions to the hospital were 212 (59% Males, 41% females) including 34% Caucasians, 25 % African Americans, 35 % Hispanics and 4 % others. Mechanical restraints are probably the most traumatizing intervention among inpatient settings, with restraint reduction and trauma informed care initiatives, mechanical restraints decreased by more than 96 % from 485 in 2005 to 20 in 2010 and only 3 in last 6 months of 2010. Physical restraints were decreased by 71% from 3033 in 2005 to 878 in 2010. Decrease in restraints contributed to improved clinical outcomes, reduction in staff and patient injuries, and improved working environment.

Conclusions: 1. This study shows downward trend in restraints among hospitalized youth after the implementation of the NASMHPD six core strategies based on trauma informed care. 2. Limitations of this study include data not available on restraints per one thousand patient bed days, and lack of control group.

PS4-30

Original Research: Treating Sleep Disorders Has Positive Outcomes in Psychiatric Illnesses

Umesh Vyas, M.D.

Summary:

Introduction: Sleep is an essential physiological need; it is an active state that is critical for our physical, mental and emotional well being. Sleep is also important for optimal cognitive functioning and sleep disruption results in functional impairment. Psychiatric and sleep disorders are common and often co morbid. The disturbance in quality and quantity of sleep can exacerbate underlying psychological distress and psychiatric illnesses. Author hypothesized that treatment of sleep disorders improves outcomes in psychiatric illnesses.

Method: Charts at the sleep disorders clinic, VAMC Milwaukee, from October to December 2007 were reviewed. Outcomes in patients with co morbid psychiatric disorders were recorded at 6, 12 and 24 months after initiation of sleep disorder treatment. These patients received a baseline psychiatric status score of 0. Change in status at each subsequent time point was scored as: +2 (marked improvement), +1 (mild improvement), 0 (no change), 1 (mild worsening), or 2 (marked worsening). Change in average score for psychiatric disorders was compared individually at each time point to baseline using the signed rank test. Compliance was compared to sleep disorder treatment between patients with and without psychiatric disorders using Fisher's exact test. Difference in score changes at each time point to baseline was compared for a specific psychiatric disorder using Wilcoxon test.

Results: 127 charts reviewed, 10 were excluded as patients died within follow up period. No death was due to suicide. Out of 117 patients 97.6% were men and 2.4% women. Age range: 21 40: 7.7%, 41 60: 42.7%, 61 80: 47.9%, >81: 1.7%. 54 patients (46.2%) had co existing psychiatric and sleep disorder diagnoses. Psychiatric status progressively improved compared to baseline (Change in average score by +0.45, +0.56, and +0.79 at 6, 12, and 24 months, respectively, $p<0.0001$). There was no difference in provider documented compliance rate to sleep disorder treatment between patients with and without psychiatric disorders, (Fisher's p value 0.1031, 0.2290 and 0.2248 respectively). Wilcoxon test was used to find if there were significant differences in score change at each time point based on the presence of a specific psychiatric disorder. Author found this was not statistically significant. This may be due to small number (N) for a specific psychiatric disorder; since most subjects had various co existing psychiatric disorders. All statistical analysis was performed in SAS (Cary, NC).

Conclusions: 1) Treatment of co morbid sleep disorders was associated with significant improvement in psychiatric disorders. 2) Psychiatric disorders did not affect compliance with sleep disorder treatment. 3) No significant improvement observed for specific psychiatric disorder. 4) There is a strong need for prospective studies with more subjects.

PS4-31

Mortality in Eating Disorders

Jaana Suokas, M.D., Jaana Suvisaari, Mika Gissler, Jari Haukka

Summary:

Objective: To determine mortality in patients treated in a specialized eating disorder unit.

Method: The sample is based on case-control design and includes 2442 patients (2329 women and 113 men) treated in an eating disorder clinic of Helsinki University Central Hospital under the period of 1995-2010. The unit comprises of a hospital ward and an outpatient clinic. For each patient four controls were selected from the National Central Population Register and matched for age, sex and place of residence. Mortality data was from National Causes of Death Register. Diagnostic information was based on a clinical diagnosis made by the attending psychiatrics at the patient's arrival. We used Poisson regression model to calculate relative risks (RR) for mortality due to all causes, all external causes of injuries and accidents, and suicide.

Results: Eating disorders were treated mostly (81%) in out-patient care, but about half (45%) of anorexia nervosa patients had also needed inpatient care. Eating disorder patients had an increased mortality: the RR for all cause mortality was 6.52 (95% Cl 3.42- 12.42) in AN, 2.97(95% Cl 1.89-4.65) in BN and 1.78 (95% Cl 0.55-5.77) in Binge eating disorder. Mortality risk in AN was highest during first years after admission but declined after that, while in BN the mortality risk started to rise two years after the admission. Relative risk for suicide was elevated both in AN (RR 5.10; 95% CL 1.37-18.98) and in BN (RR 6.07; 95% Cl 2.48-14.86)

Conclusions: Mortality rates in the study conform the serious nature of eating disorders. It also demonstrated an increased risk of suicide among both AN and BN patients.

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POSTER SESSION 5

Saturday, October 6; 8:30 a.m.–10:00 a.m.

PS5-01

Personality Disorders: An Overview in the Geriatric Population

Mridul Mazumder, M.D., Shilpa Srinivasan, M.D., James Bouknight, M.D., Anuj Goel, M.D.

Abstract: Personality disorders are relatively common (some studies indicating they affect 9 to 14% of the U.S. population), a significant cause of suffering, and notoriously difficult to treat. As these disorders are varied, so are their courses through the lifespan – some lessen in overall severity whereas others become more burdensome. Further, they often impede care (albeit in some instances driving more frequent health care visits) and worsen co-morbid mental and physical illnesses. This review summarizes recent scientific literature on personality disorders in the elderly. Quantitative and qualitative aspects of these disorders are compared to their presentations in younger populations. This information has direct application in informing clinicians with guiding principles, prognosis to approach and manage these complex illnesses. Metrics reviewed include prevalence, incidence, comorbidity, treatment options, and severity over the lifespan. Articles that focus on studies of personality disorders in the geriatric age range over the past five years will be identified. Our method entails a PubMed search including the mesh terms: elderly, geriatric, personality disorder. Limits in the search engine included: meta-analysis, practice-guideline, randomized control trial, review, clinical trial, letter, and case reports. Other constraints in our search included links to full text and English language only articles. We excluded articles pertaining to late onset personality changes due to general medical conditions, dementias, etc., as our focus is on the long term course of personality disorders.

PS5-02

Symptom Remission in Elderly Patients With Schizophrenia: 4.5-Years Longitudinal Study in Multiracial Urban Setting

Mudassar Iqbal, M.D., Imran Khan, M.D., Mirnova Ceide, M.D., Carl Cohen, M.D.

Abstract:
Rationale: Although prior studies found that approximately half of older community-dwelling adults with schizophrenia were in symptomatic remission, these findings have been based on cross-sectional data. This study describes changes in symptom remission rates and predictors of remission on 4.5 year follow-up.

Methods: The study consisted of 250 persons with schizophrenia spectrum disorders aged 55 and over living in NYC who developed the disorder prior to age 45. Data on 104 follow-up interviews are presented. Mean follow-up was 52 months (range: 12 to 116 months); mean age was 60.5 years +/- 5.2 years, 55% were male, and 55% were white. The Remission in Schizophrenia Working Group criteria (<4 on eight selected positive, negative, and general items of the PANSS) was used with an additional criteria of having no history of hospitalization within the previous year in order to qualify for remission status.

Results: On follow-up, there was a non-significant decline in the percentages meeting our remission criteria (49% baseline; 40% follow-up). Twenty-five percent of subjects met remission criteria at both assessments, 35% did not meet remission criteria at either assessment, 25% went from meeting remission criteria at T1 to not meeting remission criteria at T2, and 16% went from not meeting remission criteria at T1 to meeting remission criteria at T2. In logistic regression, there were two significant baseline predictors of overall remission at T2: community integration and number of entitlements.

Conclusion: The longitudinal data indicated that overall symptom outcome differs considerably from what was suggested by initial cross-sectional data, and suggests considerable flux in symptoms in later life. Only one-fourth of the subjects attained permanent remission and one-third never attained remission. The largest group fluctuated between two outcome categories. Two social factors-community integration and number of entitlements – had significant impact on remission rates at follow-up. This indicates the clinical importance of building social supports and providing an economic safety net for older adults with schizophrenia.

PS5-03

Met and Unmet Needs of Schizophrenia Patients in Relation With Psychopathology

G. Codruta Alina, Prof. Miclutia Ioana Valentina, M.D., Ph.D.

Abstract:
Background: Reducing symptoms and meeting patient's needs is an essential component of the treatment in schizophrenia. Severity of symptomatology is one of the most consistent factors associated to the number of patient's needs. Fulfillment of needs has to be negotiated between service users and formal careers

Objectives: The aims of the present study are to identify the most common needs of people with schizophrenia and to relate the number and type of met and unmet needs to symptom dimension in a sample of schizophrenic patients who live in community.

Method: 90 patients with schizophrenia living in the community were evaluated with PANSS, GAF and The Camberwell Assessment of Needs.

Results: People with more severe clinical symptoms have more unmet needs. Staff detected more needs then patients do. Mean number of needs detected by patients was 3.71, while staff detected a mean of 6.84, these differences being statistically significant. Low GAF scores are related with the presence of basic needs, functioning needs and service needs. The presence of needs connected to activities of daily living is related to the intensity of negative symptoms. Positive psychopathology is associated with a higher number of met needs.

Conclusions: The evaluation of needs and unmet needs is necessary and complementary to clinical evaluation and should be taking in account when designing treatment plans and community services for people with schizophrenia.

Key words: schizophrenia, needs, psychopathology.

PS5-04

Cognitive Remediation, Clinical State and ERP's Markers in Schizophrenia

Albert Boxus, M.Psy., Palix Christine, Rossi Pierre, Nouar Kheira

Abstract: Schizophrenia is a heterogeneous clinical condition associated with various clinical outcomes indicating existence of diverse neurobiological underlining alterations. Event related potentials (ERPs) can give some light on that assumption as they are associated with neural mechanisms and cognition. Event-related potentials (ERPs) can provide objective indices of cognitive dysfunction based on the electrophysiological response of the brain. They reflect complex mental processes, and involved cognitive processes, especially attention and memory, which are necessary to the different mental operations resulting in the accomplishment of the task. They contributed significantly to a better knowledge of the different steps of the information processing, and they are an indispensable asset to cognitive psychology. They are an equally precious asset to psychiatric clinic, where they provide for a better understanding of cognitive dysfunctions associated with psychic disorders. Disorders of thought and intellectual functions that characterize schizophrenia have raised an interest in cognitive approach. It allowed highlighting anomalies in information processing schemes. ERPs allow the objective measurements of this anomaly. Cognitive remediation is one of the therapeutic approaches to improve cognitive function in schizophrenia.

Methods: 12 patients met strict DSM IV criteria for schizophrenia. There were all stabilized since more than six months. They underwent a PANSS, a BPRS and a BISC evaluation. We studied MMN, P300 at the same time. They were retest after 6 months cognitive remediation treatment about insight ability with the same methods without any change in their medication.

Results and Conclusions: Cognitive remediation treatment improved ERP'S in the same way than the clinical evaluation. This improvement is significant for MMN andP300. MMN amplitude improvement seems to be specific of insight ability improvement. ERP's reflect a cognitive improvement in schizophrenia and could give a help to the physician to evaluate the improvement and adapted the therapeutic approach in schizophrenia.

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PS5-05

Psychiatrists' Preferences for Benefit and Risk Outcomes and Formulation in Schizophrenia Treatments: A Conjoint Analysis Study

Michael Markowitz, M.D.; Bennett Levitan, Ph.D.; Ateesha F. Mohamed, MA; F. Reed Johnson, Ph.D.; John F. P. Bridges, Ph.D.; Larry Alphs, M.D.; Leslie Citrome, M.D.

Abstract:

Objectives: To quantify psychiatrists' preferences for tradeoffs across improvement in symptoms and changes in adverse events (AEs) associated with oral and long-acting injectable schizophrenia treatments and to evaluate how adherence information affects these preferences.

Methods: Psychiatrists' preferences were assessed using conjoint analysis, implemented in a web-based survey to assess schizophrenia treatment benefits, risks, and alternative formulations. U.S. psychiatrists who treated at least 5 schizophrenia patients per month completed training on the nature of the benefits and risks followed by two series of choice questions. Psychiatrists were asked to choose from competing scenarios characterized by various levels of symptomatic response in 3 domains (improvement in positive symptoms, negative symptoms, and social functioning) and four AEs (weight gain, extrapyramidal symptoms [EPS], hyperprolactinemia, and hyperglycemia). In addition, psychiatrists were asked to choose preferences based on formulation (pill daily, monthly injection, or injection every 3 months), percent of patients with at least 25% improvement in positive symptoms, and percent of patients with EPS. A follow-up question with patient adherence information was included. The conjoint analysis questions were analyzed using random-parameters logit and bivariate probit models.

Results: 197 of 200 psychiatrists completed the survey adequately. Improvement in positive symptoms from no improvement to very much improved was the most preferred outcome over the range of levels included in the survey and was assigned a mean relative importance score of 10 (other outcomes were scaled relative to this one). Other outcomes in decreasing order of importance were: improvement in negative symptoms from no improvement to very much improved (5.2; 95% CI: 3.6-6.8), social functioning from severe to mild problems (4.0; 95% CI: 2.8-5.2), no hyperglycemia (1.8; 95% CI: 1.1-2.5), no 15% weight gain (1.7; 95% CI: 0.9-2.4), no EPS (1.4; 95% CI: 0.8-2.0), and no hyperprolactinemia (1.2; 95% CI: 0.6-1.7). In the second set of choice questions, for adherent patients, percent of patients with at least a 25%-improvement in positive symptoms was most important with a mean relative score of 10, followed by percent of patients with EPS (3.0; 95%CI: 2.0-3.9) and formulation (1.6; 95% CI: 0.0-3.2). As the adherence decreased, formulation became more important and injections were preferred to daily pills. For patients who missed or skipped 50% of their doses of oral medication in the past, psychiatrists regarded a 20%–25% increase in efficacy as equal in importance to switching a patient from an oral to a monthly injectable.

Conclusions: These results suggest that psychiatrists make treatment decisions primarily based on improvement in positive symptoms, with improvement in negative symptoms and social functioning having a secondary role. Choice of formulation becomes more important as adherence declines.

PS5-06

Assessing Medication Adherence and Healthcare Utilization and Costs Patterns Among Hospital Discharged Patients With Schizoaffective Disorder

Michael Markowitz, M.D.; Sudeep Karve, Ph.D.; Dong Jing Fu, M.D., Ph.D.; Jean Pierre Lindenmayer, M.D.; Chi Chuan Wang, Ph.D.; Sean D. Candrilli, Ph.D.; Larry Alphs, M.D., Ph.D.

Summary:

Educational Objectives: At the conclusion of this presentation, the participant should be able to understand patterns in medication adherence and healthcare utilization at various clinically relevant pre admission and post discharge periods among patients experiencing schizoaffective disorder related inpatient admission.

Purpose: Following hospital discharge, patients with schizoaffective disorder have a high likelihood of re-hospitalization. The objective of this study was to assess patterns in psychotropic medication adherence and health-care utilization and costs during clinically relevant pre admission (in 60 day intervals, over 6 months) and post discharge periods (in 60 day intervals, over 12 months) among patients with schizoaffective disorder.

Methods: We conducted a retrospective cohort analysis of the MarketScan Medicaid database (2004 2008). Patients with an inpatient admission for schizoaffective disorder and continuous health plan enrollment were included. Medication (antipsychotics, antidepressants and mood stabilizers) adherence (proportion of days covered [PDC]) and all cause and schizoaffective disorder related healthcare utilization and costs were assessed during the pre admission and post discharge periods. Healthcare utilization and costs (2010 U.S.$) were compared between each adjacent 60 day post discharge period using univariate and multivariate regression analyses. No adjustment was made for multiplicity.

Results: Among 1,193 patients included, 39% were male, 43% black, and 92% were 'discharged to home for self care' following an inpatient admission. Medication adherence rates declined in the pre admission periods (182 121 days:65%; 120 61 days:49%; 60 0 days:46%). Compared to the 60 day pre admission period (46%), the adherence rate increased in the initial 60 day post discharge period (80%) and remained relatively stable in the remaining five 60 day post discharge periods (range: 58% 63%). Both schizoaffective disorder related (mean: $2,370 vs. $1,765; p<0.001) and all cause (mean: $5,277 vs. $4,310; p<0.001) healthcare costs were significantly higher in the initial 0 60 day post discharge period compared with the adjacent 61 120 day post discharge period. The primary drivers of schizoaffective disorder related costs in the 0 60 day post discharge period were rehospitalization (mean: $860; SD: $3,923) and pharmacy (mean: $954; SD: $926). Both all cause and schizoaffective disorder related costs declined and remained stable after the initial 60 day post discharge period.

Conclusion: We observed a high rate of rehospitalization during the initial 60 day post discharge period compared with the 61 120 day post discharge period among patients with schizoaffective disorder. The medication adherence and resource utilization patterns outlined in our study should help identify high risk patients and aid in the designing of interventions that may help reduce the likelihood of inpatient admissions and the associated downstream.

PS5-07

Switching to Iloperidone From Risperidone, Olanzapine, or Aripiprazole in Patients With Schizophrenia: Tolerability of Two Methods

Matthew Brams, M.D., Gus Alva, M.D., Marla Hochfeld, M.D., Adam Winseck, Ph.D., Farid Kianifard, Ph.D., Xiangyi Meng, Ph.D.

Abstract:

Objective: "Switching" antipsychotics are a common therapeutic strategy. We describe adverse event (AE) findings for the first 2 weeks of a 12-week randomized, multicenter, open-label trial evaluating 2 methods (gradual vs. immediate) of switching to iloperidone in adults with schizophrenia exhibiting efficacy/tolerability problems with risperidone, olanzapine, or aripiprazole.

Methods: Patients (aged 18–64y) experiencing inadequate efficacy and/or poor tolerability on risperidone, olanzapine, or aripiprazole were randomized 1:1 to immediate switch (i.e., immediate discontinuation of current treatment at baseline) or gradual switch (i.e., over the first 2 weeks [to 50% on D1, 25% by Week 1, 0% by Week 2]) to open-label iloperidone. Patients were titrated over 4 days to iloperidone 6mg BID, followed by increases (no more than 4mg/d) up to 12mg BID, if needed, during Week 2–12. The primary variable was the Integrated Clinical Global Impression of Change (I-CGI-C) and the primary analysis time point was Week 12. AEs were evaluated at each visit.

Results: 500 Patients were randomized and received iloperidone (gradual switch, 240; immediate switch, 260), with 175, 155, and 170 patients switched from risperidone, olanzapine, and aripiprazole, respectively. During the first week of iloperidone treatment, patients who switched from risperidone had the lowest incidence of AEs (40.6% of patients) compared with those who switched from olanzapine (52.3%) or aripiprazole (56.5%). The most common AEs were dry mouth and dizziness for each cohort. Dizziness was more common in the immediate- vs. gradual-switch groups for all 3 prior treatments: risperidone (11.7% vs. 4.9%); olanzapine (13.2% vs. 10.1%); aripiprazole (16.7% vs. 10.0%). AEs decreased during the second week of iloperidone treatment, with incidences similar for patients who switched from risperidone (26.0%), olanzapine (30.0%), or aripiprazole (28.6%). Dizziness rates decreased in all cohorts, with no clinically important differences between immediate- and gradual-switch groups (risperidone, 3.3% vs. 0%; olanzapine, 2.7% vs. 2.6%; aripiprazole, 2.4% vs. 1.3%). Discontinuations due to AEs decreased from Week 1 to Week 2 (risperidone, 4.0% to 3.0%; olanzapine, 5.8% to 2.0%; aripiprazole, 7.6% to 2.5%). During Week 1, discontinuations due to dizziness occurred most frequently in patients who immediately (vs. gradually) switched from aripiprazole (5.6% vs. 0%) compared with risperidone (1.1% vs. 0%) or olanzapine (1.3% for both switch methods). Fewer discontinuations due to dizziness occurred during Week 2 (risperidone: 2.2% [immediate] vs. 0% [gradual]; 0% with prior olanzapine or aripiprazole treatment).

Conclusion: Incidence of AEs and discontinuations due to AEs decreased over the first 2 weeks of iloperidone treatment, regardless of prior antipsychotic. Both switch methods are appropriate when switching to iloperidone, although dizziness may occur more frequently within the first week following an immediate

PS5-08

Clinical Outcomes Following Two Methods of Switching to Iloperidone From Risperidone, Olanzapine, or Aripiprazole in Patients With Schizophrenia

Gustavo Alva, M.D., Matthew Brams, M.D., Marla Hochfeld, M.D., Adam Winseck, Ph.D., Farid Kianifard, Ph.D., Xiangyi Meng, Ph.D.

Abstract:

Objective: Changing ("switching") antipsychotics is a common therapeutic strategy when a patient's current antipsychotic has limited efficacy/tolerability. We describe the results of a 12-wk randomized, multicenter, open-label trial evaluating 2 approaches (gradual vs. immediate) to switching to iloperidone in adults with schizophrenia exhibiting efficacy and/or tolerability problems with risperidone, olanzapine, or iripiprazole.

Methods: Patients (aged 18–64 y) diagnosed with schizophrenia experiencing inadequate efficacy and/or poor tolerability on risperidone, olanzapine, or aripiprazole were randomized 1:1 to immediate switch (i.e., immediate discontinuation of current treatment at baseline) or gradual switch (i.e., occurring over the first 2 wks [to 50% on D1, 25% by Wk1, 0% by Wk2]) to open-label iloperidone. Patients were titrated over 4 days to iloperidone 6 mg BID, followed by increases (no more than 4 mg/d) up to 12 mg BID, if needed, during Wk2–12. The primary variable was the Integrated Clinical Global Impression of Change (I-CGI-C), rated from 1 (improvement) to 7 (worsening), and analyzed using an analysis of variance model at Wk12.

Results: 500 Patients were randomized and received iloperidone (gradual switch, 240; immediate switch, 260), with 175, 155, and 170 patients switched from risperidone, olanzapine, and aripiprazole, respectively. Study completion rates for gradual- and immediate-switch groups were 70.0% and 68.5%. Patients were (mean ± standard deviation) 43.3±11.0 years of age; 56.6% Black/African American; and 33.0% women. I-CGI-C at Wk12 improved to a similar extent for gradual- and immediate-switch groups: least-squares means for patients switched from risperidone were 2.815 and 2.674 (95% CI: -0.229, 0.511); from olanzapine, 2.870 and 3.027 (95% CI: -0.548, 0.235); and from aripiprazole, 2.792 and 2.811 (95% CI: -0.405,

0.368). Frequency of adverse events (AEs) was similar in the gradual- and immediate-switch groups for patients switched from risperidone (70.4% and 75.5%, respectively) and olanzapine (82.3% and 84.2%); for switches from aripiprazole, AEs were more common in the gradual- vs. immediate-switch group (92.5% and 80.0%). In each cohort, discontinuation rates due to AEs were lower in the gradual-switch group (risperidone, 7.4% and 12.8%; olanzapine, 11.4% and 14.5%; aripiprazole, 12.5% and 17.8%). Types of AEs were similar among the risperidone, olanzapine, and aripiprazole groups and included dizziness, dry mouth, and somnolence.

Conclusion: Switching to iloperidone by either an immediate or gradual (cross-titration) method did not reveal any clinically important differences in clinical outcomes after 12 wks, based on a clinical global impression scale (I-CGI-C). Results were similar including similar overall safety/AE profiles, regardless of the specific agent that was switched from (risperidone, olanzapine, aripiprazole), for patients switched to iloperidone 12–24 mg/d.

PS5-09

Quality of Life Outcomes: Evaluations in Community Behavioral Health Organizations Patients With Schizophrenia Treated With Paliperidone Palmitate

Jessica Panish, M.S., Lian Mao, Ph.D., Qin Li, Ph.D., Lynn Starr, M.D., John Fastenau, M.P.H.

Abstract:

Objective: To evaluate quality of life (QOL) outcomes in patients with schizophrenia receiving paliperidone palmitate (PP) in Community Behavioral Health Organizations (CBHOs).

Methods: The Research and Evaluation of Antipsychotic Treatment in Community Behavioral Health Organizations, Outcomes (REACH OUT) study is an ongoing, longitudinal, non-interventional, observational registry collecting information on patients with schizophrenia receiving primary treatment at CBHOs. Scheduled assessments occurred at study enrollment, 6 months, and 12 months. QOL was assessed using the Lehman Quality of Life Interview (QOLI) – brief version, which includes patient s' self-ratings of satisfaction on nine domains, using a 7-point Likert scale from terrible (1) to delighted (7). This analysis includes patients receiving PP, who completed the 6 months follow-up as of March 2011. Results were summarized descriptively.

Results: The interim sample includes 168 patients. Mean age was 40.7 years (SD 12.8), 72.3% were male, 59.9% white, 22.8% Black, 69.5% single, 68.9% lived in a private house or apartment, and 76.2% had Medicaid or medical assistance. The average (±SD) amount of money one spent on themselves per month increased from enrollment to 6 months ($32.1±$189.9). Average general life satisfaction increased 0.2 ± 1.2 from enrollment to 6 months. There was no mean change from enrollment for satisfaction with daily activities. Mean changes from enrollment increased with satisfaction with family contact (0.2 ± 1.4), social relations (0.1 ± 1.2), finances (0.3 ± 1.5), and health (0.2 ± 1.1). There was an average decrease (-0.1 ± 1.1) in satisfaction with safety from enrollment to 6 months.

Conclusions: This interim analysis suggests that QOL was maintained over 6 months in patients with schizophrenia treated with PP. Further analyses of the entire study sample are needed to confirm this finding.

PS5-10

Satisfaction With Medication and Quality of Care Among Patients With Schizophrenia Treated With Atypical Long-Acting Therapies

Jessica Panish, M.S., Lynn Starr, M.D., Lian Mao, Ph.D., Qin Li, Ph.D., John Fastenau, M.P.H.

Abstract:

Objective: To evaluate medication satisfaction for the atypical injectable antipsychotics, paliperidone palmitate (PP) and risperidone Consta (RC), and satisfaction with quality of care among patients with schizophrenia in a sample of Community Behavioral Health Organizations (CBHOs).

Methods: An ongoing, longitudinal, non-interventional observational registry, Research and Evaluation of Antipsychotic Treatment in Community Behavioral Health Organizations, outcomes (REACH OUT) collects information on patients with schizophrenia receiving treatment at CBHOs. Scheduled assessments occur at enrollment, 6 months and 12 months. Sites obtain data from chart abstractions, clinician assessments, and patients. The medication satisfaction questionnaire (MSQ) is a validated single-item questionnaire that evaluates satisfaction with antipsychotic medication on a 7-point scale from "Very dissatisfied" (1) to "Very satisfied" (7) in patients with schizophrenia. A 1.0-point change on the MSQ reflects a clinically meaningful difference in treatment satisfaction. MSQ outcomes assessed were mean scores and percent of patients satisfied or very satisfied at enrollment and 6-months. A 4-point scale from "Not at all satisfied" (1) to "Very satisfied" (4) measured satisfaction with quality of care at the sites.

Results: As of March 2012, 247 patients completed baseline and 6-month interviews. Mean (SD) age was 41 (12.3) years, 72.7% were male, 54.6% were white, 72.4% were single, 71.1% lived in a private house, and 88.1% had either Medicare or Medicaid. Of these, 168 (68.0%) received PP: 49 (19.8%) new and 119 (48.2%) continuous users. Seventy-nine (32.0%) received RC: 13 (5.3%) new and 66 (26.7%) continuous users. There were 146 PP and 71 RC patients who completed the 6-month visit with MSQ at both enrollment and 6-month visits. At enrollment, 71.2% of PP users and 71.8% of RC users indicated that they were either satisfied or very satisfied with medication. At 6 months, 71.8% of PP users and 74.6% RC users indicated they were satisfied or very satisfied. At enrollment, most PP and RC users indicated very satisfied with the quality of care at the site, 74.5% and 66.2% respectively. At 6 months, 79.3% of the PP users and 64.8% of the RC users were very satisfied with quality of care from the site.

Conclusions: This interim analysis suggests that a majority of patients treated with PP or RC were highly satisfied with their treatment and quality of care and their level of satisfaction appeared to be maintained over a 6-month period. Further analyses of the entire study sample and medication use patterns are needed to confirm these findings. Supported by funding from Janssen Scientific Affairs, LLC.

PS5-11

Efficacy of Aripiprazole Intramuscular Depot for the Long-Term Maintenance Treatment of Schizophrenia

Robert Forbes, Ph.D., John M. Kane, M.D., Raymond Sanchez, M.D., Pam Perry, M.S., Na Jin, M.S., Brian Johnson, M.S., Robert D. McQuade, Ph.D., William H. Carson, M.D., Wolfgang Fleischhacker, M.D.

Abstract:

Objective: To evaluate the efficacy and tolerability of once-a-month ripiprazole intramuscular depot (ARI-IM-depot), a dopamine partial agonist, for maintenance treatment in adults with schizophrenia

Methods: Subjects requiring chronic treatment with an antipsychotic were eligible, and subjects not already on aripiprazole monotherapy were cross-titrated during weekly visits from other antipsychotic(s) to oral aripiprazole monotherapy during the 4–6 weeks oral conversion phase (Phase 1). All subjects entered a 4–12-week oral stabilization phase (Phase 2) and received oral aripiprazole (10–30 mg/day). Subjects meeting stability criteria for 4 weeks then entered an IM-depot stabilization phase (Phase 3), wherein they received ARI-IM-depot injections every 4 weeks (400 mg, single decrease to 300 mg permitted) with co-administration of oral aripiprazole tablets in the first 2 weeks. Subjects meeting stability criteria for 12 consecutive weeks were randomized (2:1) to ARI-IM-depot or placebo during a 52-week, double-blind, maintenance phase (Phase 4). The primary endpoint was time-to-impending relapse. Safety and tolerability were also assessed

Results: 710 subjects entered the oral stabilization phase, 576 progressed to ARI-IM-depot stabilization and 403 patients were randomized to double-blind, placebo-controlled treatment. The study was stopped early because efficacy was demonstrated by the pre-planned interim analysis (conducted after 64 relapses). Time-to-impending relapse was significantly delayed in ARI-IM-depot compared with placebo in both interim and final analyses ($p<0.0001$, log-rank test). The rate of impending relapse was significantly lower with ARI-IM-depot than placebo at endpoint (final analysis 10.0%, n=27/269 vs. 39.6%, n=53/134; hazard ratio, 5.0; 95% confidence interval: 3.2–8.0; $p<0.0001$). Improvements in Positive and Negative Syndrome scale (PANSS) Total score were maintained with ARI-IM-depot treatment but showed significant worsening with placebo (mean change at Week 52: ARI-IM-depot, 1.4, placebo, 11.6; $p<0.0001$). Additionally, Clinical Global Impressions – Severity scores showed significant differences favoring ARI-IM-depot ($p<0.0001$). The most common treatment emergent adverse events (AEs; occurring =5% of aripiprazole-treated subjects and greater than placebo) were insomnia (10.0% vs. 9.0%), tremor (5.9% vs. 1.5%), and headache (5.9% vs. 5.2%), respectively. Most AEs were mild or moderate in severity. The incidence of injection-site pain in the ARI-IM-depot stabilization phase was 5.9%, while in the ARI-IM-depot maintenance phase was 3.0% vs. 3.7%, respectively, for ARI-IM-depot compared with placebo

Conclusions: ARI-IM-depot significantly delayed time-to-impending relapse compared with placebo and was a well-tolerated maintenance treatment option in schizophrenia.

PS5-12

Effects of a Long-Acting Injectable Formulation of Aripiprazole on Secondary Efficacy Outcomes in Maintenance Treatment of Schizophrenia

Pamela Perry, M.S., William H. Carson, M.D., Raymond Sanchez, M.D., Na Jin, M.S., Robert A. Forbes, Ph.D., Robert McQuade, Ph.D., Wolfgang Fleischhacker, M.D., John Kane, M.D.

Abstract:

Objective: To evaluate the secondary efficacy outcomes from a clinical trial of a once-monthly intramuscular-depot-formulation of aripiprazole (ARI-IM-depot) as maintenance treatment in adults diagnosed with schizophrenia

Methods: Subjects requiring chronic treatment with an antipsychotic were eligible, and subjects not already on aripiprazole monotherapy were cross-titrated during weekly visits from other antipsychotic(s) to oral aripiprazole monotherapy during a 4–6-week oral conversion phase (Phase 1). All subjects entered a 4–12-week oral stabilization phase (Phase 2) and received oral aripiprazole (10–30 mg/day). Subjects meeting stability criteria for 4 weeks then entered an IM-depot stabilization phase (Phase 3), wherein they received ARI-IM-depot injections every 4 weeks (400 mg, single decrease to 300 mg permitted) with co-administration of oral aripiprazole tablets in the first 2 weeks. Subjects meeting stability criteria for 12 consecutive weeks were randomized (2:1) to ARI-IM-depot or placebo during a 52-week, double-blind, and maintenance phase (Phase 4). Secondary efficacy assessments included mean changes in the Personal and Social Performance (PSP) scale scores, mean changes in Positive and Negative Syndrome Scale (PANSS) Positive and Negative scores, and mean change in the Investigator's Assessment Questionnaire (IAQ) scores, a scale designed to evaluate response to antipsychotics

Results: 710 patients entered oral stabilization, 576 progressed to ARI-IM-depot stabilization and 403 patients were randomized to double-blind treatment. The study was stopped early because efficacy was demonstrated by the pre-planned interim analysis (conducted after 64 relapses). Mean changes in PSP scale scores (last observation carried forward [LOCF]) showed improvement during the oral (3.0) and ARI-IM-depot stabilization 2.6) phases. Mean change in PSP scores during double-blind treatment showed greater functional stability with ARI-IM-depot (-1.7) than placebo (-6.2) (p=0.0002 vs. placebo). Mean PANSS Positive and Negative subscale scores (LOCF) improved during the oral (-2.1 and -1.2, respectively) and ARI-IM-depot stabilization phases (-1.0 and -1.2). Mean change during double-blind treatment in PANSS Positive (Week 52 LOCF, 0.4 vs. 4.3; p<0.0001) and Negative (Week 52 LOCF, 0.2 vs. 1.6; p<0.0001) subscale scores all showed symptom stability with ARI-IM-depot treatment, but showed significant worsening with placebo. Mean IAQ Total score also remained stable (Phase 2, 31.3; Phase 3, 30.6). During double-blind treatment, the mean change was +1.3 for ARI-IM-depot vs. +3.8 for placebo-IM-depot (p<0.0001)

Conclusions: Improvements in symptoms, functioning and overall response to treatment were achieved during stabilization and maintained in patients during Phase 4. ARI-IM-depot thus offers a new option for maintenance therapy of schizophrenia with a different risk–benefit profile than currently available treatments.

PS5-13

Patient-Reported Outcomes With Aripiprazole Intramuscular Depot for Long-Term Maintenance Treatment in Schizophrenia

Raymond Sanchez, M.D., Brian Johnson, M.S., Na Jin, M.S., Robert A. Forbes, Ph.D., William Carson, M.D., Robert D. McQuade, Ph.D., John M. Kane, M.D., Wolfgang Fleischhacker, M.D.

Abstract:

Objective: To characterize the adherence profile of aripiprazole-intramuscular-depot (ARI-IM-depot) by examining patient-reported outcomes with long-term treatment for schizophrenia

Methods: Patients requiring chronic treatment with an antipsychotic were eligible. Patients not already on aripiprazole monotherapy were cross-titrated during weekly visits from other antipsychotic(s) to oral aripiprazole monotherapy during a 4–6-week oral conversion phase (Phase 1). Subjects entered a 4–12-week oral stabilization phase (Phase 2) and received oral aripiprazole (10–30 mg/day). Subjects meeting stability criteria for 4 weeks then entered an IM-depot stabilization phase (Phase 3) in which they received 400 mg ARI-IM-depot injections every 4 weeks (single decrease to 300 mg permitted) with co-administration of oral aripiprazole in the first 2 weeks. Subjects meeting stability criteria for 12 consecutive weeks were randomized to ARI-IM-depot or placebo during a 52-week, double-blind maintenance phase (Phase 4). Mean changes in patient-reported outcomes were assessed from baseline to last visit in Phases 2–4 using the Drug Attitude Inventory (DAI) (1), Medication Adherence Questionnaire (MAQ) (2), and Patient Satisfaction with Medication Questionnaire (PSMQ)-Modified (3)

Results: 710 patients entered oral stabilization (633 had been titrated to oral aripiprazole during Phase 1); 576 progressed to IM-depot stabilization, and 403 patients were randomized to double-blind treatment. The study was stopped early because efficacy was demonstrated by the pre-planned interim analysis (conducted after 64 relapses). Mean DAI scores remained similar across phases (Phase 2, 20.2; Phase 3, 20.4; Phase 4 ARI-IM-depot, 21.1 vs. placebo, 22.2), indicating a positive (adherent) attitude towards medication. Mean MAQ scores were 0–1, indicating high adherence behavior. PSMQ scale scores were assessed for Phases 3–4 and showed a high level of treatment satisfaction between baseline and last visit, respectively: Phase 3, 97.0% vs. 92.8%; Phase 4 ARI-IM-depot, 97.0% vs. 92.7%; Phase 4 placebo, 96.2% vs. 85.0%. The percentage of patients with a preference for the current medication between baseline and last visit, respectively, was also high (Phase 3, 93.4% vs. 89.1; Phase 4 ARI-IM-depot, 94.8% vs. 86.2%; Phase 4 placebo, 97.7% vs. 85.7%). Finally, there was a sustained percentage of patients reporting less-to-no side effects between baseline and last visit, respectively: Phase 3, 88.0% vs. 86.9%; Phase 4 ARI-IM-depot, 90.3% vs. 88.9%; Phase 4 placebo, 92.6% vs. 89.0%

Discussion: ARI-IM-depot offers a new treatment option for the long-term management of schizophrenia with the potential to improve adherence to medication resulting from improved patient-reported outcomes and medication satisfaction.

References:

1) Hogan T, et al. Psychol Med 1983;13:177–183; 2) Morisky, D., et al. Med Care 1986;24:67–74 and; 3) Kalali A. Curr, Med Res Opinion 1999;15:135–137.

PS5-14

Efficacy of Lurasidone in Schizophrenia: Results of a Factor Analysis of Short-Term Trials

Josephine Cucchiaro Ph.D., Robert Silva, Ph.D., Yongcai Mao, Ph.D., Antony Loebel, M.D., Stephen R. Marder, M.D.

Abstract:

Objective: The 5-factor model derived from the PANSS scale is one of the most widely accepted approaches to a more differentiated evaluation of the efficacy of antipsychotic medication (Marder SR et al, J Clinical Psychiatry 1997;58:538–546), and provides a comprehensive assessment of symptom domains relevant to functional status and long-term outcome of schizophrenia. The aim of the current analysis was to evaluate the efficacy of lurasidone across five previously validated PANSS factors (positive, negative, disorganized thought, hostility, and depression/anxiety).

Method: A post-hoc factor analysis was performed on pooled data from 5 positive six-week, double-blind, placebo-controlled trials of subjects hospitalized with an acute exacerbation of schizophrenia who were randomly assigned to fixed, once-daily doses of lurasidone 40 mg (n=290), 80 mg (n=334), 120 mg (n=290), 160 mg (n=121), or placebo (n=497). Data were analyzed using a mixed model repeated measures (MMRM) model with an unstructured covariance matrix. Effect sizes (ES) were calculated from an ANCOVA analysis (LOCF-endpoint) as the between-treatment group difference in LS mean change scores divided by the pooled standard deviation of the change scores.

Results: Baseline characteristics were highly similar in the pooled lurasidone (n=1035; mean PANSS total score, 96.1) and placebo (n=497; mean PANSS total score, 96.1) groups. At endpoint, treatment with lurasidone was associated with significantly greater improvement in the PANSS total score compared with placebo (-22.6 vs. -12.8; P<0.001; ES, 0.42). Significantly greater endpoint improvement (P<0.001 for all comparisons) was observed for lurasidone versus placebo across all five PANSS factors. Changes for lurasidone vs. placebo were -8.4 vs. -6.0 (ES, 0.35) in the PANSS positive factor; -5.2 vs. -3.3 (ES, 0.32) in the PANSS negative; -4.9 vs. -2.8 (ES, 0.40) for disorganized thought; -2.7 vs. -1.6 (ES, 0.34) for hostility; and -3.2 vs. -2.3 (ES, 0.29) on depression/anxiety factors. Lurasidone160 mg dose was consistently associated with the highest effect size for each factor.

Conclusions: In this pooled, post hoc factor analysis of lurasidone placebo controlled trials, treatment with lurasidone across the daily dosing range of 40-160 mg, was effective in improving all 5 PANSS factors, suggesting efficacy across the spectrum of symptoms associated with schizophrenia. Sponsored by Sunovion Pharmaceuticals Inc.

PS5-15

Effectiveness of Lurasidone vs. Quetiapine XR for Relapse Prevention in Schizophrenia: A 12-Month, Double-Blind Study

Antony Loebel, M.D., Josephine Cucchiaro, Ph.D., Jane Xu, Ph.D., Kaushik Sarma, M.D., Andrei Pikalov, M.D., Ph.D., John M. Kane, M.D.

Abstract:

Objectives: To evaluate the efficacy and safety of lurasidone vs. quetiapine XR (QXR) in preventing relapse in subjects with chronic schizophrenia.

Methods: After completing an initial double-blind, placebo-controlled, 6 week trial with fixed doses of lurasidone (80 mg; 160 mg) or QXR (600 mg), subjects received 12 months of double-blind, flexible once-daily doses of lurasidone (40-160 mg) vs. QXR (200-800 mg). The primary a priori efficacy comparison was between subjects treated with lurasidone (n=139) and QXR (n=79) who were clinical responders after acute treatment. The primary endpoint, time-to-relapse, was analyzed using a Cox proportional hazards model, with a pre-specified non-inferiority margin for the risk of relapse hazard ratio of 1.93.

Results: Lurasidone was non-inferior to QXR in risk for relapse over the 12 month treatment period (hazard ratio 0.728, 95% CI [0.410, 1.295]). The risk of relapse in lurasidone treated subjects was reduced by 27.2% (hazard ratio 0.728) compared with QXR. The Kaplan-Meier estimate of the probability of relapse at 12 months was lower for lurasidone vs. QXR (0.237 vs. 0.336). Treatment with lurasidone (modal daily dose 120 mg) was associated with a significantly greater change in PANSS total scores compared with QXR (modal dose 600 mg) on an MMRM analysis. Rates of adverse events =5% in the lurasidone group were akathisia (12.6%), headache (10.6%), insomnia (7.9%), anxiety (6.0%), Parkinsonism (6.0%), and weight increased (6.0%). Analysis of changes from acute study baseline to 12 months of treatment (OC) with lurasidone and QXR, respectively, showed a mean change in weight of +0.7 vs. +1.2 kg; a median change in glucose of +1.0 vs. +1.0 mg/dL; a median change in cholesterol of 0.0 vs. +4.0 mg/dL; and a median change in triglycerides of -18.0 vs. -7.0 mg/dL. There were no clinically meaningful changes in other laboratory or ECG parameters on either drug.

Conclusions: This long-term, double-blind study demonstrated non-inferiority of lurasidone to QXR in prevention of relapse over a 12 month period, with a 27.2% reduction in relapse risk compared with QXR. Treatment with lurasidone was associated with few adverse effects on metabolic parameters, and a minimal effect on weight. The safety and tolerability of lurasidone was consistent with the results of previous studies. Trial Registration: clinicaltrials.

gov identifier: NCT00789698 Sponsored by Sunovion Pharmaceuticals Inc.

PS5-16

Effect of 12 Months of Lurasidone on Weight in Subjects With Schizophrenia

Andrei Pikalov, M.D., Jonathan M. Meyer, M.D., Yongcai Mao, Ph.D., Josephine Cucchiaro, Ph.D., Antony Loebel, M.D.

Abstract:

Objective: Individuals with schizophrenia have an increased prevalence of obesity (Newcomer et al, 2005). Furthermore, notable differences have been reported among atypical antipsychotics in effects on weight. This post-hoc analysis was conducted to evaluate the effect of 12 months of treatment with lurasidone on weight and body mass index (BMI) in subjects with schizophrenia.

Method: A post-hoc observed case (OC) analysis was performed on pooled data from 6 clinical studies that evaluated the safety of 12 months of treatment with lurasidone (40-120 mg/day).

Results: The analysis sample consisted of 371 subjects who completed 12 months of treatment with lurasidone (mean age, 42.4 years; male, 66.6%; white, 31.0%; black, 24.8%, Asian, 40.2%; other, 4.0%). The mean (SD) weight at baseline was 74.0 (19.1) kg and the mean BMI was 25.9 (5.3) kg/m2, with 3.2% of subjects meeting standard BMI criteria for being underweight, 48.8% normal weight, 26.4% overweight, and 21.6% obese. On an OC analysis, the mean change in weight was -0.74 kg at 3 months, -0.65 kg at 6 months, and -0.71 kg at 12 months. The mean change in BMI was -0.26 kg/m2 at 3 months, -0.22 kg/m2 at 6 months, and -0.24 kg/m2 at 12 months. An increase of =7% in weight occurred in 2.7% of subjects at 3 months, 8.6% at 6 months, and 17.6% at 12 months. An decrease of =7% in weight occurred in 9.7% of subjects at 3 months, 17.1% at 6 months, and 22.2% at 12 months. Overall, 12.0% of subjects shifted, by month 12, from the underweight/normal BMI category at baseline to the overweight category, and none to obese. Conversely, 28.6% of subjects shifted, by month 12, from overweight to normal weight.

Conclusion: The results of this pooled analysis of subjects who completed 12 months of treatment suggest that lurasidone, in the dosing range of 40-120 mg, was associated with a low potential for clinically significant weight gain. Sponsored by Sunovion Pharmaceuticals Inc.

PS5-17

Advancing Standards of Care for People With Schizophrenia: A Pilot Behavioral Intervention Program

Charles Ingoglia, M.S.W., Mohini Venkatesh, Linda Rosenberg, MSW, Bill Schmelter, M.D., Antony Loebel, M.D., Krithika Rajagopalan, Ph.D.

Abstract:

Introduction: Mental health interventions for schizophrenia have traditionally focused on treating symptoms. However, programs that incorporate behavioral health interventions aimed at achieving measurable and sustained improvements in daily living activities (DLA) and functioning are needed to advance mental health care among people with schizophrenia.

Objective: The National Council for Community Behavioral Health (NCCBH) Care implemented a behavioral program ("Advancing Standards of Care for People with Schizophrenia") to pilot a treatment intervention, Wellness Self-Management (WSM) to improve real-world functioning. Intervention effectiveness was assessed by the level of improvements in DLA and functioning.

Methods: Ten behavioral health organizations were selected to be the study sites and all participating patients in this 6-month WSM pilot were treated in a usual care manner (i.e., no protocol specified pharmacologic treatments). WSM is a group curriculum based on illness management and recovery (IMR), a nationally recognized evidence-based practice that helps adults with schizophrenia self-manage their mental and physical health issues through a set of weekly lessons (Salerno A et al. Psychiatr Serv 2011;62:456-8). WSM effectiveness was assessed by Daily Living Activities-20 (DLA-20), a validated clinician administered 20-item outcome measure (Scott, RL et al, Research on Social Work Practice 2001;11:373-389) at baseline, 2, 4, and 6 months. DLA-20 assesses the limitations in various DLA including communications, coping skills, physical and mental health care practices, and problem solving across 5 domains (i.e., health practices, housing maintenance, communication, safety, and managing time). The DLA-20 scores ranging from 20-140 were then mapped into a global assessment of functioning (GAF) 1-100 scale used by clinicians to assess patient functionality. Higher scores on both scales indicate greater functioning.

Results: From a total of 568 outpatients with schizophrenia, average age 45.7 years, 292 subjects (52%) completed the pilot program. At baseline, 20% of patients had severe limitations in all areas of functioning as measured by DLA-20. At six months, mean DLA-20 GAF score increased by 3.31% among all patients, and increased by 18.36% among patients (n=206) that showed any improvement in DLA-20 GAF score. Patients in the program also had substantial improvements in 3 DLA-20 functional subscales: communications (3.51 to 3.95), interaction with one's social network (3.8 to 4.23) and coping skills (3.3 to 3.78).

Conclusions: Overall, this intervention was effective in improving daily living activities, including communication, coping skills, and social-interactions among adults with schizophrenia that potentially results in improved functioning. Behavioral interventions such as these may help adults with schizophrenia improve functioning and social interactions. Supported by Funding from Sunovion Pharmaceuticals.

PS5-18

Switching to Lurasidone in Patients With Schizophrenia: Tolerability and Effectiveness of Three Switch Strategies

Joseph McEvoy, M.D., Leslie Citrome, M.D., M.P.H., David Hernandez, B.A., Jay Hsu, Ph.D., Andrei Pikalov, M.D., Ph.D., Josephine Cucchiaro, Ph.D., Antony Loebel, M.D.

Abstract:
Objective: To evaluate the safety, tolerability and effectiveness of switching clinically stable, but symptomatic non-acute patients with schizophrenia or schizoaffective disorder to lurasidone.

Methods: Non-acute patients who met DSM-IV criteria for schizophrenia or schizoaffective disorder and who were considered to be appropriate candidates for switching current antipsychotic medication to lurasidone, were randomized to three switch strategies: a 40/40 group (N=74) was started on a dose of 40 mg/d for 2 weeks; a 40/80 group (N=88) was started on a dose of 40 mg/d for 7 days, then increased to 80 mg/d for 7 days; and an 80/80 group (N=82) was started on a dose of 80 mg/d for 14 days. All patients were then treated for an additional 4 weeks with lurasidone 40-120 mg/d, flexibly dosed. The prior antipsychotic agent was tapered and discontinued over the initial 2-week study period. Patients were stratified based on whether the primary pre-switch antipsychotic was sedating (olanzapine, quetiapine) or non-sedating (all others). Time to treatment failure was evaluated, defined as insufficient clinical response, exacerbation of underlying disease or discontinuation due to an adverse event (AE). Safety parameters were also assessed.

Results: Switching to lurasidone was well-tolerated with 81.1% completing the 6-week study. No clinically relevant differences in efficacy or tolerability were noted when comparing the 3 different switch strategies. Time to treatment failure numerically differed among patients who had been receiving a sedating antipsychotic (35.8% of the total) immediately prior to the switch to lurasidone compared to those who were receiving a non-sedating antipsychotic (log rank p=0.101), with a treatment failure rate of 11.6% vs. 5.8%, respectively. Treatment with lurasidone was associated with LS mean within-group improvement at endpoint on the PANSS of -5.8 (95%-CI, -7.0, -4.5; Cohen's d, 0.5). For the total sample, treatment with lurasidone was associated with -0.3 kg mean decrease in weight, and a median reduction in both cholesterol (-1.0 mg/dL) and triglycerides (-6.0 mg/dL).

Conclusion: In this study, switching to lurasidone was well-tolerated using a cross taper strategy regardless of initial dose used or rate of titration. Patients switching to lurasidone demonstrated clinically relevant improvement in efficacy measures. Overall reductions in weight, lipids and glucose were observed, and the AE profile was similar to previous lurasidone studies. Trial Registration: clinicaltrials.gov identifier: NCT01143077. Sponsored by Sunovion Pharmaceuticals Inc.

PS5-19

Structural Basis of Fronto-Thalamic Dysconnectivity in Schizophrenia: A Combined DCM-VBM Study

Gerd Wagner, Ph.D., Kathrin Koch, Ph.D., Claudia Schachtzabel, C. Christoph Schultz, M.D., Ralf G. Schlösser, M.D.

Abstract:
Objectives: Several lines of evidence suggest that cognitive control deficits may be regarded as a connecting link between reported impairments in different cognitive domains of schizophrenia. In particular, due to its strong interconnections a thalamic dysfunction in schizophrenia has been assumed to have adverse modulatory influence on connectivity between frontal brain regions leading thus to abnormal functional activation and cognitive control deficits. However, the precise interplay within the underlying fronto cingulo thalamic network during cognitive control and its structural correlates has only been sparsely investigated in schizophrenia. We hypothesized that schizophrenic patients demonstrate a disruption in effective connectivity, which is accompanied by abnormal white matter volume in this network.

Methods: To test these hypotheses, a univariate data analysis and effective connectivity analysis using dynamic causal modeling (DCM) were combined to examine cognitive control processes in 36 patients with schizophrenia and 36 matched healthy controls. All subjects performed an adapted version of the Stroop task while undergoing fMRI scans. To relate the effective connectivity parameters to the underlying white matter (WM) structure voxel-based morphometry (VBM) was performed. The WM volume from the resulting clusters of significant group differences were correlated with anatomically corresponding connectivity parameters.

Results: In the fMRI analysis, patients demonstrated a significantly decreased BOLD signal in the fronto-cingulo-thalamic network. In the DCM analysis, a significantly decreased intrinsic, task and region dependent effective connectivity between thalamus and dorsolateral prefrontal cortex (DLPFC) as well as anterior cingulate cortex (ACC) was detected in patients in comparison to healthy controls. WM volume decreases were observed in patients in the mediodorsal thalamic and in the frontal cortex, which were positively correlated with parameter of effective connectivity from the thalamus to dACC and DLPFC.

Conclusions: Present results provide strong evidence for an abnormal fronto-cingulo-thalamic effective connectivity and a deficient thalamic modulation of the fronto-cingulate connectivity, which seems to be the basis of cognitive control deficits in schizophrenia. Moreover, the data indicate that disrupted white matter connectivity in thalamus and in the fronto-thalamic network may constitute the determining cause of fronto-thalamic dysconnectivity leading probably to abnormal thalamo-cortical synchronization.

Acknowledgments: This study was supported by the German Research Foundation (DFG SCHL 400/2-1).

PS5-20

Treatment Resistant Catatonic Schizophrenia in a Young Male

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Abstract:

Background: Schizophrenia is one of the leading mental disorders in U.S. today. It can affect both males and females equally. There are five types of schizophrenia; Paranoid, Disorganized, Undifferentiated, Residual, and Catatonic. Case: We present a 21 year old Caucasian male who was admitted for catatonic condition without auditory or visual hallucinations and without delusions. There were no reported depressive, manic or other psychotic symptoms. Patient has a history of schizophrenia, catatonic type for more than a year with four prior psychiatric hospitalizations. He had been treated previously with Risperdidol 2 mg and cogentin. At present he was on Haldol 12 mg, Ativan 1 mg BID and cogentin 1 mg BID. Pt was compliant with the medications but delay in even one dose would lead to a catatonic episode. On examination he was catatonic and selectively mute, looking blankly in the air and making no eye contact. He was unable to provide any information and was unable to follow commands due to his catatonia. He was started on Haldol 12 mg QHS, Cogentin 1 mg BID and Ativan 1 mg BID. Previously he had poorly tolerated Risperdol and Elavil. Electro-cognitive therapy (ECT) was discussed with family as a potential treatment but family was not agreed for that.

Discussion: Antipsychotics work by antagonizing the dopamine receptors (D1 & D2) at the post synaptic cleft. Also they antagonize Serotonin and Histamine receptors, which account more for adverse effects. Risperidone, a second generation antipsychotic, has more selectivity for the D2 receptor and has less adverse effects. Due to adverse effects, our patient was unable to tolerate Risperidone. Lorazepam binds GABA-A receptors, thereby increasing affinity for GABA and its receptors, thus causing more frequent opening of channels. In a recent study done in 2011 for treatment high-dose lorazepam was beneficial for 28% or patients. The final and most effective treatment for resistant Schizophrenia Catatonic is Electro-Convulsive Therapy (ECT). ECT has proven to be standard in treatment when all other therapies have failed in Schizophrenia Catatonic type. Adverse effects seen in ECT include transient memory impairment, prolonged seizures, and tardive seizures. In our case both medications could not be tolerated. ECT would be the most appropriate next step in management for our patient. Unfortunately, the treatment plan was declined.

Literature References:

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2) Consoli A, Boulicot V, Cornic F, Fossati P, Barbeau M, Cohen D. Moderate clinical improvement with maintenance ECT in a 17 year old boy with intractable catatonic schizophrenia. Eur Child Adolescent Psychiatry. 2009 Apr;18(4):250-4. Epub 2009 Jan 20. PubMed. PMID: 19156356

PS5-21

Vaptans: A Potential New Approach for Treating Chronic Hyponatremia in Psychotic Patients

Dawn Filmyer, M.S.; Alex G. Geboy, M.S.; Richard C. Josiassen, Ph.D.; Jessica L. Curtis; Rita A. Shaughnessy, M.D., Ph.D.; Nina Skuban, M.D.

Summary

Background: Hyponatremia (serum sodium concentration [Na+] < 136 mEq/L) is a potentially life-threatening condition often presenting chronically in patients with psychotic disorders. Vasopressin antagonists have recently shown in short-term studies to correct hyponatremia in diverse patient populations, including individuals with both psychosis and idiopathic hyponatremia. However, the safety and efficacy of long-term administration of vaptans is only beginning to be investigated. The objective of this study was to assess whether one of the vaptans, specifically tolvaptan, maintained its safety and efficacy over a prolonged period in patients with psychosis and chronic idiopathic hyponatremia.

Methods: SALTWATER was a multicenter, open-label extension of the Study of Ascending Levels of Tolvaptan in Hyponatremia. Of the 111 subjects enrolled in SALTWATER, eight were male patients with both psychosis and idiopathic hyponatremia who received oral tolvaptan. All had evidence of impaired water excretion demonstrated either by persistent hyponatremia (< 135 mEq/L) despite fluid-restriction or standard evidence of SIADH (i.e., urine osmolality > 100 mOsmoles/Kg with [Na+] < 130 mEq/L). Study assessments occurred on Day 1 (baseline and 8 hours after first dose), Days 2 through 14 (to end of titration), and Day 31; every 8 weeks from Weeks 10 through 58; every 12 weeks from Weeks 70 through 214; and a follow-up visit 7 days after the last dose of tolvaptan. Safety was assessed at all visits.

Results: These subjects provided a total of 7406 patient-days of exposure to tolvaptan. Mean serum [Na+] for the eight psychotic patients increased from 131.6 mEq/L at baseline to >135 mEq/L throughout the observation period ($P < 0.05$ versus baseline at most points). No drug-related adverse events led to study discontinuation.

Conclusion: Chronic hyponatremia is known to have deleterious effects on the quality of life for many patient groups. These preliminary results suggest that oral tolvaptan provides rapid, effective, and safe treatment of chronic hyponatremia in patients withpsychotic disorders and that the effect is safely sustained over long periods of time. This represents an important step forward in treating this significant unmet need in psychotic populations.

PS5-22

Reductions in Falls and Medical Costs Associated With Vaptan-Corrected Chronic Hyponatremia in Psychotic Inpatients

Alexander Geboy, M.S.; Dawn M. Filmyer, M.S., Danielle Martin, B.S., Jessica L. Curtis, Rita A. Shaughnessy, M.D., Ph.D., and Richard C. Josiassen, Ph.D.

Summary:

Background: Chronic hyponatremia (serum sodium [Na+] < 136 mEq/liter) occurs in a significant fraction of psychotic patients, and has been associated with an increased rate of falls. Falls and fractures increase morbidity and mortality in this population and impact medical costs associated with treatment. We wondered whether the correction of abnormal serum [Na+] with vasopressin-receptor antagonists (vaptans) might reduce the risk for falls and fractures and decrease medical costs associated with treatment.

Methods: Retrospective review of hospital chart records of psychotic inpatients diagnosed with hyponatremia without polydipsia and exposed to a vaptan for a minimum of 6 months. Chart review included demographic data, pharmacy records (6 months prior to vaptan initiation and 6 months on drug consecutive), recorded medical events, daily level of nursing supervision, and untoward events.

Results: Seven chronically hyponatremic cases were identified (5 males; mean age 56.6+6.2yrs; range duration of hospitalization 8-46 yrs). Significant reductions were observed between chronic hyponatremic state prior to vaptan therapy (6 months) and normonatremic state on vaptan therapy (6months): days of restricted privileges 94 to 32; aggressive/assaultive behaviors 18 to 6; traumatic falls 4 to 0; non-traumatic falls 26 to 2; emergency room visits 11 to 5; seizures 1 to 0; days of 1:1 close observation 187 to 0; days of q-15 minute checks 2 to 0; and mean drug costs $10,303.91+6,065.95 to $7,992.352+ 3,581.519.

Conclusions: In light of the beneficial health consequences and medical cost reduction, the correction of chronic hyponatremia using vaptans in highly selected cases warrants serious consideration.

PS5-23

From Community Integration to Successful Aging in Schizophrenia

Carolina Jimenez, M.D.; Helen H. Ryu, M.D., Elena F. Garcia Aracena, M.D., Carl I. Cohen, M.D.

Summary:

Introduction: Successful aging (SA) requires absence of disease and disability in conjunction with high cognitive, physical and social functioning. While the role of physical health should not be underestimated, in schizophrenia it may be relevant to explore other psychosocial views such as community integration (CI). CI examines the extent of independence, physical, social, and psychological integration of patients. Hence, it is considered and empirical measure of recovery. This study examines: (1) the relationship of CI and SA in older adults with schizophrenia; (2) the changes in CI and SA over time.

Methods: The study consisted of 254 persons with schizophrenia spectrum disorders aged 55 and over living in NYC who developed the disorder prior to age 45. Data on 102 patients followed for a mean of 51 months is presented. Mean age was 60 years, 55% were male, and 55% were white. High SA was defined as scoring 5 out of 6 on the SA Scale, and high CI as scoring 10 out of 12 on the CI Scale.

Results: At baseline, the CI and SA scales had a correlation of 0.41(16% shared variance). There were no significant T1–T2 (time 1 time 2) differences in the scores of CI (7.9 vs. 8.0) and SA (3.4 vs. 3.3). Notably, only 13% achieved high CI at T1 and T2, 61% never attained high CI, and 24% fluctuated between high and low CI. Similarly, only 11% achieved high SA at both times, 68% of the patients never attained high SA, and 23% fluctuated between high and low SA.

Conclusions: There was little movement towards CI and SA in this population, with about equal numbers moving in and out of these categories, and only a small percentage remaining permanently in them. Therefore, CI and SA cannot be considered on a linear continuum; rather they assess different paradigms of positive aging. This study was funded by National Institute of General Medical Sciences grants SO6 GM 74923 and SO6 GM 5465.

PS5-24

Achievement of Remission is Similar With Iloperidone and Haloperidol: A Meta Analysis of 3 Year Long, Double Blind Studies

Marla Hochfeld, M.D.; Saeeduddin Ahmed, M.D., Adam Winseck, Ph.D., Xiangyi Meng, Ph.D.

Summary:

Objective: To assess remission following iloperidone treatment using criteria modified from Andreasen et al.1 Data were pooled from 3 randomized, double blind studies lasting up to 52 weeks in which iloperidone was equivalent to haloperidol in time to relapse (primary efficacy variable).

Methods: Patients with schizophrenia or schizoaffective disorder received a flexible dose of 4–16 mg/d of iloperidone (n = 1231) or 5–20 mg/d of haloperidol (n = 403). The intent to treat population, consisting of all randomized patients who received at least 1 dose of study medication and had at least 1 postbaseline efficacy assessment, was analyzed. Remission was defined as a rating of = 3 (mild or less) at 1 or more study visits (occurring every 1 5 weeks) for the following Positive and Negative Syndrome Scale (PANSS) items (item number): delusions (P1), unusual thought content (G9), hallucinatory behavior (P3), conceptual disorganization (P2), mannerisms/posturing (G5), blunted affect (N1), social withdrawal (N4), and lack of spontaneity (N6). Patients achieving consecutive remission met these criteria at 2 or more consecutive assessments. Hazard ratios (HRs) and 95% confidence intervals (CIs) for iloperidone over haloperidol were determined using Cox proportional hazards regression.

Results: For patients with schizophrenia or schizoaffective disorder, 670/1146 (58.5%) receiving iloperidone and 222/379 (58.6%) receiving haloperidol achieved remission at 1 or more study visits (HR [CI] of 0.93 [0.80, 1.09]). A total of 568/1087 (52.3%) of these iloperidone treated patients and 193/351 (55.0%) of haloperidol treated patients experienced consecutive remission (0.91 [0.78, 1.08]). When schizophrenia patients were analyzed separately, 627/1080 (58.1%) receiving iloperidone and 210/365 (57.5%) receiving haloperidol achieved remission at one or more study visits (0.94 [0.80, 1.09]). Remission at consecutive study visits occurred in 530/1027 (51.6%) schizophrenia patients receiving iloperidone and 181/338 (53.6%) receiving haloperidol (HR [CI] of 0.92 [0.78, 1.09]).

Conclusions: In studies lasting up to 1 year, a similar percentage of patients on iloperidone and haloperidol achieved remission at individual and consecutive study visits. Funding: Novartis Pharmaceuticals Corporation.

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PS5-25

The Severity and Demographics of Schizophrenia Patients Switching to Depot Antipsychotic Agents

Dario Mirski, M.D.; Jay Lin, Ph.D.; Steve Offord, Ph.D.; Bruce Wong, M.D.

Summary:

Background: Depot antipsychotic agents were developed to improve compliance to therapy in schizophrenia patients. Current practice in newly diagnosed schizophrenia is to start with an oral agent then switch to a depot agent if compliance is inadequate. However, this therapeutic sequence potentially selects the most severe patients for depot therapy. We examined the severity and demographics of patients prior to the initiation of depot agents in comparison to incident schizophrenia prior to oral therapy.

Method: Schizophrenia patients were identified from the MarketScan Commercial database, a U.S. national health plan database, between 1/1/2005 and 9/30/2010. Index events were patients initiating treatment with depot antipsychotics compared to patients initiating treatment with an oral antipsychotic. The 12 months prior to the index event dates were compared. Patients were required to be >= 13 years at the index event and have >= 12 months of continuous health plan coverage prior to the index event. Schizophrenia severity was estimated from the need for hospitalization for schizophrenia, the length of stay in hospital (LOS) for schizophrenia and requirement for outpatient care. Charlson comorbidity index (CCI) was calculated to determine general disease severity. Medication possession ratio (MPR) was used as a measure of drug compliance. Statistical analysis was undertaken in SAS.

Results: 3,004 patients met inclusion criteria. 394 patients initiated depot agents and 2,610 oral agents with a mean age of 41.7 ± 15.5 and 37.1 ± 15.9 years, respectively. CCI scores (0.58 vs. 0.47; p=0.06) were similar between groups. Prior to the initiation of depot agents, the median MPR for prior oral antipsychotic agents was 0.28 ± 0.37. The number of hospital admissions in the 12 months leading up to the initiation of depot therapy was higher than that in newly diagnosed schizophrenia initiating oral therapy, 1.6 ± 1.66 vs. 0.82 ± 1.10, p<0.0001 and the hospitalization LOS was 16.93 ± 20.68 vs. 6.18 ± 11.02 days. The number of outpatient healthcare claims were significantly higher in the group subsequently receiving depot drugs, 51.37 ± 53.56 vs. 41.54 ± 46.62, p=0.0001. Total medication claims were also higher in this group, 27.87 ± 30.10 vs. 19.77 ± 28.14, p<0.0001. Emergency room visits were numerically higher prior to the receipt of depot agents vs. oral agents, but not statistically significant 2.98 ± 7.75 vs. 2.33 ± 8.40.

Conclusions: In current psychiatric practice, patients initiating depot therapy had more severe and difficult to control schizophrenia than newly diagnosed patients, creating a channeling bias in any real-world assessment of effectiveness of depot medication.

PS5-26

I Fans Study Design to Evaluate Iloperidone 12 24Mg/D After Gradual or Immediate Antipsychotic Switch in Suboptimally Treated Schizophrenia Patients

Peter Weiden, M.D.; Leslie Citrome, M.D., M.P.H., Farid Kianifard, Ph.D., Linda Pestreich, Adam Winseck, Ph.D., Marla Hochfeld, M.D.

Summary:

Objective: Completing a successful switch in atypical antipsychotic treatments to achieve optimal therapeutic outcomes for the patient with schizophrenia is a frequent but not fully understood issue. We describe the design of an ongoing 12 week randomized, multicenter, open label trial evaluating clinical outcomes with iloperidone following 2 switching approaches (gradual or immediate) in adults with schizophrenia exhibiting suboptimal efficacy and/or safety/tolerability from their current antipsychotic treatment of olanzapine, risperidone, or aripiprazole. Iloperidone is a D2 and 5 HT2A antagonist antipsychotic indicated for the treatment of schizophrenia in adults.

Methods: A total of 501 patients were randomized (1:1 to gradual or immediate switch) in 3 approximately equally sized cohorts that were defined by patients' current antipsychotic treatment (olanzapine, n=157; risperidone, n=174; aripiprazole, n=170). Patients are adults (aged 18 64 y) diagnosed with schizophrenia and experiencing inadequate efficacy and/or poor tolerability due to extrapyramidal symptoms (EPS)/akathisia, elevated prolactin, weight gain, somnolence/sedation, agitation, or anxiety on current treatment with olanzapine, risperidone, or aripiprazole for =30d. Key exclusionary criteria are: other current primary Axis I disorder, pregnancy, chemical dependency within 6 months, failed drug screen, QTcF >450 ms for men or >470 for women, risk of suicide, and/or nonstable antidepressant dose. Patients in these cohorts will be switched to iloperidone either by (a) immediate discontinuation of current treatment at baseline (BL; Day 0) or (b) gradual discontinuation by reducing current treatment to 50% on Day 1, 25% at Week 1, and 0% at Week 2. Patients will receive open label iloperidone 1 mg twice daily (BID) on Day 1 titrated over 4 days to 6 mg BID, followed by increases up to 12 mg BID, if needed, during Weeks 2–12. The primary variable is the Integrated Clinical Global Impression of Change (I CGI C) and the primary analysis time point is Week 12. The secondary variables are changes from BL in Efficacy CGI of Severity (E CGI S), Safety and Tolerability CGI of Severity (ST CGI S), and Integrated CGI of Severity (I CGI S). Additional safety evaluations will consist of adverse event reporting (Weeks 1–12), vital signs (Screening–Week 12), weight (Screening–Week 12), ECGs (Screening and Week 1), physical exams (Screening and Week 12), and clinical laboratory evaluations (Screening and Week 12), with fasting glucose, lipids, and prolactin additionally assessed at Week 7. The Treatment Satisfaction Questionnaire for Medication (TSQM) will be assessed at BL and Week 12.

Conclusion: This study design aims to contrast immediate and gradual switching approaches to inform clinicians of the efficacy, safety, and tolerability of iloperidone 12 24 mg/d in patients with schizophrenia requiring a change in therapy. Research support by Novartis Pharmaceuticals Corporation.

PS5-27

Switching From Olanzapine to Lurasidone: Results From a 6-Month Open Label Extension Study

Stephen Stahl, M.D.; Vamsi K. Bollu, Ph.D.; Krithika Rajagopalan, Ph.D.; Andrei Pikalov, M.D.; Jay Hsu, Ph.D.; Antony Loebel, M.D.

Summary:

Objective: In recent longer-term treatment studies of schizophrenia, all-cause treatment discontinuation has been used as a clinically meaningful composite measure of treatment efficacy, safety and tolerability. The aim of this post-hoc analysis of a 6-month lurasidone open-label extension (OLE) study was to compare the efficacy, safety, and all-cause discontinuations among patients switching to lurasidone from olanzapine or placebo vs. patients continuing on lurasidone during a 6 month OLE study.

Methods: The core study for this 6-month OLE was a 6-week, double-blind (DB), placebo-controlled trial of lurasidone 40mg and 120mg fixed doses, with olanzapine 15mg as an active-treatment arm (for assay sensitivity). Eligible patients continuing into the OLE received lurasidone fixed dose (80mg) for 1-week followed by flexible dose (40-120mg). Assessments included for analysis were: efficacy (PANSS total score changes); safety (changes in cardio-metabolic parameters), rates of all-cause discontinuation and reasons for discontinuation.

Results: From 246 evaluable patients in the OLE, 115 patients continued on lurasidone, 69 and 62 patients switched from olanzapine or placebo to lurasidone, respectively. Mean total PANSS scores decreased from 66.6 (OLE baseline) to 54.9 (OLE endpoint); with similar PANSS score improvements seen among those switching to lurasidone and those continuing on lurasidone. While no significant weight changes were observed among lurasidone patients during DB or when they continued on lurasidone in OLE, patients switching from olanzapine to lurasidone showed significant and sustained weight loss during OLE. Improvements in lipids and other cardio-metabolic parameters were also observed among patients switching from olanzapine to lurasidone. Total all-cause discontinuations were 54% (n=133) at OLE endpoint; with similar rates of discontinuations between those who stayed on lurasidone (n=60, 52%) and those switching from olanzapine (n=38, 55%) or placebo (n=35, 56%), respectively. Discontinuation rates due to lack of efficacy (14%, 8%, and 11%, respectively) or adverse effects (14%, 10%, and 12%, respectively) were also similar among patients staying on lurasidone or switching from olanzapine or placebo, respectively.

Discussion: In this post-hoc analysis, patients with schizophrenia who switched from olanzapine (DB phase) to lurasidone (OLE) maintained efficacy improvements at 6-months and experienced similar rates of all-cause discontinuations as those who continued on lurasidone. In addition, significant weight loss and improved lipid and other cardio-metabolic parameters were observed after switch to lurasidone. Funded by Sunovion Pharmaceuticals Inc.

PS5-28

Effectiveness' Comparison of Trifluoperazine and Clozapine Treatment at Patients With Anhedonia in Paranoid Schizophrenia: A Pilot Study

Nataliia Orlova, M.D., Elena Khaustova, Ph.D., M.D., Mykhailo Shkliar, M.D.

Abstract:

Objectives: negative symptoms have influence to social functioning and quality of life. Treatment of them is one of the burn problems of modern psychiatry. For schizophrenia treatment use as conventional neuroleptics and atypical antipsychotics. Very important for improvement psychiatry service are patient's compliance and adherence.

Aims: the efficacy and safety anhedonia treatment by conventional neuroleptics and atypical antipsychotics at patients with paranoid schizophrenia were learned.

Methods: 60 patients with paranoid schizophrenia (295.30) with anhedonia were randomized on two groups: patients who treated by trifluperazine (N=30) and by clozapine (N=30). They were examining before treatment and via 1, 2, 3, 4 treatment weeks with SHPS, PANSS negative, SDS, GAF, GWB, and CGI.

Results: the efficacy and safety of choosing medicines during the therapy are in the Table 1. Patients who treated by clozapine had clinical improvement in main negative symptoms (anhedonia, negative PANSS, social functioning, quality of life) and had some times side effects: hypotension. They had positive clinical improvement on CGI. Treatment by trifluperazine had low efficacy on studying symptoms and an extrapyramidal side effects. Patients had worse compliance and adherence than patients treated by clozapine.

Conclusions: successful anhedonia treatment is possible with atypical antipsychotics. Application those group of medicine gives more anhedonia weakening than conventional neuroleptic treatment. Treatment by atypical antipsychotics has fewer side effects and has good influence to compliance and adherence.

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PS5-29

Improving Metabolic Health in Patients With Severe Mental Illness

Robert Cabaj, M.D., Sun H. Kim, M.D., M.S., Jeannine Mealey, M.S., L.M.F.T., Suzanne M. Moore, N.P., Sandra Santana-Mora, M.A., Celia Moreno, M.D., Patrick Miles, Ph.D., Nang Du, M.D., Todd Feeley, M.D., John Herbert, M.D., Doriana Bailey, M.D., Alan K. Louie, M.D.

Abstract: Patients with severe mental illness are at increased risk for obesity and obesity-associated metabolic disorders, including type 2 diabetes, dyslipidemia, and hypertension. Unfortunately, certain antipsychotic medications used to treat these patients may promote weight gain and obesity-associated diseases. Recent guidelines have emphasized screening patients on antipsychotic medications with fasting glucose and lipid measurements; however, adherence has been poor. For example, a recent study found that only

27% had testing for glucose and 10% for lipids prior to starting antipsychotic therapy. To improve the health of their patients, the San Mateo County Behavioral Health and Recovery Services (BHRS) have started to provide primary care services directly within the psychiatric clinics through a nurse practitioner. The objective of this study was to evaluate the effectiveness of this program in screening and managing mental-health patients for common metabolic abnormalities.

PS5-30

The Efficacy of Levomilnacipran in the Treatment of Major Depressive Disorder: Results From A Phase III Clinical Trial

Carl Gommoll, M.S.; Anjana Bose, Ph.D., Changzheng Chen, Adam Ruth, Ph.D.

Summary:

Objective: Levomilnacipran (1S, 2R milnacipran) is a potent and selective serotonin and norepinephrine reuptake inhibitor (SNRI) with preference for the norepinephrine transporter. To determine the efficacy of levomilnacipran sustained released (SR) across symptom domains in major depressive disorder (M.D.D), prospective and post hoc analyses were conducted on a positive fixed dose Phase III trial (NCT00969709).

Methods: An 11 week, double blind, multicenter, parallel group, placebo controlled, fixed dose study in patients aged 18 65 years who met DSM IV TR criteria for M.D.D. Patients had a current major depressive episode >=8 weeks and a score >=30 on the Montgomery Asberg Depression Rating Scale Clinician Rated (MADRS CR). The study comprised a 1 week single blind, placebo lead in, 8 week double blind treatment, and 2 week double blind down taper. Patients were randomized to placebo or once daily levomilnacipran SR 40 mg, 80 mg, or 120 mg, initiated at 20 mg and titrated to target dose over 7 days.

Primary Efficacy: MADRS CR total score change from baseline to end of Week 8 analyzed using a mixed effects model for repeated measures (MMRM) approach on the intent to treat (ITT) population. Secondary efficacy: Sheehan Disability Scale (SDS) total score change from baseline to Week 8 analyzed using a similar approach. Additional efficacy: HAM.D.17, SF 36, CGI S, and CGI. Safety and tolerability were evaluated. Post hoc analyses evaluated change from baseline to Week 8 on MADRS CR single items (MMRM, ITT).

Results: The least squares mean difference (LSM.D.) for MADRS CR total score change from baseline showed all dose groups were significantly superior to placebo: levomilnacipran SR 40 mg (3.23, P=.0186), 80 mg (3.99, P=.0038), and 120 mg (4.86, P=.0005). On the SDS, significantly greater improvement versus placebo was seen for levomilnacipran SR 80 mg (LSM.D., 2.51; P<.05) and 120 mg (LSM.D., 2.57; P<.05). For levomilnacipran SR 80 and 120 mg dose groups, significant improvement relative to placebo was also seen on the HAM.D.17, SF 36, CGI S, and CGI I assessments. Improvement across symptom domains was demonstrated by significantly greater decrease in most MADRS CR single item scores for levomilnacipran SR 80 mg and 120 mg versus placebo (P<.05). Levomilnacipran SR was generally well tolerated; however, significantly more patients in the levomilnacipran SR groups discontinued due to AEs (1.7% for placebo and 7.3%, 14.5%, and 6.7%, for levomilnacipran SR 40 mg, 80 mg, and 120 mg, respectively).

Conclusions: Levomilnacipran SR 40 mg, 80 mg, and 120 mg demonstrated significant, dose proportional improvement in depressive symptoms relative to placebo. Post hoc analysis demonstrated superiority for the levomilnacipran 80 and 120 mg doses across symptom domains. Levomilnacipran SR was generally well tolerated; however, significantly more levomilnacipran SR patients discontinued due to AEs. This study was funded by Forest Laboratories, Inc.

PS5-31

Managed Care Cost Savings Associated With the Use of Long Acting Injectable Formulations of Antipsychotic Agents in Schizophrenia

Jay Lin Ph.D.; Bruce Wong M.D., Steve Offord Ph.D., Dario Mirski M.D.

Summary:

Background: Compliance to oral antipsychotic agents has been estimated to be less that 50% some studies. Second generation depot agents were developed with the primary intent to improve compliance to medications in schizophrenia patients. We examined the managed care cost implications in real practice of the use of depot antipsychotic agents.

Method: Schizophrenia patients were identified from the MarketScanTM Commercial database, a U.S. national health plan database, between 1/1/2005 and 9/30/2010. Index events were patients initiating treatment with depot antipsychotics compared to patients initiating treatment with an oral antipsychotic. The 12 month post-index costs for inpatient and outpatient care were compared. Incident oral antipsychotic use was chosen as a comparison to incident depot use as it is likely to be a more costly time period of schizophrenia care. Patients were required to be >= 13 years at the index event and have >= 12 months of continuous health plan coverage prior to the index event. Changes in healthcare costs representing reimbursed payment were measured from the healthcare claims in the database. Medication Possession Ratio (MPR) was used as a measure of drug compliance. Data is expressed as mean ± standard deviation. Statistical analysis was undertaken in SAS.

Results: 3,004 patients met inclusion criteria. 394 patients initiated depot agents and 2,610 oral agents with a mean age of 41.7 ± 15.5 and 37.1 ± 15.9 years. The median MPR prior to the initiation of depot agents was 0.28. Between the 12-month of follow-up and baseline periods, the change in schizophrenia-related hospital costs of depot agents vs. oral agents was -\$5,981 ± \$16,554 vs. \$758 ± \$14,327, p<0.0001. The depot group was associated with both larger reductions in the mean number of hospital admissions, -0.60 ± 1.37 vs. 0.05 ± 0.99, p<0.0001 and mean length of stay for hospital admissions -7.46 ± 20.68 vs. 0.60 ± 12.49, p<0.0001. Changes in the cost of outpatient care also favored depot agents, \$134 ± \$8,280vs. \$658 ± \$3,260, p=0.023. The cost of psychiatric medications were higher in the depot group during the post-index period, \$4,132 ± \$4,533 vs. \$2,562 ± \$2,714, p<0.0001.

Conclusions: In managed care, switching patients to depot antipsychotic agents to manage schizophrenia is less costly overall than the management of newly diagnosed schizophrenia patients with oral agents. The cost savings coming from reductions of hospitalizations and outpatient care outweigh the cost increase from psychiatric medications.

PS5-32

Evaluation of Antipsychotic Tapering Protocol in a Clinical Practice

Sandra Steingard, M.D.

Abstract: It is common practice to treat acute psychotis with antipsychotic medications. Once individuals recover, it is recommended that these medications continue indefinitely. The rationale for promoting long-term treatment with neuroleptics for people who have been diagnosed with schizophrenia was based on the results of the relapse studies. In these studies, people who had been treated with neuroleptics during the acute phase of their illness were randomized to continue on either medications or placebo. In most studies, they were then followed for 1-2 years. The relapse rate in the group who was not on medication was much higher. According to one large meta-analysis, relapse in those who remain on medications is 16% as compared to 53% of those who were taken off their medications. The relapse rate was lower in those studies in which the drugs were slowly tapered as opposed to abruptly discontinued. Although these data point out the benefits of maintenance medications, they also demonstrate that if all patients remain on medication indefinitely, there are a sizable number who are being unnecessarily exposed to the long term effects of these medications. It is difficult, however, to determine who these individuals are. This risk of relapse needs to be balanced against the long term effects of these medications. The rate of tardive dyskinesia is estimated to occur in about 3-7% of people exposed to these medications over the course of one year. Many of the currently prescribed antipsychotics lead to obesity and metabolic syndrome. There is recent data associating these drugs with reduce cortical volumes. There is other data suggesting that some people are at risk of super sensitivity psychosis where over time, they become resistant to the effects of these medications. Unfortunately, there are no guidelines on how to taper or even how to discuss these challenges with patients. Gathering systematic data from a practice where patients are all treated in as consistent a manner as possible would be helpful not only to an individual physician but to other colleagues as well. This poster will report on the one year data from a clinical practice in antipsychotic taper is being discussed and managed in a systematic way with all patients in the practice.

PS5-33

Very Early Onset Schizophrenia: Clinical Features, Genetic Correlations and Treatment Modalities

Marek Makuch, M.D., Sarah Sheikh, M.D., Kristina Brown, M.S.

Abstract:

Background: Very Early Onset Schizophrenia (VEOS) is a rare disorder which presents with psychosis before age 12. Much like its adult onset counterpart, the pathophysiology of childhood onset schizophrenia is not completely understood. Approaching VEOS requires knowledge of common clinical presentations which are unique to this subset of patients; as well as common developmental disorders which may be a misdiagnosis or co-morbidity of VEOS. This literature review will examine the salient features of VEOS as well as the need for clinical trials assessing appropriate treatment modalities for this unique condition.

Methods: A review of the current literature from 1994 to May 2011, utilizing the search terms: childhood onset schizophrenia, very early onset schizophrenia, child psychiatry, genetics, cytogenetics and autism spectrum in the PubMed database. 11 articles were identified, reviewed and the results were synthesized by the study team. No contact with patients was required.

Results: The symptomatic presentation of childhood onset schizophrenia are described with 80% presenting with auditory hallucinations, 74 % with flat or inappropriate affect, 63% with delusions, 40% with formal thought disorder and 37% with visual hallucinations. The course is insidious with psychiatric symptoms beginning at a mean of age 4.6 years and diagnosis at a mean age of 9.5 years. With the exception of developmental variation in content of delusions and other features; the symptomatology and etiology was similar to that found in adolescents and adults. The results show a strong familial and genetic component in cases of VEOS, as well as a Co-Morbidity and association with childhood onset schizophrenia (COS) and pervasive

developmental disorders in 50% of patients. Genetic mutations, such as the 4 nucleotide deletion in the UPF3B gene, draw a common link between COS and autism spectrum/developmental disorders. Brain imaging studies found an early acceleration or left shift of "increased gain" in brains of both patients with COS and those with autism spectrum disorders; with the growth occurring at age 1-3 in autism and early adolescence in COS. A subsequent global loss of cortical grey matter is common to both conditions. A delayed/disrupted white matter (WM) growth, and a progressive decline in cerebellar volume is noted in COS patients as well as their healthy siblings. The studies helped to rule out causality of non-genetic factors in COS, such as obstetric complications, socioeconomic status, psychological trauma, and early puberty. They found that higher rates of pre-morbid abnormalities (33% incidence of mental retardation, 33% incidence of ADHD, 66% with milestone delay), greater history of disease prevalence in 1st degree relatives (42% with family history of schizophrenia), and larger rates of cytogenetic abnormalities in the COS group suggested genetic factors may be key. The studies also highlighted pre-morbid function.

PS5-34

Pilot Survey of Cognitive Behavioral Psychotherapy (CBT) Supervisors to Determine Their Supervisory Practice and Learning Needs

Diana Kljenak, M.D.

Summary:

Background: Substantial empirical support for cognitive behavioral therapy (CBT) effectiveness in treatment of various psychiatric disorders has been demonstrated. Adequate training in CBT results in improved therapist competence and patient outcomes. Effective clinical supervision is an essential part of the training in CBT. However, we do not have a complete and accurate understanding of how supervisors themselves acquire competence in CBT or of the methods of CBT supervision they use. The need for training of supervisors is widely accepted and there is evidence that it can be effective.

Methods: We piloted an anonymous self-administered questionnaire survey to CBT supervisors who have attended a supervisory peer support group. The survey included questions on kind of training CBT supervisors have had both in CBT and in CBT supervision, supervisory methods they currently use and their perceived educational needs.

Summary of Results: 12 supervisors were invited to participate, and 7 responded (58 % response rate). Most (86%) trained CBT by attending various workshops. 57% received their training during residency in psychiatry. Only 43% have attended a formal teaching/supervision course. Modeling of the structure of CBT session during the supervision was done always or often by 57% of respondents. More than 50% of responders never or rarely observed trainee's therapy session either through direct, video or audiotape observation. 100% of the respondents were interested in receiving further training in CBT supervision with 86% of the respondents believing that this training should be done through a formal course.

Conclusion and Discussion: This pilot survey has provided a baseline analysis of CBT supervisors' supervisory practice and educational needs. Surveyed CBT supervisors have expressed a strong need to receive further training in CBT supervision through a formal course. The needs assessment will serve as a platform for the development of a faculty development program for CBT supervisors. By addressing psychotherapy supervisors learning needs more successful psychotherapy supervision outcomes are likely which may positively influence therapy outcomes.

PS5-35

The Impact of Comorbid Anxiety Disorders in Subsyndromally Depressed Participants Presenting for a Depression Prevention Research Intervention

John Kasckow, M.D.; J. Karp, M.D.; E. Whyte, M.D.; C. Brown, Ph.D., A. Begley, MS; S. Bensasi, BA; C.F. Reynolds, M.D.

Summary:

Background: Subsyndromal depressive disorders in late life are: 1) common in primary care; 2) associated with functional impairments (Lyness et al. Am J Geriatr Psychiatry, 15:214, 2007); and 3) frequently comorbid with anxiety disorders. Comorbid anxiety may worsen the "high stress" state and exacerbate the negative effect on functioning and health related quality of life. We examined psychiatric comorbidity in subsyndromally depressed older individuals referred for an indicated depression prevention project that utilized Problem Solving Therapy adapted for primary care. We hypothesized that functioning would be better in those with subthreshold depression alone vs. those with subthreshold depression + comorbid anxiety.

Methods: This NIMH sponsored intervention included 237 participants, age 50 and older with CES D scores > 10. We determined rates of psychiatric comorbidities among the participants using DSM IV criteria.

Results: Participants had 1 or more of 38 different DSM IV diagnoses: 21.1% had no DSM IV diagnosis; 37.1% had 1; 29.6% had 2, 7.6% had 3; 3.8% had 4; and 0.8% had 5 psychiatric diagnoses. The prevalence of these conditions will be presented. We compared levels of health related quality of life and psychosocial functioning in 3 groups of participants: 1) those with subthreshold depression only (n = 126), 2) those with subthreshold depression + a current DSM IV anxiety disorder (n = 58) and 3) those with subthreshold depression + a current comorbid anxiety disorder + a past history of an anxiety disorder (n =33). Between the 3 groups, there were no differences in RAND12 physical or mental functioning composite scores. However, using the Late Life Function and Disability Instrument, we observed differences in Social Role Domain scores (F(2,173)=3.63, p=0.029). Post hoc testing showed that the 'subthreshold depression only' group had higher Social Role Domain scores than the 'subthreshold depression + current anxiety disorder' group [28.7 (5.5) vs. 21.1 (6.0) respectively].

Conclusions: In this sample of individuals with subsyndromal depression, many were diagnosed with a comorbid psychiatric condition. Many individuals exhibited current or past history of anxiety disorders in addition to having a subthreshold depressive disorder. Those having only subthreshold depression exhibited higher social functioning compared to those with subthreshold depression + a current anxiety disorder. Our findings suggest that it is important to consider screening subsyndromally depressed individuals for current anxiety disorders. Supported by P30 MH090333 and P60 M.D.000207 (CFR). The contents do not represent the views of the Department of Veterans Affairs of the U.S. government.

PS5-36

A Randomized Controlled Trial of Escitalopram and Telephone-Administered Psychotherapy in Major Depressive Disorder: Focus on Work Productivity

Raymond Lam, M.D.; Sagar V. Parikh, M.D.; Rajamannar Ramasubbu, M.D., M.Sc.; Erin E. Michalak, Ph.D.; C.V. Manjunath, M.D.

Summary:

Objectives: There is still little information about gains in work productivity with effective treatment of major depressive disorder (M.D.D), in part because the intensive nature of randomized controlled trials (RCTs) makes it difficult for working patients to participate. In this study, we used a novel clinical trials methodology to examine work productivity outcomes in treatment of M.D.D.

Methods: The WORKER Study was a 12-week RCT of escitalopram plus cognitive-behaviour therapy (CBT) in employed patients with M.D.D. Eligible patients were treated with 10-20 mg of escitalopram and then randomized to 8 sessions of a validated brief CBT program administered by trained therapists over the telephone, or to adherence reminder telephone calls. Outcome measures included the Montgomery Asberg Depression Rating Scale (MADRS) administered by blind raters over the telephone, and work productivity questionnaires (e.g., Lam Employment Absence and Productivity Scale [LEAPS], Sheehan Disability Scale [SDS]) were completed on-line over a secure web site. Analysis was conducted using repeated measures multivariate analysis of variance in a modified intent-to-treat sample (patients who had at least one post-baseline assessment).

Results: A total of 105 patients were randomized, with 98 evaluable patients in the modified intent-to-treat sample. At the primary 12-week endpoint, there were no significant differences between conditions in change in MADRS score or in response or remission rates. However, the escitalopram + Tel-CBT condition showed significantly greater improvement than the escitalopram + reminders condition on measures of work productivity (LEAPS) and psychosocial functioning (SDS).

Conclusions: Compared to escitalopram alone, the addition of telephone-administered CBT did not improve symptom-based depression rating scale scores or response/remission rates in patients with M.D.D, but did significantly improve functional outcomes, including work productivity. These results also confirm other studies showing differences between symptom-based and functioning outcomes, suggesting that these outcomes should be assessed independently in clinical trials of M.D.D.

PS5-37

Personality Disorders in Female Adolescents in a Residential Program

Samuel Neuhut, M.D.; Diana L. Santiago, M.D., John E. Lewis, Ph.D., Mercedes Briones, Psy.D., and Jon A. Shaw, M.D.

Summary:

Introduction: Twenty five adolescent females in a residential program were assessed for ADHD, personality trait/disorders, and a history of sexual abuse. Personality traits/disorders have been documented as occurring in the adolescent population (Krueger & Carlson, 2001).

Hypothesis: A history of sexual abuse will be correlated dimensionally with the number of personality trait items on the SCID II PQ.

Methods: Subjects (mean 15.1 years) were administered the SCID II PQ (Crawford et al., 2005), Stop Signal Task (Aron & Poldrak 2005), and the Trauma Symptom Checklist for Children (Singer et al., 1995). The sexual abuse was confirmed by multiple sources.

Results: The most common Axis I diagnoses were Mood Disorder NOS (58%), Depressive Disorders (34%), PTSD (12%), Conduct Disorder (88%), and ADHD (100%). Utilizing the Stop Signal Task, all of the females met the threshold criteria for ADHD. Ninety two percent of adolescents were found to have a personality disorder; the most common being Antisocial (72%), Borderline (52%), and Passive Aggressive (28%) personality types.

Conclusion: We found that 60% of the adolescent females had a well documented history of sexual abuse. The history of sexual abuse was significantly related to the number of endorsed personality trait items on the Cluster

B modules and on the total SCID II PQ score. Of the top ten personality trait items endorsed by the sexually abused subjects, only two came from the Borderline Personality Disorder module.

Discussion: The high prevalence of personality traits/disorders found to be co morbid with ADHD is consistent with previous literature (Burket et al., 2005). The finding that sexual abuse is related to the number of endorsed personality disorder trait items on both Cluster "B" modules and on the total SCID II PQ score suggests the value of a dimensional approach to understanding the psychological ramifications of sexual abuse in our population.

References:

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PS5-38

Characteristics Associated With Antipsychotic Drug Adherence Among Schizophrenic Patients In A Us Managed Care Environment

Bruce Wong, M.D.; Steve Offord, Ph.D., Dario Mirski, M.D., Jay Lin, Ph.D.

Summary:

Background: Antipsychotic drug therapy for treating schizophrenia is effective in managing symptoms and preventing relapses. However, non adherence to antipsychotic drug therapy in patients with schizophrenia is prevalent. Methods to improve adherence are of critical importance to reduce the burden of the disease.

Objective: To identify potentially distinguishing factors that are predictive of patients who adhere to antipsychotic therapy.

Methods: Patients in the U.S. with schizophrenia between 1/1/2005 and 9/30/2010 were identified from the MarketScan Commercial healthcare claims database. Patients included in the study were >=13 years of age and had at least 12 months of continuous coverage before (baseline) and after (follow up) the earliest antipsychotic usage (index event). Medication adherence was estimated with a medication possession ratio (MPR), which represents the time each patient possessed a drug compared to the total expected duration of therapy. Patients with an MPR >=0.7 during the follow up period were allocated to the high adherence cohort. Those with an MPR <0.7 were assigned to the low adherence cohort. Patient demographics, comorbidities, and concomitant medication usage were measured during the baseline period. Statistical analysis was carried out using SAS.

Results: 1,462 patients with schizophrenia met the inclusion criteria; 396 (27%) were classified as highly adherent with a mean ± standard deviation (SD) MPR of 0.92±0.10 and 1,366 (73%) were classified as having low adherence with a mean ± SD MPR of 0.24±0.19. With the exception of the highly adherent patients being older (41.1 vs. 38.4 years; p=0.004), demographic characteristics were similar between the two cohorts. A greater proportion of highly adherent patients were diagnosed with peripheral vascular disease (2.0% vs. 0.8%; p=0.04) and had concomitant use of anticonvulsants (42.4% vs. 34.1%; p=0.003) and antihyperlipidemics (20% vs. 13.8%; p=0.004), although the overall Charlson comorbidity index was not different between the high adherence and low adherence cohorts.

Conclusions: Only 27% of patients with commercial health plans in this analysis were highly adherent to antipsychotic medication, reflecting the magnitude of the adherence problem in patients with schizophrenia. Highly adherent patients were older, experienced more peripheral vascular disease, and received more antihyperlipidemic and anticonvulsant medications. These results could indicate that adherence to antipsychotic agents is assisted by a "reminding event," such as an illness or use of concomitant medication. Further study is required to clarify the role of the co morbid diseases vs. concomitant medications in the risk of antipsychotics non adherence.

PS5-39

Antipsychotic Drug Adherence Correlates With Hospitalization Rates and Length of Stay Among Medicare and Non Medicare Schizophrenia Populations

Ross Baker, Ph.D.;Bruce Wong, M.D.; Steve Offord, Ph.D.; Dario Mirski, M.D.; Jay Lin, Ph.D.

Summary:

Background: Non adherence to antipsychotic medications is due to multiple factors including, in part, disease state and tolerability of currently available antipsychotic medications. Both compound the more general reasons for non adherence to medication often seen in other conditions.

Objective: To determine whether there is a relationship between medication adherence, all cause hospitalization rates, and hospital length of stay (LOS) in Medicare and non Medicare patients with schizophrenia.

Methods: Patients with schizophrenia who were >=13 years of age and used antipsychotic medications between 1/1/2005 and 9/30/2010 were identified from the MarketScan Medicare and Commercial health care claims databases. Antipsychotic medication adherence was estimated with a medication possession ratio (MPR) for the first year of medication use. Patient demographics and comorbidities were measured at baseline. All cause hospitalization rates and LOS were determined for the follow up period and their relationship to MPR was assessed using generalized linear models. Statistical analysis was carried out by SAS.

Results: 1462 schizophrenia patients were identified from the non Medicare population and 354 from the Medicare population who received a new prescription for an antipsychotic agent, the most common being risperidone, aripiprazole, and quetiapine. Non Medicare patients were 50% female with a mean age of 39.1 years. Medicare patients were 65% female with a mean age of 71.4 years. Medicare patients were sicker, with Charlson comorbidity index (CCI) mean scores of 1.77 compared with non Medicare patients who had a mean CCI score of 0.50 ($p<0.05$). During the first year after the initiation of an antipsychotic agent, the mean ± standard deviation MPRs were 0.43±0.35 and 0.49±0.37 for the non Medicare and Medicare populations, respectively. Hospitalizations for schizophrenia occurred at a mean rate of 0.23 hospitalizations per patient year in non Medicare patients and 0.18 hospitalizations per patient year in Medicare patients. Among non Medicare patients, an increased MPR was associated with a lower hospitalization rate (0.195 hospitalizations; $p=0.011$) and shorter LOS (2.11 days; $p=0.018$). Similarly, among Medicare patients, higher adherence was associated with fewer hospitalizations (0.261 hospitalizations; $p=0.044$) and shorter LOS (4.77 days; $p=0.021$).

Conclusions: We find an inverse relationship between antipsychotic medication adherence and hospitalization rates and LOS in both Medicare and non Medicare schizophrenia patients. This relationship provides evidence that improving medication adherence in schizophrenia can reduce hospitalizations, LOS, and thus reduce overall healthcare costs. Antipsychotic medications are the mainstay for treating schizophrenia and thus, there is a significant challenge for health care professionals and patients to manage medication adherence to reduce the burden of schizophrenia on patients and health care resources.

PS5-40

Drug Compliance and Associated Outcomes in Schizophrenia Patients Before and After the Initiation of Depot Antipsychotic Agents

Steve Offord, Ph.D.; Dario Mirski, M.D.; Jay Lin, Ph.D.; Bruce Wong, M.D.

Summary:

Background: Depot antipsychotic agents are primarily used to manage poor drug compliance in the treatment of schizophrenia. Compliance behavior surrounding the use of depot agents in monitored clinical practice such as registries or clinical trials is difficult to quantify because of the bias introduced by the monitoring (Hawthorne effect). We studied the magnitude of non compliance in patients prior to the receipt of depot agents and the subsequent healthcare outcomes of compliance using healthcare claims data. The results may aid clinical practice decisions in schizophrenia management.

Method: Schizophrenia patients were identified from the MarketScan Commercial database, a U.S. national health plan database, between 1/1/2005 and 9/30/2010. Index events were patients initiating treatment with depot antipsychotics compared to patients initiating oral antipsychotics. New oral antipsychotic users were chosen as the comparison group since it is the cohort most likely to exhibit good compliance, creating a conservative comparison cohort. Patients were required to be >= 13 years at the index event and have >= 12 months of continuous health plan coverage prior to (baseline) and after (follow up) the index event. Medication compliance was estimated with a medication possession ratio (MPR), which represents the time each patient possessed a drug compared to the total expected duration of therapy. MPR are expressed as median ± standard deviation. A lower MPR indicates lower drug compliance. Statistical analysis was undertaken in SAS.

Results: 3,004 patients met inclusion criteria. 394 patients initiated depot agents and 2,610 oral agents with a mean age of 41.7 ± 15.5 and 37.1 ± 15.9 years, respectively. Prior to depot initiation, median MPR was 0.28 ± 0.37 which improved to 0.79 ± 0.34, while on depot agents, a relative increase of 182%. The median MPR during follow up periods was significantly higher in the Depot vs. Oral cohort, 0.79 ± 0.34 vs. 0.58 ± 0.35, $p<0.0001$. Hospital visits fell from 1.6 ± 1.66 in the baseline period to 0.7 ± 1.20 admissions per patient following the initiation of depot agents ($p<0.0001$). The total length of stay also decreased significantly from 16.9 ± 20.7 days to 6.6 ± 14.4 days ($p<0.0001$). There was no significant change in overall outpatient resource usage including the number of emergency room visits.

Conclusions: Upon initiation of depot antipsychotics, patients had significantly improved drug compliance. In addition, patients initiating depot antipsychotic agents for schizophrenia treatment have significantly better drug compliance in comparison with patients initiating oral agents. The improvement in compliance is associated with reduced hospital admissions and short hospital length of stay.

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Saturday, October 6; 3:00 p.m.–4:30 p.m.

POSTER SESSION 6

PS6-01

Psychiatric Family Home-Treatment Autism: From Practice to Evidence Based Practice

Cisca Aerts, M.D., Jan Pieter Teunisse, Ph.D.

Abstract:

Introduction: Autism Spectrum Disorder (ASD) determines to a large extent the lifestyle of the person with ASD and his environment; but there is no home treatment specifically for families with ASD. We developed a competence directed home-treatment: the Psychiatric Family treatment for Autism (PFA), specially for families with one or more persons with ASD.

Aims: To involve every family member to improve the individual and family strengths. A family trainer works weekly at home at targets the family made.

Methods. We did 2 studies: 1. We measured the treatment adherence of the 6 principles of PFA: focus on autism, responsibility of the parents, empowerment, systemic, methodize, respectful attitude – by home observations and questionnaires with parents and the family workers. 2. We measured the effectiveness of PFA before (T1), after(T2) and in the 6 months follow-up (T3) of the treatment with standardized and validated questionnaires (VGFO, SCL-90, SDQ) focused on the parents' practices, parents' personal well-being and their perception of each of their children's problems. Also each child of the family answered a questionnaire about his competences (CBS-A/K).

Results: 1. The principles of the PFA are confirmed by a high agreement of the family workers and the parents. There is high treatment integrity. 2. We demonstrated a significant improvement of the parents' perception of their children's problems (SDQ) in T2 and T3. The parental functioning and the personal well-being of the mothers have a significant progress at the end of the treatment. Also the self-esteem of the children with and without ASD is improved.

Conclusion: 1. The PFA does what she says that she does (treatment integrity). 2. The new developed family home treatment in families with ASD (PFA) has a positive impact of all the family members. Next step is a multicenter study.

PS6-02

Homelessness and Mental Illness: The Medical Students' Viewpoints

Charity Pires, B.S., Sarah Hilton, M.S., Faneece Embry, B.S., Anthony Ahmed, Ph.D., Edna Stirewalt, B.S., Adriana Foster, M.D.

Abstract:

Background: Georgia Health Sciences University (GHSU) medical students have been funded by the American Psychiatric Foundation to screen and refer homeless people to mental health treatment and to increase community awareness about mental illness and homelessness. Prior volunteer experience with the homeless has been shown to increase the likelihood for medical students and residents to seek further opportunities to work with such population.

Objectives: 1) To evaluate medical students' attitudes towards the homeless and people with mental illness; 2) to assess whether having volunteered in homeless clinics influenced medical students' attitudes towards the homeless.

Methods: After GHSU IRB approval, 1st and 2nd year GHSU students were asked to complete an anonymous survey measuring their attitudes towards the homeless including willingness to help, emotional responsiveness, empathy and stigma, assessed on 4-point Likert-type scale and their attitudes about mental illness on the Mental Illness Clinician Attitude Scale – medical student version (MICA). MICA's 16 items are measured on a 6-point scale. We assigned students to 2 groups, an experienced group and a no-experience group, based on having volunteered with the homeless or having not volunteered. We calculated mean and SD for each homeless attitudes scale component or the MICA scale, and used Fisher's Exact test, Person's Chi-squared test with Yates continuity correction and Welch's two sample t-test to compare the means in the experienced vs. no-experience groups.

Results: 62 students completed the survey in its entirety. The students in the experienced group (n=37 students, M = 13.20, SD=2.97) scored higher on the 6-item empathy towards the homeless subscale, than those with no experience (n=25 students, M= 11.49, SD= 3.25), a statistically significant difference [t= 2.15, df= 54.62, p= .036]. The mean MICA score for our 1st & 2nd year students (M= 68.44, SD= 7.96) was higher when compared to another medical student sample assessed with same scale (3rd years at King's College in London, UK, N=125, M= 40.58, SD= 7.22). The mean difference between these samples (95% CI: 25.56-29.63) in mental illness stigma achieved statistical significance [t= 27.09, df= 60, p<.0001) with our medical student sample demonstrating greater stigmatizing attitudes towards the mentally ill.

Conclusion: Our data suggests that at GHSU, volunteer experience with the homeless is associated with increased empathy in medical students. It is unknown whether the volunteer experience leads to increased empathy or whether students who are already more empathetic towards the homeless are more likely to volunteer. GHSU students score higher than a comparable sample on stigmatizing attitudes towards mentally ill. There is a dire need for effective educational approaches that expose medical students to underserved homeless and mentally ill populations. This work was funded by the American Psychiatric Foundation.

PS6-03

Medical Students' Attitudes Towards the Mentally Ill and Towards the Homeless: A Possible Overlap

Charity Pires, B.S., Sarah Hilton, M.S., Faneece Embry, B.S., Edna Stirewalt, B.S., Adriana Foster, M.D., Anthony Ahmed, Ph.D.

Abstract:

Background: There is growing interest in the attitudes of providers about patients, especially impoverished, psychiatric patients, whose quality of care and recovery can be impacted by these attitudes. Despite the co-occurrence of homelessness and mental illness, existing studies of negative provider attitudes have examined mental illness and homelessness separately, without consideration of the possible overlap of both constructs. Possible overlap – negative provider attitudes about the homeless – may contribute to further disregard about mental illness, increased social distance and substandard care.

Objectives: We examined the association between attitudes towards mental illness and homelessness in a medical student sample. A

Methods: After IRB approval, GHSU 1st and 2nd year medical students volunteered to complete an anonymous questionnaire (N = 73). Mental illness stigma was measured with the Mental Illness Clinician Attitude Scale – medical student version (MICA). Responses on the measure are rated on a 6-point Likert scale and scores range from 16 to 96 with higher scores indicating greater stigmatizing attitudes. Given the heterogeneity of domains assessed by the measure, we summed responses on the MICA into 4 subscales – perceived dangerousness/level of comfort, views about psychiatry, social distance, and attitudes regarding physical health. We measured attitudes towards the homeless using 18 items drawn from an instrument used by Link et al (1995) grouped into 4 subscales – stigma, emotional responsiveness, empathy, and willingness to help, with each item rated on a 4-point Likert scale. We used a canonical correlational analysis to examine the association between mental illness and homelessness stigmatizing attitudes.

Results: Attitudes towards the mentally ill overlapped with attitudes towards the homeless. All of the rationally-derived subscales demonstrated adequate reliability with Cronbach's alpha ranging from .679 to .832. Only the first canonical variate pair was significant (rc = .645, Wilks' ? = .526, ?2 (16) = 33.04, p<.01) and it linked low scores on – perceived negative views about psychiatry, and physical health – to high scores on stigma about the homeless, and low scores on empathy and willingness to help the homeless. Redundancy analyses showed that attitudes towards mental illness explained 17.9% of the variance in attitudes towards homelessness, whereas attitudes towards homelessness explained 18.1% of the variance in attitudes towards mental illness.

Conclusion: Medical student attitudes about the mentally ill predict or overlap with their attitudes towards the homeless, suggesting that a subset of students may demonstrate negative attitudes about the homeless and the mentally ill. Both attitudes may emanate from common causal psychological processes that are yet to be determined. This work was funded by a grant from the American Psychiatric Foundation.

PS6-04

Trials and Tribulations Post Match: International Medical Graduates' Perspective

Shaneel Shah, M.D., Sharath Puttichanda, M.D., Prakash Chandra, M.D., Michael Reinhardt, M.D., Deval Zaveri, M.D., Jamuna Theventhiran, M.D., Stephen M. Goldfinger, M.D.

Abstract:

Objective: International Medical Graduates (IMGs) comprise a significant portion of the total U.S. resident physician body. In this qualitative study of IMGs' experiences entering into the U.S. medical culture, we seek to express the trials, tribulations, and – at times – joys that follow a successful residency match.

Methods: An online anonymous survey was distributed to IMG residents at the State University of New York (SUNY) Downstate Psychiatry Residency Program Residents were given a one month window to respond. These responses were reviewed and qualitatively trended with representative quotations presented.

Results/Conclusions: Some common stressors faced by IMGs as they enter residency include the financial burden, time limitations, visa issues, acculturation, and adaptation to the U.S. health care system. An active and healthy rapport between incoming IMG residents and their programs, including their immediate supervisors, attending physicians, chief residents as well as senior colleagues can help to address these issues. Assistance from ECFMG in the form of guidelines or an online program would be a crucial step to facilitate this transition.

PS6-05

Thriving, Not Just Surviving: Designing a Resident Well-Being Program

Hetty Eisenberg, M.D., Ellen Haller, M.D.

Abstract: Psychiatry residents grow in their skills, knowledge, and competence exponentially during each year of training. Unfortunately, this intense growth can come with a price. Training, although often very rewarding, can also be isolating and inspire low morale. Direct and vicarious trauma in the workplace, heavy workload and long hours, personal life struggles, professional disappointments, powerless positions in large institutions, and scant resources for support – these are just some of the roadblocks to resident well-being. Each year of residency challenges trainees' minds, bodies, and spirits in unique ways. In order to support psychiatry residents at UCSF so that they can more fully thrive, rather than survive, throughout training, the UCSF Department of Psychiatry funded a senior resident to develop and direct the establishment of a UCSF Psychiatry Resident Wellness Program during the 2012-2013 academic year. This poster will present the findings of the initial phase of this funded project: the research component that spearheads laying the groundwork for the UCSF Psychiatry Resident Wellness Program. Presented outcomes will include information on already existing wellness/well-being programs in residency programs around the U.S., and information on programs designed for other healthcare workers, including medical students, nurses, and relief workers. Potential differences regarding the needs of these diverse populations will be discussed along with the impact of those differences on components of successful wellness programs. This presentation will also detail the process of establishing contacts and interviewing wellness "mentors" at institutions around the country, as it narrates the insight gained from these discussions. In addition, it will present the results of a survey of current residents at UCSF about their well-being, a needs assessment used to determine what areas of wellness UCSF residents feel most need to be addressed. Furthermore, the challenge of determining which modalities are most appropriate for a resident wellness program at UCSF will be outlined.

PS6-06

Reasons for Referrals to Psychiatry in Emergency in a Tertiary Care Hospital Setting and Utilization of Resident Resources

Varinderjit Parmar, M.D., Peter Szymczak, M.D., Ewa Talikowska-Szymczak, M.D., Dianne Groll, Ph.D.

Abstract:
Background: Referrals to psychiatry account for a large proportion of primary care (PC), and in-hospital medical and paramedical services. Psychosocial and emotional distress is related to the high use of health services including those services provided by psychiatry residents. Few studies have focused on the primary reasons behind psychiatric referrals in emergency rooms in tertiary care settings and their impact on health services. Certainly, no significant studies have focused on frequent psychiatry referrals and their impact, specifically, utilization of psychiatry resident resources within these settings.

Purpose: The aim of this study is 1) to determine the most predominant cause of referrals to a psychiatry department in an emergency room in a tertiary care setting, and 2) to determine the number of hours spent by psychiatry residents on managing these frequent referrals.

Methods: In this retrospective study, data from 2010 and 2011, at Kingston General and Hotel Dieu Hospitals will be collected and examined to determine the primary causes of referrals by the emergency department to psychiatry; in addition, the approximate number of hours spent by psychiatry residents on management of these patients will be determined.

Conclusion: The results of this study will show the most frequent reasons for referrals to the psychiatry department in emergency tertiary care center. Furthermore, this study will assist in channeling resident resources in a more effective way which ultimately benefits patient population. As well, this study will highlight important topics that need to be incorporated into core residency academic teaching in psychiatry residency.

PS6-07

International Medical Graduates in Psychiatry: Decoding Their Journey Through the Interview Trail

Lama Bazzi, M.D., Carolina Jimenez, M.D., Suprit Parida, M.D., Sherif Ragab, M.D., Stephen M. Goldfinger, M.D.

Abstract:
Objectives/Background: International Medical Graduates (IMGs) account for half the applicants to the national residency matching program (NRMP). About 25% of physicians practicing in the United States are IMGs, contributing significantly to the U.S. health care system. Moreover, IMGs provide care for many ethnic minorities, and work in areas underserved by primary care physicians. The process IMGs go through on the interview trail and the challenges they face in choosing a program have gone largely unaddressed. We aim to describe this journey through the eyes of IMGs, represented by the psychiatry residents of SUNY Downstate Medical Center.

Methods: An anonymous electronic semi-structured survey was administered to IMG residents of SUNY Downstate psychiatry program. They answered questions about their experiences during the residency interview season. The

data was compiled and analyzed qualitatively. Quantitative enumeration was used to identify recurring themes.

Results: The most common themes depicted in the responses were: 1) concern of securing a position compelled candidates to apply to a large number of programs 2) financial constraints were cited as a limiting factor in attending interviews, arranging accommodations and traveling comfortably 3) anxiety during interviews was common at the beginning of the season, but dissipated as the interview season progressed 4) factors influencing the decision to accept an interview invitation included location, finances, number of interview invitations received, visa status and type of program. When it came to rank list orders for the match or considering pre-matches, the type of program (community vs. university) seemed to hold the greatest weight in the decisions made by residents.

Conclusions/Discussion: IMG residency applicants consider many factors, including finances, number of interviews, location of programs, visa type sponsored, type of program and research opportunities in choosing programs. Although our sample size was small and limited to one program in psychiatry, it allows for some insight into the hurdles residents face while interviewing. By providing some insight into the obstacles residents face while interviewing, and a deeper understanding of their choices, we believe some of the systemic issues might be ameliorated. Considering ECFMG assistance in the form of clear and easily accessible guidelines or an online program tailored to IMGs in the application process could be useful.

PS6-08

Cartooning in the USA: Communication Through an Evolving Art Form

Lawrence Richards, M.D.

Abstract: With roots in English pictorial representation, hand bill dissemination, and single large sheet poster like displays as ways of communicating, it was relatively easy for colonists in N. Am. to ‘carry on’ cartooning’s development. Ben Franklin, who among other things was an early American publisher, is credited with America’s first political cartoon, captioned with a very clear communication to other colonists contemplating rebellion: “Unite or Die.” This presentation has roots which include posters in the last two Chicago IPS, and this author’s training days at IL. State Psychiatric Inst. where he learned from one of his greatest teachers, and later a past President of APA the newspaper comics were written for adults, albeit most Americans still have childhood memories of enjoying the Sunday Funnies which were in color. Color and the Comics in newspapers became early 20thC reasons for purchasers to select between papers; this became a source of competitive maneuvering between the Hearst and Pulitzer publishing chains, even incorporating one of the earliest foci of corporate espionage which resulted in the phrase of yellow journalism. The ink for yellow was difficult to reproduce on newsprint paper, and the first newspaper to command that capacity had a distinct sales advantage. See the Smithsonian Institution’s text for further details on “The Yellow Kid” comic strips and “sports star like” corporate wooing of its author. Electronic technology began to change all this. The mid 20thC featured movie was preceded by a B/W Movie-Tone news film and then a colored cartoon. Television changed that, but it has not become a modality for cartooning despite its capacity for cartoon like shows. Dick Morris, the political consultant, has been using the single frame political cartoon on his i’net site; many of these show the pictorial quality of printed cartoons. It remains to be seen if the current texting craze results in the trading of single frame cartoons as U.S. children once traded ten cent comic books. Evolution continues, be it among microorganisms, mammals, movies or cartoons. Dr. Richards has witnessed some of the rise and decline of art and content in U.S. newspaper comics; this contrasting decline was shown between posters at the last two Chicago IPS. It continues. Some major magazines carry on great quality sans color, with The New Yorker and Playboy being considered the top of the line for single frame cartoonists. This poster serves to further document the current status of the aforementioned while displaying the underlying psychiatry via historical comics from Smithsonian’s Collection and the last year’s newspapers, i’net, and The New Yorker, these mostly from Oct., 2011.

References:

1. The Smithsonian Collection of Newspaper Comics. The Smithsonian Institution, Blackbeard, B and Williams, M. Eds; H. N. Abrams, New York, 1984.
2. The Comics Since 1945. Walker, Brian. H. N. Abrams, New York, 2002.

PS6-09

Psychiatric Problems and Physical Symptoms After a Shooting Incident

Joris Yzermans, Ph.D., F. van der Sman-de Beer

Abstract:
Objective: To explore the health consequences of eye witnessing a shooting incident in a shopping mall in Alphen aan den Rijn, the Netherlands (April, 9th, 2011), in which seven residents were killed and more than 10 others were seriously wounded.

Method: Electronic Medical Records of General Practitioners (GP) and Psychiatrists were used as well as databases of Social Workers and Victim Support Netherlands (SHN). All data of 143 eye-witnesses and surviving relatives (60% female, mean age 40 years) were used to explore the course of psychological problems and physical symptoms in the first year post incident. Because every citizen is on the list of just one general practice it was feasible to create a baseline (pre-post) measurement. Non-eye witnessing residents

were used as a reference group (N=122; 53% female, mean age 42 years).

Results: Compared to the preceding year, health care utilization (GP) was increased, especially during the first two months post incident: on average 3.9 GP-encounters in the preceding year and 4.5 in the first year post incident, while the reference group had on average 3.5 encounters in both years. People presented especially with anxiousness (prevalence 48/1,000), distress (81/1,000) and medically unexplained physical symptoms (321/1,000 in the preceding year and 379 in the year post incident; the reference group 279/1,000 in the latter year). 60% of the 143 eye-witnesses had at least one encounter with Victim Support Netherlands shortly after the incident. These persons had on average 5.6 encounters with their GP in which they presented similar problems and symptoms. In ambulant mental care, fourteen adults and 5 children were diagnosed with PTSD, five adults with major depression and six children with behavioral problems. Eighteen adults as well as eighteen children (of which 4 did not show up) were referred by GPs (more than one DSM-IV code was possible to a maximum of three). Social workers had encounters with 30 survivors for which the code '(dealing with) major shocking event' was most frequently registered.

Conclusions: Monitoring (physical and mental) health of people exposed to a horrible event using existing registries turned out to be a strong tool. In this case policy-makers could conclude that regular care was able to handle all incident-related demands, caregivers could receive refresh courses how to care for patients who presented (regularly) with unexplained symptoms and eye witnesses were stimulated to have contact with fellow survivors in order to regain control over their lives. Although GPs saw more psychological problems and unexplained symptoms, relatively few persons developed (full-blown) PTSD. The study was funded by the regional Municipal Health Service and the city council.

PS6-10

Lessons Learnt From a Study that Failed to Assess Patients and Caregivers Requests for Dementia Services

Matthias Schützwohl, Ph.D.

Abstract:

Introduction: It is well-known that the use of dementia services is low both for patients with dementia and their caregivers.

Aim: To assess health-services utilization, requests for services and barriers into treatment by surveying at least 135 caregivers of patients with mild to severe dementia and 45 patients with mild dementia.

Methods: Recruitment was limited to caregivers and patients living in three different regions in the Free State of Saxony, Germany, with a total population of about 750,000. A number of recruitment strategies were implemented and applied over a period of 12 months, including information flyers distributed to 74 doctor's offices as well as to an unknown number of drugstores and public libraries; flyers distributed in the context of conferences, e.g. related to the World Alzheimer's Day; 4,274 posters put up in drugstores, public libraries, housing associations, garden plot associations, and meeting places for the elderly; advertisements placed in two daily newspapers with a paid circulation of about 36,000; internet ads placed on several relevant websites.

Results: As a result of this tremendous effort, the research group was contacted by n=52 caregiver-patient pairs, n=35 of which met the inclusion criteria and could be included into the study.

Conclusion: This result confirms that it is difficult to access patients with dementia and their caregivers. In addition, patients with dementia as well as their caregivers seem to see no benefit from participating in such research or might be prevented from participating for organizational reasons. We also think that fear for stigmatization and self-stigmatization act as barrier both into research as well as into treatment.

Implications: Implications such as the implementation of activities addressing the stigma associated with dementia will be discussed.

PS6-11

The Effect of Universal Health Coverage in Massachusetts on Psychiatric Patient Reports of Affiliation With Primary Care

Beth Murphy, M.D., Bruce M. Cohen, M.D., Ph.D.

Abstract:

One main goal of Universal Health Coverage (UHC) proposals in the United States is to encourage better access to care, with the potential to produce both a healthier population and reduced costs. In particular, it was hoped that this new venture would shift vulnerable populations away from receiving care in the costly emergency medical system and towards primary and preventive care. A specific population with traditionally high rates of emergency room use and lack of access to primary care is individuals with severe psychiatric illness. People with chronic psychiatric illnesses receive poorer medical care and have higher morbidity and shorter life-expectancy. Medical care for this population is more expensive due to both an elevated risk for several chronic comorbid illnesses, including diabetes and cardiovascular disorders, and worse outcomes for these comorbid diseases. Preventive and early care for this group, particularly in the treatment of cardiac disease and diabetes, might have a significant impact on the health of patients with chronic psychiatric illness. Massachusetts implemented a UHC program in 2006. Success for this

program's goals can be examined by looking at rates of insurance coverage, access to a primary care physician, and lower incidence of preventable disease. This study looked specifically at success of the program among individuals with psychiatric illness severe enough to warrant inpatient hospitalization at a tertiary care academic treatment center. We examined clinical and demographic factors and noted whether a primary care physician was identified for each patient. Pilot data from the first 300 patients in this study indicate that patients requiring psychiatric hospitalization in 2008 (post-implementation of UHC) did not report higher rates of primary care physician affiliation than in a similar group of patients admitted prior to UHC in 2005. In 2008, 33% of patients reported a primary care physician on admission compared with 40% in 2005. Patients in different diagnostic categories were variably impacted. Some diagnoses, such as bipolar spectrum disorders had stable but low levels of having a primary care physician (36%). Other diagnoses, such as depressive disorders were associated with a significant decline in having an identified primary care provider from 2005 (60%) to 2008 (25%). Further analysis with a larger sample will be important to guide targeted interventions in order to improve primary care affiliation as a first step in establishing preventive care use in this vulnerable population.

PS6-12

The Impact of Atypical Antipsychotic Medications on the Use of Health Care by California Medicaid Patients With Schizophrenia or Bipolar Disorder

Jiang Yawen, B.S., Jeffrey McCombs, Ph.D.

Abstract:

Objective: Compare the use and costs of medical care for patients with schizophrenia or bipolar disorder using atypical and typical antipsychotics.

Method: Antipsychotic drug therapy episodes were identified using Medi-Cal claims data from 1994 to 2003. First, a total of 296,440 atypical antipsychotic (AAP) therapy episodes initiated following formulary expansion in October 1997. These AAP episodes were then matched with episodes of typical antipsychotic (TAP) drug therapy using propensity scores. Nearly half [47%] of matched TAP episodes were drawn from the formulary expansion period when AAP use was restricted. The impact of AAP use on duration of therapy, adherence, health care cost, and the risk of hospitalization, nursing home admission risks and attempted suicide was estimated over a one-year post-treatment period were analyzed using multivariate statistical methods including OLS, GLM, two-part model, logistic regression and Cox regression. Analyses were conducted by episode type [augmentation, switching, delayed switching and restarting].

Results: AAP use significantly increased duration of drug therapy [+54 days for restart episodes and >170 days for switching and augmentation episodes] which decreased the risk of drug therapy termination between 40% [restart episodes] and 72% [augmentation episodes]. Not surprisingly, AAP use was associated with significantly higher drug costs [$389 to $1,385] across all episode types. Logistic regressions and Cox regressions consistently showed that using AAPs significantly reduced the risk of acute hospital admissions but had mixed effects on the risk of admission to either psychiatric hospital or nursing homes. AAP use had no significant impact on the risk of attempted suicide for augmentation or switching episodes but was associated with an increased risk in restart episodes. Two-part models for institutional services found that using AAPs decreased acute hospitalization cost per patient, but had mixed effects on psychiatric hospitalization cost and nursing home cost. When summed together, higher drug costs were only partially offset by reductions in medical costs for switching, restarting and augmentation episodes, resulting in increased total one year post-treatment costs in switching and restart episode types [$559 to $1,483]. GLM results confirmed these OLS results: AAP use increased total one year post-treatment costs [$284 to $1,873] and drug costs [$586 to $1,730] in all four episode types.

Conclusion: Using AAPs significantly improved drug therapy adherence but also increased drug cost per episode. There is very little evidence that the increased adherence and higher drug costs associated with AAP use are offset by decreased costs of other medical services.

PS6-13

The Impact of Implementation of a Psychiatric Emergency Department on Restraint Utilization

Maryam Rakhmatullina, M.D., Abraham Taub, D.O., Merima Jurici, M.D., Corey Weiner, M.D., Kenneth Sable, M.D., Christian Fromm, M.D., Theresa Jacob, Ph.D., M.P.H., Antonios Likourezos, M.A., M.P.H., Lucas McArthur, E.D., ECRIP Fellow

Abstract:

Introduction: Use of restraints is detrimental for patients' physical and mental health. Though it helps in managing agitated patients, adverse outcomes have been reported. There is evidence of increased morbidity and even mortality associated with it. Staff involved in restraint placement may sustain psychological and physical injury as well. Psychiatric emergency departments (ED) have been established to improve quality of patient care including safety. However, there are no studies examining the impact of Psychiatric EDs, with their specialized approach to management of agitation, on the culture of restraint utilization.

Objective: To determine if implementation of a Psychiatric ED has an impact on the culture of restraint utilization in the general ED.

Methods: In this IRB-approved retrospective study, we reviewed charts of patients who required the use of physical restraints for agitation and/or aggressive behavior in our general ED during a 3-year period: 1 year before and 2 years after the opening of a Psychiatric ED. The outcomes focused on include: number of patients in restraints, number of patients placed in restraints without prior medication administration, number of extremities in restraints, duration of restraint episodes, medications, and adverse outcomes. In addition, patient demographics, time of patients' arrival, time of the day restraints were initiated, length of ED stay, years of work experience and gender of physicians ordering restraints are recorded.

Results: Electronic charts of the 250,000 patients that visited the Maimonides Medical Center ED during this 3-year period approximately 70,000 adult patients/year), were searched using the keyword "restraint." Of these, about 1% of cases were restraints that pertained to the management of agitated patients. Data is now being reviewed for those restraint episodes as outlined above.

Conclusions: Analyses of the data would demonstrate whether the availability of having a Psychiatric ED improved the quality and safety of patient care as evidenced by a reduction and overall safer approach to restraint utilization. The outcomes of this study will guide further steps in implementing hospital wide restraint reduction initiatives that include: cultural changes that relate to restraint usage, enhancement of staff-training in conflict de-escalation techniques and the development of a Restraint Code Team ultimately resulting in decreased restraint related morbidity and mortality.

PS6-14

Patient Non-Attendance in an Outpatient Psychiatry Clinic: Reasons and Solutions

Adeel Meraj, M.D., Mushfiqur Rahman, M.D., Albert Poje, Mahmood Khan

Abstract:

Objective: To calculate the rate of non-attendance, contributing factors, and strategies to improve attendance in an outpatient psychiatry clinic.

Method: A chart review was conducted of patients who did not keep their outpatient clinic appointments in a community mental health clinic serving a population of approximately 160,000 individuals with a high level of unemployment, social deprivation and ethnic minority status in Bradford, England. Patients who did not keep their appointments between November 2006 and January 2007 were then contacted by either phone or mail to find out their reasons of non-attendance, willingness to attend future appointments and suggestions to improve future attendance.

Result: Of the 312 patients scheduled for an appointment, 87 did not show up (27.8%). 70% of the no shows were between 31 and 65 years of age with no significant gender difference. 70% of these clients were unemployed, 50% were either single, divorced or widowed and 60% were South Asian. 34% carried a diagnosis of depression followed by 31% with schizophrenia, 67% had between 1 to 3 no shows in the previous year. Of those who did keep their appointments, 70 were follow-up patients. An attempt was made to contact all the 70 patients by phone or by mail, to ask set of structured questions. Out of the 70 patients we attempted to contact, 38 (54%) responded, 97% of these patients were willing to attend future appointments. 40% of these patients had forgotten and 27% said they were too ill to attend. When asked what could improve their attendance, patients identified a reminder, help with transportation and flexible timing as potential solutions to clinic non-attendance.

Conclusion: Outpatient clinic non-attendance is a challenge for all clinicians. It causes lost efficiency by increasing waiting time, wasting healthcare resources, and can be a predictor of disease severity in psychiatric patients. Our study highlights reasons and possible solutions to improve non-attendance in a psychiatry clinic. A potential strategy to reduce non-attendance is to regularly conduct a survey to look at the reasons for non-attendance and implement solutions using an individualized and evidence-based approach.

PS6-15

Building a Team Involved in Prevention and Treatment of Primary Polydipsia in a Psychiatric Outpatient/Inpatient Population: A Pilot Study

Varinderjit Parmar, M.D., Varinderjit Parmar, M.D., Peter Szymczak, M.D., Ewa Talikowska-Szymczak, M.D., Dianne Groll, Ph.D., Felicia Iftene, M.D., Ph.D.

Abstract:

Background: the disturbances of water homeostasis among psychiatric patients have been widely recognized, particularly the condition whereby patients consume excessive quantities of liquid, which is termed "polydipsia." Long-term effects of excessive fluid consumption may include bladder dilatation, potentially leading to hydronephrosis and renal failure, hypocalcaemia, congestive heart failure, gastrointestinal dilatation and hypotonicity, hypothermia, and osteopenia with an increased incidence of fractures. Seen in both episodic and chronic polydipsia, water intoxication can be a reoccurring condition, which carries with it a substantial risk of morbidity and mortality. In a previous study we found that there is a lack of information on this topic, not only regarding the patients, but also the caregivers' professionals involved in their care.

Purpose: This study we try to increase the awareness of the professionals on this topic and actively involve them in the prevention/therapeutic process.

Methods: Approximately 100 mental Health Professionals and Volunteers will be approached to participate in 5 types of small groups workshops (5-10 participants/group) on the topic of Primary Polydipsia in psychiatric population (Community Outreach Teams-COT; Provincial Psychiatric Hospital-Providence Care, Kingston Ontario. The groups will include: case managers, nurse, social workers, psychologists recreational, case managers, occupational therapists, spiritual care; family doctors and nurse practitioners; medical residency program; home operators. Initial and final evaluation of their knowledge, will be done by using a questionnaire with 10 questions (7 multiple choice and 3 open questions) related to this topic. The open questions will offer us the opportunity to have ideas related to how to build a possible network, where each professional has his place and is able to perform his specific role. A brochure with the materials collected (guidelines) will be published in the future. The change in knowledge was measured pre-post intervention using t-tests. Results in increase in awareness on this topic was demonstrated, as well as active involvement in building a network, finding the best intervention strategies and realizing a guideline of intervention at each level.

Conclusion: Results from this study help us to understand whether more needs to be done in the direction of actively involving the medical staff and volunteers in well-coordinated assistance of psychiatric patients diagnosed with Primary Polydipsia.

PS6-16

Presentations to Psychiatry in Emergency in a Tertiary Care Hospital Setting and the Seasonal Patterns Associated With the Diagnoses: A Retrospective

Varinderjit Parmar, M.D.

Abstract:

Background: Referrals to psychiatry account for a large proportion of primary care (PC), and in-hospital medical and paramedical services. Visitations to the ER are often observed to follow certain seasonal patterns. Few studies have focused on seasonal presentations of psychiatric illness in the emergency room setting. Certainly, no significant studies have focused on gathering data on seasonal presentations of psychiatric illness in an emergency department of a tertiary care center.

Purpose: The aim of this study is 1) to determine the seasonal pattern of referrals to psychiatry in the emergency department of a tertiary care center. 2) to use this information to better equip emergency room resources based on seasonal psychiatric presentation.

Methods: In this retrospective study, data from 2007 till 2011, at Kingston General and Hotel Dieu Hospitals will be collected and examined to determine the seasonal variation of psychiatric diagnoses in the emergency department these tertiary care hospitals.

Conclusion: The results of this study will show the seasonal patterns of referrals to the psychiatry in an emergency department of a tertiary care center. Furthermore, it will help departments of psychiatry to better equip emergency room resources based on seasonal psychiatric presentation. As well, this study will highlight important topics that need to be incorporated into core residency academic teaching in psychiatry residency.

PS6-17

A Survey of Physician Attitudes Towards Psychogenic Non-Epileptic Seizures and Driving

Umer Farooq, M.B.B.S., Venkata Kolli, M.B.B.S., Jayakrishna Madabushi, M.B.B.S., Vidhya Selvaraj, M.D.

Abstract:

Background: Psychogenic non-epileptic seizure (PNE) or pseudo seizure refers to recurrent paroxysmal episodes that mimic epileptic seizures resulting from a variety of psychogenic processes. In the DSM-IV PNE is classified with conversion disorders, with unconscious motives contributing significantly to the disorder. The prevalence of psychogenic seizures is not entirely clear; however it is felt to be a relatively common condition with prevalence estimated between 10-40% of those referred to epilepsy centers for evaluation. 4-10% of patients diagnosed with epilepsy suffer from comorbid pseudo seizures. In a study of 1,590 patients underwent video EEG (V-EEG) monitoring study at the University of Alabama, 514 (32.4%) were diagnosed with PNEs and 29 (5.3%) were found to have both PNEs and Epilepsy. Though PNE is relatively common, there is a dearth of literature on assessing PNE and driving. Psychiatrists, neurologists and family physicians face the challenge of providing opinion on driving with this population. In a survey of 37 American physicians around half supported restrictions to drive and a third felt no restrictions were needed. If the patient with PNE has a seizure whilst driving, there is a possibility of physicians being liable for any accidents caused. In a survey of 41 German epileptologists, 2/3rd of the participants felt decision of driving advice should be assessed on an individual basis. However, there are currently no guidelines that we are aware of, PNE and driving.

Objective: The aim of the current study is to ascertain and compare the opinion among neurologists, psychiatrists and family physicians opinion on assessing PNEs and driving.

Methodology: We obtained IRB approval from Creighton University, and we will use Electronic questionnaires which will be sent to both residents and staff physicians working in psychiatry, neurology and family medicine (in Omaha Nebraska). We hope to obtain a decent survey response and would analyze the data to find both the overall opinion and compare differences between specialties using chi square and T test. This survey would be helpful to ascertain the current opinion and uncover any group differences in assessing and providing driving advice to patients with PNE.

References:

1. Benbadis SR, Blustein JN, Sunstad L. Should patients with psychogenic nonepileptic seizures be allowed to drive? Epilepsia. 2000 Jul;41 (7):895-7; 2) Specht U, Thorbecke R. Should patients with psychogenic nonepileptic seizures be allowed to drive? Recommendations of German experts. Epilepsy Behav 2009; 3) Comprehensive text book of psychiatry Volume 3. Chapter on psychogenic non epileptic seizures. Page 2297 and 2298.

PS6-18

Polypharmacy in Posttraumatic Stress Disorder (PTSD)

Chandresh Shah, M.D.

Abstract: War leads to death, destruction and defeat (at least to one side).But the war does not end there…it continues to sow seeds for (future) development of Posttraumatic Stress Disorder (PTSD). America has fought and is still fighting wars at home and abroad. Now she is facing the Herculean task of caring for those with PTSD. U.S. Food and Drug Administration has approved only 2 drugs in treatment of PTSD. U.S. Departments of Veterans affairs and Defense have recommended other medications. This study looks into use of medications in treatment of PTSD. Veterans diagnosed with PTSD and enrolled in PTSD Clinic for at least 12 months were studied. Those with no other significant comorbid psychiatric illness for previous 6 months and being stabilized on psychiatric medications for at least 3 months were evaluated by reviewing their medical records. There were 97 male patients (age=59.50+13.34 years). 79.20% of patients received antidepressant medications. Only 1/2 of patients received antianxiety and only 1/3 of patients received mood-stabilizer medications. Only 13.86% of patients needed antipsychotic while 21.78% needed sedative-hypnotic medications. The "nightmare/dream" medication was prescribed to 16.83% of patients. The use of antidepressant medication was significantly higher ($P<0.05$). It was interesting to find that more than 75% of patients received more than one medication. There were almost 1/4 of patients receiving 2 medications and almost 1/5 of patients receiving 3 or 4 medications. The precise neurobiology of PTSD is not well-understood, nor is the exact mechanism of actions of various psychiatric medications. There is understanding and consensus on how these medications are useful for various psychiatric symptoms. PTSD is a complex condition. These data show that various psychiatric medications are used individually, but more often in combination to treat PTSD ($P<0.05$). Even though antidepressant medications are used more frequently, polypharmacy of antianxiety, antipsychotic, mood-stabilizers and sedative-hypnotic medications is very common.

PS6-19

The Benefits of a Cambodian Health Promotion Program

Sarah Berkson, B.A., Shin Daimyo, M.P.H.

Abstract:

Background: Cambodians suffer from depression, post-traumatic stress disorder, and chronic medical disease at rates far in excess of national averages. The Harvard Program in Refugee Trauma's Cambodian Health Promotion Program seeks to address this burden of disease by offering Cambodians culturally tailored health education in a small group setting.

Methods: From 2007 to 2011, a health professional and a bicultural health educator co-supervised a 5-session health promotion group for Cambodian survivors of torture. The health promotion groups covered five major topics from Western and Cambodian worldviews. The topics included: 1) the meaning of health and mental health; 2) nutrition; 3) exercise; 4) stress; management and sleep hygiene, and 5) health practitioner-patient communication. The bicultural worker administered semi-structured Pre and Post Health Promotion Questionnaires. The data presented here are the results from 126 health promotion group participants.

Findings: Changes between the Pre and Post health promotion groups demonstrated significant improvements in health status, lifestyle activities, sleep, and depression. Participants revealed greater confidence in communicating to their primary health care practitioner.

Interpretation: Culturally tailored Cambodian health promotion education administered in a small group setting may improve health and mental health behaviors.

Conclusion: Culturally tailored health promotion education in a small group setting can promote healing in survivors of torture. It is an intervention worthy of further research and development.

PS6-20

Ambient Temperature and Humidity Influence Criminal Behavior

Christopher Janusz, M.D., Kiranmai Yarlagadda, M.D., Nwayieze Ndukwe, M.D., Aditya Radhakrishnan, B.S., Donald Ciccone, Ph.D., Tolga Taneli, M.D.

Abstract:

Objective and Introduction: We sought to determine whether there was an increase in the frequency of violent crime as a function of increasing ambient temperature or humidity. Previous studies suggest rates of violent crime may increase with rising temperature. In the present study we relied on publicly available crime statistics and weather data to examine the association between specific types of crime (robbery, aggravated assault, murder and rape) and ambient temperature and humidity in Des Moines, Iowa. The historic weather data by ZIP codes was obtained from http://www.wunderground.com.

Method: Publicly available crime data from July 2005–October 2011 (2313 days) were obtained from the City of Des Moines Police Department for urban ZIP codes 50309, 50310, and 50311. SPSS (version 20, IBM) was used for statistical analysis. The maximum and mean ambient temperature and humidity ranges were divided into equal quartiles. We examined the frequency of robbery, aggravated assault, murder and rape by quartile. Pearson's Chi Square Test (Type I error set at p<.05) was used to compare the frequency of crimes across humidity and temperature quartiles.

Results: The total number of crimes during the study period were: 1015 aggravated assaults, 627 robberies, 251 rapes and 11 murders. The actual number of days with one or more crimes during this period were 823 in the case of aggravated assault (35.6% of study days), 534 days in which a robbery was committed (23.1%), 238 days for rape (10.3%), and 11 for murder (0.5%). In the case of aggravated assault the percentage of crime days per maximum temperature quartile, from lowest to highest respectively, were 26.4%, 30.0%; 37.0%, and 39.1% (?^{2} = 17.280, p<.01). A similar linear increase was observed for mean temperature quartile (?^{2} = 17.032, p<.01). For robbery and rape, there was a significant, but non-linear, difference in the occurrence for maximum temperature. There was no association between mean humidity and any crime type. Maximum humidity showed a non-linear association with aggravated assault, only (?^{2} = 9.388, p = .025).

Conclusion: The present study provides additional evidence of a linear association between criminal behavior, specifically aggravated assault, and increasing ambient temperature. No such association was observed for other crime types. These findings may have implications for law enforcement and emergency medical and psychiatric service preparedness.

Key Words: Temperature, Humidity, Aggravated Assault, Rape, Murder, Robbery, occurrence, violent crime.

PS6-21

Telepsychiatry: An Emerging Modality in Behavioral Health

Asim Rizvi, M.D.; Yakir K. Vaks, M.D., Sarah Sheikh, M.D.

Summary:

Background: Telepsychiatry has proven to be reliable, effective, and efficient in treating hard to reach patients with mental illness. Previous studies examining the effect of therapeutic alliance, provider satisfaction, and the overall effectiveness of telepsychiatry show a strongly positive result. Improved access to pediatric and geriatric patient populations is one such favorable outcome of using videoconferencing to engage psychiatric patients. Overall, telepsychiatry has had an empowering effect on patients, providers, educational programs, and communities. Although telepsychiatry is not a novel concept (the earliest documentation on the subject is from the University of Nebraska in the 1950s using a two way closed circuit television system) and previous literature reviews on the subject have been published, significant advances in consumer technology in recent years coupled with the reduction of cost of such videoconferencing equipment has the potential to make telepsychiatry even more empowering and accessible. The advent of tablet computers and smartphones with high definition movie capabilities only helps to spawn an era where a larger number of psychiatrists can treat mental health patients in distant areas.

Methods: A review of the current literature, utilizing the search terms: telepsychiatry, effective treatment modalities, remote assessment, child psychiatry, geriatric psychiatry, community psychiatry, technology in psychiatry. 17 articles were identified, reviewed and the results were synthesized by the study team.

Results: The most current published literature on the subject of telepsychiatry indicates that the modality is clinically efficacious and an increasingly more efficient tool that can be utilized to great effect by psychiatrists. A 2004 survey of telemedicine programs in which 88 programs responded showed that 49% of such programs were predominantly focused on mental health. In addition to its increasing prevalence, one randomized investigation of 23 youths evaluated through both telepsychiatry and face-to-face, 96% of the diagnoses and treatment recommendations were comparable across the two modalities, with comparable family satisfaction.

Conclusion: The most current published literature on the subject of telepsychiatry shows that it is a clinically efficacious and increasingly more efficient tool that can be utilized to great effect by psychiatrists, both in hard to

reach populations and in areas with better availability of psychiatric care.

PS6-22

Factors Associated With Re-Admission to a Psychiatric Unit

Cheryl Ann Kennedy, M.D.; Saima Latif, M.D., Nicole Guanci, M.D., Donald Ciccone, Ph.D.

Summary:
Objective: Hospital administrators and doctors are under increasing pressure to reduce the cost of inpatient psychiatric treatment while, at the same time, maintaining quality of care. One factor contributing to the cost of psychiatric treatment is a rapid relapse in symptoms requiring re-admission to hospital. To examine this issue, we compared patients who required psychiatric readmission within 5 months to a similar group of patients who did not. Our aim was to identify factors that might allow us to reduce the risk of frequent readmission.

Method: Data were obtained by reviewing charts for a consecutive series of inpatient admissions from July through October 2009 (N=357). The unit has 34 beds with 12 beds for involuntary admissions (civil commitment). The following variables were examined: demographic factors; administrative issues related to admission and discharge; and psychiatric factors (diagnosis at discharge, co-morbid substance use disorder, medications at discharge).

Results: The overall mean length of stay (LOS) was 11.3 days during the study period compared to an expected LOS of 9.5 days (University Hospitals Consortium) and the 150 day re-admission rate was 13.4% (n=48/357). There was no significant difference in first admission LOS between those that were readmitted versus those that were not. None of the demographic factors (age, gender, race, ethnicity) predicted re-admission. Voluntary versus involuntary (civil commitment) admission was significantly associated with increased risk of readmission ($p<.01$) as was the presence or absence of psychotic disorder diagnosis ($p<.05$). Patients discharged home were also less likely to be readmitted than those discharged to a boarding home ($p<.01$). Finally, those with a discharge diagnosis of substance use disorder were less likely to require readmission ($p=0.02$).

Discussion: Patients with the most serious disorders (psychotic) were at the greatest risk for multiple admissions over the 5-month time frame of our study. Serious illness coupled with community placement appeared to pose the greatest risk of psychiatric readmission. Patients who were discharged home and thus had the benefit of increased social support were less likely to be readmitted than those who required boarding home placement. Psychiatric patients discharged to boarding homes may require an increased level of care if they are to avoid the risk of frequent readmission. Surprisingly, patients with a co-morbid substance use disorder were less likely to be readmitted within a 5-month time span. Whether these patients are able to avoid readmission in the short run (through self-medication) while having a higher rate of readmission in the long run is unknown and will require further research.

PS6-23

Pro Depression Scale Development: A New Depression Scale, The Rosenberg Mood Scale

Leon Rosenberg, M.D.; Howard Hassman, D.O.

Summary: A new Depression Rating Scale, the Rosenberg Mood Scale (RMS) is presented. According to the 2009 FDA Guidance for Industry regarding Patient Rated Observations (PROs) "sponsors should provide documented evidence of patient input during instrument development.(1.)" Previous work on a PRO depression scale includes two poster sessions comparing the McManus Rosenberg Rating Scale for Depression, the MRRS-D, and the MRRS-D-SR-FC (self-rated with Forced Confirmation) with other scales in 2005 (2.) and 2008 (3.), and 10 interviews that were conducted in 2011 with experts such as David Sheehan and Stuart Montgomery to assess opinions about the MRRS-D-FC. As a result, that previous self-rated scale, the MRRS-D-SR-FC has been replaced with this new PRO Depression Rating Scale, the RMS. ("It is expected that the instrument will change as data is collected.(1.)") 14 characteristics of PRO instruments reviewed by the FDA include concepts being measured, response options and recall period. This work includes early data on Response Options on the RMS. The primary author established a conceptual framework that severity is equal to frequency since DSM-IV criteria for a Major Depressive Episode is based upon frequency ("depressed mood most of the day, nearly every day.(4.)"). Frequency of symptoms remains the sole measure of this PRO's severity; item response-options needed to be developed to capture frequency of symptoms. We have chosen to use a 7 point Likert Scale with interval constancy and tested it a diverse patient and a diverse clinician group in response to the FDA Guidance for Industry regarding PROs in this preliminary study of item response options in the RMS and other existing scales. Complete statistical analysis is in progress. 1. Guidance for Industry Patient-Reported Outcome Measures: Use in Medical Product Development to Support Labeling Claims. Office of Communications, Division of Drug Information, Center for Drug Evaluation and Research, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 51, Room 2201, Silver Spring, M.D. 20993-0002. 2. A New Depression Rating Scale, NCDEU 2005 3. A New Self Rated Depression Rating Scale, NCDEU 2008 4. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, Washington, DC, American Psychiatric Association, 2000.

PS6-24

Impact of a Coordinated, Community-Based, Behavioral Health, Crisis System of Care on the Acute Psychiatric Admission Rate From a Specialized Behavior

Kathleen Crapanzano, M.D.; Jerry Heintz, M.D.; Jan Kasofsky, Ph.D.; Glenn Jones, Ph.D.

Summary:

Objective: To evaluate the effectiveness of a coordinated, community-based response to behavioral health crises as measured by comparing psychiatric hospitalization rates of people presenting to a specialized behavioral health, community-based hospital emergency room versus a social work supported general emergency room.

Method: In response to a documented increase of psychiatric crises experienced by a public emergency room in the post-Hurricane Katrina receiving community of Baton Rouge, Louisiana, and coincident with a statewide shortage of acute psychiatric inpatient beds, a coordinated crisis system of care was created. Psychiatric admissions from a large public emergency room, supported by psychiatric social workers in the two years prior to this program being instituted, were compared to admission rates in the year after a coordinated approach was established and included a dedicated psychiatric emergency room.

Results: The rate of individuals placed in inpatient care was significantly lower with the coordinated approach of physicians and social workers within the specialized emergency room, the local public mental health clinics and law enforcement ($p<0.05$).

Conclusions: Previous research documents the effectiveness of psychiatric emergency services as being beneficial to de-escalate/resolve crises, prevent long term hospitalization, and relieve pressure on inpatient units. This study confirms this finding and further documents how a coordinated community crisis response system is fundamental to the successful discharge of people from the emergency room to non-hospital, community-based alternatives. It is anticipated that the reported findings will continue to improve as the coordinated, community-based, crisis system matures.

PS6-25

Predictive Value of 4 Different Definitions of Subthreshold Post Traumatic Stress Disorder: Relationship to Severity of Symptoms and Functioning

John Kasckow, M.D.; Derik Yaeger, Ph.D.; Kathryn M. Magruder, M.P.H., Ph.D.

Summary:

Background: Post traumatic Stress Disorder (PTSD) is highly prevalent and is associated with marked psychiatric comorbidity and impairment across a number of psychosocial domains. Although subthreshold PTSD is not a formal diagnosis, it has been used in research to characterize individuals who report clinically significant trauma related symptoms but do not meet full diagnostic criteria for PTSD. There is no agreed upon "gold standard" to determine whether a particular definition of subthreshold PTSD accurately identifies patients. We have examined 4 distinct definitions of this subthreshold syndrome (based on Blanchard, Schnurr, Marshall, and Stein) with the aim of comparing the 4 in their ability to predict PTSD symptom levels and levels of functioning.

Methods: The dataset came from a regional sample of 815 primary care veterans at 4 VAMC's who had been assessed with the Clinician Administered PTSD Scale (CAPS) and were also administered the PTSD Checklist (PCL) and SF 36. We used multiple linear regression with multi level categorical variables to determine which of the 4 definitions of subthreshold PTSD (i.e., based on Blanchard, Marshall, Stein and Schnurr) predicted PTSD symptom scores and mental health functioning. The reference population comprised patients not meeting CAPs criteria for PTSD.

Results: The prevalence of subthreshold PTSD ranged from 4.0% to 9.7% with the Marshall definition yielding the greatest number of cases. Furthermore, only the Marshall definition positively predicted PTSD symptom scores and negatively predicted mental functioning scores while taking into account the 3 other definitions.

Conclusions: Based on our approach involving criterion validity, only the Marshall definition appears to predict PTSD symptom severity and mental functioning. Longitudinal study is also needed to better determine if these results are stable over time. The contents do not represent the views of the Dept. of Veterans Affairs of the U.S. government.

PS6-26

Trauma and Mental Illness Among African American Male in Juvenile Detention

Kenneth Rogers, M.D.; Eunice Peterson, M.D.; Julius Earle, M.D.

Summary:

Objective: African American males are confined in juvenile justice facilities more frequently than other demographic groups. Confinement in a detention facility raises significant issues for psychiatrists since 60% of youth detained in juvenile justice settings have a psychiatric illness. Many of these youth have unidentified and untreated trauma histories. The objective of this study is to identify the types and level of trauma experienced by African American males in a juvenile detention setting.

Methods: African American males ages 12 18 detained in a juvenile detention facility were interviewed using the Youth Self Report (YSR) Scale and the Diagnostic Interview Schedule for Children (version IV). Additionally, all youth received a comprehensive psychiatric interview using Kiddie Schedule for Affective Disorders and Schizophrenia (K SADS). The parents of the youth were administered the Child Behavior Checklist (CBCL). The total, internalizing, and externalizing T scores were analyzed for both the CBCL and the YSR. A clinical history was obtained from the parents.

Results: Seventy percent of youth met criteria for a psychiatric disorder. When using stringently defined behavioral symptoms (T score=70; 2 SD above the mean on the CBCL) along with the presence of a psychiatric diagnosis, 40% of youth met the criteria for mental health service need. The most common disorders were anxiety disorders (55%), Affective Disorders (53%), and Disruptive Behavior Disorders (43%). This was the first detention for 62% of African American youth. Most youth (68%) were from urban areas while the remaining youth were from rural communities. There were no significant differences between the legal charges of African American and Caucasian youth on variables including types of legal charges or urban vs rural homes. On initial interview 47% of African American males reported experiencing a traumatic event. The events that were specifically asked about included physical/sexual abuse, being threatened or attacked by another individual, witnessing a crime or being a victim of a crime, or being in an accident. The parents of the youth identified traumatic events in 42% of youth. When data from both the parents and the youth were combined, 110 youth (60%) had been exposed to some type of traumatic event. These findings were consistent with the findings for the DISC IV which found that 101 youth (55%) met criteria for an anxiety disorder with 87 youth (48%) meeting criteria for PTSD. There were also a number of youth who had a history of significant trauma, but did not meet criteria for PTSD or other anxiety disorders such as Acute Stress Disorder.

Conclusions: These findings are likely underestimates of the level of trauma experienced by this population. Although they experienced multiple traumas, many youth did not meet criteria for PTSD. More work is needed to identify coping skills in this population.

PS6-27

Helping Hands Grant Award

Leah Katta and Gabriella Polyak from University of Miami Miller School of Medicine and their "Let's Talk About It" program.

PS6-28

Helping Hands Grant Award

Leigh Morrison from University of Cincinnati College of Medicine and her "Off the Streets" program.

PS6-29

Helping Hands Grant Award

Danielle Alkov from University of California, San Francisco and her PTSD in formerly incarcerated individuals program.

PS6-30

Helping Hands Grant Award

Tiffany Covas from Wake Forest University and her program to expand mental health services at the student-run free clinic.

PS6-31

Varenicline in Outpatient Psychiatric Heavy Smokers

Faruk Abuzzahab, M.D.; F. S. Abuzzahab, Sr., M.D., Ph.D.; K. B. Abuzzahab, RN, JD, LLM; P. Dorsen, M.D.

Summary:

Introduction: Smoking cessation is a challenge for psychiatric patients. The possible emergence of suicidal ideation, hallucinations, nightmares, insomnia and increase in anxiety has limited the application of denicotinezation.

Methods: Ten outpatients with DSM IVR diagnosis of schizoaffective bipolar, and unipolar depressive disorders with nicotine dependence were given varenicline for smoking cessation. Starting dose followed the recommended guideline of 0.5 mg per day for 3 days then 0.5 mg twice per days for 4 days. On day 8, 1 mg. twice a day, was prescribed for a month. The dose was increased up to 4 mg. per day after the first month which is above the approved recommendation.*

Results: The average amount of cigarettes per day was 32. This dropped to 8 cigarettes per day at the end of the study. These patients were closely monitored for any worsening of their psychiatric symptoms which did not occur. These patients tolerated Varenicline well even at 4 mg.

Conclusions: In this very small sample open label study, Varenicline was effective in reducing cigarette smoking when it was used above the recommended dose in outpatient psychiatric heavy smokers. *The use of Varenicline above 2 mg. per day is considered off label not approved by the FDA. Supported in part by Psychopharmacology Fund and Minnesota Medical Foundation.

PS6-32

Helping Hands Grant Award

Travis Ladner from Vanderbilt University School of Medicine and the program “Helping Raise Awareness for Mental Illness and Improving Referral to Community Health Agencies.”

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SYMPOSIUM 1

Thursday, October 4; 8:30 a.m.–11:30 a.m.

Practical Solutions: Meeting the Special Challenges in Delivering Primary Care to People With Serious Mental Illnesses

Chair: Hunter L. McQuistion, M.D.

Presenter(s): Benjamin G. Druss, M.D., M.P.H., Jeanie Tse, M.D., Andrew J. Kolodny, M.D., Ralph Aquila, M.D.

Educational Objectives: At the end of the session, the participants should understand the historical challenges of delivering primary care to people with serious psychiatric disorders.

Summary: Federal health reform is driving key changes in the way mental health services are delivered and consequently in the way health professionals practice. As such, there is increasing energy aimed at integrating behavioral health and primary care. Simultaneously, as historical reality, the needs of people with particularly complex social and health problems – those with serious mental illnesses – have been particularly challenging to address effectively. Moreover, the advent of second generation antipsychotic medication, particularly their metabolic side effects, have brought even greater attention to physical health, highlighting an already critical need to ease primary care access for this patient population. While there have been inventive efforts over the years in bringing nonpsychiatric medical care to this population, there has been little systemic incentive to permit their proliferation. Health policy developments have introduced medical/healthcare homes, which strive to deliver more cost-effective and comprehensive care and have practical potential to encourage ongoing success of models that combine primary care delivery with behavioral health. After characterizing general approaches on serving this population's need for total wellness in the context of their own recovery goals, particularly with primary care access, and illustrating past efforts to do so, this symposium will explore three models located in New York City that integrate primary care services into mental health settings that serve people with serious mental illnesses: from within a general hospital, from within a community-based behavioral health organization (CBHO), and from a uniquely arranged collaboration between a CBHO and a general hospital. The presenters will describe their respective approaches and discuss ground-level implementation challenges from both behavioral health and primary care vantage points. The issues brought forward by these three models will seed group discussion among the panel and symposium participants concerning the strengths and challenges of each and will explore how providers can create mechanisms for this form of integrated care and meet professional and services challenges in doing so.

1. Recovery-Oriented Care Management for People in Community Behavioral Health Programs

Jeanie Tse, M.D., Marcia Titus-Prescott, R.N.

Summary: People with serious mental illness (SMI) have a higher prevalence of cardiometabolic and other physical health disorders, including rates of obesity and diabetes two to three times that of the general population. Although an estimated 60% of the excess mortality in this group can be prevented or treated, people with SMI experience multiple barriers to care, including discrimination, lack of provider training, and fragmentation of the health care system. Communication among community behavioral health and primary care providers is challenging, given that they often work in different locations with some differences in philosophies of care. Recovery-oriented keys to integrated care provision in the community may include designation of a nurse with both medical/surgical and behavioral health experience who can facilitate interprovider communication and triage high risk patients. In the community, this nurse trains and supports paraprofessional care managers to provide direct care and advocacy for patients. A second recovery-oriented key to integrated care may be patient self-management training, using materials designed to address poor health literacy among people with SMI. The Healthy Living and Diabetes Self-Management Toolkits use motivational interviewing (MI) language to support patients in considering changes in health behaviors, with personalized recovery goals in mind. These Toolkits dovetail with nursing and paraprofessional efforts in creating an informed, activated patient who will communicate and advocate with both primary care and behavioral health providers. A third key to integrated care may be co-location of primary care and behavioral health services. Videoconferencing technology may permit virtual co-location as well. While there are fiscal and regulatory barriers to achieving this type of integration in the community, creation of opportunities for clinical case conferences, as well as informal opportunities for interprovider dialogue, may prove vital to creating person-centered health homes for people with SMI.

2. Co-Locating Primary Care Services in a Community Mental Health Center.

Andrew J. Kolodny, M.D., Kenneth Harris, M.D., Ph.D.

Summary: The Community Mental Health Center (CMHC) at Maimonides Medical Center in Brooklyn serves the behavioral health needs of approximately 1500 adult patients. They can be characterized as ranging from high-functioning adults treated for mood disorders to people with serious and persistent mental illness as well as those with various degrees of developmental disabilities. The expansion of co-located primary medical care services at the CHMC has been aimed at developing the concept of a patient-centered mental health home. Patients with the most intensive care needs, who typically are also socioeconomically disadvantaged, are likely to benefit the most from the model. However, the primary care clinic is currently open to all patients enrolled in CMHC programs. An internist was hired by the department of psychiatry and works closely with case managers and psychiatrists, mostly via email and telephone contact, and via the shared electronic medical record. The department has also hired a medical assistant who is available to measure vital signs and draw blood for all CMHC patients, even if they are not enrolled in on-site primary care. The medical-behavioral health care team works together to advocate for patients as they interface with residential, home care, vocational and other service agencies. The primary care doctor is also available for medical consultation if patients are admitted to the CMHC inpatient units or to provide inpatient medical care at Maimonides if needed. Most care providers have been happy with the increased communication and mutual understanding of patients' behavioral and medical care needs, but we face several challenges. There is an increasing number of undocumented or otherwise insurance-ineligible patients who receive psychiatric treatment under the NY OMH catchment area program. Providing of primary medical care to these patients is problematic in our setting, because there is not a funding mechanism to make full primary care services available to them. Interdisciplinary case conferences are desirable but there is currently no mechanism to reimburse these, limiting the time that providers can devote to them. We hope to use our model to set standards of care for the mental health home concept that may lead to new reimbursement structures that reward this coordinated care for this population of patients with multiple needs.

3. Connecting the Dots; Primary Care, Psychiatry and the Fountain House Model

Ralph Aquila, M.D., James Naughton, M.D., Keith McCarthy

Summary: Men and women with schizophrenia and bipolar disorder, especially those who are or have been homeless, are substantially more likely to have co-morbid medical illnesses than the general population. Furthermore, they are more likely to receive substandard medical care, especially in urban areas, putting them at greater risk for complications and decreased life expectancy. This gap in medical treatment for the mentally ill occurs for many reasons. Primary care physicians often do not treat patients with severe mental illness (SMI) in their practices, for reasons including unfamiliarity with the identification and management of mental illness and fear of persons with these disorders. General practitioners often do not have the time, interest, or experience to provide adequate care for such patients. The problem is further intensified by the patients themselves, who typically do not seek out primary care because they have a mistrust of doctors and medical institutions. Often they do not seek medical treatment until they are in the advanced states of an illness. Patients can easily access both psychiatric and primary care services at the center, and each year we deliver community-based care to more than 500 people with SMI. We provide many traditional services along with more integrated services as well as preventative care and wellness initiatives. Our services are a team effort for the patient, including primary care doctor, psychiatrist, and community agencies, all in a fully integrated electronic records system. Key to the twelve years of success at our center has been our partnership with these agencies in particular, Fountain House. Fountain House is a world renowned recovery center for persons with SMI. Often times a Fountain House worker will be present with the patient to guarantee all needs are met. Housing partners many times are involved to complete the picture. Consistent coordination of medical and psychiatric care over time is crucial to helping meet the individual needs of patients who suffer from co-morbidities. A collateral benefit of the center is its cost efficiency. Central coordination of medical and psychiatric services eliminates duplication and high costs, incurred through inpatient or emergency room care.

SYMPOSIUM 2

Thursday, October 4; 8:30 a.m.–11:30 a.m.

"Getting to Zero": New Issues in HIV Prevention

Chair: Mark Zamorski, M.D.

Presenter(s): Deniz Fikretoglu, Ph.D., Kerry Sudom, Ph.D., Neil Greenberg, M.D., M.Psy., Amy B. Adler, Ph.D., Paul Kim, M.A.

Educational Objectives: By the end of the session, the participants should be able to recognize the role of treatment for HIV as prevention, understand recent literature supporting use of PrEP, understand the potential risks and benefits of initiating prophylactic treatment and identify populations at the highest risk of infection with HIV and potential interventions.

Summary: In recent years, HIV has been transformed from a universally terminal condition into a chronic disease state managed by highly active anti-retroviral therapy (Haart). In spite of advances in treatment, HIV transmission rates have proven largely steady with over 50,000 new cases in the U.S. and over 2.7 million new cases worldwide each year. This persistently high transmission rate has reinforced the idea of preventative strategies as being essential to the control and ultimate eradication of this disease. Traditional preventative strategies have focused upon behavioral modifications including consistent condom use coupled with messages of risk reduction designed to encourage safer sex. However, there remains a subset of individuals at high risk for HIV acquisition that have not embraced traditional preventative strategies. Haart therapy has demonstrable value in reducing the rate of HIV transmission by a) engaging more people in treatment with subsequent reduction of viral load and decreased risk of HIV transmission, and b) involving prophylactic treatment to reduce the risk of infection with HIV. In this presentation we will discuss the current thoughts on "treatment for prevention" and pre-exposure chemoprophylaxis for the prevention of HIV(prep). There will be a discussion of the potential mental health implications and controversies regarding these treatment protocols. There will also be a presentation of the populations with the highest rate of HIV infections, a discussion of the risk behaviors in this population, and potential interventions in an attempt to reduce transmission of HIV.

SYMPOSIUM 3

Thursday, October 4; 8:30 a.m.–11:30 a.m.

Special Access, Special Barriers, and Special Opportunities: Lessons From a Decade of Military Research in Three Nations

Chair: Mark Zamorski, M.D.

Presenter(s): Deniz Fikretoglu, Ph.D., Kerry Sudom, Ph.D., Neil Greenberg, M.D., M.Psy., Amy B. Adler, Ph.D., Paul Kim, M.A.

Educational Objectives: By the end of the session, the participants should be able to describe the leading barriers to care in military organizations in Canada, the U.S., the UK, and Australia.

Summary:

Background: While mental health treatments are more effective than ever, only a minority of those with mental disorders actually receives care. Military organizations in the U.S., UK, and Canada have largely overcome the structural barriers that plague their civilian mental health care systems, and service members do not face the socioeconomic marginalization or delusional thinking of those with psychosis. However, special structural barriers (such as concern about the impact of care-seeking on one's military career) and disproportionate attitudinal barriers (e.g., stigma) could be problematic. Military organizations also have special opportunities to overcome barriers, for example by changing confidentiality protections, requiring mental health training, doing outreach into the workplace, etc.

Methods: This symposium will draw on a decade of military research on barriers to care by authors from three nations. Population-based data will be reviewed on the prevalence of different barriers and their association with care-seeking in many settings. Evidence from randomized trials of the impact of mental health training programs on barriers will be reviewed.

Results: Even where structural barriers are minimal, only a minority of those with need will seek care. Disorder severity is a strong predictor of care-seeking, but there is substantial dysfunction in those with subclinical conditions. Failure to recognize a need for care is the most prevalent barrier. Among those who recognize unmet need, the most prevalent barrier is the desire to manage problems on one's own. Concerns about career impact are common, but these perceptions may not reflect reality. Those with mental disorders report each and every barrier at two to three times the rate of those without mental disorders. Perceived stigma is a prevalent barrier. However, there is no evidence of greater stigma in military personnel, and it does not predict failure to seek care. In contrast, negative attitudes towards care (e.g., that it is ineffective or harmful) do inhibit care. Barriers to engagement in care appear to overlap substantially with barriers to initial care-seeking. There is evidence that perceived barriers can be influenced by mental health training, but the effect on care-seeking is unknown.

Conclusions: Despite cultural/organizational differences, these key findings converge across all four nations. An Occupational Model of Mental Health will be used to identify special opportunities to overcome these barriers. Clinical opportunities to address barriers will be explored. Military organizations have clear opportunities for quality improvement, including radically restructuring the system of care to meet the preferences of personnel. Practical implications for civilian providers and administrators will be highlighted. Military organizations provide a glimpse of what barriers to care would look like for those with serious mental illness if structural barriers were overcome.

1. Barriers to Seeking Mental Health Care in U.S. Soldiers Returning From Combat: Beyond Stigma

Amy B. Adler, Ph.D., Paul Kim, M.A., Lyndon Riviere, Ph.D., Jeffrey L. Thomas, Ph.D., and Thomas Britt, Ph.D.

Summary: Stigma associated with seeking mental health care is a significant concern among service members with psychological health problems (Gould et al., 2010). However, in a recent study, Kim et al. (2011) factor analyzed a series of items reflecting potential barriers to care and found that while stigma attitudes did not correlate with mental health care utilization, attitudes toward mental health care did. In order to better understand these attitudes, new items were developed and tested which consisted of both perceptions of mental health care utility and positive attitudes toward personal efficacy in managing mental health problems. The present study reports on data from more than 2,000 U.S. soldiers surveyed approximately 6 months after returning home from a combat deployment. The survey included scales on barriers to care, combat experiences, mental health symptoms, and mental health care utilization. The barriers to care items were analyzed and found that perceptions toward behavioral health care and clinical self-reliance factored separately; their association with mental health care utilization was also assessed. By expanding the conceptualization of barriers to care, the U.S. Army can identify additional opportunities for intervention, adapting mental health care delivery and psychoeducation to address these barriers.

2. A Comparison of Stigma and Barriers to Care Across Personnel From Five Military Nations

Neil Greenberg, M.D., M.Psy., Matthew Gould, Psy.D., Amy Adler, Ph.D., Mark Zamorski, M.D., Carl Castro, Ph.D., Natalie Hanily, Ph.D., Nicole Steele, Ph.D., Steve Kearney, Ph.D.

Summary: A comparative analysis of stigmatising beliefs across five nations (United States, United Kingdom, Australia, Canada and New Zealand) showed that whilst military personnel reported a number of beliefs which could act to impede help seeking, the main attitudinal beliefs were the perception that one's leaders and colleagues might think less of them [if they sought help]. Further analysis of how military personnel overcame barriers to care [including but not limited to stigma] will also be presented so as to identify possible exploitable methods of encouraging help seeking which may ultimately lead to improvements in whole force mental health status. The nature of the belief systems of military personnel also provide an excellent template for considering how stigma and barriers to care operate in non-military organisations.

3. Need for Mental Health Care, Perceived Barriers, and Care-Seeking Propensity in Canadian Forces Personnel Deployed in Afghanistan

Kerry Sudom, Ph.D.

Summary: Mental disorders are prevalent on deployed operations, but only a small fraction of those with problems access care due to a range of barriers. Delivery of mental health care on deployment poses logistical challenges, and care may be far less available and accessible in more forward areas, where need is likely to be concentrated. The deployed setting may also foster particular attitudinal barriers to care, such as the tendency to "soldier on" in the face of illness or injury, which may reflect the organizational climate of the deployed setting. Effectively overcoming barriers to care on military operations requires a rich and complete understanding of the interrelationships among need, perceived barriers, and care-seeking propensity. To this end, a survey measuring need for care, perceived barriers, and care-seeking propensity was administered to Canadian Forces personnel during deployment in Kandahar Province, Afghanistan in 2009–2010. Among those individuals with a mental disorder, there was limited interest in getting professional help. Complex characteristics of barriers to care on deployment were found: stigma had no association with care-seeking propensity; perceived structural barriers were associated with greater care-seeking propensity; and perceived structural barriers were greater in more isolated locations. Only negative attitudes towards care had the expected negative association with care-seeking propensity. Research and practical considerations are discussed.

4. Barriers to Mental Health Service Use in the Canadian Military: Findings From an Epidemiological Survey

Deniz Fikretoglu, Ph.D., Mark Zamorski, M.D.

Summary:
Introduction/Objectives: In 2002, Statistics Canada conducted the first epidemiological survey of mental health and mental health service use among Canadian Force (CF) members. To our knowledge, the Canadian Community Health Survey – Canadian Forces Supplement (2002) was the first large scale, epidemiological survey of mental health and mental health service use in an active military population. The objective of this abstract is to summarize findings on barriers to mental health service use from this epidemiological survey, review methodological challenges in military epidemiological surveys of mental health and service use, and outline future directions for mental health services research in military populations.

Methods: Data from the 2002 survey (N=8441) were used. Statistical analyses including logistic regression, classification and regression trees, zero-inflated negative binomial regressions, Kaplan-Meier curves, and Cox regressions were employed to examine mental health service use rates, adequacy, delays, and barriers.

Results: A significant portion of the CF fails to use mental health services; the services received do not seem to meet minimal adequacy guidelines; there are significant delays in accessing services. There are distinct sets of barriers in making the initial contact with services, accessing services in a timely manner, and receiving adequate services. Many of these barriers are those that have been reported in civilian populations (e.g., fear of being stigmatized), while others (e.g., lack of trust in military mental health services, fear of career implications) are unique or particularly relevant to the military setting. While epidemiological surveys have certain strengths, they are limited in their assessment of barriers. Foremost among these is the inability to fully delineate the factors driving the most prevalent barriers to care. We will discuss our efforts to overcome some of these methodological limitations in the next cycle of the Canadian Community Health Survey – Canadian Forces Supplement in 2012.

Conclusions: We will summarize findings from epidemiological research on barriers to mental health service use in the Canadian military, identify methodological challenges in military epidemiological surveys, and map out possible ways to start overcoming some of these challenges.

SYMPOSIUM 4

Thursday, October 4; 8:30 a.m.–11:30 a.m.

50 Years in Midtown: Past, Present, and Future of Mental Health and the Metropolis

Chair: Mark Opler, Ph.D., M.P.H.

Presenter(s): Lewis A. Opler, M.D., Ph.D., Lawrence H. Yang, Ph.D., Ernest J. Millman, Ph.D., M.P.H.

Educational Objectives: Understand the landmark Midtown Manhattan study and the impact it had on public psychiatry and mental health, as well as other key findings of the past 50 years.

Summary: Fifty years ago, the Midtown Manhattan Study investigators undertook one of the first investigations into the mental health of a major urban center. Their findings revealed a much higher-than-anticipated burden, bringing the conversation around mental health, stigma, urban life, and culture into the mainstream. In the past 50 years, tremendous advances have been made in our understanding of the risk factors, incidence, and prevalence of various disorders. Global strategies for prevention and the unique issues of urban populations continue to challenge public psychiatry and public policy. This session will review the past, present and future of this area, reflecting on the lessons that a landmark study may offer to help guide us for the next 50 years.

1. Recollections of the Midtown Manhattan Study

Lewis A. Opler, M.D., Ph.D., Mark Opler, Ph.D., M.P.H.

Summary: In 1962 – 50 years ago – Mental Health in the Metropolis: The Midtown Manhattan Study was published. Sadly, Thomas A.C. Rennie, MD, whose vision had secured funding and who had recruited the multidisciplinary team that carried out this landmark study, had died in 1956. Fortunately, most of the data had been collected before his death, and Alexander H. Leighton, MD, ably oversaw the completion of analysis and publication of key findings. Rennie's vision was two-fold. First, Rennie recognized the need to find out how many in the community were suffering from psychiatric problems: this was very different from simply counting the number of persons who presented for treatment. Second, Rennie hoped to identify the sociocultural factors which impacted severity of mental suffering. Remarkably, he recognized that a multidisciplinary team was needed, and, in addition to himself, recruited another psychiatrist (Stanley T. Michael, MD); two sociologists (Leo Srole, PhD and Thomas S. Langner, PhD), and a cultural anthropologist (Marvin K. Opler, PhD). The study found that one in five persons in Midtown Manhattan could benefit from professional intervention, while another three in five could benefit from less intensive assistance. At the time, these findings were distorted in the popular press, which incorrectly reported some version of (and we paraphrase) "Cornell Psychiatry Departments says that 80% of New Yorkers have mental illness!" In fact, the one in five figure regarding those in need of professional help is not dissimilar to more recent data. But perhaps as important as the specific findings was the development of new methodologies plus a commitment to addressing social and cultural factors impacting on mental illness: the Midtown Manhattan Study, along with a handful of other studies conducted after World War 2, helped create social and cross-cultural psychiatry as new and important disciplines. Fifty years after Mental Health in the Metropolis was published, the creators of this symposium wished to gather together with other professionals to reflect on the lesson of the Midtown Manhattan Study as well as to underscore the importance of continuing to address impact of sociocultural variables on mental health as well as the need to define protective as well as causal factors of mental illness in the environment.

2. Urbanicity and Impacts Upon Social Integration in China

Lawrence Yang, Ph.D.

Summary: The speaker will discuss how rural vs. urban residence impacts social integration (i.e., effects on marriage and employment) upon people with schizophrenia in China. The speaker will present results from the only dataset that ascertains psychotic patients (n=393) from a population sample representing 12% of China's population. This dataset also contains a sizeable, and unique, cohort of untreated psychotic patients. The main findings indicate that rural residence has a powerful effect on improving work outcomes among people with schizophrenia, an effect that persists regardless of treatment status. Further, rural residence also leads to better marriage outcomes for people with schizophrenia. These findings will be discussed in the context of social factors within China, and the influence of other potential social forces (i.e., stigma) upon social integration outcomes will be described.

3. The Midtown Study Challenge to Public Mental Health

Ernest J. Millman, Ph.D., M.P.H.

Summary: Community studies of psychiatric disorder in the general population have long been a basis for the planning of mental health services. The Epidemiological Catchment Area study and the National Comorbidity Studies broadened the scope of such research to the all of the United States. The findings of these studies have been contrasted to those of such community studies as the Midtown Manhattan Study. The citation of the Midtown study by eminent scholars during the half-century since 1962 indicates the continued applicability of its data to this issue. The Midtown study assessed mental health in a manner comparable to Axis V of the DSM-IV. It estimated that, in 1954, 23.4% of the adult residents in one area of Manhattan had an "impaired" level of mental health, defined as corresponding to a clinically significant need for treatment. Largely stated, this may be the best replicated finding in psychiatric epidemiology. This prevalence rate has posed the public mental health challenge of professionally helping all in need. The investigators of both the Midtown and New Haven studies had great confidence in the efficacy of office-based psychotherapy. Presentations of the Midtown study have discussed pharmacotherapy, the community mental health movement, self-help, counseling, social casework, psychoeducation, and stress management and relaxation training. As the second half-century following the publication of the Midtown study begins, psychologists are demonstrating renewed interest, in Kazdin and Blase's phrase, "rebooting psychotherapy research and practice to reduce the burden of mental illness."

4. The Next 50 Years: Preventive Approaches to Mental Health in the Metropolis

Mark Opler, Ph.D., M.P.H.

Summary: Research and practice are typically separated by a vast gulf, representing the lag between realization of a research finding and our technical or political ability to realize it. The key to making prevention in mental illness a future reality lies in closing this gap. This presentation will review the most promising research findings that could, in the course of the next five decades, accelerate our efforts and reduce the global burden of mental illness. Drawing on epidemiology, clinical and basic neuroscience, and evidence-based practice, this review will conclude the session.

SYMPOSIUM 5

Thursday, October 4; 8:30 a.m.–11:30 a.m.

Cross-Cultural Psychiatry With Indigenous North Americans

Chair: Lewis Mehl-Madrona, M.D., Ph.D.

Presenter(s): Chief Phillip Scott, M.A., Becky Chief Eagle, A.A., Patric Roberts, D.Min., Sc.D., Dallas Chief Eagle, M.A., Michael Valenti, Psy.D., Barbara J. Mainguy, M.A., M.F.A.

Educational Objectives: At the conclusion of this session, the participant should be able to: list three Native American ceremonies and describe how these are naturalistic psychosocial therapies (Sundance, Talking Circle and the purification Inipi or Breath of Life Ceremony (Sweat Lodge).

Summary: This symposium provides an opportunity for dialogue among mental health practitioners serving Native American (and other indigenous) communities, Native American mental health practitioners, and other minority groups and providers. We begin with a presentation on Native American concepts of mind, mental health, and mental illness elucidated in a qualitative study involving traditional elders. We discuss how the differences in these concepts from conventional psychiatric thought, especially the conventional biomedical model, and how these differences can lead to misconnections between providers and clients. Then three presentations follow describing Native American practices that are becoming more and more widely used in addictions treatment and mental health treatment, including the talking circle, the sweat lodge, and the sundance. These presentations include qualitative research data and outcome measures. The final presentation will portray a program where Native American health practitioners are working alongside psychiatrists. This symposium will allow practitioners to gain insight into the 'translation' of Native American healing ceremonies into psychotherapeutic language, and to understand the ways in which including traditional healing has been effective in creating understanding and positive responding among the Native American population. Practitioners will also be invited to consider the value of including these naturalistic psychosocial ceremonies in the context of allopathic treatment and western psychotherapeutic treatments.

1. Traditional North American Indigenous Views of Mind and Mental Health: Finding a Meeting Place Between Culture and Psychiatry

Lewis Mehl-Madrona, M.D., Ph.D., Barbara Mainguy, M.A., M.F.A.

Summary: Based upon a series of consensual discussions with Native American elders, we present a model for Native American concepts of mind and mental health, which include the idea that mind is a story that exists within relationships which may be with other people, elements of nature, spirits, Creator, and others. Identity is described as the story we tell ourselves to make sense of all the stories that have ever been told about us. Mental health is described in terms of balance within relationships, of maintaining harmony and balance within relationship. Suffering occurs when harmony and balance are disrupted. Crucial to the elders was the concept that there are no bad or defective people, only bad stories that people have heard about themselves and come to believe. Most interesting was the Lakota concept of nagi which consists of all the beings who have ever influenced the person together with all the stories that they have told about the person. Nagi can be imagined more as a swarm that surrounds a physical body than as a self that exists within a brain. Examples are provided in which elders encourage those coming to them for healing to cast away the stories that tell them they are bad people or evil or that something is wrong with them and to listen to the traditional stories and to testimonies from others who have overcome adversity in order to be inspired to overcome their own situations and to change the story of their life. The presenter draws parallels between these aboriginal views and the developing narrative paradigm within Western academic traditions, especially the current work in Discursive Psychotherapy by Hermans and Hermans. We will explore how these aboriginal models for mental health influence collaborative work with traditional cultural healers. The author will describe his practice alongside traditional healers, including how to approach healers and how to prepare people to consult with traditional healers. We will dialogue with indigenous healers within this symposium to better understand how psychiatry and traditional Native American culture should intersect.

2. American Indian Ceremony as Naturalistic Therapy

Barbara J. Mainguy, M.A., M.F.A.

Summary: Health care practitioners have explored ceremony in healing for its transpersonal aspect and for its intention of binding together community in a commitment to wellness. The collectivist cultural healing paradigm has been explored as a working model of a social constructionist 'dialogical-self', and the storytelling nature of ceremony has been compared to narrative psychology. Practitioners are also attracted by the psychological effectiveness of ceremony for those who participate. Conventionally hard-to-treat groups – veterans, addicts, at-risk youth – respond to the qualities of the Sun dance, sacred drama, the Inipi (sweat lodge) and the Hocokah (healing circle) with positive decision-making and health-sustaining behavior. Sacred drama uses action based therapy, to rewrite personal narrative. Sun dancers spend four days and nights without food or water in a circular arbor with a ceremonial tree at its centre, where they sleep, pray and dance'rounds' devoted to specific groups or causes – elders, children, warriors, the terminally ill, the young people, the community as a whole. The dancers accept or renew a sacred obligation to be healing for themselves and the community. The Dance attracts the recovery and veteran populations. The talking circle establishes a safe non-hierarchical place in which all present have the opportunity to speak without interruption. Communication is regulated through passing a talking piece, an object of special meaning or symbolism. After comments by the circle keeper about the purpose of the talking circle, he/she passes the talking piece to the person on the left, clockwise. Only the person with the talking piece can speak. We report upon 1500 people participating in talking circles in which 415 people completed baseline and end MYMOP2 forms (My Medical Outcomes 2). The Inipi, or 'breath of life' ceremony is the traditional sweat lodge, and is used as a purification rite as well as an opportunity for healing in community. In this ceremony, hot stones are carried into a canvas covered dome-like structure, built of willow saplings. Water is poured onto the stones. The ceremony includes prayers and songs and a smoking of the sacred pipe (canunpa). This paper presents the results of the a qualitative study interviewing participants about their reasons for attending sweat lodges and what perceived benefit they receive. Many aboriginal participants suffered from alcohol-related problems and/or drug problems.

3. Collaborative Medicine in the 21st Century

Chief Phillip Scott, M.L.A., E.M.T.

Summary: With reference to contemporary medicine, the terms alternative, integrative and complementary are problematic. They signify a particular bias and perception of primacy. It is not necessary to alter the native. Traditional medicine (which refer to Indigenous practices), is an ancient, elegant, complex and highly sophisticated form with rigorous protocols, modalities, philosophies and training. It requires approximately ten years of arduous apprenticeship to become a traditional healer/Native doctor. It is an entire system and paradigm in and of itself. As such it can stand alone, as it has for millennia in countless cultures, and is still in the majority in terms of the medicine practiced throughout the world. The moniker integrative implies and suggests an incorporation or assimilation of certain elements of one subject or entity into the body of another, the latter serving as the primary source. To select and extract certain methods and modalities of traditional medicine in an attempt to place them within the context of allopathy, is a desecration of Indigenous arts and sciences, dilutes their power and potency and compromises their efficacy. Furthermore, it is perilous to utilize a technique or a portion of one out of context and without fully comprehending or mastering it. A complement is an aspect (a part) that adds value to a separate system. Traditional and other forms of medicine (such as Acupuncture, Ayurveda, bodywork) are not complements to allopathy but rather, are its colleagues, its equals. The time has arrived to change not only the vernacular but shift the prevailing paradigm and perspective as well. Therefore, I espouse collaborative medicine. Collaboration involves mutual respect for each practitioner's areas of experience, knowledge and contributions. It is a fertile, creative cooperation where communication and solidarity prevail for the benefit of those whom we serve. Every modality and form of Medicine has its merits and strengths, its drawbacks and weaknesses. We are far more effective when we honour the diversity of the manifold means of healing, support each other and collectively unite our talents in the relief of suffering. By providing a palette of possibilities (in essence, each modality a distinct and unique color), there is a greater chance of individuals painting the images and reality of healing on the canvas of their lives.

4. Interfacing Cultures: Examples of Work With Indigenous People From Moloka'i, Hawai'i and Pine Ridge, South Dakota

Michael Valenti, Psy.D., Rebecca Three Stars, Dallas Chief Eagle, Patric Roberts, D.Min.

Summary: On the Pine Ridge Reservation in South Dakota, Rebecca Three Stars works with young women to provide cultural practices as alternatives to gang life, alcohol and drug addiction, and criminal behavior. These cultural practices highlight the seven sacred ceremonies of the Lakota people and visits to one or more of the seven sacred sites.

Young people learn the seven laws of the Lakota and find ways to support each other and to find meaning and purpose through the traditional stories and practices of Lakota culture. These ways include ceremonies like the "making of women," the "vision quest," the "making of relatives," the "breath of life" ceremony (sweat lodge), the "sundance," the yuwipi ("they tie him up") and the luwonpi ("praying in the dark") ceremonies, among others. Similar processes are happening on the island of Moloka'i, Hawai'i, in which mental health and addiction services are moving forward more rapidly than ever before through the utilization of traditional cultural practices including means of communication and conflict resolution inherent in Ho'opono'pono (similar to the Lakota talking circle) and traditional martial arts and hula practices. Psychiatry is coming to terms with these naturalistic mental health and addictions prevention and treatment practices which are working far better than conventionally designed services and become part of an overall strategy for life management. We link these ideas to the developing well-briety movement and other concepts emerging among North America's and Hawai'i's indigenous people.

5. Maka Si Tomni: Lakota Autopoietic Healing Through Sacred Renewal

Patric Roberts, D.Min., Sc.D., Dallas Chief Eagle, M.A.

Summary: It has been frequently observed (Duran, 2000; Mehl-Madrona 2007, 2010) that people who suffer respond to treatment that takes into account ideas and understandings from the culture of which they are a part. American Indian people are often experiencing a hybrid culture, or multiple ways of expressing an illness. All too frequently, American Indian men suffer to find a healthy way of being, not only at the edge of two cultures, but within their own. Maka Si Tomni is a program aimed at facilitating leadership, empowerment, initiative and mental wellness among Lakota men. Maka Si Tomni works with conventional ideas for mental health and addictions, and brings in Lakota cultural ideas as well as ceremony, narrative and community. This presentation will discuss and review the experience of implementation of this program on the Pine Ridge Reservation in South Dakota, with data gathered from the MYMOP II questionnaire. Patric Roberts and Dallas Chief Eagle, a healing elder, work alongside conventional practitioners to bring about the possibility for deep change in their community.

6. Maka Si Tomni: Lakota Autopoietic Healing Through Sacred Renewal

Dallas Chief Eagle, M.A., Patric Roberts, D.Min.

Summary: It has been frequently observed (Duran, 2000; Mehl-Madrona 2007, 2010) that people who suffer respond to treatment that takes into account ideas and understandings from the culture of which they are a part. American Indian people are often experiencing a hybrid culture, or multiple ways of expressing an illness. All too frequently, American Indian men suffer to find a healthy way of being, not only at the edge of two cultures, but within their own. Maka Si Tomni is a program aimed at facilitating leadership, empowerment, initiative and mental wellness among Lakota men. Maka Si Tomni works with conventional ideas for mental health and addictions, and brings in Lakota cultural ideas as well as ceremony, narrative and community. This presentation will discuss and review the experience of implementation of this program on the Pine Ridge Reservation in South Dakota, with data gathered from the MYMOP II questionnaire. Patric Roberts and Dallas Chief Eagle, a healing elder, work alongside conventional practitioners to bring about the possibility for deep change in their community.

7. The Stone Boy Women's Society: A Case Study of Culturally-Based Intervention: On the Pine Ridge Reservation in South Dakota

Becky Chief Eagle, A.A.

Summary: Rebecca Three Stars works with the Stone Boy Women's organization. The Stone Boy group works with young women to provide cultural practices as alternatives to gang life, alcohol and drug addiction, and criminal behavior. These cultural practices highlight the seven sacred ceremonies of the Lakota people and visits to one or more of the seven sacred sites. Young people learn the seven laws of the Lakota and find ways to support each other and to find meaning and purpose through the traditional stories and practices of Lakota culture. These ways include ceremonies like the "making of women," the "vision quest," the "making of relatives," the "breath of life" ceremony (sweat lodge), the "sundance," the yuwipi ("they tie him up") and the luwompi ("praying in the dark") ceremonies. Most importantly, is the women's Throwing of the Ball ceremony, a sacred rite of healing for women, which has been almost forgotten. The fledgling society was formed because of the overwhelming despair and loss of identity, and the social ills that accompany esteem and identity issues. The Stone Boy Women's Society uses traditional spiritual ceremonies to help women and children heal, restore balance and construct lasting self esteem and confidence that will allow them to become successful members their tribe and of the society at large. There has been some limited success with non-Native interventions, those interventions do not successfully address issues of diminished self worth, mistrust, alienation, and isolation that are internalized from the cultural oppression that has occurred at Pine Ridge and other American Indian reservations in the past centuries cultural discomfort and lack of self esteem cause failures for many young women who have the talent and determination for success. Such failures cause a downward spiral in spiritual, social, emotional and educational life. Each of the society's leaders is an established member of the tribal community and a trainer in the Lakota techniques and practices that have been used in traditional Lakota society to educate and transition women and adolescents to constructive adulthood.

SYMPOSIUM 6

Thursday, October 4; 2:00 p.m.–5:00 p.m.

Improving Lives and Lifespans: Opportunities for Psychiatrists Collaborating With Primary Care

Chair: Lori Raney, M.D.

Presenter(s): Steven S. Sharfstein, M.D., M.P.A., Benjamin G. Druss, M.D., M.P.H., Kathleen Reynolds, M.S.W., Jürgen Unützer, M.D., M.P.H.

Educational Objectives: At the conclusion of the session, participants should be able to appreciate the spectrum of program possibilities available to psychiatrists in collaborating with primary care.

Summary: New models for collaborating with primary care continue to show we can improve on 1) the delivery of primary care services in public mental health settings and 2) the detection and treatment of mental illness in primary care settings. The ability to make changes in both these arenas shows promise in changing the course of co-morbid illnesses and "bending the cost curve" while improving health status. Psychiatrists provide a crucial link between primary care and behavioral health and the "added value" of including their expertise in well-designed systems of integrated care can lead to improved lives and life spans in these populations. Community psychiatrists are at the forefront of translating emerging evidence-based collaborative care practices into real world applications and find themselves with a host of possibilities. Through taking a population based view of their local health care needs and applying emerging research, they have the opportunity to design programs that can truly bring about health care change. This Symposium brings together experts along the spectrum of collaboration with primary care to provide a unique glimpse at these opportunities. Dr. Ben Druss, whose research focuses on improving the overall health status of patients in public mental health settings, will present his findings from the PCARE study and other initiatives. Dr. Jürgen Unützer will discuss his work in improving the detection and treatment of mental illness in primary care settings, focusing on the emerging "core principles" of effective collaborative care. Kathy Reynolds, MSW and Director of the Center for Integrated Health Solutions, will give an update on the progress of the 64 SAMHSA/HRSA grantee sites which are bringing primary care services into mental health settings. Dr. Lori Raney will describe a practical example from rural Colorado of program development and implementation along this continuum. Dr. Steve Sharfstein will serve as a Discussant for this Symposium.

1. The Mental Health Integration Program

Jürgen Unützer, M.D., M.P.H.

Summary: We will present results from the Mental Health Improvement Program, a partnership of over 100 community health centers and 30 community mental health centers in Washington State in which psychiatrists provide systematic case reviews and consultation to hundreds of primary care providers caring for patients with common mental illnesses throughout the state. Over 24,000 clients have been served through the program to date, including 71% with diagnoses of depression, 48% with anxiety disorders, 17% with posttraumatic stress disorder, 38% with comorbid substance abuse, and 15% with bipolar disorder. We will present results of a systematic quality improvement program in which systematic measurement based treatment to target and psychiatric consultation were implemented in the context of an innovative Pay-for-Performance program.

2. Improving Physical Health and Healthcare for Patients Treated in Specialty Mental Health Settings

Benjamin G. Druss, M.D., M.P.H.

Summary: Patients treated in specialty mental health settings are at risk for worse quality of medical care, higher costs, and adverse health outcomes including excess mortality due to medical causes. This presentation will review the literature on the problem of excess morbidity and mortality in persons with serious mental illnesses, and strategies for improving care delivery and self management in this population.

3. Transformation of an Organization: Collaborative Care in Rural Colorado

Lori Raney, M.D.

Summary: Axis Health System (AHS) provides mental health services to 5 counties in the southwest corner of Colorado. Colorado ranks the highest in suicides in the country and this organization's priority over the past 6 years has been to bring integrated care to the area to help deal with this and other mental health issues. AHS has taken a population based approach to assessing the mental health needs in the area and initiated a number of projects to meet this goal, with 7 sites engaging in collaboration with primary care at this time. These include a federally qualified health center, a rural health center, 3 school based health centers, one private pediatric practice and one newly opened fully integrated health care center. Dr. Raney will share examples of how her agency has successfully applied the research presented earlier in this symposium by Drs. Druss and Unutzer and modified it to fit the needs in her area. She will first share examples of joining with existing primary care clinics to improve the identification and treatment of mental illnesses using a collaborative team based approach. Next, she will describe the process used by AHS to design and build a facility that is fully integrated in its approach to comprehensive collaborative care. This project not only brought primary care services to over 1000 existing patients but also expanded the organizations capacity to provide integrated services to the community at large, creating a "21st century healthcare clinic."

4. Primary and Behavioral Healthcare Integration (PBHCI) Grantees: Lessons From the Field

Kathleen Reynolds, M.S.W.

Summary: SAMHSA has funded 64 behavioral health sites from across the country to specifically bring primary care services into mental health and substance abuse organizations. The first cohort of grantees, now in their third year of operation, have generated significant, improved health outcomes for persons with serious and persistent mental illness. This presentation will identify the core outcomes from the grantees and discuss the implications of these outcomes for the public mental health and substance abuse system.

SYMPOSIUM 7

Thursday, October 4; 2:00 p.m.–5:00 p.m.

Suicide: From Risk Assessment to a Never Event

Chair: Yad M. Jabbarpour, M.D.

Presenter(s): Paul S. Appelbaum, M.D., Paul M. Schyve, M.D., Michael F. Hogan, Ph.D., Michael A. Gillette, Ph.D., Geetha Jayaram, M.D., M.B.A.

Educational Objectives: At the end of the session, the participant should be able to analyze the basis for viewing suicide as a serious adverse event; as well as a "never event" and the history of such in our health care system.

Summary: Suicide is the 11th leading cause of death among Americans. Suicide is a high risk, yet relatively low frequency event for which we are not good at predicting. There are over 33,000 suicides per year in the U.S. with 5–6% occurring in hospitals, translating to nearly 1,800 inpatient suicides per year. Suicide is a leading Joint Commission Sentinel Event in our nation. In addition, suicide is the number one cause of psychiatric malpractice settlements and verdicts. In 2001, the term "Never Event" is attributed to Ken Kizer, MD, former CEO of the National Quality Forum (NQF), in association with serious reportable events – such as wrong-site surgery – events which should "never" occur. Over the decade, adverse events have been added to the list of "serious reportable events" by NQF, including infant discharge to the wrong person, unintended retention of a foreign object in a patient after surgery or other procedure, and artificial insemination with wrong donor sperm or wrong egg. The National Quality Forum has also identified "patient suicide, or attempted suicide, resulting in serious disability while being cared for in a healthcare facility" as a serious reportable event. In 2011, the National Action Alliance: Clinical Care & Intervention Task Force made efforts to develop a best practice toolkit toward suicide prevention. The group's core value sets a bold vision for suicide as a "Never Event": "the belief and commitment that suicide can be eliminated in a population under care (boundaried population), by improving service access and quality and through continuous improvement (rendering suicide a "never event" for these populations)." Toward this vision, recommendations are made to the U.S. Department of Health and Human Services, accreditation agencies, state entities and other key stakeholders to elevate systems of care to promote suicide as a never event; with the "ultimate goal of zero deaths among members/patients."Suicide as a "Never Event" is juxtaposed to clinical best practice and ethics. Suicide is not a single event but a complex issue, arising out of an interrelationship of biological, psychological, social, cultural and spiritual factors for a person. Suicide risk assessment and risk reduction are crucial to all levels of mental health services. Suicide risk assessment is standard of practice; not prediction. In addition, clinicians serve persons in a recovery-oriented mental health system, balancing non-maleficience with beneficience with patient autonomy. Human free will potentially makes suicide a different serious event than wrong-site surgery or than wrong donor sperm/wrong egg artificial insemination. Nevertheless, best practices to support clinicians and improve suicide care in health care systems are needed to realize the goal of decreasing suicides.

1. The Ethics of Suicide as a Never Event

Michael A. Gillette, Ph.D.

Summary: The concept of a "Never Event" logically entails the notion of blame. Given the clear implication that exclusive responsibility for such an event rests with the provider organization, two ethical issues develop. The first issue involves a question of fairness if culpability is inappropriately assigned. The second, and more interesting, ethical issue involves the potentially unethical pragmatic consequences of the assignment of culpability. Once providers realize that they will be held responsible for certain outcomes, regardless of the combination of causal factors involved, it becomes rational for them to seize greater control over contributing factors. They must do so in order to reduce the likelihood of an adverse outcome and, thereby, reduce their own exposure to findings of "never events." The most obvious way to increase control over contributing factors will be to secure greater control over the unpredictable aspects of any case. In the provision of mental health services, the most unpredictable aspect is the patient him/herself. However, greater provider control implies reduced patient autonomy. Ironically, the effort to make in-hospital suicides "never events" in order to protect patient safety is likely to have a negative impact on patient autonomy, even for patients who present little or no suicidal risk. In this paper, I will argue that a blanket standard that makes every in-patient suicide a "never event" will have negative ethical outcomes for the majority of patients receiving psychiatric care, and that it may even do violence to our notions of recovery-based services.

2. Suicide Care in Systems Framework: A Report and Recommendations to Save Lives in Clinical Settings and Health Systems

Michael F. Hogan, Ph.D.

Summary: On World Suicide Prevention Day in September 2010, Secretaries Sibelius (DHHS) and Gates (DOD) launched the Action Alliance on Suicide Prevention. The Action Alliance is a public-private partnership dedicated to the vision of "a nation free from the tragic experience of suicide." It is chaired by Sen. Gordon Smith now with the National Association of Broadcasters (private co-chair) and Secretary of the Army John McHugh (public co-chair). One mission of the Action Alliance is to update the National Strategy for Suicide Prevention (NSSP). The NSSP was developed just a decade ago under Surgeon General Satcher, but research and experience in suicide prevention has developed rapidly and an update is timely. The Action Alliance is addressing other priorities through Task Forces including members and invited experts. The Task Force on Clinical Care was co-chaired by Mike Hogan, Ph.D. (Commissioner of Mental Health, New York) and David Covington (Director of Adult Services, Magellan Health Services Maricopa County Arizona). To quote from the report of the Task Force "we set out to identify the best practice toolkit for better suicide care. What we found most compelling were the cultural and system changes that were common in the most innovative suicide intervention programming. This thought paper lays out a logic map model for replication." The paradox of suicide is that while it is shockingly common (over 36,000 deaths in 2009, more than deaths from prostate cancer, auto accidents, homicides or AIDS) it is also a relatively rare event in populations. The national average rate of suicide deaths is about 11–12 per 100,000 lives annually. Even in groups with strongly elevated risk (e.g. elderly men) the rate stays below 1/10,000. Thus trying to prevent deaths from suicide is a little like finding a needle in a haystack. The Clinical Care Task Force discovered another perspective on suicide prevention. There are unquestionably organizations (the best known and documented being the 1990's U.S. Air Force) that have adopted comprehensive approaches for entire "boundaried populations" they are responsible for – and seen dramatic reductions in deaths from suicide. We found examples of this approach in health care also. These examples share core elements: leadership, and a "just culture" that seeks accountable improvement in performance, without blame – explicit goals to save lives – use of a wide range of interventions and tools.

3. Successful Inpatient Suicide Prevention: Promoting a Culture of Safety in Managing 60,000 Admissions, 880,000 days, and 30 years of Quality Practice

Geetha Jayaram, M.D., M.B.A.

Summary: Suicide, the second most frequent sentinel event in hospitals, occurs on inpatient psychiatric services at a rate of 1,800 per year. The Joint Commission (JC) reported 816 of them by June 2010, 99 in 2011. Previous research has focused on areas of patient evaluation, disease management, symptom assessment and the use of risk prevention tools. In reviewing our near misses for inpatient suicide, we noted that there were few publications reporting a system-wide integrated approach to successful suicide prevention that we employ; such systems should incorporate staff training and deployment, thorough patient assessment, environmental protections, complete handoffs and patient care protocols. Our goals in this symposium are to present a pertinent literature review; describe the methods we have used to achieve successful suicide prevention among inpatients for 32 years, including promoting safety attitudes and a culture of safety; briefly discuss case examples of close calls that permitted us to retool our systems to protect in patients. Our Statistical comparisons and significant results using the National Inpatient Database will be discussed.

4. Suicide as a Sentinel Event

Paul M. Schyve, M.D.

Summary: The joint commission has promulgated a requirement – a national patient safety goal – that a healthcare organization identify patients at risk for suicide, identify features in the environment that increase risk, address the immediate safety needs of at-risk patients, and provide at-risk patients and their families with suicide prevention information when leaving the care of the healthcare organization. Based on the root and contributing causes Identified for suicides within and shortly following discharge from Healthcare organizations, recommendations for endeavoring to make suicide a "never event" will be discussed

SYMPOSIUM 8

Thursday, October 4; 2:00 p.m.–5:00 p.m.

Psychotherapy and Psychosis

Chair: Daniel J. Carlat, M.D.

Summary: Conflicts of interest (COI) in psychiatry may affect various aspects of professional practice. In this symposium, speakers from a variety of backgrounds will describe different aspects of COI. The 2010 Affordable Care Act included a provision known as the Physician Payments Sunshine Act (PPSA). The PPSA will require drug and device makers to publicly report gifts and payments made to physicians and teaching hospitals, and we will discuss how this will impact psychiatrists. We discuss the ethical arguments, pro and con, regarding one particular type of industry/physician interaction: industry funded continuing medical education courses. We will describe the patients' perspective on COI: An academic ethicist recounts her medical illness and treatment by a neurologist who accepted money from drug makers without her knowledge. An academic psychiatrist will review research on the extent to which drug industry sponsorship may influence the outcomes of clinical trials. Finally, we will discuss whether conflicts of interest are in reality a distraction from some of the larger issues confronting the psychiatric profession.

1. An Update on National Policies Relating to Medical Conflicts of Interests

Daniel J. Carlat, M.D.

Summary: Several new pieces of federal and state legislation and new policies of professional associations have been introduced over the last several years pertaining to conflicts of interest in medicine. The 2010 Affordable Care Act included a provision known as the Physician Payments Sunshine Act (PPSA). The PPSA will require drug and device makers to publicly report gifts and payments made to physicians and teaching hospitals, and we will discuss how this will impact psychiatrists. In addition, the American Medical Association has adopted new ethical language potentially limiting the role of industry in funding continuing medical education (CME), which will likely also affect psychiatric education. I will review recent initiatives, including the work of the Pew Prescription Project, and discuss their implications for psychiatric practice.

2. Serving Two Masters: Relationships With Industry in Medical Education

Paul Appelbaum, M.D.

Summary: The pharmaceutical industry has had a significance presence in medical education, from the preclinical years through continuing education of practicing physicians. Given the prominence of industry involvement, a good deal of concern has been expressed over the possibility of bias, although few studies have examined the question directly. Two recent studies of audience perceptions in accredited CME presentations have shown low rates of perceived bias; these findings are consistent with either the absence of bias or with difficulties attendees may have in detecting bias. Other studies have shown that industry-supported presentations affect physicians' subsequent prescribing behavior. Anecdotal reports by physicians recruited to serve in industry-sponsored speakers' bureaus detail the pressures that they faced to conform their presentations to companies' marketing goals. How might the potential for industry bias in medical education be dealt with? Strategies designed to educate doctors about industry bias have been insufficiently tested. Disclosure as practiced today may provide insufficient information to identify and correct for bias. Management strategies have included requirements for pre-review of slides and teaching materials, perhaps a promising approach, but one that presumes adequate knowledge on the part of the screeners to detect bias-induced distortions. Alignment of incentives between presenters and audiences, based on similar principal-agent problems in other walks of life, may be a more promising strategy. This could include insulation of planners and speakers from direct contact with industry or their agents, and in some circumstances relinquishment of industry support. The complexities of this issue defy simple solutions, but the success of any approach must rest on a recognition of the problems, as well as benefits, created by industry involvement and the likely consequences of proposed interventions.

3. Conflict of Interest – From a Patient's Perspective

Maran Woolston, M.A.

Summary: After diagnosing me with relapsing-remitting multiple sclerosis (rrms) in 2008, my neurologist suggested that I enroll in a clinical trial he was conducting, and after I refused, he eventually pressured me to begin disease-modifying therapy. On the day I agreed to begin copaxone, my neurologist asked if he could forward my name to a patient support company called shared solutions – a company I soon realized is a subsidiary of Teva Neuroscience, the manufacturer of copaxone. After enduring five months of painful daily injections that left a welt at each injection site, and after receiving multiple phone calls, gifts, and invitations to free dinners from shared solutions, I discontinued treatment. When my neurologist strongly urged me to begin a different ms treatment, tysabri – a drug that has been documented to cause severe brain damage and death in some patients – I wanted to be sure I could trust him. As a result of a sunshine law in Minnesota, physicians are required to publicly disclose income they receive from the pharmaceutical and device industries. When I searched for my neurologist's name in the disclosure database, what I found caused me to lose trust in him completely. I never returned to his clinic.

4. Competing interests in Clinical Trials in Psychiatry

Roy Perlis, M.D.

Summary: The majority of large randomized clinical trials in psychiatry are sponsored by pharmaceutical or device manufacturers. Reports of smaller trials also often include authors with disclosed financial competing interests. On the other hand, a growing consensus supports the exclusion of authors with such competing interests from the process of preparing treatment guidelines. These circumstances lead to an interesting scenario in which leading clinical trialists are excluded from the process of formulating guidelines precisely because of their expertise. This session will describe empirical results regarding competing interest in clinical trials, and explore the consequences of stringent financial competing interest policies.

5. Professional Suicide

David Healy, M.D.

Summary: The debate on links between industry and academia has centered on conflicts of interest. This focus is almost entirely irrelevant to physicians but plays well for pharmaceutical companies. The key issue for physicians is to understand how drugs and pharmaceutical companies are regulated and to deploy this knowledge to the benefit of their patients and to their own professional advantage. Recent years have seen significant failures on the part of physicians to appreciate both where their patients' and their own professional interests lie and as a result treatment induced death has likely become the leading cause of death within the mental health domain and the professional status of psychiatrists is being eroded by an ever wider dispersion of prescription privileges. There are three aspects to the regulatory apparatus physicians need to appreciate: first, the patent status of drugs; second, the effect of prescription only status on therapeutic practice and finally the role of clinical trials and access to the data from trials. The combined effects of these factors point to a key function for doctors that only they can fulfill and on which their professional futures may depend – the detection, reporting and investigation of treatment related events.

SYMPOSIUM 9

Thursday, October 4; 2:00 p.m.–5:00 p.m.

Psychotherapy and Psychosis

Chair: Lewis Mehl-Madrona, M.D., Ph.D.

Presenter(s): Chief Eagle Dallas, M.A., Lewis Mehl-Madrona, M.D., Ph.D., Barbara J. Mainguy, M.A., M.F.A.

Educational Objectives: At the conclusion of the session, participants should be able to describe the narrative and dialogical therapy approach to psychosis in terms of changing frontal lobe function.

Summary: Conventional psychiatry has largely abandoned non-pharmacological therapies for psychotic disorders. Nevertheless, a robust literature exists to support psychosocial treatment of psychotic disorders, especially that generated by Loren Mosher, MD. Research by the World Health Organization has also supported the psychosocial therapy of psychosis in small communities. This presentation begins with Dr. Mehl-Madrona presenting his outcome data on psychotherapy for people who have been diagnosed with psychotic disorders. Mehl-Madrona's data shows recovery from psychosis in 80% of patients who are treated four or more years with psychosocial therapy. Then Ms. Mainguy presents the principles and some outcome data for "Hearing Voices" group, which presents an opportunity for people to learn how to manage voices that medications do not address. Finally, Dallas Chief Eagle will present how indigenous cultures (primarily those of North America) manage psychotic disorders naturalistically within the culture without need for expert opinion, reflecting what was found in the World Health Organization studies.

1. Results of Intensive Dialogical Self Therapy With People With Psychosis

Lewis Mehl-Madrona, M.D., Ph.D.

Summary:

Background: Psychotic individuals are rarely primarily treated with social interventions. We present a case series of 51 patients in which this was the primary intervention and report their outcomes.

Design: Qualitative/quantitative study of a patient population who were psychotic and who were managed primarily with narrative therapy.

Setting: Academically based, psychiatric inpatient and outpatient practice.

Participants: Fifty one individuals interacted with the senior author while they were psychotic.

Methods: Patients stories were analyzed using the methods of modified grounded theory and narrative inquiry. Chi square analysis was conducted regarding the symptom severity of people's most severe presenting symptoms.

Results: Of the 51 individuals, 38 were able to manage psychosis and to pass through it without the use of medication or with medication on contact with the author that was slowly titrated to zero. Another 9 managed very well on low dose medications. Three individuals required higher levels of medication and one became progressively worse despite all efforts and was eventually hospitalized in the State Hospital. The overall cost-benefit is very favorable to society, except that little insurance covered the services provided and most of the services were provided by the senior author without compensation.

Conclusions: It is possible to recover from psychotic disorders without medication. Each person's narrative is unique and not necessarily transferable to any other person. How people arrive at successful solutions is varied and makes sense only within their local context and knowledge communities. The results do not hint at one algorithmic solution, but suggest the need for individualized approaches that build upon the previous successes of the person, enroll family and friends in a community effort, and collaborate with those communities to apply various approaches as desired by the people themselves. Perhaps this will become a new paradigm for psychiatric services.

2. Hearing Voices Groups Using Native American Healing Ideas

Barbara J. Mainguy, M.A., M.F.A.

Summary: Alternative approaches to medication for those who hear voices are tried with some degree of trepidation. This paper will focus on a group for those who hear voices that uses sacred drama and other action methods to engage a person with their voices in order to work with them to negotiate a workable 'self' that accounts for the voices but does not give in to directives that are not useful. This intervention is used with some care but has been effective in cases where little else has worked. The program itself is based on Native American ideas of healing that include the idea of a person being many voices, thanks to a radical perspective of what a 'self' might be. Hermans Dialogical Self Theory (2010) discusses an idea of self that approaches that of the Lakota world. Lakota see a person as an instantiation in a swarm of forces acting upon them, all of which have ontological status as 'beings' (Voss, D'Ouville, et al, 1999). Instantiating these voices is therefore a common way of understanding the self. This aboriginal paradigm has been adopted to working with those who hear voices, providing an alternative strategy to help mediate between voices and provide an 'executive' controller who can work towards situation-appropriate behaviour. The objective is to provide a greater level of care than might be available through medication alone.

3. Indigenous (Native American) Approaches to Managing Psychosis

Chief Eagle Dallas, M.A., Lewis Mehl-Madrona, M.D., Ph.D.

Summary: When psychosis occurs within Native American families, it is often managed without expert intervention. Families coalesce around their psychotic members and provide a scaffolding that leads to recovery. This presentation discusses how this happens in Native American communities and how this parallels findings by the World Health Organization in third world countries for the treatment of schizophrenia. It appears that family and community support is very important for recovery and that these factors naturally exist and coalesce in Native American communities.

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SYMPOSIUM 10

Friday, October 5; 8:30 a.m.–11:30 a.m.

Trauma Informed Care and Confronting Organizational Racism: An Integrated Approach to Systems Change for Consumers and Providers

Chair: Paula G. Panzer, M.D.

Presenter(s): Keris Myrick, Ph.D., Joan Adams, L.C.S.W., Kenneth Hardy, Ph.D.

Educational Objectives: At the conclusion of this session, the participant should be able to do the following: articulate the goals and objectives of Trauma Informed Care and Systems of Care that confront Organizational Racism

Summary: Trauma Informed Care (TIC) is an organizational structure and treatment framework that involves understanding, recognizing and responding to the effects of all types of trauma. It emphasizes safety (physical, psychological, social and moral), participation (Bloom 1997) and empowerment for consumers, providers and systems. The essentials require connection (relationships), protection (promotion of safety and trustworthiness), respect (choice and collaboration) and redirection (teaching and reinforcing skills and competencies) (Hummer et al, 2009). "Using a trauma lens" in service delivery requires recognition of the occurrence and impact of violence and neglect on recipients of mental health services, recognizing the trauma contagion to providers and systems, and understanding the varied responses to trauma across presentations, coping skills and diagnoses. Confronting Structural Racism involves recognizing and addressing the impact of racial and cultural identity, power and structural racism in work with clients, staff and systems and countering the burden of silence. This starts from the stance that race is a social and political construct – not a biological one. It involves examination and understanding of the notions of privilege and subjugation, self-identification, race, culture and class. Clinical care in a system which confronts structural racism includes recognition of the traumatic impact of racism and the cumulative effect of daily racial microaggressions (verbal, behavioral or environmental indignities). Using a "racial lens" in service delivery requires similar essentials as TIC – "connect, protect, respect and rebuild." In this symposium these distinct areas of study, their intersection, and their mutual integration will be examined. This will be done by addressing the core components of trauma informed care and addressing structural racism and then looking at the experience of this intersection for individuals in recovery based systems of care. Attendees are invited to bring their questions and examples of Creating Trauma Informed Care and Confronting Structural Racism. This symposium is part of an OMNA On Tour Track, designed as a one day sequence of symposia and interactive workshops exploring the intersection of trauma and racism on mental health and how the intersection of trauma informed care and confronting organizational racism can benefit systems and individuals.

1. Trauma Informed Care: Core Components and Stories of Change

Paula G. Panzer, M.D., Christina A. Grosso, LCAT, ATR-BC, BCETS

Summary: Trauma Informed Care (TIC) is an organizational structure and treatment framework that involves understanding, recognizing and responding to the effects of all types of trauma. It emphasizes safety (physical, psychological, social and moral), participation (Bloom 1997) and empowerment for consumers, providers and systems. The essentials require connection (relationships), protection (promotion of safety and trustworthiness), respect (choice and collaboration) and redirection (teaching and reinforcing skills and competencies) (Hummer et al, 2009). "Using a trauma lens" in service delivery requires recognition of the occurrence and impact of violence and neglect on recipients of mental health services, recognizing the trauma contagion to providers and systems, and understanding the varied responses to trauma across presentations, coping skills and diagnoses. Trauma Informed systems are the safest settings in which to address the impact of traumas and micro-aggressions for the individual and family. Systems of care can be created both top down and bottom up – with shared values and definitions about care and safety. This paper will address the collaborative process of creating a system of care which can offer an integration of a trauma informed and anti-racist lenses which feel whole, welcoming and relevant to the participant.

2. Organizational Process of Change Toward Becoming an Anti-racist Organization

Joan Adams, L.C.S.W.

Summary: We start with the premise that race, as a social political construct, and structural racism are embedded in the fabric of all social institutions in the United States, and that in order to become an anti-racist organization the institution must analyze its relationship to structural racism and struggle to change. The symposium presentation will examine an ongoing organizational initiative, Confronting Organizational Racism (COR), at JBFCS, a large social service agency in New York City that provides a range of services to a racially, culturally and religiously diverse population of children, adolescents and adults. The COR initiative addresses the impact of race, culture, structural racism and power on service delivery and staff relations. The workshop will provide information about the history and context, and rational for developing the COR initiative, which is strongly supported by the CEO and included in the agency's Strategic Plan. We will describe the current structure and functions of COR. JBFCS also has a strong commitment to infusing a Trauma Lens in to organizational and clinical work; as such, the intersection of addressing racism and understanding trauma is meaningful to this organizational change process. The presentation will address the intersection of organizational power dynamics, clinical manifestations of racial trauma, and staff experiences with white skin privilege and racial oppression. The presentation will give examples of lessons learned about engaging and developing buy-in from various levels of the organization; and ongoing work toward organizational change. Examples of our process and struggle include requiring and supporting anti-racism training for all agency managers at Director Level and above and shifting from a single leadership model to a group leadership structure. Another example is addressing racial dynamics in providing client care and in strengthening staff diversity and inclusion at specific programs. Finally, we will also describe the establishment of an Anti-racism and Multicultural Consultation and Training Service that supports other agencies in this change process; establishment of Policies around transfer of clients and transfer of supervisees; and the establishment of guidelines for increasing the pool of job candidates whose background reflects the racial/ethnic makeup of the population.

3. Racial Oppression and the Invisible Wounds of Trauma

Kenneth Hardy, Ph.D.

Summary: Interactions with members of oppressed groups are often complicated by the presence of invisible wounds. These wounds are the culmination of ongoing experiences with injustice, degradation, and discrimination. While the invisible wounds of race-related trauma may not be readily discernible to clinician or client, they have a profound impact on the course of treatment and its outcome. Clinicians' lack of awareness and sensitivity to the wounds of race-related trauma can stifle the joining process and unwittingly contribute to therapeutic ways of being and interventions that are counterproductive to effective treatment. Such innocent acts of insensitivity are often the unspoken, unacknowledged micro-acts that contribute to the premature termination of treatment and perception that racially oppressed people are resistant to treatment. This presentation will examine the anatomy of racial oppression as a manifestation of trauma and its impact on the life experiences of those who are targeted. It will explore the multitudinous ways in which intervention strategies can unwittingly contribute to acts of secondary traumata for clients whose life experiences have been maligned by prejudice and discrimination. Strategies for uncovering and addressing the invisible wounds of race-related trauma will be discussed. Participants also will be encouraged to explore the ways in which their personal experiences with racial oppression both enrich and constrain their work.

SYMPOSIUM 11

Friday, October 5; 8:30 a.m.–11:30 a.m.

Recovery From Trauma: A Model for Integration of Individual and Family Therapy in Serious Mental Illness

Chair(s): Marissa F. Miyazaki, M.D., Madeleine Abrams, L.C.S.W.

Presenter(s): Joseph Battaglia, M.D., David A. Stern, M.D., Kristina H. Muenzenmaier, M.D., Tanya V. Azarani, M.D.

Educational Objectives: By the conclusion of the session, participants will be able to identify and discuss barriers to integration of individual and family therapy in the treatment of trauma in individuals with serious mental illness.

Summary: In the mental health system, consumers diagnosed with serious mental illness have often experienced trauma, sometimes within the family. An experience of trauma often leads to guilt and shame, an effect that can ripple across the family system and lead to individual isolation and estrangement of family members from each other. Sometimes, family members were the perpetrators of or passive witnesses to the trauma. Frequently, family members have themselves been victims of trauma. Regardless of the context, mental health professionals are not well-equipped to deal with the complexity of such situations. Consumer, therapist, family and system barriers lead to avoidance of family involvement. It has been our experience, however, that the integration of individual and family therapy is not only appropriate but essential for healing to occur. This workshop will address the importance of integrating family therapy into the process of recovery from trauma. An essential component of recovery is reconnecting consumers with family and social networks. We will provide an overview of the barriers and challenges to such integration, using clinical case examples from our own training institution. We recognize that despite the importance of a multi-systems approach, and despite the preliminary evidence for the efficacy of such interventions, few systematized models or clinical guidelines exist. In this workshop, participants will be introduced to creative systems-based strategies represented by a four-phase integrative model of individual and family therapy targeted for mental health professionals working in the public mental health sector. We will offer a comprehensive treatment approach focusing on the different stages of trauma recovery and the integration of the clinical modalities of individual and family therapies, with a special focus on recovery for consumers and families who have experienced significant trauma. Finally, participants of the workshop will be encouraged to share their own experiences and challenges in integrating individual and family therapy for serious mental illness associated with trauma within the family.

1. Historical Overview of Individual and Family Therapy

Joseph Battaglia, M.D., Marissa F. Miyazaki, M.D.

Summary: Psychotherapy, at the beginning of the twentieth century, centered on individual therapy and the patient therapist relationship. Beginning with Sigmund Freud, the genesis of psychopathology was viewed as arising from the family system. Freud and his successors maintained that psychopathology resulted from neurotic conflicts arising, from destructive interactions in the family, and that treatment would be most effective if conducted in isolation from the harmful influences of such family members. Thus the aim of psychoanalysis, the prevailing theoretical, approach throughout the early twentieth century, was to repair damage created by early traumatic experiences within the family system. Families were viewed as a barrier rather than resource in the treatment of individual pathology. In this segment a historical overview of the developments of family therapy will be provided, with a focus on how family therapy evolved from the existing psychoanalytic paradigm. This will include an overview of some of the major historical figures in the area of family therapy with severe mentally ill individuals. Features unique as well as common to both modalities of individual and family therapy will be outlined and explored, with the aim of providing a theoretical and historical background and rationale for integrating individual and family therapy in the treatment of serious mental illness.

2. Barriers to Integration of Individual and Family Therapy

Kristina H. Muenzenmaier, M.D.

Summary: While the need for assessment and treatment of PTSD and trauma related disorders in the psychiatric population has been widely acknowledged, significant gaps remain in the implementation of treatment for PTSD and co-occurring disorders in the public mental health sector. In order to understand those gaps, we will discuss barriers related to patients, clinicians, and larger systems as they relate to trauma informed interventions. Historically, approaches to individual and trauma treatment did not include family systems approaches. This presentation will discuss barriers hindering the implementation of trauma informed interventions and family systems approaches in this population. We will outline the complexities and the overlap of these different approaches. Case examples will illustrate how those barriers can be overcome and how clinicians can improve their understanding in working with trauma related issues in people with severe mental illness.

3. Importance of Integration of Individual and Family Therapy

Tanya V. Azarani, M.D.

Summary: Traditional concepts of resilience, usually within the field of child development, have focused on intrinsic individual fortitude in the face of adversity, namely dysfunctional familial influences. Not only are families often overlooked as a potential source of resilience, they are often blamed for its destruction. Relational resilience refers to the resilience that develops within a family in response to crises. Contemporary theories recognize the protective potential of the family unit, and the role of relational resilience in engendering long term resilience within each family member. The relational resilience paradigm has changed the way that families are perceived, shifting from a "damaged" to a "challenged " family perspective, where families, like the individuals within them, are no longer considered intrinsically flawed, but transiently challenged and capable of recovery. The integration of individual and family therapy is a necessity, given the complexity of human functioning, and the need for multifactorial interventions in the treatment of severe mental illness and trauma. Integration facilitates a more comprehensive understanding of the individual, intrapsychically and interpersonally within the rich context and systems that have helped shape development. People with severe mental illness, especially those who have been confined to state hospitals for extended periods of time, face unique challenges that require the support of the family unit. The integration of individual and family interventions can provide those with severe mental illness the benefits of relational resilience and provides a broader context for understanding the individual. This segment of the symposium will explore aspects of individual and family therapy with special emphasis on the importance of integrating both modalities in the care of those with trauma and severe mental illness.

4. Family Model for Treating Trauma

Madeleine Abrams, L.C.S.W.

Summary: Historically, and even currently despite its lack of political correctness, families have been blamed and stigmatized for serious mental illness in a family member. This attitude is even more exaggerated in cases of trauma, particularly when it occurs within the family. Thus, families of people with both serious mental illness and trauma frequently have been ignored, disempowered, blamed, and stigmatized. In working with this population, we have seen how the exclusion of the family has contributed to lack of progress in working with an individual coping with serious mental illness and trauma. When the family is integrated into the treatment, we have seen evidence that the individual progresses and the family suffering and guilt is alleviated. Whenever possible, families are able to be reconnected in a more positive manner. This presentation will begin with outlining a four phase model for working with families coping with trauma and serious mental illness that we developed in our program. Central to constructing the model are several premises and assumptions which we consider to be basic to an understanding of the experience of families fitting these criteria. The model consists of strategies for engagement, interventions to be implemented, working through and reintegration of the family, and consolidation thus enabling the development of a new model for relationships. Application of the model will be discussed and reinforced with clinical illustrations. The audience will be encouraged to work on vignettes as well as offer examples from their own experience.

SYMPOSIUM 12

Friday, October 5; 8:30 a.m.–11:30 a.m.

Collaborating With Faith-Based Organizations to Reduce Racial Disparities in Mental Health Treatment

Chair(s): Sidney H. Hankerson, M.D., M.B.A., Ezra E. Griffith, M.D.

Presenter(s): Karinn A. Glover, M.D., M.P.H., Carl C. Bell, M.D., Alfiee Breland-Noble, Ph.D., M.H.S.C., Chisina T. Kapungu, Ph.D.

Educational Objectives: At the conclusion of the session, participants should be able to identify barriers that contribute to racial disparities in mental health treatment among African Americans.

Summary: The NIMH Working Group on Research on Affective Disorders suggested that community-based interventions hold promise for reducing racial/ethnic disparities in mental health treatment. African Americans, compared to White Americans, underutilize traditional psychiatric services and are more likely to cite religious factors as an extremely important component of treatment for major depression. Among the many barriers that contribute to African Americans' underutilization of traditional psychiatric services include stigma, distrust of providers, cultural insensitivity, financial cost, and lack of access. The Black Church is a trusted institution that occupies an important social, religious, and cultural role in many African American communities, making the church an ideal setting in which to promote increased access to mental health care through community-based interventions. Indeed, African American clergy have been referred to as "gatekeepers" for mental health referrals in the Black community. Hankerson and Weissman conducted a systematic review of published studies of church-based programs for mental disorders among African Americans and concluded that the Black Church is currently an underutilized resource for reducing racial disparities in mental health care. Mental health providers who collaborate with the Black Church may be well positioned to overcome barriers that contribute to racial disparities in psychiatric care. Thus, the overall objective of this symposium is to equip mental health professionals with strategies to engage African Americans in mental health treatment by collaborating with faith-based organizations. Our panel includes academic researchers with expertise in collaborating with churches to provide psychiatric services to African Americans in a culturally sensitive, empirically-based, and innovative way. Dr. Griffith will discuss the cultural significance and therapeutic elements of the Black Church and how they can impact psychiatric treatment. Dr. Hankerson will present findings from his NARSAD Young Investigator Award that adapts and tests the effectiveness of IPT for depressed African Americans delivered in a church setting. Dr. Breland-Noble will outline her K-Award research project AAKOMA, which was designed to develop and test an intervention for increasing African American adolescent depression treatment use and utilized strategic community engagement with a focus on Faith Based Health Promotion. Dr. Kapungu will highlight the development and evaluation of a culturally sensitive, family and faith-centered HIV prevention program for African American girls (age 13–16) and their primary female caregivers. Dr. Glover will discuss how practitioners from community mental health centers can collaborate with faith-based organizations. Finally, Dr. Bell will comment on the importance of involving indigenous support systems, like the Black Church, to implement evidence-based public health interventions.

1. Engaging Depressed African American Youth and Families via the Black Faith Community: Lessons From The AAKOMA Project

Alfiee Breland-Noble, Ph.D., M.H.S.C.

Summary: The AAKOMA Project was designed to develop and test an intervention for increasing African American adolescent depression treatment use. Treatment development and pilot testing for the intervention, entitled AAKOMA FLOA, included strategic community engagement with a focus on Faith Based Health Promotion. The treatment development phase of the study benefitted from significant faith community involvement and yielded important findings regarding the recruitment of African Americans to clinical research via strategic community engagement (based on Bell and colleagues' Seven Field Principles). AAKOMA FLOA Pilot intervention findings highlight the preliminary utility of the depression treatment engagement intervention (100% of youth completing the intervention initiated depression treatment compared to 75% of the delayed control group) and factors that support the recruitment and engagement of a reportedly difficult to reach population (depressed African American youth and families). Overall, the study provides support for the use of qualitative methods for treatment development, the employment of strategic Community Based Participatory methods in working with African American youth and families and the heretofore under-realized promise of Faith Based Health Promotion for mental health clinical research with diverse populations.

2. Bridging Faith and Health: Lessons Learned From a Family and Faith-Centered HIV Prevention Program

Chisina T. Kapungu, Ph.D., Donna Baptiste, Ph.D., Sally Berko, R.N., B.S.N., Penny Willis, M.Div.

Summary: The African American church has been an underutilized resource within the HIV prevention field. Religious organizations have a potentially important role in educating young people about sexuality. However, there are currently very few empirically supported family and faith-based HIV prevention programs specifically tailored for African American girls. The primary objective of this study was to develop and evaluate a culturally sensitive, family and faith-centered HIV prevention program for African American girls (age 13–16) and their primary female caregivers. The family and faith-centered program was developed from a theoretically-based "grassroots" HIV intervention created by the Religious Coalition for Reproductive Choice (Generation to Generation) and an evidence-based HIV prevention program designed for African American girls (SiHLE). The intervention was piloted with a sample of African American families to obtain participant feedback and evaluate program feasibility. The family and faith-centered HIV prevention program aimed to strengthen knowledge and skills that were empirically linked to teen sexual behavior including parental monitoring, parent-adolescent communication, refusal and negotiation skills and peer influences. Results from the pilot highlight the acceptability and feasibility of family and faith-centered HIV interventions which address the sexual risks of African American girls.

SYMPOSIUM 13

Friday, October 5; 2:00 p.m.–5:00 p.m.

Prevention & Wellness in Behavioral Health Care: From Research to Standards to Community

Chair: Yad M. Jabbarpour, M.D.

Presenter(s): Carl C. Bell, M.D., Frances M. Harding, M.D., Mary Cesare-Murphy, Ph.D., Margaret Swarbrick, Ph.D., OTR/L, William R. Beardslee, M.D.

Educational Objectives: At the conclusion of the session, participants will learn and be able to describe prevention models in the field of behavioral health care.

Summary: Over the 20th Century, prevention in the field of medicine has grown as a worthy public health focus. In 1963, President John F. Kennedy set a vision for the U.S. community mental health system; the same year in his message to Congress he set a vision for prevention: "Prevention will require both selected specific programs directed especially at known causes, and the general strengthening of our fundamental community, social welfare, and educational programs which can do much to eliminate or correct the harsh environmental conditions which often are associated with mental retardation and mental illness." It is only in recent decades when evidence based practices in psychiatric services have supported prevention in behavioral health care, wellness and health promotion. As we move into the 21st Century, the tipping point is here. On one hand persons with severe mental illness die on average 25 years sooner than the general population. On the other, clinicians, advocates, family members and the persons served are beginning to change toward the goal of preventing mental illness, substance abuse and medical comorbidity, and to minimize risk for those with problems. In addition, accrediting agencies, the federal government and other organizations are leading system transformation as exemplified by the work of The Joint Commission, SAMHSA, and the Institute of Medicine toward operationalizing the vision of prevention, wellness and health promotion.

SYMPOSIUM 14

Friday, October 5; 2:00 p.m.– 5:00 p.m.

A Primer on the Social Determinants of Mental Health

Chair: Michael T. Compton, M.D., M.P.H.

Presenter(s): Frederick J.P. Langheim, M.D., Ph.D., Carol R. Koplan, M.D., Ruth S. Shim, M.D., M.P.H., Christopher J. Oleskey, M.D., M.P.H., Marc W. Manseau, M.D., M.P.H.

Educational Objectives: At the conclusion of the session, participants will understand and define the concept of the social determinants of mental health.

Summary: In the 19th century, Dr. Rudolph Virchow noted that "Medicine is a social science, and policy its instrument. The physician has a responsibility to cure society's ills." This symposium challenges public, community, and social psychiatrists to consider their responsibility in addressing policies and politics that are damaging to the mental health of our communities. The presentations will focus on the social determinants of mental health and mental illness; that is, those factors stemming from where we grow, live, work, learn, and age that impact our overall mental health and well-being, and those factors that contribute to mental illness. Although there has been much previous focus on social determinants of physical health, there has been surprisingly little emphasis on the social determinants of mental health. Although mental illnesses are often underpinned by genetic predisposition and likely also by gene-by-environment interactions, we will highlight the social determinants of such disorders, given that the social determinants are likely malleable through social and policy interventions. Each presentation will conclude with a call to action that includes intervention recommendations from individual, community, and policy levels, and how individual psychiatrists can lead in this pursuit. This symposium is of particular relevance to pubic, social, and community psychiatrists, as well as health service researchers. The presenters are members of the Prevention Committee of the Group for the Advancement of Psychiatry (GAP), who will draw from their current work in defining, classifying, and characterizing the social determinants of mental health. This series of presentations will provide a survey of the recent literature on health inequalities and inequities along socioeconomic gradients between and within countries. Categories of social determinants of mental health, some of which will be discussed in depth in this presentation, include: adverse early life experiences, interpersonal difficulties and strife, low educational attainment, employment insecurity and poverty, housing and food insecurity, inadequacies in the natural and built environment, political inequity and lack of political power, poor access to healthcare, and inequities based on gender, race, ethnicity, sexual orientation, and disability.

1. Overview of Social Determinants of Mental Health

Ruth S. Shim, M.D., M.P.H.

Summary: This portion of the presentation will discuss the concept of social determinants of mental health and mental illness using the World Health Organization's definition of social determinants of health, the "syndemic" concept, the ability to influence the social determinants through policy change, and literature on health inequities across and within countries. Emphasizing the connection to social justice, this presentation will review how addressing the social determinants of mental health is an ethical imperative.

2. Adverse Early Life Experiences as Social Determinants of Mental Health

Carol R. Koplan, M.D.

Summary: Carol Koplan, MD will review the impact of early childhood experiences on mental health, highlighting the "Adverse Childhood Experience" (ACE) study, childhood trauma, foster care, and separation from parents. Recommended interventions will focus on early home visits, prevention of child abuse and domestic violence, treatment of perinatal maternal depression, and increasing social inclusion and connectedness.

3. Economic Social Determinants of Mental Health: Employment Insecurity, Poverty, and Inequality

Marc W. Manseau, M.D., M.P.H.

Summary: Marc Manseau, MD, MPH will cover economic factors as social determinants of mental health and illness. Economic influences on health and illness include both absolute deprivation and relative inequality, both of which independently affect health and well-being in complex ways via distinct and overlapping pathways. Poverty can be addressed on both the individual and ecologic levels. An examination of the economic determinants of mental health and illness has important policy implications, related to various topics including unemployment, under-employment, minimum wage standards, and the impact of the widening gap between the rich and the poor n the United States.

4. A Primer on the Social Determinants of Mental Health

Christopher J. Oleskey, M.D., M.P.H.

Summary: This symposium will examine the social determinants of mental health. Topics covered include an overview of the social determinants of mental health, the impact of adverse early life experiences, natural and built environments as social determinants, and the impact of barriers to accessing mental health care. The primer will also include activities that psychiatrists may engage in to improve mental health in their communities by addressing these social determinants.

5. Poor Access to Care as a Social Determinant of Mental Illness

Frederick J.P. Langheim, M.D., Ph.D.

Summary: Poor access to care is a social determinant of mental illness. In September 2011, the Census Bureau announced that 50 million people were without health insurance in 2010, approximately 1 million more than in 2009. Even with insurance, access to mental health care remains problematic due to the limited numbers and geographic clustering of providers, as well as historic separation of mental health care from general medical health coverage. Despite legislating parity, a recent survey in California demonstrated routine violation of parity laws with ongoing poor access to care. This in the face of data from Oregon (among the strictest states with respect to mental health parity) which demonstrated no increased cost among 4 insurance providers despite the state legislating full access to drug and alcohol treatment and mental health coverage. Clearly the interplay of mental illness and substance use with other medical illness warrants full access and underscores the need for preventive mental health care despite delayed realization of benefits. Primary care is most poised to implement these preventive measures, if only provided adequate time and resources, both of which are anathema to the current fee-for-service system. Truly universal coverage with nation-wide integration of medical records and coordinated care is likely to provide greater capacity and incentive for maintaining mental health, rather than treating illness, and thereby address the developing crisis of cost of health care in the United States.

SYMPOSIUM 15

Saturday, October 6; 8:30 a.m.–11:30 a.m.

Prescribing Buprenorphine in Groups

American Association of Community Psychiatrists

Chair(s): Benjamin Crocker, M.D., David A. Moltz, M.D.

Presenter(s): M. Louisa Barnhart, M.D., M.P.H., Robert V. McCarley, M.D., Curtis N. Adams, Jr., M.D.

Educational Objectives: At the conclusion of the session, participants will be able to describe the treatment benefits of prescribing buprenorphine in loosely bound, structured prescribing groups.

Summary: Our symposium will describe several different models of medication groups in which buprenorphine is prescribed for the treatment of opiate dependence. The chairman will review the history and literature regarding psychotropic medication groups and address their use in primary care integration and in other settings where there is a shortage of psychiatric specialty prescribers. The Co-Chair will describe a group suboxone prescribing system within a substance abuse treatment service. The three other presenters will describe different group models in which buprenorphine is prescribed in a variety community mental health clinic settings serving dually diagnosed patients. Several clinical case histories will be presented to illustrate the role of group process in addictions and dual diagnosis treatment. While the focus of our symposium will be on the use of groups to optimize access to suboxone within the context of group based treatment, we will also address more generally the issues of confidentiality, shared decision making, group confrontation of denial and of stigma, and the cultural differences between treatment cultures that have traditionally been segregated into mental health and substance abuse camps. Each of our presenters will describe in detail the process that led to the formation of treatment groups that include the prescribing of suboxone, the barriers to this, and how they were overcome. At least two of use will describe the use of suboxone prescribing groups to educate and motivate trainees and other prospective buprenorphine prescribers to overcome stigma and anxiety and actually start doing the work. While as of the date of this submission we have not recruited a primary care physician or addictionologist who prescribes buprenorphine in groups to present with is, it is our intent to do this, and we know of several possible candidates.

1. Prescribing Buprenorphine in Groups

Curtis N. Adams, Jr., M.D.

Summary: Suboxone maintenance therapy for opioid dependence can be delivered in a group format in a community mental health center. The groups can be Suboxone-specific groups or general Integrated Dual Diagnosis Groups. In this talk, we will discuss group formats, Suboxone induction, provider credentials, treatment phases, the prescriber's role and payment for Suboxone therapy.

2. Prescribing Buprenorphine in Groups

Robert V. McCarley, M.D.

Summary: This Segment of Prescribing Buprenorphine in Groups will discuss the utilization of Suboxone maintenance treatment in a group format at a community psychiatry clinic. The topics will include: rationale for group treatment, different formats utilized, use of group as a higher level of care, opportunities for "graduation" from group, urine toxicology screens, the protocol for slips and relapses, patient benefits of peer support, efficiencies of this model, and anxieties of prescribing in a group setting. Included in the discussion will be examples of both successes to emulate and mistakes to avoid. By the conclusion of the talk prescribers will be encouraged to begin their own group.

3. Prescribing Buprenorphine in Groups

M. Louisa Barnhart, M.D., M.P.H.

Summary: This segment will discuss ideas and issues around the early organization of a suboxone group. Advertisement coverage issues, sample topics and writing a group worth of prescriptions will be covered. Avoidable pitfalls will be shared. Boost your confidence to start your own group.

SYMPOSIUM 16

Saturday, October 6; 8:30 a.m.–11:30 a.m.

Changing the World: Trauma-Informed Integrated Systems Transformation for Multi-occurring Disabilities in Iowa

American Association of Community Psychiatrists

Chair: Kenneth Minkoff, M.D.

Presenter(s): Maria A. Morcuende, M.D., Christie A. Cline, M.D., M.B.A., Michael Flaum, M.D.

Educational Objectives: At the conclusion of the session, participants will be able to understand the eight principles of a comprehensive continuous integrated system of care and their application to system design within a trauma informed and integrated philosophy.

Summary: Individuals and families with multi-occurring conditions of all kinds (including mental health, substance abuse, developmental disability, brain injury, trauma, health, criminal justice, housing, etc.) represent a population with poorer outcomes and higher costs in multiple domains, presenting with sufficient frequency in all systems and services that it is recognized that "multi-occurring conditions are an expectation, not an exception." As a result, there has been increasing recognition of the need for developing a systemic approach to serving these individuals. Minkoff and Cline have developed an implementation process for a model termed Comprehensive Continuous Integrated System of Care, in which within existing resources in any system, all programs can be designed as "hopeful, strength-based, person-centered (recovery oriented) trauma-informed co-occurring programs" meeting minimal standards of recovery oriented co-occurring capability, but each program has a different job, to provide matched services to its existing cohort of clients and families with co-occurring conditions based on a set of consensus best practice principles within an integrated hopeful philosophy. In this symposium they describe the model, and the 12 step implementation process and implementation toolkit, based on strategic planning and continuous quality improvement principles. The remainder of the symposium is dedicated to describing the ongoing quality improvement process for implementation of system wide changes in the capacity to provide integrated services at the state and regional level in Iowa, as part of statewide transformation activity. This includes alignment between the development of integrated services for MH/SA populations, the expansion to include DD/BI services in alignment with Olmstead implementation, the initiation of implementation of trauma informed care, and the application of vision driven system design to regionalization efforts in both adult and children's system populations. Presentations will review the overarching system wide strategy to utilize quality improvement as a vehicle for implementation of recovery oriented "multi-occurring" capability within complex, scarce resourced systems, and then specific strategies by which Iowa has made progress in improving the delivery of integrated services for individuals and families with multi-occurring mental health, substance use, DD/BI,, trauma conditions, and other complex needs. Strategies will include addressing state level improvement processes, including the development of a cadre of change agents, aligning trauma informed service development with the integrated system improvement process, improving universal multi-occurring capability at the program level, and building trauma informed, multi-occurring workforce competency.

1. Comprehensive Continuous Integrated System of Care for Multi-Occurring Conditions: Description of the Framework

Kenneth Minkoff, M.D.

Summary: Individuals with multi-occurring (MH, SA, DD, BI, trauma, health, etc.) conditions are an expectation, not an exception throughout the service system, associated with poor outcomes and high costs in multiple domains. To provide more welcoming, accessible, integrated, continuous, and comprehensive services in a system of care with scarce resources, the CCISC model organizes a framework for system design in which every program is a multi-occurring program meeting minimum standards of hopeful, person-centered (recovery oriented) multi-occurring capability within the context of its existing resources, but each program has a different job, based first on what it is already designed to be doing, and the people with multi-occurring conditions already there, but providing matched services based on a set of research derived integrated consensus best practice principles within the context of its existing resources. Similarly, each person delivering service or support is a multi-occurring "helper" meeting standards of multi-occurring competency regardless of licensure or job description, to provide properly matched services to the clients in his or her caseload. This presentation summarizes the model, the eight principles, and the twelve step program of CCISC implementation involving a strategically planned CQI process that incorporates a "top-down, bottom-up and back again" interactive design, in which the system, programs, clinical practices, and clinician competencies all progress together building on existing system strengths and resources.

2. Implementing Systems Change on the Ground at the State and Local Community Levels

Michael Flaum, M.D.

Summary: This presentation will describe experiences at the state level in organizing, building support for, and sustaining a more integrated system of care for adults across a broad range of clients, providers, administrators and funders of services. Through a public-academic partnership, the Iowa Consortium for Mental Health facilitated quarterly trainings and site visits over a two year period by Drs. Minkoff and Cline, and supported the development of a statewide group of "change agents," the Iowa Co-Occurring Resource Network. The presentation will discuss lessons learned at the state level and highlight specific implementation strategies within the local community around the University of Iowa.

3. Becoming Trauma-Informed: Anticipating Barriers to Implementation in the Assessment Process

Maria A. Morcuende, M.D.

Summary: Trauma-Informed Care is an organizational structure that understands the full impact of trauma in the lives of the clients, and is committed to the safety of clients and clinicians receiving and providing services within the system. Building and maintaining clinician's competence to effectively deliver Trauma-Specific Services, or models for the treatment of the consequences of trauma, requires the support of a trauma-informed organization. We performed an organizational assessment of eight Mental Health Centers initiating the process of becoming trauma-informed as part of the Trauma-Informed Care Initiative in Iowa. In this presentation we will examine strengths and limitations of our assessments in anticipating barriers to the implementation process. Building on our experience, we will reflect on the need of a model for system transformation that focuses on existing resources and integrating Trauma-Informed Care with development of recovery oriented systems and multi-occurring capability, and is used to guide the initial assessment process.

4. CCISC: Real World Application and Implementation Strategies

Christie A. Cline, M.D., M.B.A.

Summary: Based on the author's experience with implementation projects in 30 states and three Canadian provinces during the past 10 years, this presentation will discuss the specific strategies by which the CCISC framework can be adapted to the needs of real world systems with complex structures and limited resources, and discuss how these strategies are relevant to the transformation process in Iowa. Topics will include the design of the quality improvement partnership that incorporates the top down, bottom up feedback loop, common traps regarding data collection, funding and training and how to avoid them, methods for implementing regional systems, programmatic improvement and staff competency development through the creation of an empowered cadre of practice improvement specialists or "change agents," and other concrete techniques. The presentation will also discuss the CCISC toolkit, including system fidelity tool (CO-FIT), program self assessment for multi-occurring capability with various populations (COMPASS-EZ for MH/SA programs; COMPASS-ID for DD/BI programs), and clinician self-assessment of attitudes and skills (CODECAT-EZ). There will be an emphasis on the fundamental clinical processes of welcoming engagement, integrated relationships, universal integrated screening, integrated longitudinal strength based assessment, and stage specific assessment and treatment/service/recovery planning, as grounding features of practice development. Finally, examples of application of the model will be discussed in a range of state and county systems across the U.S. and Canada.

SYMPOSIUM 17

Saturday, October 6; 8:30 a.m.–11:30 a.m.

Co-Creation of Meaning: Consumer and Family as Educator of Psychiatry Residents to Promote Recovery and Enhance Training

Chair(s): Jeffrey Kerner, M.D., Madeleine Abrams, L.C.S.W.

Presenter(s): Joseph Battaglia, M.D., Marissa F. Miyazaki, M.D., Elie Isenberg-Grzeda, M.D.

Summary: In an era of short-term treatment models, rapid transitions between hospital and community, and shorter rotations of residents working with people with serious mental illness, it is necessary to develop creative ways to teach systems-based practice and the therapeutic relationship. Central to both effective training and recovery is the ability to counter both residents' and families' hopelessness and helplessness about navigating complex systems to foster change for people with chronic psychiatric and psychosocial problems. We have developed a model for training residents that enables rotating residents to be part of a greater whole held together by the consumer, family, and a supervisor who remains consistent with the different residents and with the family. While families know that they will work with many residents in the course of their treatment, they may feel that they are passive recipients of service as they have no control over changes. By explicitly defining their role as educators, they feel empowered. Through this mutually beneficial relationship, residents learn family therapy skills, attitudes that reflect compassion and humility, and an ability to interface with treatment providers and multiple systems of care in order to provide continuity of care and empower themselves as well. In this session, we will describe the model and give clinical examples which embody principles of collaboration and creation of mutual purpose and meaning. The panel includes consumers, family members, psychiatry residents, and supervisors presenting their experiences and the model together through participation in discussion and videotaped segments. We will demonstrate examples of families teaching residents about the difficulty in navigating systems while residents, experiencing the same frustrations, learn to develop creative strategies for advocacy. Additionally, residents learn to mobilize strengths in consumers and families who give back to the residents by educating them about hope, trust, and compassionate understanding. We hope to engage the audience in a dialogue about collaborative ways to teach and inspire residents and to promote recovery of families and consumers.

1. A Comprehensive Approach to the Individual: An Integration of Individual and Family Therapy

Joseph Battaglia, M.D.

Summary: The psychiatry residency program of Albert Einstein College of Medicine in the Bronx includes a six month rotation on an inpatient unit at an intermediate care state psychiatric facility known as Bronx Psychiatry Center. The training environment at this long term care facility for severely mentally ill clients encourages residents to embrace a comprehensive approach to the individual that included an integration of individual and family therapy. Families are viewed as part of a larger system, and it was felt that in order for families to sustain themselves they required support from the therapist, treatment team and hospital system. In a setting where feelings of hopelessness and futility are common, residents instill hope and reinvigorate a system that at times could become stagnant or resistant to change. They do this by carefully building alliances through creative interventions, not just their clients but their client's family members, to better understand their specific needs, strengths and limitations. Residents are given the time, space, resources and encouragement to immerse themselves in the world of their clients and their clients' family members, including home visits and meeting alone with their family members.

2. Experiences In Navigating Complex Mental Health Systems

Marissa F. Miyazaki, M.D.

Summary: For family members of patients with severe mental illness, negative experiences in navigating complex mental health systems can lead to an erosion of trust in the system. This can be difficult for their treatment providers, who may struggle to regain this trust. This situation is even more complicated in a training environment, where meaningful alliances are subject to frequent disruption by resident turnover. This can present a unique challenge for the incoming residents, who must forge a new alliance with patients and their families. A training philosophy that views the family as educator of residents not only empowers the family but strengthens the alliance with their providers. In this segment of the symposium we have invited one family to share their experiences with the mental health system and a residency training environment. We will illustrate how a training approach that viewed family as educator helped rebuild trust and promoted healing and recovery for the patient.

3. A Review of the Literature on Couples Therapy as a Long-Term Treatment Modality

Elie Isenberg-Grzeda, M.D.

Summary: Since the 1950's, treatment of chronic mental illness has moved to the community, and an estimated 40% of patients live with their families. Spouses of patients with mental illness commonly face unique challenges. Working with families is a common clinical scenario encountered by psychiatric residents; however, residents face obstacles to providing family therapy. Family therapy is an evidence-based treatment, and is reflected in the APA guidelines on the treatment of several axis I disorders. A review of the literature on family psychiatry is presented, as it pertains to issues unique to spouses with mental illness and the challenges that psychiatric residents confront in working with such populations. An evidence base exits to guide certain aspects of couples therapy in which one member has mental illness. Couples therapy is an effective modality for long-term treatment.

SYMPOSIUM 18

Saturday, October 6; 8:30 a.m.–11:30 a.m.

Urban Psychiatry

Chair(s): Josephine M. A. Caubel, M.D., Wilco Tuinebreijer, M.D.

Summary: More than 50% of the world population lives in cities, four out of five Europeans do, and the worldwide migration to mega cities is not expected to stop. As a consequence, urban health is a major subject of interest. Cities are not only sources of creativity and possibilities. Environmental, socio-economic and infrastructural factors affect the well-being of a city's population and can cause mental (1) and somatic diseases of their dwellers. The influence of the ongoing economic crisis is unpredictable. The incidence of psychopathology is higher in urban environments than in rural settings (2). Psychiatric institutions in highly urbanized regions face specific problems as homelessness, drug abuse and diverse populations. During this symposium, speakers working in the field of urban and municipal psychiatry will depict the Amsterdam and Parisian couleur locale of coping with universal urban mental health challenges.

SYMPOSIUM 19

Saturday, October 6; 2:00 p.m.–5:00 p.m.

Cultivating Physical Health and Wellness in Adults With Serious Mental Illnesses

Chair: Elizabeth Vreeland, M.S.N.

Presenter(s): Theresa Miskimen, M.D., Shula Minsky, Ed.D., Michele A. Miller, M.S.N., Sally Mravcak, M.D., Jill M. Williams, M.D., Anna Marie Toto, Ed.M.

Educational Objectives: At the conclusion of this session, the participant should be able understand evidence-based rationale for integration of physical and psychiatric care.

Summary: Many consumers of mental health services face the harsh reality that they may die decades earlier than people without mental illness. A number of factors contribute to the high rate of medical problems in people with serious mental illnesses (SMI). These include, but are not limited to: modifiable lifestyle risk factors including obesity, poor diet and limited physical activity, the added burden from medications, reduced access to health care, and tobacco addiction. A report from the Substance Abuse and Mental Health Services Administration (SAMHSA) states that if these conditions were managed, the resulting care would most likely "make the biggest difference in the health of consumers." The SAMHSA Wellness Campaign has a goal to reduce health disparities in people with mental illness and models are emerging to examine different ways to optimize care. The University of Medicine and Dentistry of New Jersey (UMDNJ) has been developing solutions and implementing strategies and programs that integrate physical health and wellness into behavioral healthcare for more than a decade. This symposia aims to describe several initiatives that support SAMHSA's Wellness Campaign that assist people with SMI to live healthier lives which can be implemented by other behavioral health care providers and organizations. To this purpose this workshop will provide evidence-based rationale for physical health integration in a behavioral care setting, describe and characterize SAMHSA's Wellness Campaign, and discuss real-life examples on how to incorporate physical health into the daily delivery of mental health services. A detailed account of topics such as strategies on how to improve access and utilization of primary care services, form and run a physical health subcommittee, choose outcome measures to assess success, and assist clinicians in developing the core clinical competencies needed to achieve integration. Theories, strategies, and approaches which foster health and wellness including person-centered care, the Transtheoretical Model of Change, motivational counseling, and wellness self-management will be presented. Furthermore issues and barriers that have prevented addressing tobacco and obesity in behavioral health settings will be discussed. Persons with SMI are more likely to use tobacco and have weight problems which contribute to their higher rates of medical morbidity and mortality. Strategies and tools including a manualized approach for working with low motivated smokers with mental illness will be presented. Data will be shared which suggests adults with SMI tend to underestimate their weight status and see themselves as less overweight than they are. This gap between reality and self-perception must be addressed if weight control and other health interventions are to be effective. Interventions including the utilization of a wellness toolkit to address overweight and obesity will also be presented.

1. Integrating Physical and Behavioral Health Care: What Can Behavioral Health Organizations Do? (Part 1)

Michele A. Miller, M.S.N., Shula Minsky, Ed.D.

Summary:
Objectives: 1. Describe the need for organization-wide approach to integration of physical health care into the behavioral health treatment of people with SMI. 2. Understand the need and benefits for multi-faceted organizational approaches and describe strategies and initiatives that facilitate integration in a behavioral health care setting. 3. Discuss strategies and interventions that have proven successful. 4. Demonstrate an understanding of how the Social Determinants of Health impact the well being and longevity of people with SMI. The need for integrating physical health into the behavioral health treatment of people with serious mental illness (SMI) is well documented. This need has also gained acceptance and support by Federal and State governing bodies as well as by certifying and funding organizations. However, little is known about how to effectively integrate physical health care into the behavioral healthcare setting. Most efforts in the area of physical health integration have thus far focused on integrating psychiatry into primary care settings. However, the SMI population receiving care in behavioral health care settings, often has limited access to the general health care system and has been identified as a special health disparities population by the Substance Abuse and Mental Health Services Administration (SAMHSA). This presentation aims to describe several initiatives at University Behavioral HealthCare (UBHC)BHC which support SAMHSA's Wellness Campaign and can be implemented in other behavioral health settings.It will focus on ways to

increase access to and utilization of medical care for people under treatment in a behavioral health care organization, using as example strategies and activities employed over the last decade at UMDNJ University Behavioral Healthcare (UBHC), one of the largest behavioral health providers in New Jersey. Areas addressed will include: the establishment of a subcommittee of the Quality Improvement Committee that focuses on the primary health care needs of consumers; development of a medical provider database to enhance staff ability to refer mental health consumers to primary health care; developing and implementing routine performance measures that address Axis III and BMI documentation ;developing "Wellness Corners" throughout the organization to encourage consumers' self-management of blood pressure and weight; monthly distribution of health information to be used by mental health clinicians.

2. Theories and Strategies to Foster Health and Wellness in People With Serious Mental Illnesses

Anna Marie Toto, Ed.M., Betty Vreeland, APRN

Summary: "People used to say things to me like: if you don't lose 20 pounds or if you don't quit smoking you're going to die ten years early. Well, I didn't care if I died early. I didn't care until I met a man and we fell in love. We got married, had a child and I wanted to live to see my grandchildren." Anonymous Service User Physical health can impact an individual's quality of life on many levels including their daily routine, employment, relationships, educational and recreational activities, and achieving recovery goals. As new models, programs, and strategies continue to evolve to address and integrate behavioral and physical health care, utilizing a person-centered care (PCC) approach can play a key role in fostering one's health and wellness. This presentation will provide an overview of person-centered and stage-based theories and strategies that can improve the physical health and well-being of people with serious mental illnesses (SMI). Case-study examples will be provided for discussion. A PCC approach for integrating wellness includes strategies, education/materials, and a menu of program options to choose from. We will examine how using this approach can help optimize health and improve outcomes. Behavioral health treatment specific to the needs of persons served offers an individualized rather than a "one size fits all" approach. According to the Transtheoretical Model of Change, understanding what "stage of change" a person is in will help determine the appropriate intervention(s) to assist in the change process and facilitate recovery and goal attainment. From a PCC perspective, it is important to understand how a person's physical health fits into their overall personal goals. Client centered counseling styles, such as motivational interviewing offer a directive method for enhancing intrinsic motivation to change by exploring and resolving a person's ambivalence. Beyond the impact on individual treatment, this presentation will discuss the organization-level impact of utilizing stage-based motivational theories to enhance behavioral health practice. For example, how can a system of care cultivate a "spirit" of motivational interviewing or PCC within the organizational culture?

3. Addressing Overweight and Obesity in Adults With Serious Mental Illnesses

Elizabeth Vreeland, M.S.N., Sally Mravcak, M.D., L.A.C.

Summary: Overweight and obesity are more prevalent in people with serious mental illnesses (SMI), and obesity is one of the most common physical health care problems in this population. Among individuals with SMI, an unhealthy lifestyle, as well as the effects of psychotropic medications, such as atypical antipsychotics, can contribute to the development of this problem. Lack of sufficient income for a healthy diet and inadequate knowledge, living skills, and social support to make use of such a diet are also factors contributing to an increased prevalence of obesity in patients with SMI. In addition to the health problems caused by obesity, people with mental illness may face stigma and discrimination associated with both the mental illness and excess weight. Furthermore, the health of people with SMI may be challenged by the misconception that people with SMI are not able to make healthier lifestyle choices. A unique obstacle in addressing weight issues with this population is that data suggests that adults with SMI tend to underestimate their weight status and see themselves as less overweight than they are. These data will be presented as well as how to address the gap between reality and self-perception of weight. Strategies and programs including Solutions for Wellness, a manualized wellness curriculum designed to inspire and assist mental health consumers to develop healthier eating and physical activity patterns, will be presented. Research findings which suggest that when some adults with SMI participate in wellness programs that it may lead to weight loss and that this weight loss may lead to improvements in physical health outcomes including systolic and diastolic blood pressure will also be presented. Strategies which prescribers can incorporate into medication management appointments and person-centered approaches which foster weight self-management will be discussed. In addition, a novel approach for how behavioral health care providers can partner with primary care providers to combat obesity will be presented.

4. Addressing Tobacco Through a Wellness Curriculum

Jill M. Williams, M.D.

Summary: Smoking rates in individuals with a mental illness or addiction are at least double the rates of tobacco use in the general population. Treatments are needed for smokers with serious mental illness (SMI) who are not ready to quit. "Learning about Healthy Living," (LAHL) was a treatment developed to provide information to mental health consumers on how addressing tobacco use enhances healthy living. Goals of LAHL are to raise awareness about tobacco use consequences, and to educate participants about and the benefits of tobacco treatment. Learning about Healthy Living includes session on other wellness topics, such as physical activity and nutrition, however, the majority of sessions focus on tobacco. This wellness curriculum is delivered by mental health staff in 20 group sessions. Incorporating tobacco information into an overall wellness curriculum helps make the material appealing to a broader audience of lower motivated smokers and also links it to other activities promoting healthy lifestyles. A group format helps to provide additional support and modeling experiences for participants who can benefit from seeing peers succeed and develop new coping strategies. LAHL was successfully pilot tested for feasibility in 9 community treatment programs; feedback from staff and consumers was positive. LAHL is a useful approach consistent with wellness and recovery in mental health. Even if some individuals continue to use tobacco, participation in a wellness curriculum like LAHL can also help to foster culture change and disseminate valuable health information to the population. The LAHL manual is available as a publicly available resource on the internet and organizations from across the country are using it in their behavioral health setting (http://rwjms.umdnj.edu/addiction/community/choices.html).

5. Addressing Overweight and Obesity in Adults With Serious Mental Illnesses – Part II

Betty Vreeland, A.P.R.N. and Sally Mravcak, M.D, L.A.C.

SYMPOSIUM 20

Saturday, October 6; 2:00 p.m.–5:00 p.m.

Innovations in Integrated Assessment, Service Matching, and Recovery Planning for Individuals With Co-occurring Psychiatric and Substance Disorders

American Association of Community Psychiatrists

Chair: Kenneth Minkoff, M.D.

Presenter(s): David Mee-Lee, M.D., Wesley E. Sowers, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to identify the clinical principles of integrated recovery oriented practice with individuals with co-occurring conditions that permit the development of appropriately matched integrated recovery plans

Summary: Individuals with co-occurring mental health and substance use disorders represent a population with poorer outcomes and higher costs in multiple domains, and often presenting in complex crisis situations with complex needs requiring accurate assessment to determine appropriate program and service matching in the context of developing an integrated person-centered recovery plan. Despite the frequency with which this type of clinical situation occurs in adult and child service settings, most systems do not have an organized and systematic approach to help clinicians with the process of integrated assessment and recovery planning throughout the continuum of care. This symposium explores the issue of integrated assessment and recovery planning for individuals with psychiatric and substance use disorders, identifies the clinical principles of successful multi-problem, multi-dimensional assessment and intervention within a recovery oriented framework of service delivery, and then illustrates structured approaches for application of those principles in real world systems to real world clients. These principles are then illustrated through a description of the most common and widely available tools for integrated assessment and recovery planning that are already available for general system use. First, Dr. David Mee-Lee will describe application of the American Society of Addiction Medicine Patient Placement Criteria – Second Edition Revised (ASAM PPC2R) (Dr. Mee-Lee is the lead developer of that document) to organizing person-centered and integrated program/service matching and recovery planning approaches for individuals with complex mental health and substance use needs. Second, the symposium will discuss the newest applications of the American Association of Community Psychiatrists Level of Care Utilization System (LOCUS 2010) (presented by Dr. Wes Sowers, the lead developer of that document) to the process of integrated assessment, level of care and service matching, and recovery planning. Finally, Dr. Minkoff will describe an integrated recovery planning template that has been developed and disseminated in system wide projects for developing recovery oriented integrated services using the Comprehensive Continuous Integrated System of Care (CCISC) framework in over 30 states In order to demonstrate the application of these tools, participants will be provided with a complex case example, assisted to use the tools, as well as their own clinical judgment, to determine appropriate interventions in the context of integrated recovery planning for that case, and then participate in a discussion to explore the current state of the art and science of assessment and recovery planning for individuals with co-occurring disorders and the clinical challenges that emerge in addressing their needs.

1. Using ASAM Criteria's Multidimensional Assessment to Develop Person-Centered Recovery Plans

David Mee-Lee, M.D.

Summary: This presentation will improve participants' knowledge in providing focused, targeted, individualized behavioral health treatment. It will provide the opportunity to practice assessment and priority identification, and translate that into a workable, accountable treatment plan that makes sense to individuals. Reference will be made to the ASAM Patient Placement Criteria assessment dimensions to help organize assessment and treatment data. 1. Review the underlying principles of the ASAM Criteria multidimensional assessment. 2. Apply ASAM multidimensional assessment to individualize service strategies and determine level of care. 3. Discuss how to use multidimensional assessment in recovery planning.

2. Software Assisted Person Centered Service Planning: The LOCUS M-POWER Planner

Wesley E. Sowers, M.D.

Summary: In this section of the symposium, typical obstacles to engaging in person centered service planning will be discussed. The development of LOCUS for aiding level of care or service intensity decisions will be considered, and how this instrument supports recovery and collaborative assessment. LOCUS has been designed to allow easy access to consumers who would like to participate in their care. The LOCUS M-POWER Planner builds on this collaborative approach, translating the areas identified as being most in need of services to a service planning format. This translation allows an efficient processing of the issues identified to enable the production of a collaborative plan that plays a positive role in the therapeutic process. A brief overview of the software will be provided as a way to stimulate discussion of the place of the EMR in the planning process.

3. Principles of Integrated Assessment and Recovery Planning for Individuals With Co-Occurring Disorders

Kenneth Minkoff, M.D.

Summary: Dr. Minkoff will begin with a brief outline of core evidence based principles of successful assessment and intervention for individuals or families with co-occurring mental health and substance use conditions, as well as other complex needs. These principles emphasize the importance of identification of multiple primary issues or conditions, focusing in a recovery framework on the person's goals for a happy, hopeful, and productive life, identification of previous periods or efforts to make progress in the context of a strength based longitudinal assessment, and then application – for each issue – of stage-matched, skill-based learning, in small steps, with big rounds of applause for each piece of progress, to help the individual learn how to address multiple issues over time. Within the context of these principles, the presentation will illustrate how to apply this approach to real world clinical situations, and to use a simple template to document integrated stage-matched recovery planning for an individual with complex needs and multiple challenges.

SYMPOSIUM 21

Sunday, October 7; 8:30 a.m.–11:30 a.m.

Discharge to Shelter: The Theory and Practice of Homeless Psychiatry

Presenter(s): Hina Tasleem, M.D., Joanna Fried, M.D., Anuj Gupta, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to understand the barriers homeless individuals struggling with mental illness face in accessing psychiatric care in traditional, institutional settings.

Summary: Homelessness disproportionately strikes people with severe mental illness, who comprise about one third of the single adult homeless population. Homeless individuals do not access traditional avenues of psychiatric care and often seek care in emergency departments and inpatient units, settings which often cannot address their housing and entitlements needs or their typically chronic psychiatric or medical problems. Treatment plans are limited and often fail upon the "discharge to shelter," creating an inadequate pattern of care demoralizing to the patient and clinician alike. As homelessness has grown over the past three decades, expanding psychiatric practice into settings where homeless people congregate – to meet them "where they are" – has redressed these barriers and attitudes, and created a new field of "Homeless Psychiatry." Since its founding in 1986, The Project for Psychiatric Outreach to the Homeless (PPOH), a New York City-based organization and APA Psychiatric Services Silver Achievement Award recipient, has developed this on-site care delivery model by extending it to a range of settings with varying resources, incorporating integrated, evidence-based practices into it, and building a training program around it. The symposium is intended both for clinicians who want to confront homelessness in their work, and for administrators looking to establish effective care delivery systems for homeless individuals in their communities. PPOH psychiatrists will discuss various aspects of Homeless Psychiatry, interspersing case vignettes and video testimonials from homeless individuals speaking about their experiences with psychiatry and PPOH.

1. Making "House Calls" to the Homeless: Providing On-Site Psychiatric Services

Joanna Fried, M.D.

Summary: We will discuss the multiple barriers to outpatient psychiatric care for individuals who are homeless, unstably housed, or formerly homeless. These individuals often intersect with multiple agencies, institutions, and service providers on a regular basis. Very few of these providers have specialized knowledge about mental health diagnoses and treatments. Often, the mental health issues that may be preventing people from achieving and maintaining stable housing go unnoticed or untreated. The embedding of mental health care providers into these settings has been found to improve mental health, housing, and criminal justice outcomes for these individuals while either maintaining or lowering the costs of services. In addition to the evidence basis, we will discuss personal experience with the benefits of making "house calls" to consumers who are homeless or formerly homeless. There are substantial logistical barriers for these individuals when it comes to working within a traditional treatment framework. Psychiatric illness, substance use disorders, and the unpredictable nature of life on the street often prevent consumers from getting to appointments on time, following up with care, taking medications as prescribed, waiting weeks to see the psychiatrist. If the mental health provider is at a location where food, shelter, clothing, and other services are available, it greatly reduces these barriers. A team approach to treatment, integrating mental health care with other services (housing, case management, street outreach) contributes to more coordinated and comprehensive care. Working on site makes it possible to work on forming an alliance with someone who is not interested in psychiatric care; this can lead to a more substantial discussion of the possibilities for treatment. Financial and time constraints may be less considerable for on-site providers, particularly when billing is not a concern. Challenges include issues like confidentiality, clinical resources, and concerns about recreating other "institutional" settings by co-locating psychiatric care in residential sites.

2. Hospitalization to Homelessness

Anuj Gupta, M.D.

Summary: The average length of stay in a hospital for a patient diagnosed with a mental illness, according to the 2007 National Hospital Discharge Survey, is 7.1 days. Acute inpatient psychiatric treatment is characterized by three main components: crisis stabilization, safety, and a focus on rapid discharge. This approach to treatment is designed to promote the role of community-based day treatment, residential services, and outpatient treatment. The current approach to inpatient treatment fails to comprehensively address the needs of the severely and persistently ill. This group of patients, many of whom are homeless or have experienced homelessness, does not access traditional avenues of psychiatric treatment. As a result, the period following hospital discharge for these individuals is particularly treacherous, one that places them at high risk for first-episode or recurrent homelessness. Numerous obstacles stand in the way of consistent, comprehensive, and continuous treatment of severely ill homeless individuals following their discharge. Medicaid or other insurance benefits are often precipitously discontinued, rendering these patients unable to see a community-based psychiatrist or obtain needed medication. The symptoms of severe illness can interfere with patients' ability to withstand the parameters of clinic treatment settings. Shelter residents are transferred without adequate documentation, interrupting the continuity of their treatment, or lose their shelter beds for sometimes arbitrary reasons. Obtaining treatment records from hospitals poses its own challenge. Individuals are frequently arrested for violations related to homelessness, leading to disruption of their entitlements, shelter status, and treatment. During my presentation, I will enumerate and describe the unique challenges faced by severely mentally ill homeless individuals following their discharge from hospitals and discuss approaches to establishing an alliance, providing treatment, and ensuring access to housing and entitlements.

3. Homeless Psychiatry and Lessons Learned in Psychiatry Residency

Hina Tasleem, M.D.

Summary: There will be three parts of this presentation: 1- The Presenter will reflect on her observation and experience from the Psychiatry residency training. During the course of her Psychiatry training, interactions with individuals suffering from mental illness and homelessness at various points of care such as Comprehensive Psychiatric emergency room, in-patient acute psychiatric care, state hospital care and day treatment programs at city hospital were commonplace for majority of residents. These experiences exposed the trainees to the recurring dilemma of suboptimal and discontinuous care, due to the pervasive disintegration in the mental health care delivery system. This included minimal psychosocial rehabilitation due to lack of a system that could allow communication and integration of coherent planning at various points of health care delivery. 2- The presenter will then describe her experience, during her third year of residency, in a Community Psychiatry rotation at the Project for Psychiatric Outreach to the Homeless (PPOH). This intensive rotation enabled the residents to develop competency in Community Psychiatry by imparting the skill-sets, unique perspective, and administrative expertise in an interdisciplinary team to work effectively with homeless individuals. Receiving training to work with homeless individuals during psychiatry residency is critical, not only from a clinical standpoint, but also in terms of training the residents about the administrative and fiscal realities of public funding. This will serve to develop and educate the young psychiatrist about cost-effective and sustainable strategies to provide optimal care. 3- Most often, limited knowledge and barriers in access to the relevant resources due to lack of appropriate training among clinicians limit their capacity to address consumers with homelessness. The presenter will describe the emphasis that Project of Psychiatric Out-reach to the Homeless (PPOH) places on adopting and disseminating various innovative strategies, ranging from efforts to maximize the integration of health care delivery and psychosocial rehabilitation, to the utilization of consumer peer involvement as an integral part of recovery-oriented comprehensive management.

WORKSHOP 1

Thursday, October 4; 8:00 a.m.–9:30 a.m.

Maintaining Recovery From Severe and Persistent Mental Disorders

Chair: Sheila Hafter Gray, M.D.

Presenter(s): Nada L. Stotland, M.D., M.P.H., John S. McIntyre, M.D., J. Pierre Loebel, M.D., Arthur T. Meyerson, M.D.

Educational Objectives: At the conclusion of the session, the participant should be able to apply objective and consensus-based biopsychosocial criteria to assess their patients' recovery from severe and persistent mental disorders, determine and advocate for the least restrictive alternative for continuing care based on the individual's functional capacities in available social environments and innovate a recovery-based mental health care model in their particular system.

Summary: Recovery from a severe and persistent mental disorder involves far more than suppression of the visible manifestations (signs and symptoms)of the disorder. It requires the application of a range of integrated biopsychosocial interventions that support continuing emotional growth. It must also provide hope for even the most disabled of our patients that the quality of their lives in the future will be better than it was in the past. We will explore the development of the classical biopsychosocial model, which began as a narrative and is now supported by clear evidence, and demonstrate how this may be implemented efficiently to achieve and maintain recovery not only for individuals but also for the population of a large integrated health care system. We will pay special attention to the challenges posed by patients who are at risk for harm to themselves or others or whose social and occupational functioning is significantly diminished as a consequence of their mental disorder. Comprehensive biopsychosocial formulation of these cases can lead to long range plans that optimizes the individual's functional capacity while meeting the appropriate legal mandate that patients be treated in the least restrictive environment. Participants will be invited to consider how they may apply these concepts in their daily work.

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WORKSHOP 2

Thursday, October 4; 10:00 a.m.–11:30 a.m.

The "Mash-Up": Community Psychiatry Meets Consult-Liaison Psychiatry in Collaborating With Primary Care

Chair: Lori Raney, M.D.

Presenter(s): James R. Rundell, M.D., John S. Kern, M.D.

Educational Objectives: At the conclusion of the session, the participant should be able to differentiate and compare competencies and skills of community psychiatrists and psychosomatic medicine psychiatrists related to integrated practice.

Summary: The world is evolving for many community psychiatrists as collaborating with our primary care colleagues becomes an expectation and responsibility in our daily work. From improving the overall health status of patients with serious mental illness to assisting our primary care colleagues in the detection and appropriate treatment of mental illness in primary care, the opportunity to have a major impact on the lives of patients in both settings presents us with a unique challenge. Many of us find ourselves utilizing skills from two psychiatric sub-specialty areas as we move between these settings to provide comprehensive collaborative care. These areas of expertise include community psychiatry and consult-liaison psychiatry. This workshop is designed to compare and contrast these two psychiatric subspecialty areas and propose that within the emerging subspecialty arena of integrated care, a psychiatrist with a combination of the two skill sets, a veritable "mash-up," will be most effective. We will start with a comparison of the definitions, skills and competencies in the two areas and go on to provide examples of one urban and one rural program and the skills sets that have been developed by the psychiatrists in these programs to meet their specific needs. The intent of this workshop is to help guide training programs and psychiatrists interested in working in this field to bridge the knowledge gap inherent in new initiatives. Dr. Jim Rundell will provide an overview and comparison of the two subspecialty areas and describe his work with the DIAMOND project. Dr. John Kern will describe his program in Merrillville, IN that includes both consultation to a FQHC and the development of an in-house SAMHSA/HRSA grantee site. Dr. Lori Raney will discuss her involvement in a variety of outpatient primary care clinics and the recent opening of a fully integrated health care facility in Cortez, CO.

WORKSHOP 3

Thursday, October 4; 1:30 p.m.–3:00 p.m.

Psychodynamic Principles Used When Prescribing Medications. Considerations About the Placebo and Other Meaning Effects

American Academy of Psychoanalysis and Dynamic Psychiatry

Chair: David L. Lopez, M.D.

Presenter(s): Eugenio M. Rothe, M.D., David L. Mintz, M.D., Elizabeth L. Auchincloss, M.D., Juan Raul Condemarin, M.D.

Educational Objectives: At the conclusion of the session, the participant should be able to describe the phenomenon of placebo, nocebo, and other meaning effects.

Summary: The placebo, nocebo, and other meaning effects are part of everyday psychiatric clinical practice.(1) Since the late 18th century, placebos are most often considered to be the inert interventions that are applied to the control group in clinical trials.(2) Under this definition, the value of the placebo has been seriously questioned.(3) In this workshop, we are using the expanded definition of placebo to also mean the affective positive response, or positive meaning effect, that the patient has towards the intervention and that it is paired with the circumstances in which it is prescribed and the patient's personal, historical, and cultural experiences. Conversely, nocebo (from the Latin "nocere," injury or damage) is a newer term that has increasingly gained acceptance in the psychiatric and general medical literature.(4) Nocebo is the negative affective response, or negative meaning effect, that patients have to medications and that is also dependent on the circumstances of the clinical situation and on the patients' backgrounds.(5)Psychodynamic psychiatrists are aware of the unconscious implications of medication prescription, and use this awareness to help the patient understand the attributes they give to the medications.(6) In this workshop, we will give a broad perspective that includes personal and emotional responses that are a reflection of complex interactions between wishes, hopes, anxieties, and expectations involving both patient and physician. Clinical experience has shown that the placebo effect, the nocebo effect, and other meaning effects to medications should be taken into account when prescribing any medications as a way to help the patient, since the affective and non-verbal messages that the clinician gives to the patient can influence how the patient responds to them.

WORKSHOP 4

Thursday, October 4; 1:30 p.m.–3:00 p.m.

Combining PTSD and Substance Use Treatment: Complex Treatment for Complex Problems or How to Integrate Virtual Reality With Other Treatment Disorders

Chair: Kathleen Decker, M.D.

Educational Objectives: At the conclusion of the session, the participant should be able to identify at least three different techniques for treating PTSD, utilize a combination of substance use intervention with prolonged exposure or cognitive processing therapy for PTSD and formulate treatment plans using virtual reality.

Summary: With increasing numbers of combat veterans returning to civilian life, many of whom have combat PTSD, the need for innovative solutions to their psychiatric needs is also increasing. Traditional approaches to PTSD treatment include treating substance use disorder first, then referring the patient to treatment for trauma. Thus, components are often treated sequentially. However, trauma and substance use are mutually negatively reinforcing, such that trauma recall often is associated with increased cravings and relapse, sometimes during treatment. Relapse, in turn, is related to increased depression and difficulty processing trauma. This video is an educational video which reviews traditional principles of PTSD treatment and then demonstrates two innovations designed to improve care of patients with trauma and substance disorder. It is comprised of three sections – 1) brief didactic section reviewing traditional treatment approaches, 2) simulated virtual reality session in dual diagnosis patient and 3) simulated "integration" session in which substance use issues are integrated with trauma responses. The story is that of a veteran with combat PTSD and comorbid alcohol and cocaine dependence. He is tormented by an event he cannot recall. His therapist has been conducting imaginal prolonged exposure and cognitive processing therapy but he continues to have vague nightmares. The therapist uses virtual reality to evoke his memories of trauma. Another therapist works with him to explore how PTSD symptoms intertwine with substance dependence. All individuals in the movie are mental health professionals "acting" but the vignettes are based on real patients' issues. The course director is the consultant for a residential substance use treatment program and regularly treats veterans with combat PTSD and substance use disorder. The "patient" is an addiction therapist and the virtual reality therapist is the coordinator for a residential PTSD program and regularly treats veterans for PTSD. The creator is trained in Prolonged Exposure, Cognitive Processing Therapy and Virtual Reality and uses all three methods to treat PTSD. The opinions and content expressed in the film are those of the author and neither represents the views of the Veteran's Administration nor the U.S. government nor the U.S. military.

WORKSHOP 5

Thursday, October 4; 1:30 p.m.–3:00 p.m.

Mental Health Courts and Diversion Programs: Everything You Need to Know But Were Afraid to Ask

Chair: Charles Amrhein, Psy.D.

Presenter(s): Kim Nessel, M.A., Virginia Barber-Rioja, Psy.D., Claudia Montoya, J.D.

Educational Objectives: At the conclusion of the session, the participant should be able to describe the range of mental health court models and jail diversion programs for people with mental illness.

Summary: Mental health courts have skyrocketed in numbers as jurisdictions seek to address the high number of people with mental illness in local jails, with nearly 300 such courts existing in the United States at this time. The success and proliferation of these courts means that treatment providers in the community, even non-forensic programs, now include increasing numbers of clients with criminal justice involvement and legal mandates. In this workshop, we will discuss audience experience with criminal justice clients and court-mandated treatment, and review the systems and clinical issues that community clinicians need to understand to ensure appropriate treatment for these justice-involved clients. Dr. Charles Amrhein, Clinical Director of the Bronx TASC Mental Health Court Program, will review the history, structure and purposes of problems-solving courts, such as drug and mental health courts. Dr. Virginia Barber, former Clinical Director of the Queens TASC Mental Health Diversion Program, will review the clinical characteristics of clients diverted through the TASC mental health programs. Claudia Montoya, the attorney-in-charge of the Bronx Legal Aide MICA project will discuss the legal and clinical challenges facing these clients and those charged with defending them. Kimberly Nessel, Senior Case Manager at the Bronx TASC Mental Health Court Program will provide specific case descriptions as a prelude to the case based discussion with participants about working with these clients within a court based diversion system.

WORKSHOP 6

Thursday, October 4; 1:30 p.m.–3:00 p.m.

Madly Gifted

Chair: Nubia G. Lluberes, M.D.

Presenter(s): Niberca Polo, M.A.

Educational Objectives: To evaluate the treatment options for the creative individual and his/her artistic talent, considering patient's concerns about their creativity and artistic skills.

Summary: Media have been key to the creation of deceitful symbols of insanity that reduce the subject's actions to mere symptomatic behavior, filling up the imagination of the viewer with terrifying and violent scenes that mislead public opinion and provoke negative reactions towards the mentally ill. They have created sinister depictions of these conditions, contributing to the growth of stigma in disproportionate levels. Bipolar Disorder, a highly prevalent mood disorder with a longitudinal course, unpredictable and debilitating (both for the patient and their families) does not escape this reality. Decades of investigation have the linked creativity and Bipolar Disorder: Richards and colleagues found greater overall creativity achievement in a combined group of bipolar and cyclothymic patients and their healthy first degree relatives; and Santosa and col. found that bipolar subjects score higher on a creativity tests than normal controls and unipolar depressive subjects. Patients themselves point out this relationship to their doctors and often refuse to get treatment due to concerns of losing their talents; some feel that the medical community – when in the search of proper treatment – does not take into account the Artistic Temperament as an important personality trait in the healing process. Bipolars require attention to risk factors, prodromal and syndromal manifestations, and health consequences. The impact of misdiagnosis and antidepressant monotherapy may significantly worsen the course as much as non-compliance to treatment. Thus it is very important to maintain ourselves up-to-date about treatment options and to pay attention to patient's concerns. Madly gifted is a 1-hour documentary created to address these concerns. Using a series of one-on-one interviews, it exposes the lives of artists – those who define themselves as such, regardless of their career paths – living with Bipolar Disorder; summarizes psychiatrists' expertise on Mood Disorders, and explores other explanations based on different theoretical approaches. The free distribution of this documentary is an effort to contribute to the idea of breaking Hollywood's stereotypes of the mentally ill and fighting stigma by having it available as a tool to educate about the disorder both the medical community and the general population. The film rough-cut was screened at the American Psychiatric Association Annual Meeting in Honolulu, Hawaii, on May 2011. The final cut will be screened in Dominican Republic as part of an art exhibition called "Under the Umbrella" on January 2012, in New York at Parsons The New School for Design on March 2012, and in Houston on May 2012. The documentary will be ready for distribution the fall of 2012.

WORKSHOP 7

Thursday, October 4; 1:30 p.m.–3:00 p.m.

Optimizing Care for PTSD, Depression, and Alcohol Use Problems: Clinical Applications of Measurement-Based Care

Chair: Darrel A. Regier, M.D., M.P.H.

Educational Objectives: At the conclusion of the session, the participants should be able to understand the use of quantitative instruments such as the seventeen-item PTSD Check List – Civilian Version (PCL-C) for monitoring PTSD, the nine-item Patient Health Questionnaire (PHQ-9) for monitoring depression, and the three-item Alcohol Use Disorder Identification Test Consumption Questions (AUDIT-C) for screening alcohol use problems in routine practice.

Summary: High prevalence of PTSD in both the general population and in high-risk populations, especially after exposure to specific traumatic events, such as combat-related trauma among service members have been well documented (1–4). Also, high rates of comorbidity of PTSD with depression and alcohol use problems have been reported (1). Prior research highlights the importance of a systematic approach to ensure adequate diagnosis and management of chronic psychiatric conditions in clinical practices (5–6). Routine follow-up and monitoring are considered essential components for the management of any chronic psychiatric or medical conditions. However, the majority of clinicians do not employ a systematic approach in monitoring patient outcomes when treating PTSD, depression, or alcohol use problems. Much like blood pressure monitoring for hypertension, a simple quantitative instrument to measure severity of illness holds significant promise in improving treatment of psychiatric conditions in primary care and psychiatry alike.

WORKSHOP 8

Thursday, October 4; 1:30 p.m.–3:00 p.m.

Dementia Update: Clinical Management and Research Horizons (AAGP)

Chair(s): Blaine Greenwald, M.D.

Presenter(s): Philippe Marambaud, Ph.D., M.S.C., Jeremy Koppel, M.D.

Educational Objectives: Recognize depression in dementia and understand the most current, evidence-based treatment strategies

Summary: The U.S. population is rapidly aging, especially the very old. Prevalence of Alzheimer's Disease and related dementing conditions is high in this population, with some studies reporting that close to half of community-based elders over age 85 are afflicted with dementia. These patients are especially relevant to psychiatrists, since nearly all experience significant behavioral abnormalities, which are associated with excess disability, patient and caregiver distress, and undesirable nursing home placement. Over the last several years, research investigations have newly informed clinical management decisions associated with concomitant depression; behavioral disturbances including psychosis, agitation and aggression; and underlying cognitive deficits. Furthermore, advances in understanding putative pathophysiological underpinnings of Alzheimer's Disease are suggesting exciting novel therapies currently being tested in experimental models. This workshop will provide a clinically-oriented update for psychiatric practitioners evaluating and treating older patients with dementia, including those with depression and agitated and psychotic behaviors, with the goal of helping psychiatrists ameliorate problematic symptoms so that patients can sustain community integration. Scientific research findings will offer a vista on new strategies for intervention.

WORKSHOP 9

Thursday, October 4; 1:30 p.m.–3:00 p.m.

The NIMH RAISE Initiative: Promoting Recovery in First Episode Psychosis Through Integrated Mental Health Care

Chair: Amy Goldstein, Ph.D.

Presenter(s): Delbert Robinson, M.D., Lisa B. Dixon, M.D., M.B.A.

Educational Objectives: At the conclusion of the session, the participants should be able to describe the characteristics of the deployment-focused approach to intervention development and testing, as applied to a phase-specific intervention designed to prevent disability associated with established schizophrenia.

Summary: Recovery After an Initial Schizophrenia Episode (RAISE) is an NIMH research initiative that seeks new approaches to fundamentally change the trajectory and prognosis of schizophrenia. By testing strategies for coordinated and aggressive treatment in the earliest stages of illness, RAISE hopes to reduce the likelihood of long-term disability commonly associated with established schizophrenia, and aims to help people with the disorder lead productive, independent lives. The NIMH has funded two ongoing studies as part of the RAISE initiative: The Early Treatment Program (ETP) and the Connection Program. This workshop will present the overall rationale for RAISE from the NIMH perspective. A representative from each study will then present their respective approach to developing and delivering a first episode treatment program with an eye to the 'real world' successes and challenges. ETP, led by Dr. John Kane at Feinstein Institute for Medical Research, is a randomized controlled trial (RCT), comparing the effectiveness of a phase-specific intervention versus usual community care for first episode psychosis. Currently ongoing in 34 community mental health centers across the United States, ETP is examining the impact of integrated, multi-disciplinary treatment on symptomatic recovery and relapse, as well as social, academic, and vocational functioning among individuals experiencing their first psychotic episode. Complementing this effort, the Connection Program is evaluating a team-based treatment program for first episode psychosis within the context of an implementation study. Currently ongoing in two states, this project, led by Dr. Lisa Dixon at the Research Foundation for Mental Hygiene, Columbia University, will identify and characterize barriers to the long term adoption of team based interventions for the treatment of FEP and explore potential solutions. The Connection Program will develop 'turn-key' products for establishing community-based FEP clinics in a variety of settings, including summaries of case finding strategies; recommendations for staffing requirements and caseloads, as well as clinical training, supervision, & quality improvement tools. NIMH supports these complementary research activities in the hope that results of the RCT, along with the practical materials that will be generated in the Implementation Study, will increase the likelihood of rapid adoption and implementation of FEP treatment programs in the U.S. mental health care system.

WORKSHOP 10

Thursday, October 4; 3:30 p.m.–5:00 p.m.

Playing With Yourself and Others: A Review of Internet Related Behavioral Addictions

Chair(s): Yener A. Balan, M.D., Noam Fast, M.D.

Educational Objectives: By the conclusion of the session, participants should be able to recognize the prevalence of behavioral addictions in the age of the internet.

Summary: Internet addiction is growing in prevalence, and people are becoming increasingly aware of its associated morbidities. Over two billion people now use the internet, as it has become incorporated into virtually every aspect of our lives from business to pleasure. In anticipation of the publication of the DSM-V, an officially codified diagnostic framework is being formed for internet addictions. Patients who have addictions to the internet, video gaming, or pornography, find these activities euphorically compulsive, but also suffer from recognized disorders such as anxiety, depression and ADHD. This workshop will introduce participants to the basic technological concepts and biopsychosocial characteristics important in understanding and addressing excessive and problematic online activities, including gaming and pornography. There will be a discussion focused on suggested strategies for identification, prevention and therapeutic interventions employed when treating these types of behavioral addictions.

WORKSHOP 11

Thursday, October 4; 3:30 p.m.–5:00 p.m.

ACOs Now and in the Future

American Association of Community Psychiatrists

Chair: Daniel Y. Patterson, M.D., M.P.H.

Educational Objectives: At the conclusion of the session, participants should be able to demonstrate understanding of the historical antecedents of the ACO

Summary: In the December 6, 2009, issue of the New Yorker, Dr. Atul Gawande make clear that Britain, France and Switzerland followed "path dependence" in creating their national health programs. By this he meant that no health plan was created out of "whole cloth," but evolved from the antecedents of past practice and events. If this applies to the United States, the past two antecedents of healthcare delivery have been fee-for-service and prepaid group practice à la Kaiser Permanente. ACOs as they are currently visualized appear to be an amalgam of these two forms of healthcare delivery which will be discussed at the workshop. There appears to be little doubt that in the future ACO's will evolve into "true" managed care systems which will have a defined enrollment population, a clearly defined delivery system, and global payment on a year-to-year basis (the Massachusetts Special Commission on Healthcare Payment Systems has recommended that "global payment become the predominant form of payment healthcare providers within five years." Vermont supports global payment for their new statewide insurance program).The workshop will outlined the challenges and opportunities involved in managing the delivery of behavioral healthcare in such an organization. Opportunities: elimination of CPT code claims payment. The elimination of insurance imposed "managed care" restraints. Opportunity to "work smart" re physician extenders, telemedicine and hospital alternatives. Challenges: risk contracting, assuring productivity in a non-fee-for-service environment and cognitive dissonance regarding concurrent fee-for-service and budgeted behavioral healthcare. Dr. Everett, chairman of the APA Council on Health care Systems and Financing, will summarize the deliberations of the Council on ACOs and review The Accountable Care Act and its implications for ACO development. Dr. Patterson will share his long clinical and administrative experience in providing behavioral healthcare in fee-for-service and prepaid group practice.

WORKSHOP 12

The Whole Package: Psychosocial Rehabilitation and Integrated Care With the International Clubhouse Model

Chair: Patrick S. Runnels, M.D.

Presenter(s): Lori D'Angelo, Ph.D., Ralph Aquila

Educational Objectives: At the conclusion of the session, the participant should be able to describe the clubhouse model of psychosocial rehabilitation, describe the unique integration of care including the clubhouse model of peer driven psychosocial rehabilitation, behavioral healthcare and primary care and have a better understanding of the benefits to those living with mental illness with this model and integration.

Summary: The International Clubhouse model is built on a unique partnership between mental health professionals and peers that seeks to create an intentional therapeutic community of comprehensive rehabilitation and reintegration. Spanning more than five decades, studies of this model have demonstrated its effectiveness in promoting wellness for individuals with severe mental illness. While the model does not directly involve psychiatric care, a few clubhouses have successfully integrated psychiatric care into their operations, and more recently, primary care as well. This presentation seeks to update the audience on the clubhouse model, as well as highlight recent evidence confirming its effectiveness at improving outcomes; then describe multiple efforts to integrate both psychiatric and primary care at programs around the country. Audience members will then get the chance to discuss the benefits and barriers of implementing such programs themselves.

WORKSHOP 13

Thursday, October 4; 3:30 p.m.–5:00 p.m.

Integration of Primary Care and Preventive Services in Assertive Community Treatment Teams

Chair(s): Nancy Williams, M.D., Erik R. Vanderlip, M.D.

Educational Objectives: At the conclusion of the session, participants should be able to critically appraise the Role of Assertive Community Treatment Teams in the physical health promotion of their clients.

Summary: Assertive Community Treatment (ACT) offers an unprecedented array of services in a multi-disciplinary team-based format to persons suffering from severe, chronic and debilitating mental illness (SPMI). ACT is one of few evidence-based models of healthcare delivery within mental health, and is being implemented in a number of new states as a standard of care for persons with SPMI. With the passage of the Affordable Care Act, renewed enthusiasm has been placed towards person-centered care, and the notion of the Person-Centered Medical Home (PCMH) as a foundation of advancements in health service delivery. Integral to this is a focus on team-based care and health-behavior change. Additionally, persons with SPMI have significantly shorter life-expectancies due primarily to cardiovascular disease (CVD). Modifiable risk factors for CVD are poorly screened for and/or treated within the SPMI population. Because of its unique structure, ACT has many functions similar to a PCMH for persons with SPMI. Many ACT teams anecdotally manage multiple physical health co-morbidities amongst their clients. In the summer of 2011, a national survey of ACT teams was distributed assessing the current state of primary care integration, with specific attention towards the role of ACT teams in the diagnosis, screening, management and referral of physical health amongst their clients. Additionally, the survey assessed the degree to which ACT teams were already functioning as PCMH's according to well-published guidelines within the primary care realm. Presenters will review the results of their survey and highlight avenues for further services research and targets of quality improvement programs for ACT teams. Presenters will also share the results of an on-going quality improvement exercise utilizing a disease registry and clinical reminders to improve adherence to recommended preventive health screening guidelines on a University-based Iowa ACT team

WORKSHOP 14

Friday, October 5; 8:00 a.m.–9:30 a.m.

Stabilizing Kinship Care Families: Services and Community Supports to Promote Wellness

Chair: Deborah Langosch, Ph.D., L.C.S.W.

Presenter(s): John Watkins, M.A.

Educational Objectives: At the conclusion of the session, participants should be able to develop an understanding of the issues kin caregiving families face.

Summary: Across the United States 8 million grandchildren, nieces, nephews, brothers and sisters are being raised by grandparents, aunts, uncles, great-grandparents and siblings as if they were their own children. The number of these kinship care families has risen steadily since 2000 and even more dramatically since the economic downturn in 2007. In New York City, almost 90,000 kin caregivers report they are the sole guardian responsible for their grandchildren (U.S. Census Bureau, 2010). These relatives are ensuring that children stay connected to their families when parents are unable to raise them. Many of the children in kincare families have been exposed to violence, traumatic events and neglect and may have lost their parents to addiction, incarceration, death, severe mental illness, poverty and most recently to military deployment. Caregivers may not always recognize and understand the impact of trauma and loss on the children they are raising and not know where to seek needed services on their behalf. This workshop will focus on the struggles and challenges kin caregiving families encounter and innovative practice and policy initiatives that enhance family wellness and stability. A best practice model, the JBFCS Kinship Care Program (KCP), and the value of community collaboration will be emphasized to address the complex needs of these families and for participants to consider for replication. Interactive discussion will focus on participant's experiences working with this rapidly growing population, their concerns and successes, sharing their effective interventions and program models and developing cross-systems approaches in their communities. Ample time will be provided to consider innovative approaches and strategies. The KCP was designed to promote family stability, maintain permanency and safety for the children and support kin caregivers in their ability to nurture and raise their relative children while they instill family values, traditions and cultural beliefs. The KCP accomplishes these goals by providing an array of comprehensive services tailored to each family's needs which create positive outcomes for children. A consumer of these services, a grandmother who is raising her grandchildren, will offer her unique perspective and share her experiences. Kinship care families face multiple challenges. Despite financial strains, behavioral challenges of the children, need for continuous advocacy, and risk to their own mental and medical health, kinship caregivers are dedicated to keeping their families intact.

WORKSHOP 15

Friday, October 5; 8:00 a.m.–9:30 a.m.

Recovery Oriented Practices in Emergency Psychiatry

American Association for Emergency Psychiatry

Chair(s): John S. Rozel, M.D.

Presenter(s): Anthony T. Ng, M.D., Jon S. Berlin, M.D., Margaret Balfour, M.D., Ph.D., Scott L. Zeller, M.D.

Educational Objectives: Participants will understand the elements of the recovery model and how person centered care differs from safety- and process-oriented care.

Summary: There has often been a perception that recovery oriented practices fit poorly in emergency mental health services. We would suggest that not only do many of the core features of the recovery model integrate smoothly into the psychiatric emergency setting but also integrating some elements of recovery into emergency settings can significantly improve clinical outcomes, risk management, and consumer satisfaction. Recovery oriented care tends to be highly person centered whereas emergency settings tend to be safety and process centered. There are inevitably conflicts between the approaches but there are also many opportunities for synergistic integration. Elements of the recovery model have been variously defined but generally include empowerment and enhancing autonomy, developing natural support systems, instilling hope, fostering self-managed coping strategies, and respecting the consumer as a whole person (not merely as a person with an illness). Some of these concepts have already permeated emergency psychiatric practice. For example, even when full autonomous choices cannot be fully allowed for safety reasons, limited consumer choice (e.g., which PRN to take) can be a valuable tool to evoke better engagement from a consumer which in turn can decrease agitation. Many other recovery oriented tools can be used to develop a better risk formulation, involve natural supports in decision making and disposition, and defusing conflict and disagreement between providers and consumers. This workshop will cover many of these issues and will invite discussion by all participants about how they have found recovery techniques useful or disruptive in emergency care. We hope to provide a springboard for participants to reconsider how they integrate recovery and person centered principles into emergency mental health work.

WORKSHOP 16

Friday, October 5; 8:00 a.m.–9:30 a.m.

The Myth of Mental Health Criminalization: Refocusing Reentry Treatment

Chair: Merrill Rotter, M.D.

Presenter(s): Katya Frischer, M.D.

Educational Objectives: At the conclusion of the session, participants will have increased appreciation for the challenges to the notion that the antidote to the criminalization of the mentally ill is better mental health treatment.

Summary: The most common explanation for the demonstrated overrepresentation of the mentally ill in the criminal justice system is that their symptoms are being "criminalized" and that ensuring good treatment will address this inequity. In this panel, we will challenge this popular hypothesis, suggest alternative explanations for the arrest and re-arrest of individuals with mental illness, and present examples of the adjunctive interventions necessary to address the problem of recidivism. Dr. Rotter will introduce the criminalization hypothesis and present data suggesting that mental health issues alone do not explain offending behavior in individuals with mental illness. Dr. Frischer will provide research on criminal thinking associated with recidivism, as well as recent mental health court diversion data supporting the need to look for alternative hypotheses. Dr. Rotter will review engagement challenges and opportunities relevant to previously incarcerated clients, and Dr. Garcia will discuss innovations in addressing criminal thinking among mentally ill offenders, with particular emphasis and cognitive-behavioral approaches. Case examples will be emphasized. Participant feedback regarding their experience with techniques that address the engagement, motivation and pro-social thinking change challenges presented by offenders with mental illness.

WORKSHOP 17

Friday, October 5; 8:00 a.m.–9:30 a.m.

The Making of a Community Psychiatrist: A Training Track for Residents

Chair(s): Paul Rosenfield, M.D.

Presenter(s): Prameet Singh, M.D., Adrienne D. Mishkin, M.D., M.P.H., Abha Gupta, D.O., Travis Kipping, M.D., Hunter L. McQuistion, M.D.

Educational Objectives: At the conclusion of the session, participants should be aware of the need for more in-depth training and competency in community psychiatry.

Summary: There is an increasing recognition of the need to recruit, train, and retain talented psychiatrists to work in the public sector, yet there are limited opportunities prior to fellowship and on-the-job training to enhance the skills and knowledge base of psychiatrists in training (Sowers et al, 2011). The Accreditation Council for Graduate Medical Education (ACGME) requires a community psychiatry experience that "must expose residents to persistently and chronically-ill patients in the public sector, (e.g., community mental health centers, public hospitals and agencies, and other community-based settings). The program should provide residents the opportunity to consult with, learn about, and use community resources and services in planning patient care, as well as to consult and work collaboratively with case managers, crisis teams, and other mental health professionals." While core experiences and rotations can help a resident meet these requirements, there are some residents who have a particular interest in community psychiatry and can benefit from enhanced training in order to engage their interest, help them commit to the public sector, and provide them with greater expertise. At the St. Luke's-Roosevelt Hospital residency program, we have created a public psychiatry training track that provides specialized didactic and experiential training in public psychiatry concepts, history, structures, and settings. Presentations in this workshop will describe the rationale for this public psychiatry track, the specific curriculum, and the experiences and projects of three residents, one of whom has finished the training and two of whom are in the midst of the training. Attendees will have the opportunity to learn about this innovative residency training program and to discuss the goals, process, and dividends of implementing such a program. Residency training directors and faculty, residents, and community psychiatrists may be especially interested to attend this workshop.

WORKSHOP 18

Friday, October 5; 8:00 a.m.–9:30 a.m.

Spirituality and Psychiatry: What Role Does Spirituality Have in Mental Health

APA/SAMHSA Minority Fellows

Chair(s): Sarah A. Bougary, M.D., Kimberly A. Gordon, M.D.

Presenter(s): Candace Fraser, D.O., Muruga Anand Loganathan, M.D., Ingrid K. Gindin, M.D., M.P.H.

Educational Objectives: At the conclusion of the session, participants should know how to facilitate non-biased religious discussions in and outside of therapy sessions.

Summary: Religion and spirituality, or the absence of it, play an important role in self-identification and the relationship a person has to his/her community. Uneasiness is felt when there arises a discussion of religion and spirituality, especially in the scientific community. This is echoed in resident training. This workshop will attempt to decrease stigma associated with religion and spirituality. The goal is to help attendees become comfortable facilitating a religious dialogue. This will be accomplished through the presentation and discussion. The presentation will include a brief summary of each religion followed by an explanation of common rationale behind religious practices. Furthermore, an exploration of religious and therapeutic techniques will be emphasized. This will be done by comparing and contrasting religious teachings and therapeutic techniques such as C.B.T and psychodynamic therapy. The presentation will end by addressing differences between culture and religion. Four spiritual groups have been chosen to facilitate this workshop; Hinduism, Judaism, Christianity and Islam. This is based on presenter's familiarity with these religious backgrounds. The discussion section of the workshop will give attendees an opportunity to practice religious openness and ask questions as appropriate. The projected practical outcome of the workshop is to help persons incorporate spirituality into a recovery plan if they so choose.

WORKSHOP 19

Friday, October 5; 8:00 a.m.–9:30 a.m.

Understanding Burnout and Protecting Ourselves

Chair: Mark Ragins, M.D.

Educational Objectives: At the conclusion of the session, participants should be able to describe six different common causes of burnout:1) Emotional detachment, 2) Change fatigue, 3) Fear overload, 4) Overwhelmed by client needs, 5) Paperwork overload, and 6) Losing our sense of helpfulness.

Summary: Professional athletes expect amazing things of themselves physically at work, far beyond any of us. They have warm-ups, training regimens, off season, time outs, work outs, substitutes, trainers and an array of coaches on the bench with them to help them, and even still many of them get physically injured. Mental Health workers expect amazing things of ourselves emotionally at work, but we have almost none of those supports. In effect, we come to work out of shape and are careless about how it's affecting us and then we're surprised when we're emotionally burned out. We can and should be more careful in understanding what the specific sources of our feelings of burnout are and how we deploy our defenses. This workshop describes six common causes of burnout in public mental health work and some things we can do to build our own resilience and protect ourselves: 1) Emotional detachment, 2) Change fatigue, 3) Fear overload, 4) Overwhelmed by client needs, 5) Paperwork overload, and 6) Losing our sense of helpfulness. It also discusses how many of the standard protective practices probably do more harm than good. Audience participants will be encouraged to apply these categories to our own situations and try to develop new protective strategies with the group.

WORKSHOP 20

Friday, October 5; 10:00 a.m.–11:30 a.m.

Loneliness and Suicide: A Family-Specific Approach Using Security-Based Self-Representations

Chair(s): Asghar-Ali A. Ali, M.D., Sheila M. Lobo Prabhu, M.D.

Presenter(s): Theron C. Bowers, M.D.

Educational Objectives: At the conclusion of the session, participants should be able to understand the role of security-based self-representations in psychiatric treatment at times of crisis or threat.

Summary: Severe, prolonged loneliness can adversely affect the intimate level of connectedness and basic self-characteristics of the individual; this can cause depression and cognitive distortions. Carefully eliciting past psychiatric, developmental, and family history may provide important information to guide relevant attachment-based care for the suicidal patient. This workshop presents an approach in which two theories are brought together in order for the treatment team to formulate a practical, novel, family-specific approach to treating the lonely suicidal patient. Security-based self-representations have been described as mental constructs derived from the internalization of security-enhancing interactions with attachment figures. These representations can be used to self-soothe during a crisis. Mikulincer and Shaver showed that exposure to a threat can heighten accessibility of security-based self-representations, resulting in improvement of depression; this was most effective in the groups that they classified as 'secure' and 'dismissingly avoidant'. These two groups best fit into the 'cohesive family' and 'formation of new family' classifications in the FIPS (Family Involvement in Preventing Suicide) model by Lobo-Prabhu et al. In the case of a 'cohesive family', the individual can think about available supportive family attachment figures and access positive aspects of self-in-relation-to-those-attachment figures. In the 'formation of a new family', it may help to access past security-based self-representations, and to form new ones by internalizing positive interactions with the treatment team and peers. The combination of these two constructs helps bridge theories about internal psychological constructs with external interactions with family and providers. The results are demonstrated in two cases in which an interdisciplinary team successfully implemented this approach to address issues of threat and loneliness in the care of two lonely, suicidal patients.

WORKSHOP 21

Friday, October 5; 10:00 a.m.–11:30 a.m.

CANCELLED

Humanizing Our Patients: The Key to the True Professionalism

APA/SAMHSA Minority Fellows

Chair(s): Deina Nemiary, M.D., M.P.H., Kimberly Gordon, M.D.

Presenter(s): Andrea M. Brownridge, M.D., J.D., Ebony Gaffney, M.D., M.B.A.

Educational Objectives: At the conclusion of the session, participants should be able to understand the difference between professionalism and humanism.

Summary: Based on 2010 data from the American Medical Association website there are 57,808 active resident/fellows in the U.S. (1). Several national Organizations have recognized the importance of promoting and fostering professionalism and humanism (2). Promoting professionalism and humanism holds the focus of research, academics, and clinical practice. (3–10). Professionalism is a way of behaving; what the physicians actually do and how they act built on a mindful declaration to place patients' interests uppermost (11). Humanism is a way of being; an innate predisposition to respond sympathetically to the needs of others (11). Professionalism and humanism have multiple domains (11). The conceptualization of professionalism is multifaceted, both in terms of focus and required behaviors, which include actions in the interpersonal (respect), ethical (integrity), practical (accountability), and personal (excellence and duty) domains. Professionalism in medicine can be seen as either theoretical or behavioral; with (empathy, integrity, trustworthy, disciplined, awareness of being a reflective practitioner, altruism, caring) or behavioral (communicating effectively, treating all patients equally, working in a team) (12). In the context of medicine, professionalism and humanism are best considered not as separate attributes of a good doctor but, rather, as closely linked (13). The Accreditation Council on Graduate Medical Education (ACGME) states that "…resident, faculty members, and program must demonstrate humanistic qualities that foster the formation of patient/physician relationships." These qualities include integrity, respect, compassion, professional responsibility, and professional attitude (14). Humanistic care is regarded as important by patients and professional accrediting agencies, but little is known about how attitudes and behaviors in this area are taught in clinical settings (15, 16).Transmission of humanistic qualities to medical students and residents is important. Evidence from may studies indicate that patients want and expect this kind of care from their doctors and more importantly care delivered in a humanistic way is associated with better health care outcomes (15). This perception points toward the need for strong efforts from medical educators to combat, foster and reward humanism in trainees and provide role models who endorse humanistic and professional values and behavior, and establish a solid foundation of learning to help trainees understand why both humanism and professionalism matter (3). Furthermore, studies that have described perceptions of humanistic qualities among resident physicians or faculty physicians, suggest that these qualities are diminished as a physician progresses in his career (13). At the conclusion of this workshop the audience should know the importance of both professionalism and humanism in medical training and practice. In addition, they should know some tools to foster humanism.

WORKSHOP 22

Friday, October 5; 10:00 a.m.–11:30 a.m.

Arresting Patients: Is Prosecution a Justifiable (and Just) Response to Inpatient Psychiatric Violence?

Chair: Elizabeth B. Ford, M.D.

Presenter(s): Merrill Rotter, M.D., Daniel S. Mundy, M.D., Paul S. Appelbaum, M.D.

Educational Objectives: At the conclusion of the session, participants will be able to state ethical principles, therapeutic principles, and practical arguments both for and against prosecution of psychiatric patients.

Summary: The problem of violent psychiatric inpatients for whom routine clinical interventions are not successful continues to challenge clinicians and hospital systems in this country. Formal institutional policies regarding the use of criminal prosecution as a management tool are generally either vague or non-existent. There is a relative paucity of literature on the subject such that the most recent study on this topic was published in (x year). This workshop aims to provide a review of arguments for and against prosecuting patients as well as guidelines that may assist in developing internal policies regarding arrest. Recent studies of arrested psychiatric inpatients will also be presented in an effort to further characterize this challenging population. Dr. Rotter will provide an overview of the purposes of punishment as they relate to psychiatric inpatients and will present recent data on applying those principles in a cohort of patients arrested in a civil state psychiatric facility. Dr. Mundy will then present very recent data from an ongoing case-control study comparing patients arrested on acute civilian units throughout New York City to a control group of patients arrested on the same charge, but outside of a hospital setting. Dr. Appelbaum will provide an overview of the ethical issues related to this topic, including the concepts of beneficence, autonomy, justice, trust and confidentiality, dual agency, and countertransference. Finally, Dr. Ford will discuss the challenges involved in creating a practical institutional policy that respects such concepts as victim's rights and staff morale while maintaining a primary emphasis on patient care and safety. Discussion following the formal presentation will include asking participants about policies at their respective institutions, exploring common challenges and concerns when arrest is considered or pursued, and assessing whether consensus exists about suggestions for formal guidelines.

WORKSHOP 23

Friday, October 5; 1:30 p.m.–3:00 p.m.

Electronic Health Records: What Psychiatrists Need to Know

APA Committee on Electronic Health Records

Chair: Robert M. Plovnick, M.D., M.S.

Presenter(s): Daniel J. Balog, M.D., Lori Simon, M.D.

Educational Objectives: At the conclusion of the session, participants should be able to list common questions and issues faced by small and solo practitioners considering the adoption of Electronic Health Records, e.g., selection, implementation, and use.

Summary: Electronic Health Records (EHRs) have been touted for their potential to improve documentation and communication to impact quality, but have also raised numerous concerns regarding their cost, complexity, and privacy limitations. Physicians who treat Medicaid or Medicare patients and demonstrate "meaningful use" of electronic health records are eligible for significant financial incentives. Starting in 2015, Medicare reimbursement rates will be reduced for physicians who do not meet this requirement. The momentum for the increased use of EHRs in Medicine continues to build. While psychiatrists are increasingly expressing interest in EHRs, for physicians in solo and small practices, the tasks of selecting, implementing, and effectively using an EHR are daunting. This workshop, sponsored by the APA's Committee on Electronic Health Records, will start with an overview of EHRs and the

Medicare/Medicaid EHR Incentive Programs. Psychiatrists in solo and small practice settings who have already adopted EHRs will share highlights of their experiences with the audience, including challenges faced and lessons learned. The workshop will conclude with ample time for attendees to pose questions to members of the Committee as well as the EHR adopters.

WORKSHOP 24

Friday, October 5; 1:30 p.m.–3:00 p.m.

How to Treat Sleep Disorders in Patients With Addiction

Chair(s): Abigail J. Herron, D.O.

Educational Objectives: At the conclusion of the session, participants should be able to recognize sleep disorders in patients with addiction.

Summary: Sleep disturbances are among the most common complaints reported by patients, and are particularly prevalent among those with substance use disorders. They are seen during times of active use as well as abstinence, and can be a significant precipitant to relapse. Clinicians may feel hesitant about prescribing sleep medications for this population due to a variety of factors, including concerns about abuse and misunderstanding of the significance of sleep disturbances. In this workshop, we will review the most recent evidence of safe and effective pharmacologic interventions for sleep disorders. We will offer specific strategies for approaching patients with co-occurring sleep disturbances and substance use disorders. Participants will be invited to bring their own experience treating patients with sleep and substance use disorders and to work with the faculty on formulating creative options for implementing these new approaches in clinical practice. The workshop is open to all psychiatrists who would like to learn more about the treatment of sleep disturbances in patients with addiction.

WORKSHOP 25

Friday, October 5; 1:30 p.m.–3:00 p.m.

Bullying: Relationships Between Sexual Orientation, Addiction, and the Legal System in American Youth

Chair: Jose Vito, M.D.

Presenter(s): Daniel Medeiros, M.D.

Educational Objectives: At the conclusion of this presentation, the participants should be able to recognize and use in their teaching a powerful tool for conveying an accurate and sympathetic depiction of the American youths victimized by bullies. The participants will learn the psychological and medical effects of drug addiction, and to demonstrate the biopsychosocial perspectives of gay and lesbian issues in their child and adolescent patients and their family.

Summary: The media have long shown a fascination with portraying the struggle and major adjustments of individuals with sexual orientation issues and the troubles of substance abuse during adolescent years. The movie "Bully" is based on a book by journalist Jim Schutze, which recounted the facts of the 1993 murder of Bobby Kent, who after years of abusing his friends and classmates, was killed by seven of his acquaintances in Ft. Lauderdale, FL. The movie depicts sex, violence, sexual orientation, and drug abuse among teenagers in America. The purpose of this workshop is to provoke a lively discussion and plan for these individuals' care, especially victims of bullying of gay, lesbian, and transgender issues have been so much in the news recently. Studies based on samples of sexual minority youth drawn from gay, lesbian, and bisexual community settings demonstrate that lesbian, gay, and bisexual youths experience high levels of victimization, ranging from verbal insults to physical assaults. Workshop participants will have the opportunity to explore and compare their own clinical experiences related with issues of working with sexual orientation and substance abuse conflicts that arise. They will have a better ability to identify the critical elements needed to learn and understand these issues.

WORKSHOP 26

Friday, October 5; 3:30 p.m.–5:00 p.m.

The Effect of Migration to United States on the Incidence of Substance Use

APA/SAMHSA Minority Fellows

Chair(s): Nicole S. del Castillo, M.D., Carissa Caban-Aleman, M.D.

Educational Objectives: At the conclusion of the session, participants will be able to discuss specific data about the epidemiology of substance abuse by different immigrant populations and examine the patters of incidence and prevalence.

Summary: In 2009, the Census Bureau reported that U.S. immigrants comprised 12.5% of the total U.S. population. This diverse group consists of many nationalities that have different cultural norms related to substance use, depending on their respective countries of origin. As immigrants adapt to the American lifestyle, they are also exposed to new substance use norms. They have to cope with acculturative stress and multiple social challenges (e.g. lack of social support, discrimination, unknown customs, being away from families, financial constraints, language barriers, limited access to health care, etc.). All of these factors predispose immigrants to an increased rate of substance use. Estimates of substance use among U.S. adult immigrants have shown that there are differential substance abuse rates across different immigrant subgroups, even among groups from the same geographic region. Research studies also indicate that substance use rates may vary by length of time in the U.S. Some studies indicate that substance use increases with increased time living in the U.S. However, some studies indicate the opposite. When these rates are analyzed separately for different countries, most studies suggest that there is wide variability in substance use patterns within subgroups of immigrants. These findings have been shown to depend on multiple contributing factors, such as type of substance, availability and advertising in particular neighborhoods, cultural norms limiting or supporting use, varying degrees of psychological stress, or differences in the rates of use in the country of origin. Other interesting factors are the average age at the time of immigration within the regional groupings, experiences of trauma during refugee processes and traditional beliefs about drugs as health-promoting substances. Considering how heterogeneous the U.S. immigrant population is, it is of utmost importance to study the socio-cultural factors that may contribute to differential substance use rates within immigrants. We will discuss specific data about the epidemiology of substance abuse by different immigrant groups and examine the patters of incidence and prevalence. A comprehensive understanding of the variability of these populations is necessary to identify specific at risk groups to target for prevention/early intervention programs. The purpose of this workshop will be to discuss the socio-cultural factors that mental health and primary care providers should consider when diagnosing, designing and implementing interventions. Since there are several barriers (such as stigma, access, etc.) that prevent treatment of these populations in mental health settings, it is imperative that primary care providers are as equally informed. The main topic of the workshop will be how acculturation and socio-cultural factors influence substance use and how we can develop interventions that address these issues to prevent and treat substance use disorders more effectively.

WORKSHOP 27

Friday, October 5; 3:30 p.m.–5:00 p.m.

Developing Training With a Racial Lens: Self-Assessment Tool and Guidelines

Chair(s): Paula G. Panzer, M.D., Kenneth Hardy, Ph.D.

Presenter(s): Caroline Peacock, M.S.W., Richard J. Gersh, M.D.

Educational Objectives: At the conclusion of the session, participants will understand the importance of using a racial lens when developing training and curricula.

Summary: The 1970s brought about an emphasis on “cultural competence” in social work and behavioral health practice. Multiculturalism, and increased awareness of race and ethnicity, became a standard part of training and practice. However, because of the generalized nature of cultural competence, specific attention to race became diluted as other important issues such as class, gender, and sexual orientation came to fit under this umbrella. As a result, many courses on cultural competency ineffectively addressed race, racism, and privilege. Often, an equalizing of oppressions took root in discussions (e.g., “As a woman, I know what it is to experience discrimination and therefore be a person of color”), and race was once again pushed to the back burner. Despite the increased attention to cultural competency in social work education, the results of such efforts were not always effective; the material was sometimes experienced as an addendum to the curriculum or irrelevant to real-life practice. Additionally, without proper training in how to facilitate dialogue about multiculturalism and cultural competency, many instructors struggled with teaching the concepts, especially if they did not have a firm grasp on the subject as it applied to their area of expertise. We have addressed this issue by creating guidelines which help trainers add a race lens to their curriculum preparation and delivery. There are four components: course process, course content, reading/assignments, and “self of the instructor.” The guidelines will be shared and used during this experiential workshop. Presenters will lead participants through portions of the self-assessment tool, and models of curriculum development will be shared and discussed. Real experiences with the use of these guidelines and possible future applications will also be discussed. This workshop is part of an OMNA On Tour Track, designed as a one day sequence of symposia and interactive workshops exploring the intersection of trauma and racism on mental health and how the intersection of trauma informed care and confronting organizational racism can benefit systems and individuals.

WORKSHOP 28

Friday, October 5; 3:30 p.m.–5:00 p.m.

Recovery-Based HIPAA

Chair(s): Mark Ragins, M.D., Anthony Carino, M.D.

Educational Objectives: At the conclusion of the session, participants will be able to understand the reasons behind the confidentiality rules to know how to alter practice ethically and legally.

Summary: Recovery based services fundamentally alter the doctor-patient relationship, the range of services offered, the variety of staff and other providers included, and the role of community development. Psychiatrists frequently facilitate consumers’ connection to mental healthcare, physical healthcare, substance use services, families, vocational services and other community support systems to support individuals in a severely fragmented system. These transformation efforts have often felt frustrated by and in conflict with HIPPA based confidentiality requirements. In addition, maintaining secrecy can often work against decreasing shame and building community integration and actually inhibit recovery. This discussion will develop thoughtful, empowering ways to practice recovery without violating HIPPA. We will use interactive group discussion, handouts and specific case reviews to outline ways providers may navigate privacy issues and empower consumers through the process. Instead of relying entirely on a series of "thou shalt not" confidentiality prohibitions, we can incorporate a series of positive, proactive, harm reduction measures. We need to understand the reasons behind the rules to alter our practice ethically and legally: To avoid shame and embarrassment from having information revealed, To avoid negative consequences of their actions, To avoid negative consequences, reduced access and reduced opportunities from stigma and prejudice, To avoid being victimized by someone else misusing their information, To avoid damaging trust in us limiting our ability to help them and emotionally retraumatizing them, and To prevent unwanted intrusion of others in their services, lives, and choices. We will emphasize: Bureaucratic and social responsibilities that often conflict with confidentiality, Altering the foundation of trust from maintaining a private individual treatment relationship to basing trust on self disclosure, shared humanity, open caring, charity, and supporting client-driven goals, Team based instead of individual based confidentiality, Incorporating consumer staff, Integrating community partners and community development, Fighting stigma and increasing opportunities by "coming out of the closet," Building resilience instead of protecting clients, and Practical ways to use confidentiality conversations with consumers to both empower and to actually build alliance.

WORKSHOP 29

Friday, October 5; 3:30 p.m.–5:00 p.m.

When Your Best Collateral is the Daily News: Treating High Profile Patients in the Criminal Justice System

Chair(s): Gareen Hamalian, M.D., M.P.H., Michael Champion, M.D.

Presenter(s): Henry C. Weinstein, M.D.

Educational Objectives: At the conclusion of the session, participants will be able to understand the risks, benefits and ethical considerations related to accessing media sources for information related to high profile incarcerated patients.

Summary: The treatment of celebrity or VIP patients has been addressed in the literature, although much of the focus is on the risk of the clinician becoming too invested in the treatment or stepping outside of appropriate boundaries and being "blinded" by a patient's high profile. Less described, if at all, is the treatment of a different kind of high profile patient – one who has been accused or convicted of a particularly notorious or gruesome crime. Caring for individuals in this situation presents unique ethical and treatment challenges. Three of these will be covered in detail in this workshop: media; countertransference; and confidentiality. First, media coverage of the crime may precede the patient's arrival into treatment. Newspaper and television reporters may have obtained information about a patient that the patient is not willing or is unable to reveal to a treating clinician. However, the information reported in the press may also be misleading or inaccurate. Should clinicians read about their patient prior to or during the treatment? Is it realistic to expect a clinician, who may also be a part of the community in which the crime was allegedly committed, to ignore mass media? Second, emotions about the nature of the alleged crime may impact a treating clinician's care of a patient accused of that crime. Countertransference can significantly impact the treatment such that a patient may receive more or less care and diligence than otherwise would be indicated. While countertransference can sometimes present as awe of the patient, much like with a celebrity, it can also, and more commonly does, present as repulsion or disgust. What tools can a clinician use to minimize the impact of countertransference on a treatment relationship? And finally, how does a clinician respect a patient's confidentiality in the midst of media reports, questions from family, friends and colleagues, and legal and correctional requirements that may limit a patient's privacy? A review of the relevant literature and case examples, including of several notorious patients whose psychiatric hospitalizations became public knowledge, will guide a discussion about suggested methods for the treating clinician caring for "high profile" patients in a criminal justice setting.

WORKSHOP 30

Friday, October 5; 3:30 p.m.–5:00 p.m.

Reintegration Challenges for Returning Veterans and the Value of Military Cultural Responsiveness Among Civilian Community Providers

Chair: Adriana Rodriguez, L.C.S.W.

Presenter(s): Rebecca Wynn, M.S.

Educational Objectives: At the conclusion of the session, participants will understand the military is a subculture in its own right.

Summary: Since 2001, approximately 2.5 million U.S. troops have served in the conflicts in Afghanistan and Iraq. The 2.5 million who volunteer to serve represent less than 0.5% of all Americans. Even if we extend the 2.5 million to include families, at most 2% of Americans understand the culture of military service today. As they return home, many veterans have a wide range of reintegration needs, including: transitioning from the military to the civilian community; education; work readiness; employment; mental health care; family stabilization; housing; and medical care. A smaller number of them are in need of urgent mental health care and suicide prevention assistance. Studies show that a large percentage of veterans want or prefer these services to be delivered within the communities where they live. Veterans and their families can get some, but not all, of their care through the VA. There is an explicit need for all services, including mental health, to be delivered by providers who are informed about the unique features of the military population, and who have veteran-specific experience. This workshop will focus on the normative reintegration challenges veterans experience as they transition to civilian life, and the importance of military cultural competence for all providers. The JBFCS Home Again: Veterans and Family Initiative provides a best-practice model for culturally responsive work with veterans. Our program has trained over 800 community service providers who work directly with veterans. Our trainers – two-thirds of whom are veterans themselves – help community providers understand the strengths of military service members and apply them to civilian situations. The training team also includes a clinician with expertise in evidence-based trauma treatments and Motivational Interviewing. Home Again addresses assumptions and dispels myths about military service that impede reintegration and success post-service. The workshop discussion will focus on Home Again's experiences training community providers to work with veterans, including successes, lessons learned, and training interventions. Home Again staff will share key teaching points with participants and begin to prepare them to welcome Veterans into all community settings – child welfare, mental health, job training, housing, legal advocacy and more. Participants will be invited to share narratives which can be used as teaching tools. The presenters will show how to integrate the veteran's perspective, trauma-informed practice, and cultural competency regarding race, gender and sexual orientation into one welcoming approach. This workshop is part of an OMNA On Tour Track, designed as a one day sequence of symposia and interactive workshops exploring the intersection of trauma and racism on mental health and how the intersection of trauma informed care and confronting organizational racism can benefit systems and individuals.

WORKSHOP 31

Friday, October 5; 3:30 p.m.–5:00 p.m.

Making Space for Courageous Conversations About Race and Culture in Human Service Organizations

Chair: Joan Adams, L.C.S.W.

Presenter(s): Shirley de Peña, L.C.S.W.

Educational Objectives: At the conclusion of the session, participants will understand and value the importance of having staff conversations around race in a human service organization.

Summary: The workshop will be didactic and interactive. We will engage the audience in examining the impact of race, culture and structural racism on social service delivery and staff diversity and inclusion. We will use an interactive experiential exercise to demonstrate the meaning of racial and cultural identity in the lives and work of participants. Participants will be helped to understand this process through a brief presentation about one model for courageous conversations. The example of an ongoing organizational initiative, Confronting Organizational Racism (COR) at JBFCS in New York City, illustrates the importance of having conversations around race, culture, and structural racism among staff of color, white staff, and in cross-racial settings. Since 2006, the organization has offered several venues for staff discussion about race and racism. These include racial affinity groups for staff that evolved from agency-wide Men of Color, Women of Color, and White Anti-Racist groups to People of Color affinity groups and White Anti-Racist affinity groups. Since 2008 People of Color and White Anti-Racist affinity groups have developed in each geographic region of the agency. Most groups meet monthly. Since October 2009, there has been a regular monthly meeting of the leaders of all the regional affinity groups. This meeting provides a place for people of color and white staff to share the concerns and process of the regional meetings, to develop responses to those concerns, and to share the concerns with the agency COR leadership. Since 2009, the Racial Affinity groups have sponsored 4 half-day Cross-Racial Dialogues, open to all staff. These have featured speakers and an opportunity for discussion with the audience. The most recent topic was "The Impact of the Culture of Imposition on Latinos, Latino Clients and Cross Racial Dialogues." Participants will be invited to reflect on implications of using a race and culture lens in their own organization and to identify one next step toward courageous conversations about race and culture in their organization. This workshop is part of an OMNA On Tour Track, designed as a one day sequence of symposia and interactive workshops exploring the intersection of trauma and racism on mental health and how the intersection of trauma informed care and confronting organizational racism can benefit systems and individuals.

WORKSHOP 32

Friday, October 5; 3:30 p.m.–5:00 p.m.

Behavioral Health Care and the NYC Child Welfare System: An Antiracist Historical Analysis of a Critical Relationship

Chair(s): Jordan Margolis, L.C.S.W., Jonathan McLean, M.S.W.

Educational Objectives: At the conclusion of the session, participants will be able to differentiate the terms diversity, multiculturalism, cultural competence, race lens, and antiracism.

Summary: As certain municipalities around the country begin acknowledging the phenomenon of racial disproportionality in their child welfare systems, race-based trauma and trauma-informed care take on particular salience in the development of both public policy and best clinical practice. Behavioral health service delivery systems have had a long and significant intersection with child welfare systems, and in an era of fiscal austerity must respond to this long-overdue race-and-trauma framework that has begun achieving measurable results. Identifying supports for and barriers to such organizational transformation is a critical step in creating racial equity in both mental health care and child welfare. This workshop will provide an historical perspective on the development of the parallel systems of behavioral health care and child welfare as relevant to the families who use both services. The historical review will highlight the relevance of (1) disproportionality, (2) organizational and individual trauma, (3) structural and individual racism, and will summarize some of the key issues for systems and consumers after decades of these issues. Then diversity, multiculturalism, cultural competency, race lens and antiracism will be defined. Participants will then be invited to discuss these issues in small groups to foster interactive, intense conversations. Issues of inequities will be brought back to the larger group for further discussion and linked to some effective group and system interventions. Concrete examples of transformative policies and practices will be shared. The presenters will focus on models in New York City. They welcome participants to bring and discuss models of care and models of change from their communities. This workshop is part of an OMNA On Tour Track, designed as a one day sequence of symposia and interactive workshops exploring the intersection of trauma and racism on mental health and how the intersection of trauma informed care and confronting organizational racism can benefit systems and individuals.

WORKSHOP 33

Friday, October 5; 3:30 p.m.–5:00 p.m.

Cross-System Service Delivery for Multi-Challenged Families: An Integrated Approach to Preventive Service Delivery

Chair: Mary Dino, L.C.S.W.

Presenter(s): Naomi Weinstein, M.P.H.

Educational Objectives: At the conclusion of the session, participants will know about an innovative, multi-disciplinary, cross-systems preventive model to generate ideas for and discussion around similar interventions at participant's home agencies.

Summary: Research supports highly integrated, collaborative work as best practice for multi-challenged families who are engaged with multiple providers. While cross-systems work can be difficult in the best of times, current economic conditions have made it harder for agencies to deliver high-quality and a well-coordinated service, even as the need for a stronger safety net at the family level has increased. During today's workshop, participants will be introduced to the New York City Administration for Children's Services (ACS) new team-based, cross-systems, intensive preventive model called the Family Treatment and Rehabilitation program (FT/R) The goal of the workshop is to generate thoughtful discussion about the benefits and challenges of such service models, and how participants might start or improve effective cross-systems programs in their municipalities or states. Participants will learn how, with secured funding, FT/R builds on the best of past cross-systems collaborative efforts, actively addresses cross-systems practice barriers at the regulatory and providers agency levels, increases the capacity of FT/R and community provider staff with a variety of training strategies and the use of standardized screening tools, creates an on-going feedback loop to continuously improve program design, implementation and sustainability in real-time. FT/R recognizes the imperative to empower families to chart their road to a self-defined recovery as the drivers of their treatment plans. Participants will be introduced to how FT/R incorporates high level of cultural sensitivity and the trauma lens into its work to support processes of safety, stabilization and self-determination. The incorporation of the trauma and cultural lens in supervision and team meetings also supports work within FT/R as a way to promote safety, value diversity and inoculate against secondary traumatic stress. Participants will be guided towards considering first steps on how these lenses could promote best practice at their home sites. This workshop is part of an OMNA On Tour Track, designed as a one day sequence of symposia and interactive workshops exploring the intersection of trauma and racism on mental health and how the intersection of trauma informed care and confronting organizational racism can benefit systems and individuals. This workshop is part of an OMNA On Tour Track, designed as a one-day sequence of symposia and interactive workshops exploring the intersection of trauma and racism on mental health and how the intersection of trauma informed care and confronting organizational racism can benefit systems and individuals.

WORKSHOP 34

Friday, October 5; 3:30 p.m.–5:00 p.m.

Health Homes and Behavioral Health Managed Care: New Approaches to Care Coordination for Seriously Mentally Ill Individuals

Chair(s): Thomas Smith, M.D., Lloyd I. Sederer, M.D.

Presenter(s): Andrew J. Kolodny, M.D., Matthew D. Erlich, M.D.

Educational Objectives: At the conclusion of the session, participants will understand how new behavioral health managed care initiatives can be shaped by a quality improvement focus and emphasis on engagement in care.

Summary: Healthcare reform efforts are underway nationally and New York State is beginning to implement health homes and managed care for seriously mentally ill individuals served in the public sector. There are several initiatives underway, and city and state mental health authorities have emphasized a focus on quality improvement, and individualized recovery-oriented perspectives. This is in contrast to traditional managed care efforts that emphasize a medical model and financial controls. The presenters will review recent implementation of behavioral health managed care and health home initiatives in New York City. Dr. Erlich will describe New York State's plan to implement fully at-risk managed care contracts over a three year period and a current initial phase focusing on making data available to hospital providers regarding care coordination activities and linkages with aftercare follow-up. Dr. Kolodny will describe the implementation of a health home in New York City that follows medical home and state-of-the-art care coordination principles for high-need individuals. Dr. Smith will review data from the New York City Mental Health Care Monitoring Initiative, in which individuals with serious mental illness who frequently disengaged from care were interviewed about their experiences with provider outreach and engagement efforts. Data will also be presented regarding providers' perspectives on outreach engagement of these individuals. The presentations will be followed by open discussion and focus on audience members' involvement in similar efforts to enhance care coordination and engagement in care for high need individuals with serious mental illness.

WORKSHOP 35

Saturday, October 6; 8:00 a.m.–9:30 a.m.

Partners in Education: Development of an Innovative Case-Based Workshop for an Interprofessional Audience

Chair: Diana Kljenak, M.D.

Educational Objectives: At the conclusion of the session, participants will be able to list several methods of educational needs assessment, understand familiar with successful method of workshop development for interprofessional audience of community providers and reflect on how this workshop could be implemented in different settings.

Summary: In Canada, and around the world, community care providers are the main source of mental health services for the majority of patients. They are the front line workers who are often first to experience difficult encounters with patients. Mismanagement of difficult clinician-patient encounters can result in poor outcomes both for patients and for clinicians. Therefore, adequate interprofessional training to enable team members to collaboratively deal with problematic clinician-patient interactions is of considerable importance. A half-day workshop was designed with the aim to enhance community health care providers' capacity to diagnose and manage "difficult" patients; the main emphasis was on education about common countertransference reactions that "difficult" patients invoke. Didactic presentation, interactive case-based exercises and video clips served as a platform for reflection on audience's countertransference reactions that then helped reframe the problem from "difficult" patient to "difficult" clinician-patient interaction. The participants endorsed increased ability to manage difficult clinician-patient encounters. Such skill building will improve clinician-patient encounters and improve health outcomes. We will outline the development and implementation of this innovative workshop for interprofessional audience. The process of interprofessional collaboration, the teaching methods and content, and the evaluation results will be described. Participants will be invited to consider the applicability of the workshop to their setting.

WORKSHOP 36

Saturday, October 6; 8:00 a.m.–9:30 a.m.

Integration of Primary Care and Psychiatry in a Public Psychiatry Fellowship

Chair: Marisa A. Giggie, M.D., M.P.A.

Presenter(s): Michael D. Williams, D.O., Thaddeus P. Ulzen, M.D.

Educational Objectives: At the conclusion of the session, participants will be able to recognize the importance of integrating primary care and psychiatry in community mental health settings.

Summary: The complex medical care of patients with mental health disorders has started to receive increased attention over the past decade (Rohrbaugh, et al, 2009). However, most psychiatric residencies offer little to no training on how to integrate effectively with primary care. Furthermore, most primary care residencies have minimal psychiatric training with limited focus on integrated care. Studies have shown that most primary care training program directors are dissatisfied with their psychiatry training (Leigh, et al, 2006). Psychiatry and primary care training directors generally agree that psychiatry training in primary care programs is inadequate and should be significantly enhanced (Leigh et al, 2008). With the advent of the primary medical home, the issue of integration of psychiatry in primary care is becoming important to teach both psychiatrists and primary care physicians. Most of the focus in graduate medical education has been on establishing combined Family Practice-Psychiatry residency programs, which have been established since the mid-1990s. The limited number of combined training programs in family medicine and psychiatry have produced encouraging results but the numbers are inadequate to address the needs of the population (Servis, 2005). The University of Alabama School of Medicine, Tuscaloosa Campus, has taken a different approach to address the need for more integration of psychiatry with primary care. It has created a public psychiatry fellowship program that focuses on integration with primary care and runs parallel to a behavioral medicine fellowship in family medicine. These two post-graduate training programs are the only ones of their kind that address training of family physicians in psychiatry concurrently with leadership training of a public psychiatry fellow. The program started in 2010 and has produced two classes of graduates. The session will focus on the development of the two fellowship programs and include reflections from its first behavioral medicine fellow in primary care.

WORKSHOP 37

Saturday, October 6; 8:00 a.m.–9:30 a.m.

Intellectual Disability and Mental Illness: Developing Clinicians, Effective Treatments, Programs and Systems of Care

Chair: Ann K. Morrison, M.D.

Presenter(s): Allison E. Cowan, M.D.

Educational Objectives: At the conclusion of the session, participants will be able to describe educational experiences which will result in resident competence in treating people with intellectual disabilities and mental illness, list effective methods to accurately diagnosis and treat people with intellectual disability and mental illness and understand strategies to increase access to mental health services for people with intellectual disabilities via a variety of service delivery models.

Summary: People with intellectual disability frequently are affected by co-morbid psychiatric illnesses and behavioral disorders. Psychiatrists, mental health professionals, developmental disability professionals, residential staff, family members and the affected individuals frequently struggle to understand the causes of and the effective interventions to decrease their internal distress and behavioral disturbance. Systems of care often are hampered by funding stream silos, complex and differing eligibility criteria, different organizational cultures including language, and "turf" issues. Access to psychiatric care is often limited due to inadequate numbers of psychiatrists with sufficient training and exposure to this type of dual diagnosis. Adequate funding and reimbursement may also limit access to care for these individuals who are largely insured by Medicaid. The workshop will address these challenges of diagnosis and treatment; access to and funding of care; enhancement of training and delivery systems. Presentations will include perspectives from a psychiatrist with experience in program development, administrative psychiatry and direct care and a psychiatrist, recently graduated from our training program, who emphasizes intellectual disability/mental illness dual diagnoses and who continues to concentrate on this in her community practice.

WORKSHOP 38

Saturday, October 6; 8:00 a.m.–9:30 a.m.

CANCELLED

Population Health Initiatives to Improve the Quality of Mental Health Care in North Carolina

Chair: Robin Reed, M.D.

Presenter(s): Tiona Guess Praylow, M.D., Thomas Pillion, M.D.

Educational Objectives: At the conclusion of the session, participants will be able to identify strategies that promote successful implementation of effective collaborative depression care initiatives in primary care. Be familiar with the evidence base behind the use of collaborative care models to target specific populations. Identify program evaluation methods to use in a collaborative care intervention.

Summary:
Objective 1: Collaborative care programs for depression screening in primary care may be more effective when used with a population with a specific set of chronic diseases. These programs are not well described in community health center settings with high rates of uninsured individuals. This presentation describes a depression-screening program for adults with poorly controlled diabetes that are served in a Federally-Qualified Health Center that serves a large immigrant population. The presentation will present data from the program evaluation of the effect of the program on the quality of depression care, quality of life, severity of diabetes, and health care costs.

Objective 2: The complex nature of the roots of obesity require a comprehensive and coordinated approach that includes policy and environmental change to maximize the background risk of obesity for all children while recognizing the unique risks of certain populations. Impoverished children, for example, are at a particularly high risk for developing obesity secondary to the greater burden of social, economic, and health disparities they incur. Treatment of children with mental illness and developmental disabilities may involve use of antipsychotic medication that cause weight gain and metabolic syndrome that leads to chronic diseases such as heart attack and stroke. The use of antipsychotic medication in children has become more closely scrutinized given the rising numbers of children receiving these medications and the safety risks, such as obesity and movement disorders, associated with them. There are efforts to understand the biologic mechanisms of weight gain related to antipsychotic exposure for an individual. In addition, there are growing efforts to encourage judicious use of antipsychotics across populations. One such effort is underway in North Carolina. This presentation examines a novel policy initiative for encouraging safe use of antipsychotics in children served by the North Carolina Medicaid population. A antispsychotic prescribing registry tracks numerous measures, including

BMI %, blood glucose and lipid panels. We will examine the effects of a policy-level initiative that tackles a complex public health issue.

Objective 3: Many people turn to clergy for help with their mental and emotional problems. Studies are needed to understand the perspective of clergy so that they can become more effective partners with mental health providers in identifying and responding to those suffering from mental illness. This study examines the referral patterns of Catholic priests in North Carolina. The presentation will present the rationale for collaboration with clergy, survey data on their referral habits within one population, and considerations for strategies for further collaboration.

WORKSHOP 39

Saturday, October 6; 8:00 a.m.–9:30 a.m.

Implementing Evidence-Based Practice in the Real World: Dialectical Behavioral Therapy at an Urban Community Mental Health Center

Chair(s): Andrew W. Hunt, M.D., Patrick S. Runnels, M.D.

Presenter(s): Angel Chapin, M.S.W.

Educational Objectives: Participants will interact with presenters to illuminate the process of implementation of a complex, multiple-provider psychotherapy system in the context of an urban community mental health center.

Summary: This interactive presentation will discuss the trials and tribulations of implementing a complex, multiple-provider psychotherapy system in the setting of an urban mental health center. DBT is, foremost, a process which always seeks to maximize the middle ground between ideals, a process which improves itself through crisis, and one which harnesses obstacles to build new levels of therapist skill while validating real effort. Presenters will focus on important implementation conflicts which, turned into dialectics, become a vehicle for implementation. These will include: task-oriented vs. relationship-oriented approach, fidelity to model vs. adaptation to setting, and motivation/overconfidence vs. demoralization/need-to-improve. These real world conflicts will act as footholds for further participant discussion. The presentation will also include a timeline of implementation which is perhaps true to form of real life expectations, and presenters will highlight invaluable elements that kept the process moving when it struggled. These include agency buy-in, dedicated team planning time, consistent repetitive self-evaluation, partnership, and mentorship.

WORKSHOP 40

Saturday, October 6; 10:00 a.m.–11:30 a.m.

It Gets Better: 21st Century Standards of Care, Policy and Advocacy for Sexual Minority Adults and Youth

Chair(s): Kenneth Ashley, M.D., Jack Pula, M.D.

Presenter(s): Littal Melnik, M.D., Aron Janssen, M.D., Stewart L. Adelson, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to understand the application of the WPATH Standards of Care in a psychiatric setting.

Summary: As community psychiatry has evolved over the past thirty years, psychiatrists have taken up the banner of advocating for vulnerable populations who need specialized mental health services. For those who care for lesbian, gay, bisexual, and transgender (LGBT) patients, this movement has opened up unique opportunities to create standards of care and expertise at local, national, and international levels. This workshop will explore some of the organizational efforts and outcomes specific to this population, and to educate interested psychiatrists so they can adapt and apply the information to their own work and communities. Given that the Joint Commission and the Institute of Medicine have paid particular attention to the need for cultural competency in working with the LGBT population, this workshop will address a timely issue within the worlds of general, community, and institutional psychiatry. This workshop will focus on several professional organizations that have contributed significant educational and clinical advances for LGBT patients. The World Professional Association for Transgender Health (WPATH) is responsible for creating and publishing the Standards of Care (SOC) used worldwide to guide clinicians in helping transgender people realize their goals for how to live comfortably and optimally. Jen Pula, MD will give on an update on the newest version of the SOC American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameter on Gay, Lesbian or Bisexual Sexual Orientation, Gender-Nonconformity, and Gender Discordance in Children and Adolescents. Stewart Adelson, MD will discuss the most recent parameters for working with LGBT children and adolescents. This is particularly challenging work because of the stigma for children and their parents, as well as the conflicts within families and schools, which child psychiatrists routinely negotiate. Setting up an LGBT Service – Modern psychiatric clinics provide better mental health care when they are culturally competent. Aron Janssen, MD will discuss how to set up a clinical service that meets the needs of LGBT youth in a sensitive and effective way. APA/Association of Gay and Lesbian Psychiatry (AGLP)/Group for the Advancement of Psychiatry (GAP) – Kenn Ashley, MD, president of AGLP, and co-chair of the APA NY Co DB Committee on LGBT Issues, as well as a member of the GAP Committee on LGBT Issues, will discuss how these professional organizations promote the mental health needs of LGBT patients and improve standards of treatment within the profession through education, outreach, and advocacy. The Joint Commission has published a field guide that aims to standardize a basic degree of cultural competency around LGBT healthcare issues at all medical centers under its accreditation. Littal Melnik will summarize the relevant recommendations.

WORKSHOP 41

Saturday, October 6; 10:00 a.m.–11:30 a.m.

When Bad Things Happen on Good ACT Teams: Helping Providers and Consumers Cope With Adverse Events on an Urban ACT Team

Chair: Ann L. Hackman, M.D.

Presenter(s): Theodora G. Balis, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to identify adverse events seen on urban ACT teams.

Summary: There is limited literature on vicarious traumatization in mental health settings and nothing specific to Assertive Community Treatment (ACT). The University of Maryland ACT team worked with an underserved population in urban Baltimore for more than twenty years. Violence, trauma and other adverse events are not unusual and impact both treatment providers and the consumer community. Despite recovery oriented treatment, the team has experienced adverse events including suicides, consumer death from preventable or treatable illness, and consumers as victims or perpetrators of violent crimes as well as other traumatic events. While such events are difficult for treatment teams in various settings, they are particularly difficult on an ACT team where treatment is intensive, where staff may work with consumers and their families or support systems over a number of years and where consumers share in a sense of community and may come to know each other well. In this workshop three psychiatrists with a total of more than 40 years of ACT work will discuss our experience with adverse events involving our consumers. We will briefly review the relevant literature, describe our team and community, and detail some of our experiences. We will focus on our approach to helping the staff deal with what has happened and continue to do their jobs We will discuss some of the traditions which the team has implemented and other efforts to help other consumers process these events and ways to help reduce vicarious trauma for providers and consumers in ACT treatment.

WORKSHOP 42

Saturday, October 6; 1:30 p.m.–3:00 p.m.

Healing Pain With Integrative Medicine

Chair: Sonya Lazarevic, M.D., M.S.W.

Presenter(s): Amy M. FitzPatrick, M.S.

Educational Objectives: At the conclusion of this session, the participant should be able to define integrative medicine.

Summary: According to NIDA, prescription opioid use has nearly tripled in the U.S. since 1991, exceeding 210 million prescriptions in 2010. The CDC reports prescription opioid overdose to be the second leading cause of accidental death in the U.S., causing more deaths than heroin and cocaine combined. Opioids are currently amongst the top three categories of medications abused. Psychiatrists face the clinically complex patient with chronic pain who is also dependent on opioids. This workshop will explore treatment options for this population, define an integrative approach to pain management and present complementary therapies used to treat common pain syndromes. The interventions presented will be evidenced based, mechanisms of action will be discussed when possible. Subjects covered will include theory of addiction from the Chinese medical perspective, and interventions on the level of dietary changes, micronutrients, botanicals, mind/body exercises, psychotherapy and acupuncture. Attendees will complete this workshop with a clear definition of the terms 'integrative medicine' and 'complementary and alternative medicine' (CAM), and will be able to identify treatments which fall under this category and appropriate referral situations. This workshop will include an instructional 'take home' technique which can be applied in the clinical setting with patients. Additional resources for further learning on this subject will be provided for attendees. An open discussion will follow.

WORKSHOP 43

Saturday, October 6; 1:30 p.m.–3:00 p.m.

Residents' Duty Hours Reform: Issues and Controversies

Chair: Ramaswamy Viswanathan, M.D., D.Sc.

Presenter(s): Kenneth M. Certa, M.D., Lenore Engel, M.D., Ellen Berkowitz, M.D., Suprit Parida, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to describe the adverse effects of long work hours, and consequent sleep deprivation and fatigue, on work performance and learning.

Summary: Sleep deprivation and fatigue among physicians have been associated with adverse outcomes, such as medical errors, motor vehicle crashes, and occupational injuries. In December 2008, the Institute of Medicine

(IOM) published its report regarding resident work hours. The 2011 ACGME regulations include many of the recommendations of the IOM report. While the intent of duty hours reform is the welfare of our trainees and patients, there is some disagreement among trainees and others as to whether some components of reform are beneficial. We will present data from one residency program to illustrate these issues and to serve as a springboard for further discussion. In that program, changes to the resident on-call policy were implemented beginning July 2010, limiting resident on-call hours to till 10 p.m. on weekdays (short calls), in contrast to the previous policy of overnight call with the post-call day off (long calls). When surveyed 8 months after the changes were implemented, sixteen of the twenty-five (64%) resident respondents preferred the short call format over the overnight call system, while 9 (36%) preferred the long call with post-call day off as their preference. Fourteen (56%) reported adverse effects of the night float system (month-long) on mood, health and personal relationships. Short calls were reported to be associated with less adverse impact on mood, health and personal relationships, along with improvement in clinical performance, learning experience and attention level during calls. The main reasons cited for the long call preference were getting the next day off, being able to take care of other work during weekdays, and increase in the number of calls with the short call system. In this workshop we will explore how to accommodate the differing needs of trainees, and variability in institutional resources available to support duty hours reform. Resident feedback following any implemented change can be an important tool for programs to assess the short term and long term impact of the policies on residents. Audience members will be encouraged to share their experiences and views, and we will facilitate educationally meaningful interactions.

WORKSHOP 44

Saturday, October 6; 1:30 p.m.–3:00 p.m.

Ask the Experts, an Insider's Perspective: A Conversation With Peer Counselors About Wellness, Recovery and Integration

Chair: Joseph P. Merlino, M.D., M.P.A.

Presenter(s): Marion Thomas, Matthew Costanzo, Magdalena Maurice, Mark Davis

Educational Objectives: At the conclusion of this session, the participant should be able to understand the basic tenets of the wellness and recovery concept.

Summary: The employment of peer counselors is a critical component in the development and application of a patient-centered, recovery-focused model of care. As "ambassadors of empathy" they approach the care of the patient from an insider's perspective. They represent hope and successful community integration, and are living proof that recovery works. Peer counselors are able to liaison for the patient with the treatment team as they utilize their personal experiences to inform the treatment approach. The employment of peer counselors facilitates the establishment of a recovery philosophy of care in an organization, as it supports the personal recovery of these employees as well as the transformation of the organization. Kings County Hospital has developed the largest peer counselor program in the country and has been a model internationally for organizations looking to develop such programs. In a highly interactive format, this workshop will provide the opportunity to learn from peer counselors themselves, about their roles and impact as integral members of interdisciplinary treatment teams.

WORKSHOP 45

Saturday, October 6; 1:30 p.m.–3:00 p.m.

Integrated Care With the DIAMOND Model: Improving Clinical Outcomes, Reducing Costs and Enhancing Patient Experience

Chair(s): Pam Pietruszewski, M.A., Nancy A. Jaeckels

Educational Objectives: At the conclusion of this session, the participant should be able to understand the role of the consulting psychiatrist within the core components of the DIAMOND depression care model, describe DIAMOND outcomes and results that accomplish the Institute for Healthcare Improvement (IHI) Triple Aim, understand how the model has expanded to behavioral health, substance use and health care home initiatives and discuss future integration activities that support health reform and wellness innovations.

Summary: More effective and efficient depression care was the goal of a 2006 statewide initiative launched by the Institute for Clinical Systems Improvement (ICSI). More than 100 health clinics were trained and certified to deliver new care under a new payment model supported by all major health plans in Minnesota. Since winning the APA Psychiatric Services Gold Award for Community-Based Programs in 2010, the DIAMOND Model (Depression Improvement in Minnesota – Offering a New Direction) has accomplished the Triple Aim of improved population health, enhanced patient experience, and controlled/reduced costs. ICSI continues its reputation as a trusted, neutral convener of innovation by establishing the DIAMOND model as a team-based, systematic approach to integrated care. This foundation sets the course for a medical home that can successfully provide care management for multiple behavioral health and medical conditions – which is the groundwork of Accountable Care Organizations. Consulting psychiatrists partner with primary care to provide case review and evidence-based clinical recommendations. Our analysis has found this role to be vital to patient depression outcomes, and opens a world of possibilities for clinical improvements in other conditions.

The National Institute of Mental Health is funding a $3 million, five-year grant to evaluate the DIAMOND initiative. Using partnership research design, the study evaluates changes in care delivery, patient outcomes, and cost-effectiveness. Clinical outcomes for DIAMOND are 5 times better than usual care with the all-team collaborative remission rate up to 70% response and 53% remission. Strong correlations were found between engaged psychiatrist, right care manager hire, patient engagement and remission. Workplace data found a direct correlation between reduced productivity and depression severity. Total cost of care savings data will be published in 2012.

WORKSHOP 46

Saturday, October 6; 3:30 p.m.–5:00 p.m.

"Telling the Tale": Using Story-Telling to Facilitate Education in Psychiatry Clerkships

Chair: Kathleen M. Patchan, M.D.

Presenter(s): Timothy Chryssikos, Ann L. Hackman, M.D.

Educational Objectives: At the conclusion of this session, the participant should understand how the use of narrative and literature can be used by patients and individuals with mental illness as a form of therapy

Summary: The purpose of this workshop is to encourage medical students in their psychiatry clerkship to review personal narratives and literature of patients with a mental illness to enhance their educational experiences and consider psychiatry as a career. There have been a number of impressive, personal narratives written in recent years. For example, Kay Jamison, author of An Unquiet Mind, described her struggles with bipolar disorder and success as a psychologist. National Book Award winner William Styron described his struggle with depression in Darkness Visible. The Spiro sisters collaborated on the biography Divided Minds, which described the struggles and triumphs of twins, one of whom is a brilliant but schizophrenic author, the other a psychiatrist. These stories deserve a place in the curriculum of any psychiatry clerkship. If medical schools were to incorporate the humanities into their curriculum, medical students might be more apt to consider the field of psychiatry. Literature can provide an opportunity to remove some misconceptions about people with mental illness while digging deeper than the neurobiology behind, definition of, and treatment for mentally ill individuals that provide the basis for didactics and SHELF exams. Literature can be supplemented with talks by people living with a mental illness. It can also be incorporated with attendance at AA meetings, NA meetings, and meetings at organizations supporting people with mental illness (such as the National Alliance on Mental Illness [NAMI]). It is my intention to have an interactive workshop. I anticipate having several speakers, which include a medical educator, a person who has written about their experiences with mental illness (or including a video of writers), and a medical anthropologist or sociologist.

WORKSHOP 47

Saturday, October 6; 3:30 p.m.–5:00 p.m.

Avoiding Psychiatric Inpatient Hospitalizations Via Emergency and Outpatient Alternatives

American Association for Emergency Psychiatry

Chair: Scott L. Zeller, M.D.

Presenter(s): Leslie Zun, M.D., Avrim B. Fishkind, M.D.

Educational Objectives: At the conclusion of this session, the participant should understand the limited availability and costs of inpatient psychiatric hospitalizations and the merits of appropriate alternatives when possible.

Summary: As the number of inpatient psychiatric beds nationwide continues to diminish, obtaining hospitalization for acutely ill psychiatric patients can be quite a daunting task. In many locations, this can frequently lead to long periods of boarding in emergency departments. Inpatient hospitalization can also be very expensive and is the most restrictive level of care for patients. Clearly, finding alternatives to hospitalization when possible are in the best interests of patients and mental health systems alike. This workshop will discuss options to help avoid psychiatric hospitalizations when appropriate. After an introductory discussion of the issues by Program Chair Dr. Scott Zeller, Dr. Leslie Zun, the Chair of Emergency Medicine at the Rosalind Franklin Medical School, will present on commencing psychiatric treatment within the emergency department. Dr. Avrim Fishkind of JSA Health will then present on the use of telepsychiatry in emergency departments and crisis programs. The final presentation will be Dr. Zeller discussing community-based alternatives to hospitalization including Acute Diversion Units, Crisis Respite Housing and Extended Observation units. There will be ample time for audience questions after each speaker.

WORKSHOP 48

Saturday, October 6; 3:30 p.m.–5:00 p.m.

Physician Mental Health: Exploring Clinical Challenges, Disruptive Behavior, and Wellness

Chair: John S. Martin-Joy, M.D.

Presenter(s): Linda L. M. Worley, M.D., Mai-Lan A. Rogoff, M.D., Michael F. Myers, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to describe typical psychological strengths and vulnerabilities of physicians.

Summary: Dedicated to the care of others, alternately idealized and demonized in the popular media, physicians are more likely than other professionals to have endured painful childhoods, to have difficulties with intimacy, to misuse prescription drugs, and to die by suicide. Even in our era of reform in medical and residency training, physicians remain at high risk of depression and burnout. This workshop will take a collaborative approach to exploring physician mental health over the life span. Our goal is to help clinicians recognize the typical strengths and vulnerabilities of physicians. We will also explore the culture of medicine, which has traditionally emphasized service but placed little value on physician self-care. Throughout, audience participation will be emphasized. John Martin-Joy, M.D., will briefly introduce the topic by reviewing physician development and vulnerability over the life span. Material will include published findings and unpublished biographical vignettes of physicians in the Study of Adult Development, an ongoing study of men selected for mental health during college in 1938–1942 and followed to the present. Michael Myers, M.D. will discuss "Clinical Challenges in the Treatment of Physicians." Physicians are often proud of their perfectionism and sense of responsibility, but the personal cost of these traits can be high. For example, when doctors enter treatment for depression, alcohol abuse, or suicidality, they may carry with them a burden of shame; treaters may collude in an unwitting strategy of denying physicians' problems. Illustrating these and other recurring themes, Dr. Myers will engage the audience in a discussion of disguised case examples from his experience treating physicians and their families. Linda L. M. Worley, M.D. will discuss "Salvaging the Careers of Distressed and Disruptive Physicians." The recent trend toward defining standards of professionalism, including a recent JCAHO mandate, has forced medicine to grapple with the issue of disruptive physicians. Dr. Worley will review the problem and engage the audience in exploring its sources. Using the example of the Vanderbilt School of Medicine's Center for Professional Health, Program for Distressed Physicians, Dr. Worley will discuss an innovative approach to addressing disruptive behavior through a transformative-learning CME course for physicians. Mai-Lan Rogoff, M.D. will discuss "Medical Student Wellness Programs: The Experience Thus Far." The medical school wellness program has emerged as a promising approach to preventing physician burnout. It aims to promote a healthy balance between work and personal life during the period when a physician's identity is being formed. Dr. Rogoff will review strength-based programs and assess their foundation in empirical data. She will then present the example of the student wellness program at the University of Massachusetts Medical School as a springboard for discussion.

WORKSHOP 49

Sunday, October 7; 8:00 a.m.–9:30 a.m.

Best Practices in Office-Based Pharmacotherapy of Substance Use Disorders

U.S. Substance Abuse and Mental Health Services Administration

Chair(s): Petros Levounis, M.D., M.A., Abigail J. Herron, D.O.

Presenter(s): Jose L. Matias Del Toro, M.D., Philip Krick, D.O.

Educational Objectives: At the conclusion of this session, the participant should be able to treat patients with FDA-approved medications for alcohol, nicotine, and opioid dependence.

Summary: Over the past fifteen years, Psychiatry has witnessed the development of many exciting clinical innovations in the treatment of patients who suffer from substance use disorders. While the science of the pharmacotherapy of substance use disorders is advancing at a significant rate, the implementation of even the most "tried and true" of these treatment innovations, including the office-based treatment of opioid dependence, has been slow. Several lines of evidence suggest that the majority of mental health systems, addiction centers, and psychiatrists in private practice resist adoption of these new practices. In this workshop, we will review the most recent evidence of safe and effective pharmacological interventions for patients who suffer from alcohol, benzodiazepine, opioid, stimulant, cannabis, and nicotine dependence. We will review best practices for the use of Food and Drug Administration (FDA) approved medications as well as experimental pharmacological agents, including the cocaine vaccine, with significant promise in the treatment of such disorders. In addition, we will discuss the integration of motivational interviewing for effectively engaging the ambivalent (or even completely disinterested) psychiatric patient in pharmacotherapy, a common problem in everyday clinical practice. Participants will be invited to bring their own experience treating patients with substance use disorders and to work with the faculty on formulating creative options for implementing these new approaches in clinical practice. The workshop is open to all psychiatrists who would like to learn more about the effective pharmacotherapeutic management of substance use disorders in office-based settings but is particularly targeted towards members in training and early career psychiatrists.

WORKSHOP 50

Sunday, October 7; 8:00 a.m.–9:30 a.m.

From Caligari to Hannibal the Cannibal: Sinister Psychiatrists in Cinema

Chair: Sharon Packer, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to List three early, mid-century, and contemporary cinema psychiatrists who show the continuum in depictions of sinister screen psychiatrists.

Summary: Most contemporary commentators on movies and mental illness focus on the ways that movies stigmatize psychiatric patients. Yet cinematic psychiatrists are exploited just as often, and are often portrayed as sinister or sadistic. Such characterizations were present since film's earliest days. Dr. Caligari and Dr. Mabuse were two of the most memorable "mad doctors" of early movies. Dr. Mabuse lived many lives before meeting his demise in Fritz Lang's 1960 version. Caligari achieved greater fame, inspiring film critic Kracauer to compare Caligari to Hitler. Hannibal the Cannibal appeared in half as many movies as Dr. Mabuse, but his cinematic career continues. Interestingly, diabolical mind doctors transcend gender, race, religion, ethnicity, nationality, even economics. Talk therapists are generally portrayed better than M.D.s or R.N.s. Hypnotists often fare the worst–even worse than "shock docs" who do ECT. Once we understand why cinema depicts so many sinister psychiatrists, and why these portrayals appeal to the public, we can deal with these unkind characterizations directly, and we can use this data to engage resistant patients. Apparently, these themes appeal to wide enough audiences to convince commercial movie makers to produce these pricey features. There must be a reason why people pay to see these movies. Since most patients are familiar with film, we can speak to patients on their terms if we familiarize ourselves with films. This workshop is not a political polemic. Rather, it examines examples of sinister cinematic psychiatrists, tells why such portrayals are popular, and shows how they help some patients address fears of relinquishing control to a "mind doctor" by rehearsing their fears and seeing that their worst fantasies do not come to pass. These films also help psychiatrists grapple with their own counter-transference and reassure themselves that they are not as bad as those dangerous or diabolical doctors seen on screen. We help providers open dialogues with patients by asking them to describe their most memorable movie scene about psychiatrists. We then address inappropriate or inaccurate expectations, derail negative transference before it begins, and build trust by showing that we value patients' opinions.

WORKSHOP 51

Sunday, October 7; 8:00 a.m.–9:30 a.m.

Older Adults With Schizophrenia: Is Outcome Good, Poor, or Mixed?

Chair: Carl I. Cohen, M.D.

Presenter(s): Mudassar Iqbal, M.D., Elena F. Garcia-Aracena, M.D., Helen H. Ryu, M.D., Carolina Jimenez, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to understand how clinical and social outcomes such as remission, depression, community integration and quality of life, change over time in older adults with schizophrenia.

Summary: The number of persons aged 55 and over with schizophrenia is expected to double by 2025. However, only 1% of the literature on schizophrenia has been devoted to older adults. Cross-sectional data have been generally optimistic about outcome for many social and clinical indicators in later life. However, virtually none of the studies have examined older adults longitudinally. In this workshop, we will examine various clinical and social outcomes of 104 older adults with schizophrenia living in various community settings in NYC who developed the disorder prior to age 45, and who were followed for a mean of 4 ½ years. Their mean age was 60 years, 55% were male, and 55% were white. We will discuss our findings regarding clinical remission, positive and negative symptoms, depression, quality of life, and community integration. A major finding from our research is that prior cross-sectional data have overstated the number persons experiencing good outcomes. Thus, depending on outcome measures that were examined, we found a core group of between 13% to 32% persons who attained a good outcome at both points in time, 27% to 60% who never attained a good outcome, and 27% to 43% who fluctuated between good and poor outcomes. We also will present findings looking at various clinical and social factors at baseline that predict each of the outcome measures at follow-up, and the impact of these outcome measures at baseline on other clinical and social factors on follow-up. The presenters and audience will have the opportunity to examine the implications of these findings with respect to future research, prospects for recovery, and clinical care.

WORKSHOP 52

Sunday, October 7; 8:00 a.m.–9:30 a.m.

The Revolving Door of Transinstitutionalization: Challenges Met and Lessons Learned in Community, Corrections and Veterans Psychiatry

Chair: Vanessa L. Lauzon, M.D.

Presenter(s): Michael Yao, M.D., M.P.H.

Educational Objectives: At the conclusion of this session, the participant should be able to define the concept of transinstitutionalization and identify current factors contributing to the high numbers of mentally ill individuals in contact with the criminal justice system.

Summary: Half a century since deinstitutionalization and the movement towards community mental healthcare, three of the largest, currently operating mental health treatment centers in the United States are Los Angeles County, Riker's Island and Cook County jails (1). Correctional systems have evolved in the last five decades into the de facto treatment facilities for an estimated 350,000 jail and prison inmates meeting criteria for serious mental illness. Nearly 40% of all individuals with a serious mental illness have been incarcerated at one point in their lives (2).These developments arises in large part from varied insufficiencies in community mental health systems for stabilizing at risk individuals and diverting their entry into the criminal justice/correctional systems (3). Once in jail or prison, the unique challenges of delivering health and mental health care within the correctional setting often results in suboptimal care for the criminalized mentally ill. As they prepare for re-entry into society, many of these same individuals are without the necessary supports in place to aid their transition and tragically cycle back into the correctional setting. This workshop will examine the phenomenon of "transinstitutionalization" by introducing examples of current intervention efforts at the points of diversion, incarceration, and reentry. These case examples will illustrate three systems-based challenges in ending transinstitutionalization – barriers to interagency collaboration, misaligned interests of embedded systems (healthcare delivery embedded within the correctional system), and the reentry challenges facing special populations such as Veterans in conflict with the law. We will also discuss the lessons learned from both successful and stalled intervention efforts and how they may be employed in the future to meet the needs of at risk individuals and break the cycle of transinstitutionalization.

WORKSHOP 53

Sunday, October 7; 8:00 a.m.–9:30 a.m.

Recovery From Sexual Abuse: Group Treatment Models for Men in the Public Mental Health System

Chair(s): Kristina H. Muenzenmaier, M.D., Joseph Battaglia, M.D.

Presenter(s): Dalit R. Gross, Psy.D., Faye R. Margolis, Ph.D., Gillian S. Langdon, M.A.

Educational Objectives: At the conclusion of this session, participants will be able to describe different group treatments for male sexual abuse survivors and how to adapt them in different settings.

Summary: In the public mental health system consumers often have experienced ongoing and co-occurring childhood abuse. However, sexual abuse in men is still under assessed and limited treatment models exist. This workshop will be discuss two different types of groups for this population. The first group presentation is an 8-week psycho-educational group for incarcerated males. Clinical issues of sexual abuse with co-morbid mental health concerns will be addressed in the context of a forensic setting. Specifically, how does one promote healing and a sense of safety in a restricted and often fear producing environment. Included in the discussion is the experience of the group leader from a system's perspective as well as the phenomenological one. Also discussed will be the results from pre/post-assessments of participating group members. The second group model presented is an integrative therapy group combining music and verbal modalities. It grew out of a multidisciplinary innovative collaboration and provides an alternate means of accessing difficult material in male inpatients with sexual abuse histories and co-morbid serious mental illness. The integrative elements of the group are aimed at facilitating emotional expression through words and music while creating a safe place for male survivors to connect with one another and feel empowered. Aspects of creating safety, exploring affect regulation, building community and practical group management will be shared. Case examples from the clinical work will be presented illustrating the rationale for combined modalities. The presentation will also address the co-leadership experience and the emotional impact of this work on clinicians.

WORKSHOP 54

Sunday, October 7; 8:00 a.m.–9:30 a.m.

Violence Risk Assessment and Screening: The Risks of Doing Too Much or Too Little

Chair: Merrill Rotter, M.D.

Presenter(s): Michael B. Greenspan, M.D., Virginia Barber-Rioja, Psy.D.

Educational Objectives: At the conclusion of this session participants will gain a better understanding of risk screening and assessment and the available technology.

Summary: Violence risk assessment is increasingly seen as a required part of clinical work in general as well as forensic settings – particularly in a public sector population. However, important domains [When to perform a risk assessment? What to assess? How much to assess?] remain variable between sites and clinicians. In this workshop we propose to review the available technology and the choices that clinicians may make between risk assessment tools, actuarial technology and clinical evaluation, and between screening and assessment. In particular we will focus on the non-mental health factors that also are associated with violence risk, and we will discuss the ethical and clinical costs and benefits of the choices available to clinicians. The workshop will commence with a survey to be filled out by participants upon arrival. Dr. Greenspan will follow with an overview of risk assessment and technology. Dr. Barber-Rioja will review the social factors that are not always captured by mental health focused risk evaluation. Finally, Dr. Rotter will lay the groundwork for the participant discussion by reviewing the ethical and clinical considerations in choosing a risk-focused approach. The remaining time will be spent reviewing the participant survey results and discussing clinician experience and case examples.

WORKSHOP 55

Sunday, October 7; 10:00 a.m.–11:30 a.m.

A Holistic Mind-Body Approach to the Treatment of Trauma and Severe Mental Illness

Chair(s): Tanya V. Azarani, M.D. Kristina H. Muenzenmaier, M.D.

Presenter(s): Elizabeth Visceglia, M.D.

Educational Objectives: At the conclusion of this session participants will gain a better understanding of research including the neurobiological bases of Mind-Body techniques in the treatment of severe mental illness and trauma.

Summary: Schizophrenia and other forms of severe mental illness are often thought of as chronic illnesses with poor outcomes. Furthermore, studies have shown that up to 98% of patients with severe mental illness have complex histories of trauma that are often under assessed or treated. Mind-body techniques including meditation and yoga are alternative healing modalities that tap into patient resilience and promote recovery of these complex and challenging populations. Recent studies have demonstrated efficacy of mind-body techniques in alleviating the symptoms of severe mental illness and trauma and improving patients' subjective quality of life. Meditation and yoga are particularly helpful in treating symptoms of psychosis and hyperarousal, especially when combined with medication and psychotherapy. Patients with psychosis often feel betrayed and entrapped by their own bodies. Their inner world is often unpredictable and frightening. Meditation builds self-awareness through focused attention upon one's thoughts and feelings. It also creates a safe space for the processing and integration of intolerable thoughts and feelings. Likewise, the practice of mental stillness intrinsic to meditation allows patients to find peace in the present moment. Yogic breathing exercises (called pranayama) and postures (asanas) help patients feel internally safe and grounded in their bodies. These practices are effective in part, by stimulating the parasympathetic nervous system through diaphragmatic breathing. Research has also shown that yoga increases GABA and serotonin neurotransmitters to alleviate symptoms of depression and anxiety. The use of mind-body skills within a group setting can also help destigmatize the experience of mental illness and foster a sense of hope and belonging in participants. In this interactive workshop participants will learn about the neurobiological bases of several mind-body techniques. The outcome of two mind-body interventions will be presented. One presenter will discuss an 8 week yoga group offered to people diagnosed with schizophrenia at the Bronx Psychiatric Center. This study demonstrated significant decreases in positive and negative symptoms of schizophrenia (PANSS scale) and improvement of patients' subjective quality of life (WHO subjective quality of life scale). The second presenter will focus on a meditation group implemented at the same facility in which patients were exposed to various mind-body techniques such as diaphragmatic breathing, biofeedback, body scan and guided imagery and yoga. Lastly, participants will gain first hand experience of a mind-body exercise using meditation and biofeedback. Workshop participants will be actively engaged throughout the workshop and during the discussion.

WORKSHOP 56

Sunday, October 7; 10:00 a.m.–11:30 a.m.

Marijuana: Drug or Medicine: Experience With the Michigan Medical Marijuana Law

Chair: James R. Hillard, M.D.

Presenter(s): Cynthia Spencer, D.O., Jennifer Stanley, M.D.

Educational Objectives: At the conclusion of this session, participants will be able to describe ways in which different states have implemented laws allowing medical marijuana.

Summary: In 2008, a referendum authorizing legal use of marijuana for medical purposes was passed 63% to 37% in Michigan. This law permitted authorization of an exemption from state anti-marijuana laws for patients who were certified by a physician as suffering from: "(a) cancer, glaucoma, or positive status for human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, agitation of Alzheimer's disease, or nail patella. (b) a chronic or debilitating disease or medical condition or its treatment that produces one of more of the following: (i) cachexia or wasting syndrome; (ii) severe and chronic pain; (iii) severe nausea; (iv) seizures, including but not limited to those caused by epilepsy; or (v) severe or persistent muscle spasms, including but not limited to, those which are characteristic of multiple sclerosis." In practice, a limited number of physicians have taken a very broad approach to certification, particularly with respect to "pain," and "nausea." As of 12/2011, 126,912 patient registrations covering over 1.25% of the state population had been issued. In 2011, the new state attorney general has concluded that while medical marijuana possession is legal, its sales through dispensaries, or most other means, is illegal. Marijuana remains illegal under federal law. Increasingly, patients seeking mental health treatment have already been prescribed medical marijuana or have it prescribed during mental health treatment. Multiple interactions between cannabis and psychotropic medication have been documented. In addition, there is a large body of evidence indicating that cannabis use may be associated with new onset of psychosis, and other psychiatric conditions, and that it can exacerbate a variety of existing conditions. On the other hand, there is a large body of evidence indicating that medical marijuana is beneficial in a number of medical conditions and that it may be superior to other available treatments for some patients. There is also a body of largely anecdotal evidence suggesting that cannabis may be beneficial for some psychiatric conditions, including anorexia nervosa, obsessive compulsive disorder and chronic insomnia. This workshop will discuss the official positions of the APA, AMA and other organizations on medical marijuana. It will also explore the implications for psychiatric practice of medical marijuana laws and the pluses and minuses of the medical marijuana law as implemented in Michigan. Ample time will be provided for participants to share their clinical experiences, to ask questions, and to make comments.

WORKSHOP 57

Sunday, October 7; 10:00 a.m.–11:30 a.m.

Gun Violence, Mental Illness, and Firearms Laws: Research Evidence and Questions for Science, Policy, and Practice

Chair: Marvin S. Swartz, M.D.

Presenter(s): Josh Horwitz, J.D., Jeffrey W. Swanson, Ph.D., Paul S. Appelbaum, M.D.

Educational Objectives: At the conclusion of this session, participants will understand the risk factors for violence in persons with severe mental illness.

Summary: Firearm violence is a major public health problem in the United States. More than 300,000 people died from gunshot injuries in the decade from 1998 to 2007 – a death toll five times greater than the number of U.S. military casualties in the Vietnam War. Tragic acts of gun violence by persons with mental illness – such as the mass shootings at Virginia Tech in 2007 and in Tucson in 2011 – suggest that the current patchwork of state and federal firearms laws may be ineffective at protecting the public from dangerous individuals. At the same time, empirical research shows that the large majority of people with mental illness are not violent, and that most violent acts are not caused by mental illness. States vary widely in their gun law regimes, procedures for implementing federal firearms laws, policies for reporting gun-disqualifying mental health records to the National Instant Check System, and programs for restoring gun rights to previously disqualified individuals. How effective are the existing gun laws in preventing violence by the few people with mental illness who are dangerous, without unduly infringing on the rights of the many who are not? What legal and policy reforms might be warranted, and what empirical evidence is needed to inform such reforms? This workshop will provide information and opportunities for discussion of the problem of gun violence in the U.S. – its prevalence, causes, and potential legal and policy approaches to reduce the problem. Specifically, the workshop will focus on what is known about the contribution of mental illness to violence and will consider the implications of this (somewhat ambiguous) research literature for law and policy that seeks to limit firearms access for people with mental disorders who may pose a danger to themselves or others. The workshop will discuss research findings on whether current federal and state firearms restrictions reduce gun violence, and will lay out an agenda for needed future research. Specific questions to be raised include: 1) Are people with a history of involuntary psychiatric hospitalization at higher risk of firearm violence than the general population or than other individuals with mental illness? 2) Do laws and policies that base gun restrictions on mental health history confer additional public safety benefit beyond the effect of restrictions based on criminal history? 3) Does the social and legal presumption of increased risk of gun violence in people with mental illness bear unintended consequences – perhaps unnecessarily infringing on the civil liberties of people with mental illness, increasing reliance on involuntary commitment, reinforcing the stigma of mental illness, and incurring public costs in collecting, managing, and reporting disqualifying mental health records?

WORKSHOP 58

Sunday, October 7; 10:00 a.m.–11:30 a.m.

The Open Dialogue Approach: Can it Work in the U.S.?

Chair(s): Mary Olson, Ph.D., Chris Gordon, M.D.

Educational Objectives: At the conclusion of this session, participants will understand the philosophical and clinical framework and principles of Open Dialogue and appreciate possibilities for improved outcomes for patients with psychiatric disorders.

Summary: Pioneered at Keropudas Hospital in western Lapland, open dialogue is a network-based model for acute psychiatric crisis. Developing out of the reform movement in Finnish psychiatry called “need-adapted care,” open dialogue unites a distinct method of psychotherapy with an integrated treatment system that enlists natural supports and delivers care in the community. Outcome studies of the Keropudas team suggest improved results for young people going through a first psychotic episode when compared with treatment as usual. In a five-year follow-up, 83% of patients returned to jobs, studies, or were looking for a job; 77% did not have residual symptoms. Dr. Olson, associate professor in residence at smith college school for social work, is the founding director of the institute for dialogical practice, and a Fulbright scholar, whose principal focus is open dialogue. She is in the process of developing a pilot study of open dialogue at the University of Massachusetts medical school. Dr. Gordon, associate clinical professor of psychiatry at Harvard medical school, currently leads a team studying with dr. Olson, and has developed a clinical program to provide psychiatric services using principles derived from open dialogue in Framingham, Massachusetts.

WORKSHOP 59

Sunday, October 7; 10:00 a.m.–11:30 a.m.

First Look: Exploring Peer Counselor Effectiveness in an Inpatient Psychiatric Setting

Chair: Joseph P. Merlino, M.D., M.P.A.

Presenter(s): Rachel Steiner, L.C.S.W., Matthew Costanzo, Jonathan Philip Edwards, M.S.W., Miriam Azaunce, Ed.M., Ed.D.

Educational Objectives: At the conclusion of this session, participants will understand the relevance of the data in terms of peer counselor effectiveness in an inpatient psychiatric setting.

Summary: The inclusion of peer counselors in the provision of mental health services to consumers is perhaps the most visible sign of the field’s commitment to the adoption of a recovery-oriented system of care. Although many benefits of using peer counselors as recovery role models, mentors, advocates and facilitators have been described in the literature, there is a paucity of evidence that quantifies their effectiveness. Despite efforts to stratify and measure the impact of Peer Counselors, there have been no widely accepted measures developed that adequately evaluate their contributions to the field. Kings County Hospital Center, Behavioral Health Services employs one of the largest complements of peer counselors in a hospital and they are fully integrated throughout the care continuum. As such, we have embarked on an exploratory process by which Peer Counseling effectiveness is identified, defined and measured. The goal of this endeavor is to take a first look at how peer counselors impact treatment outcomes and to establish meaningful benchmarks. The initial focus has been on measuring the impact that the presence and integration of Peer Counselors in the treatment planning process has on (1) recipients’ level of satisfaction with their treatment process and their perceptions about their ability to recover; (2) the level of engagement in treatment demonstrated by recipients of care; (3) clinical outcomes such as adherence to treatment demonstrated by show rate to outpatient appointments after discharge from inpatient services. In order to judge the outcomes that are attributable to the peer counselors’ presence and integration in the treatment planning process, particular attention is paid to the effectiveness of their training and the efficiency in which they utilize the “tools of their trade” to engage recipients in treatment, including orienting newly admitted recipients of care to their environment, exploring expectations for treatment and assisting recipients in the identification and expression of their concerns and goals for treatment, and utilization of life experiences and empathy to provide supportive counseling. In addition, we will discuss several innovative approaches adopted by the department to support peer counselors in pursuing a career trajectory that is not typically offered in hospitals or other traditional mental health settings, and foster opportunities for peer counselors to parlay their lived experience and knowledge of recovery into various career endeavors including but not limited to advancement into other human service-oriented positions.

WORKSHOP 60

Thursday, October 7; 10:00 a.m.–11:30 a.m.

Using Recovery Principles as an Integrative Paradigm in Training Community Psychiatrists

Chair: Robert S. Marin, M.D.

Educational Objectives: At the conclusion of this session, participants will appreciate the value of recovery principles as means to improve teaching, clinical training, consultation, and supervision.

Summary: The recovery movement has gained significant momentum in the past 5 years. Although systems of care have made commitments to providing recovery oriented services, the behavioral health workforce has not yet achieved the level of competence needed to deliver such services adequately. In response to this need, several initiatives are underway to enhance recovery oriented training in various sectors of the behavioral health system. In this workshop, we describe and demonstrate the application of recovery principles to a community psychiatry education curriculum. We will describe the content and the process that permit use of recovery principles as an educational paradigm allowing a coherent and unified approach to didactic teaching, supervision, consultation, and mentoring. Then we will engage workshop participants by asking them to develop a list of recovery principles and to consider how they might be applied to clinical, academic and administrative settings of the behavioral health system. We will consider applications to clinical interactions, leadership, advocacy, quality improvement, teaching and supervision, and consultation, among others. The workshop will be highly interactive and will create a process that illustrates how psychiatrists can integrate recovery principles in the education and training of residents and fellows.

WORKSHOP 61

Sunday, October 7; 10:00 a.m.–11:30 a.m.

Health Homes, Integration and the Public Safety Net: Implications for Psychiatry

Chair: Kathleen Reynolds, M.S.W.

Presenter(s): Lori Raney, M.D., Joseph J. Parks, M.D.

Educational Objectives: At the conclusion of this session, participants will be able to identify the role of psychiatry in the national movement for the implementation of health homes

Summary: An agreed upon national model for health care delivery, the health home model will need mental health and substance services integrated to achieve the desired health outcomes. The conceptualization of how to integrate these services and the role of the psychiatrist and behavioral health team is critical to success of the model. There will also need to be unique aspects of a health home for persons with serious and persistent mental illness. This workshop will provide participants with an understanding of the elements of a health home for persons with serious and persistent mental illness as proposed in the Affordable Care Act legislation. The national model for a health home for persons with mental illness from the State of Missouri will be reviewed. As the first health home for persons with SPMI, the Missouri application provides needed guidance for financing, outcomes and the role of the psychiatrist in the health home. The workshop will also include a discussion of how the evolution of health homes will modify the role of the community psychiatrist in the public mental health system.

WORKSHOP 62

Sunday, October 7; 10:00 a.m.–11:30 a.m.

Why Psychiatrists Don't Do Psychotherapy Even Though it Works

Chair: Joyce West, Ph.D., M.P.P.

Presenter(s): J. Christopher Perry, M.P.H., M.D., Eric Plakun, M.D.

Educational Objectives: At the conclusion of this session, participants will be able to understand recent trends in the decline of psychotherapy being provided by psychiatrists in the U.S. and identify key factors affecting the provision of psychotherapy by psychiatrists in the United States and Canada.

Summary: Although psychotherapy is a core aspect of psychiatric training and practice, recent data indicate a decline in the provision of psychotherapy by psychiatrists, with a concomitant move toward increased provision of pharmacotherapy (West et al., 2003; Mojtabai & Olfson, 2008). This decline has been anecdotally attributed to issues of service demand and payment. There is little data about barriers to the practice of psychotherapy, or about the effect of these changes on patient and therapist goals for treatment or psychiatrists' satisfaction with their practices. The American Psychiatric Institute for Research and Education (APIRE), the APA Committee on Psychotherapy by Psychiatrists (COPP) and members of the Canadian Psychiatric Association designed a joint 36-item email survey as a "Study of Psychiatrists' Practices and Barriers to Psychiatric Treatment," conducted in both countries simultaneously. The electronic survey was emailed to three thousand randomly selected APA members with email addresses, excluding medical students and residents, while the Canadian version was emailed to all Canadian psychiatrists and residents who had given CPA permission to contact by email. After excluding those with undeliverable email addresses (N=109), 14% (N=407) of surveyed U.S. psychiatrists responded; 97% of the respondents (N=394) reported currently treating psychiatric patients. In Canada 431 (24%) practitioners responded, of whom 91% currently treated patients. In their last typical work week, U.S. respondents provided psychotherapy to 55% of patients, while Canadian respondents provided psychotherapy to 67%. Provision of psychotherapy combined with pharmacotherapy was six times more common than psychotherapy alone. The survey found many parallels between practices and barriers to treatment in both nations, with some noteworthy differences. While psychiatrists in the U.S. and Canada report providing psychotherapy for most patients (usually combined with medications), a large proportion of patients are not currently receiving psychotherapy from their psychiatrist. Although most psychiatrists would be interested in providing psychotherapy to their patients, they face a number of financial, administrative and other workforce barriers, which will be described. After presentation of survey results concerning factors affecting [1] provision of psychotherapy by psychiatrists, [2] choice of goals for treatment, and [3] practitioner satisfaction, the majority of the workshop time will focus on interactive discussion of the problem and potential responses to the decline of provision of psychotherapy by psychiatrists in both countries.

WORKSHOP 63

Sunday, October 7; 10:00 a.m.–11:30 a.m.

Legal Definitions of Mental Illness: Are They Outdated?

Chair: Elizabeth B. Ford, M.D.

Presenter(s): Arthur R. Williams, M.D., M.A., Shelly Cohen, M.D., J.D.

Educational Objectives: At the conclusion of this session, participants will understand the evolution of how state mental hygiene laws have come to govern the use of civil commitment for individuals with mental illness.

Summary: Involuntary civil commitment of psychiatric patients has evolved over the 60 years from a process with limited judicial oversight to one in which the law plays a prominent role, from formally requiring both mental illness and dangerousness to, in some states, requiring a court order to commit a mentally ill patient. While on the surface these concepts may seem relatively straightforward, a review of the United States' state mental health law statutes reveals that the statutory definitions of both mental illness and dangerousness vary dramatically across states and, in many cases, have not been updated "on the books" to reflect the advances in psychiatric research and practice over the last 25 years. This is problematic in part because it perpetuates legal and public impressions that mental illness is ill-defined and vague. This workshop will focus primarily on the definition of mental illness as it applies to civil commitment in emergency, inpatient, and outpatient civil commitment settings across the nation, highlighting the inconsistencies across states specifically regarding inclusion and exclusion criteria (i.e. substance use disorders, personality disorders). A comprehensive review of the legislative and case law history of each civil commitment statute will be discussed so as to better understand how the country as a whole, and the states specifically, have, over time, addressed the complex parens patriae state interest of involuntarily treating individuals with mental illness. This will lead to a discussion about the possible need for legislation to better reflect clinical practice and psychiatric knowledge, focusing on whether statutes should be revised to specifically include substance use and/or personality disorders in the legal definition of mental illness for commitment purposes. Clinical-legal challenges to this proposal will be explored, including the shrinking resources available to individuals who do not currently meet civil commitment criteria, respect for patient autonomy, beneficence, justice, and concern about the potential slippery slope of unnecessary confinement. New York State mental health laws and recent court decisions will provide detailed case examples to illustrate the above challenges and audience participation about their respective state practices will be encouraged.

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APA Institute on Psychiatric Services

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