

CONTINUING MEDICAL EDUCATION

SYLLABUS

AND

PROCEEDINGS SUMMARY

FOR THE

58th

INSTITUTE ON PSYCHIATRIC SERVICES

October 5–8, 2006

New York, NY



APA's Leading Educational
Conference on Public and
Community Psychiatry

INSTITUTE ON PSYCHIATRIC SERVICES
American Psychiatric Association
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AMERICAN PSYCHIATRIC ASSOCIATION 58TH INSTITUTE ON PSYCHIATRIC SERVICES

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Statue of Liberty



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.

**Industry-Supported
Symposium 1**

**Thursday, October 5
6:30 p.m.-9:30 p.m.**

**HELPING DEPRESSED PATIENTS
ACHIEVE REMISSION: ADVOCACY FOR
IMPROVEMENT**

Supported by Bristol-Myers Squibb Company

A. John Rush, M.D., *Professor of Psychiatry; Vice Chair, Department of Psychiatry; and Betty Jo Hay Distinguished Chair in Mental Health, University of Texas, Southwestern Medical Center, 5323 Harry Hines Boulevard, Room E5.506, Dallas, TX 75390-7208*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to:

1) Recognize factors contributing to heterogeneity in response and remission and the implications for treatment outcomes; 2) Evaluate strategies for partial or non-responders that include switching, augmentation, and combination treatments; 3) Examine the role of pharmacogenetics in treatment selection; and 4) Design a treatment plan that utilizes non-pharmacologic and pharmacological strategies to achieve remission.

SUMMARY

Symptom remission is the goal of treating depression. However, most patients are “treatment resistant” and don’t achieve remission with any one treatment, likely reflecting the heterogeneous pathobiology underpinning depression. Current practice recommends a range of ‘trial and error’ sequential treatment steps, including switching, augmentation, or combination treatments. Unfortunately, few prospective randomized controlled trials have compared multiple augmentation or switch treatments. This symposium will present findings from controlled treatment trials—including the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial—that have investigated augmentation/combination treatments at the second and third treatment steps and switch treatments at the second, third, and fourth treatment steps.

**No. 1A
HETEROGENEITY IN RESPONSE AND
REMISSION: IMPLICATIONS FOR
OPTIMIZING TREATMENT**

A. John Rush, M.D., *Professor of Psychiatry; Vice Chair, Department of Psychiatry; and Betty Jo Hay Distinguished Chair in Mental Health, University of Texas, Southwestern Medical Center, 5323 Harry Hines Boulevard, Room E5.506, Dallas, TX 75390-7208*

SUMMARY:

The treatment of depression aims to achieve and sustain symptomatic remission, because it is associated with better function and a better prognosis. However, no single treatment produces remission in more than half the patients. Consequently, multi-step treatment algorithms have been developed to improve outcomes utilizing augmentation or combination treatments and/or several switches to different treatments. The evidence to evaluate such algorithms will be presented. The use of combination (e.g., two medications or medication plus psychotherapy) has been suggested to create greater rates of remission. Results of these studies will be reviewed. Finally, achieving remission acutely is only the beginning of efforts to sustain remission over the longer-term. The long-term outcomes of depressed patients who entered 1-year follow-up after responding or remitting with an initial or subsequent treatment attempt will be reviewed. These long-term outcomes also document the heterogeneity of depressed patients in the likelihood of sustaining acute remission.

**No. 1B
SWITCHING TREATMENTS: FOR WHOM
AND TO WHAT EFFECT?**

Maurizio Fava, M.D., *Director, Clinical Depression and Research Program, Psychopharmacology Unit, Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114*

SUMMARY:

As many as 50% of depressed patients show only partial or no response to treatment with antidepressants, and failure to achieve response or remission is a common reason for switching antidepressant treatments. Similarly, intolerance or the presence of significantly burdensome side-effects may lead to treatment discontinuation and to switching antidepressant agents. The switching strategy involves substitution of another agent for the agent that has either caused intolerable side effects or has failed to induce the desired response. In clinical practice, switching to a different class of antidepressants is typically the most popular choice, although a substantial proportion of clinicians favor a switch within the same class. There is a clear paucity in the literature of studies comparing the efficacy of switching strategies in depression and, in particular, of the switch within the class vs. the switch to a different class. The Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial provides a unique opportunity to examine the effectiveness in real world settings of switch treatments at the second, third, and fourth treatment steps. This presentation will review both the STAR*D results as well as the existing literature on the efficacy

of switching antidepressants among depressed patients who have not tolerated or responded to antidepressant treatment. Finally, the presentation will discuss the available data suggesting the predictive role of specific clinical characteristics with respect to response to switching antidepressants.

No. 1C
OPTIMIZING ANTIDEPRESSANT TREATMENTS: USE OF AUGMENTATION AND COMBINATIONS TO ACHIEVE REMISSION

Madhukar H. Trivedi, M.D., *Professor of Psychiatry, University of Texas Southwestern Medical Center, 6363 Forest Park Road, #1300, Dallas, TX 75235*

SUMMARY:

Although a large number of treatment alternatives exist for depression, no one treatment is effective for everyone, and many patients with depression do not experience a satisfactory clinical benefit from their initial treatment. For various reasons including inadequacy of pharmacological management, less than 30% of patients benefit sufficiently (i.e., have a remission) from a first antidepressant trial. The remaining 70% (non-remitters and non-responders to the initial treatment) must move on to the "next step" where patients receive some alternative to the initial failed trial or more commonly either an augmentation or a combination of pharmacotherapy.

Many recent efforts including the Texas Medication Algorithm Project, NIMH funded STAR*D project and NIMH funded REVAMP project all aim to determine the most effective treatment strategies for patients who do not benefit adequately (symptom remission) from initial treatment. The treatment protocols aim to determine and to implement an adequate dose and duration of medication (or psychotherapy) at every stage following the initial failed trial.

The most challenging task facing clinicians centers around choosing the best augmentation or combination of pharmacological and of psychotherapeutic treatments and addressing the clinical, pharmacodynamic, pharmacokinetic challenges with polypharmacy to ensure optimal care. Current evidence for efficacy of augmentations and combinations including the results of STAR*D will be discussed.

No. 1D
PSYCHOTHERAPY: FOR WHOM AND TO WHAT EFFECT?

Michael E. Thase, M.D., *Professor of Psychiatry, University of Pittsburgh Medical Center, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

Several forms of psychotherapy have established efficacy for treatment of depression, but most of the data are derived from studies of less severely impaired outpatients. Moreover, although this segment of the population is the most likely to use mental health services (and thus efficacy data are very relevant to the public health), they are also the easiest to treat and might respond equally well to numerous other interventions. The proper role of psychotherapy for treatment of more severe depressive states continues to be a more contentious issue. This presentation will review more recent studies of psychotherapy and will focus on more severely or persistently depressed patient groups, including those with recurrent, chronic, treatment-resistant, and bipolar disorders. It is concluded that focused-forms of psychotherapy are useful alternatives to pharmacotherapy for the easier to treat and increase the chances of response/remission and reduce the risk of relapse when added to adequate pharmacotherapy. There is still too little data pertaining to alternate psychotherapies to conclude that one is the psychological treatment of first choice for patients with more severe and persistent mood disorders, although cognitive behavior therapy has been the most extensively studied.

No. 1E
PHARMACOGENETICS: CAN WE CUSTOMIZE THE TREATMENTS FOR DEPRESSION?

Roy H. Perlis, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, ACC-815, Boston, MA 02114*

SUMMARY:

Many clinical challenges remain in the management of depression such as optimization of dose, control of adverse reactions, and poor response to pharmacological treatment. There is a paucity of evidence regarding clinical predictors of antidepressant response. The expanding field of pharmacogenetics provides new insights regarding the influences of genetics features on pharmacological response. As pharmacogenetic research accelerates, the potential for optimizing and customizing psychopharmacology to the individual patient increases. Understanding variations in the sequences of genes whose products are known to be targets of different drugs may provide clinicians with clues regarding response to treatment and the potential for side effects. In a study presented at the 2005 NCDEU, 246 cognitively intact patients with MDD, 65 years and older, were treated for 16 weeks with paroxetine or mirtazapine. Researchers found that the epoE4 allele was a predictor of antidepressant efficacy, whereas polymorphism in the 5HT2A gene

was associated with side effects. This presentation will focus on aligning depressive subtypes into more complex categories based on genotyping. Examples of the role of pharmacogenetics in predicting response to AEDs in epileptic patients will be the model for the discussion on the subtyping of depression.

REFERENCES:

1. Depression and Bipolar Support Alliance, April 2005
2. Wells KB, Stewart A, Hayes RD, et al. The functioning and well-being of depressed patients: results from the Medical Outcomes Study. *JAMA* 1989;262:914-9
3. Murray CJ, Lopez AD. Evidence-based health policy: lessons from the Global Burden of Disease Study. *Science* 1996;274:740-3
4. Kessler, RC, et al. Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry* 2005;62:616-27
5. Greenberg PE, Stiglin LE, Finkelstein SN, Berndt ER. The economic burden of depression in 1990. *J Clin Psychiatry* 1993;54:405-18.
6. Hirschfeld RM, et al. The nationale depressive and manic-depressive association consensus statement on the undertreatment of depression. *JAMA* 1997;277:333-40
7. Rush AJ, Fava M, Wisniewski SR, et al. Sequenced treatment alternatives to relieve depression (STAR*D): rationale and design. *Control Clin Trials*. 2004 Feb;25:119-42.
8. Trivedi MH, Rush AJ, Crismon AL, et al. Clinical results for patients with major depressive disorder in the Texas Medication Algorithm Project. *Arch Gen Psychiatry*. 2004;61:669-80.
9. Manber R, Arnow B, Blasey C. Patient's therapeutic skill acquisition and response to psychotherapy, alone or in combination with medication. *Psychol Med*. 2003 May;33(4):693-702.

**Industry-Supported
Symposium 2**

**Friday, October 6
6:30 p.m.-9:30 p.m.**

CONSIDERATIONS IN TREATMENT OPTIONS FOR BIPOLAR DEPRESSION

Supported by AstraZeneca Pharmaceuticals

Michael E. Thase, M.D., *Professor of Psychiatry, University of Pittsburgh Medical Center, 3811 O'Hara Street, Pittsburgh, PA 15213*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate knowledge of treatment options for bipolar depression, including the role of psychotherapy in bipolar depression; the pros and cons of

antidepressant therapy in bipolar depression; and gain knowledge of novel treatment options beyond conventional antidepressants.

SUMMARY:

This symposium will consist of three presentations that address considerations in treatment options for bipolar depression. They include the role of psychotherapy, the use of antidepressant therapy, and treatment options beyond conventional antidepressants. Dr. Swartz will discuss the role of psychotherapy in bipolar depression. Her presentation will focus on evidence that demonstrates advantages of providing bipolar-specific psychotherapy in addition to pharmacotherapy. Dr. Thase will examine the pros and cons of antidepressant therapy in bipolar disorder. Dr. McIntyre will discuss treatment options for bipolar depression beyond psychotherapy and conventional antidepressants. His presentation will include combination and integrated treatment approaches. These discussions will be followed by a question and answer session.

No. 2A

EXAMINING THE PROS AND CONS OF ANTIDEPRESSANT THERAPY IN BIPOLAR DEPRESSION

Michael E. Thase, M.D., *Professor of Psychiatry, University of Pittsburgh Medical Center, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

There have been enormous changes in treatment standards and practices for bipolar affective disorders over the past decade. New forms of treatment—including the novel anticonvulsant lamotrigine and the entire class of atypical antipsychotics are now widely used, while use of lithium salts and, to a lesser extent, divalproex and carbamazepine have decreased. Within this climate of change, the proper role of antidepressants in management of bipolar affective disorders remains controversial.

More frequent and disabling than the manic episodes, bipolar depression has a progressive, episodic, and chronic nature, with much higher rates of treatment resistance. Although there is a strong push to use antidepressant to lessen such suffering, there are multiple reasons to minimize antidepressant use. Foremost among these considerations is an almost shockingly sparse amount of evidence documenting the efficacy of antidepressants in bipolar depression and a lack of consensus about the appropriate duration of therapy. There are also important concerns about the risks of induction of mania and rapid cycling. This presentation will focus on the use of antidepressants in bipolar depression, specifically addressing

their pros and cons and making recommendations for current practice.

No. 2B
ROLE OF ADJUNCTIVE
PSYCHOTHERAPY FOR BIPOLAR
DEPRESSION

Holly Swartz, M.D., *Assistant Professor of Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213-2593*

SUMMARY:

Although effective medications for the acute treatment of mania are plentiful, it has become increasingly clear that current pharmacotherapeutic options have limited efficacy in treatment of bipolar depression. As a result, time to remission for a depressive episode in bipolar I disorder is longer than time to remission for a manic episode, and many patients continue to experience subsyndromal depressive symptoms and poor psychosocial functioning after the syndromal depression remits. Bipolar-specific psychotherapy, when administered in conjunction with pharmacotherapy, may play an important role both in the treatment of acute bipolar depression and in the long-term management of residual depressive symptoms. Several well-described psychotherapies including psychoeducation, cognitive-behavioral therapy, family-focused therapy, and interpersonal and social rhythm therapy have demonstrated efficacy in the treatment of bipolar I disorder in general and in the management of bipolar depression specifically. This presentation will focus on empirical evidence demonstrating the incremental advantages of providing bipolar-specific psychotherapy in addition to pharmacotherapy for the treatment and prevention of bipolar depression.

No. 2C
BEYOND ANTIDEPRESSANTS:
TREATMENT OPTIONS FOR BIPOLAR
DEPRESSION

Roger S. McIntyre, M.D., *Chair, Mood Disorders Psychiatry Unit, University of Toronto, 399 Bathurst Street, ECW-3D-003, Toronto, ON, Canada M5T*

SUMMARY:

The symptomatic portrait of bipolar disorder is comprised largely of depressive symptoms. Moreover, depressive symptoms are associated with suicidality, neurocognitive impairment, medical morbidity and they portend functional impairment. The evidentiary base supporting the use of somatic therapies and psychosocial interventions in the acute and maintenance treatment of bipolar depression is woefully inadequate. Although lithium is a treatment alternative, its effectiveness in real world settings is less than ideal. Both expert consensus and evidence-based treatment guidelines for bipolar disorder emphasize the need for established treatment options for the depressed phase of the illness.

This presentation will review novel treatment avenues beyond conventional antidepressants for the depressed phase of bipolar disorder. Both acute and maintenance phases of the illness will be emphasized, as will combination and integrated treatment approaches.

REFERENCES:

1. Thase ME, Sachs GS. Bipolar depression: pharmacotherapy and related therapeutic strategies. *Biol Psychiatry* 2000; 48(6):558–72).
2. Swartz HA, Frank E, Kupfer DJ. Psychotherapy of bipolar disorder. (2006) In: *Textbook of Mood Disorders*. Edited by Stein DJ, Kupfer DJ, Schatzberg AF. Arlington, VA: American Psychiatric Publishing, Inc., pp. 405–419.
3. Thase ME, *Harvard Rev Psychiatry* 2005; 13(5): 257–271.
4. Rucci P, Frank E. Suicide attempts in patients with Bipolar I disorder during acute and maintenance phase of intensive treatment with pharmacotherapy and adjunctive psychotherapy. *Am J Psychiatry* 2002; 159(7):1160.

INNOVATIVE PROGRAMS: SESSION 1

MINORITIES AND DUAL DIAGNOSIS

**Innovative Program 1 Thursday, October 5
10:00 a.m.-11:30 a.m.**

ADAPTING RELAPSE PREVENTION AND HARM REDUCTION SKILLS TO MINORITIES WITH DUAL DIAGNOSIS

Thad A. Eckman, Ph.D., *Director, Dual Diagnosis Treatment Program, Greater Los Angeles Health Care Facility, 11301 Wilshire Boulevard, Los Angeles, CA 90073*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to modify the slippery slope of addiction relapse to abstinence for cross-culture purposes; and understand the modification of the skills for drug refusal, asking for support, leveling with therapists and psychiatrists, responding to slips before they become serious relapses; and making U turns away from high-risk situations.

SUMMARY:

Although integrated treatments for the dually diagnosed are evidence-based, it is not clear what specific types of treatment modalities to employ within this approach. Most treatments attempt to teach new concepts and skills related to avoidance of drugs and alcohol, but the cognitive and symptomatic attributes of severe mental disorders often interfere with the learning process. Patients come from various ethnic and racial backgrounds and often suffer from PTSD in addition to chronic psychosis. The Substance Abuse Management Module, developed for this population at a VA hospital, is based on relapse prevention and harm avoidance within the context of basic principles of human learning. Skills such as cutting a slip off before it becomes a major relapse, refusing drugs from dealers or friends and family, seeking support at times of craving, leveling with treatment providers, reporting symptoms and side effects to a psychiatrist, avoiding or escaping from high-risk situations for relapse, and climbing the slippery slope toward abstinence and a healthy life-style. These skills are taught in group sessions with coordination provided by case managers who connect the patients with psychiatrists, 12 step programs, community social services, and sober living residences. Research has shown clinically and statistically significant reductions in drug/alcohol abuse among persons with psychosis. An important element in this module is adapting the skills being taught to the cultural values and family

expectations of each patient. “One suit does not fit all” and “only penguins, not patients are alike”.

TARGET AUDIENCE(S):

Mental health and substance abuse professionals.

REFERENCES:

1. Roberts L, Eckman T, Shaner A: *Overcoming Addictions: Skills Training for the Seriously Mentally Ill with Substance Abuse*. New York: WW Norton, 1999.
2. Shaner A, Eckman T, Roberts L, Fuller T: Feasibility of a skills training approach to reduce substance dependence among individuals with schizophrenia. *Psychiatric Services* 54:1287–1289, 2003.

**Innovative Program 2 Thursday, October 5
10:00 a.m.-11:30 a.m.**

THE MATRIX MODEL WITH DUALY DIAGNOSED LATINOS, ASIANS, AND ARABS

Jeanne L. Obert, M.S., M.A., *Executive Director, Matrix Institute, 12304 Santa Monica Boulevard, Suite 208, Los Angeles, CA 90025*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to identify the culturally competent components of integrated treatment programs for the dually diagnosed from Arab, Asian, and Latino backgrounds; and adapt motivational interviewing, relapse prevention, and harm avoidance procedures to varied cultures.

SUMMARY:

The Matrix Model offers a multi-component treatment and rehabilitation therapy for persons with addictions and mental disorders. The Matrix Model begins with motivational interviewing to engage clients in treatment, moving them from the “contemplation” to the “actively involved” stage of participation. Individual and group treatment focus on encouraging patients to identify personal goals that are meaningful and consistent with their particular values, family, and cultural background. In the Matrix Model, the therapist functions simultaneously as teacher and coach, fostering an encouraging, non-confrontational relationship with the patient and using that relationship to reinforce positive behavior change. Standard psychoeducational lectures explain the processes that sustain addictive behavior and the rationale for the therapeutic components. The components include relapse prevention, family involvement, self-help involvement, urinalysis and breath testing, individual

sessions, early recovery groups, relapse prevention groups, and social support groups. Early recovery groups teach patients how to (a) use cognitive tools to reduce craving; (b) schedule their time; and (c) connect with community support services such as sober living and 12 step groups. Throughout, coordination with psychiatric providers on a frequent basis is paramount to recovery. Integration of substance abuse treatment with that of mental disorders is accomplished using phone, in-person conferences, and a listserv e-mail communication.

TARGET AUDIENCE(S):

Professionals working with dually diagnosed individuals.

REFERENCES:

1. Obert JL, London ED, Rawson RA: Incorporating brain research into the multi-component Matrix Model. *Journal of Substance Abuse Treatment* 23:107-113, 2002.
2. DeClemente CC, Prochaska JO: Toward a comprehensive, transtheoretical model of change: Stages of change in addictive behaviors. In WR Miller & N Heather (Eds) *Treating Addictive Behaviors*, 2nd edition. New York: Plenum Press, 1998, pp 3-24.

**Innovative Program 3 Thursday, October 5
10:00 a.m.-11:30 a.m.**

LEARNING HEALTHY PLEASURES BY MINORITIES WITH DUAL DIAGNOSIS

Timothy G. Kuehnel, Ph.D., *Psychiatric Rehabilitation Consultants, P.O. Box 2867, Camarillo, CA 9301-2867*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to use cultural competence in teaching dually diagnosed patients to acquire and maintain 'healthy pleasures' as a means of stabilizing them in a sober life style; and identify and understand the mechanisms used to coordinate different agencies and treatment providers to create an integrated dual diagnosis treatment program.

SUMMARY:

Replacing the drug habit and its manifold subjective, mood enhancing, anxiety reducing, and socializing benefits with healthy habits and pleasures can be effective in maintaining abstinence and recovery from mental disorders and substance dependence. The healthy pleasures must have a strongly reinforcing effect on the individual to displace the powerful euphoria and relaxation evoked by illicit drugs. Because of individual differences, healthy pleasures underline the aphorism, "different strokes for different folks". Nowhere is this more

important for treatment providers than with individuals from different cultures. Cultural competence, as well as an empirical approach to identifying healthy pleasures are essential for effective treatment of minorities with dual diagnosis. For example, Asian-Americans are more attuned to activities that provide clear and rapid feedback of instrumental success, while unacculturated Latinos respond more to activities that involve family members and friends from the same background. Healthy habits are activities that have tangible effects such as personal hygiene, physical exercise, volunteer and remunerative work. Healthy pleasures are enjoyable activities that "feel good" and are consistent with sobriety. Teaching healthy habits and pleasures requires social modeling, sober buddies, video-assisted learning, positive reinforcement and encouragement from the therapist, and reinforcer sampling. Healthy pleasures will be clarified in the treatment of a person of Arab background.

TARGET AUDIENCE(S):

Mental health and substance abuse professionals.

REFERENCES:

1. Mueser KT, Noordsy DL, Drake RE, Fox L: *Integrated Treatment for Dual Diagnosis*. New York: Guilford Press, 2003.
2. Dixon L, McFarlane W, Lefly H, Lucksted A, Cohen C, Falloon I, Mueser KT et al: The state of evidence-based practices for services to family members of people with psychiatric conditions. *Psychiatric Services* 52:903-910, 2001.

INNOVATIVE PROGRAMS: SESSION 2

INNOVATIVE TREATMENT IN HOSPITAL SETTINGS

**Innovative Program 4 Thursday, October 5
1:30 p.m.-3:00 p.m.**

HOME TREATMENT FOR ACUTE MENTAL DISORDERS: AN ALTERNATIVE TO HOSPITALIZATION

David S. Heath, M.D., *Psychiatrist, Hazelglen Service, 424 Clairbrook Crescent, Waterloo, Ontario, Canada N2L 5V7*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to describe what mobile crisis home treatment is and how it fits into mental health systems; and describe the evidence base for this model.

SUMMARY:

The idea of designing a mental health service specifically to avoid hospitalization and treat acutely ill patients in their homes, has received high-profile international attention in the last decade.

The U.S. Surgeon-General, and the Canadian Federal Government have issued reports recommending the development and expansion of such services, which are now widely available in Britain and Australia.

Reasons for this increased interest are many and varied. They include: 1) Worldwide reduction in beds; 2) Cost reduction; 3) Mental health laws limiting hospital care; 4) Consumers and families desire to avoid hospital admission and 5) Community care has advantages over hospital care for certain groups and disorders. In addition there is a strong evidence base for home treatment of acute mental disorders.

In this session, participants will learn the core features of acute home treatment (here termed mobile crisis home treatment) how it is different to PACT, and its important role in mental health systems. The research will be reviewed, and the key elements and principles of mobile crisis home treatment will be outlined. A case history of mobile crisis home treatment will be presented.

TARGET AUDIENCE(S):

Mental health professionals, administrators, and planners who are interested in alternatives to hospitalization.

REFERENCES:

1. Heath, D. S: Home Treatment for Acute Mental Disorders: An Alternative to Hospitalization, New York, Routledge, 2005.
2. Kluitner, H: Inpatient treatment and care arrangements to replace or avoid it: Searching for an evidence-based balance. *Current Opinion in Psychiatry* 1997; 10: 160–167.

**Innovative Program 5 Thursday, October 5
1:30 p.m.-3:00 p.m.**

PSYCHIATRIC USE OF PRN ORDERS IN A LARGE STATE HOSPITAL SYSTEM

Gregory M. Smith, M.S., *Chief Executive Officer, Department of Administration, Allentown State Hospital, 1600 Hanover Avenue, Allentown, PA 18109*; Robert H. Davis, M.D., *Associate Medical Director, Department of Public Welfare, Pennsylvania Office of Mental Health and Substance Abuse Services, Building 32, Harrisburg, PA 17105*; Dung P. Tran, M.D., *Chief Medical Officer, Allentown State Hospital, 1600 Hanover Avenue, Allentown, PA 18109*; Karen L. Wolfe, M.S., R.N., *Department of Nursing, Allentown State Hospital, 1600 Hanover Avenue, Allentown, PA 18109*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to understand the results of a 14-month study on the psychiatric use of unscheduled medications in the Pennsylvania State Hospital system, from March 2004 through May 2005; appreciate the positive effects on patient safety measures when unscheduled psychiatric medications are reduced; and realize potential barriers to discontinuing the psychiatric use of PRN orders.

SUMMARY:

Summary: Beginning in March 2004, the nine hospitals that comprise the Pennsylvania State Hospital system, with an average monthly census of 2,000 people, began a year-long study to measure the amount of unscheduled psychiatric medications being administered and reduce its use. The hospital system serves people with severe mental illnesses and provides 60,000 days of care each month.

Method: Each hospital's 24-hour nursing report was modified to record the unscheduled use of psychiatric medications administered via PRN and STAT physician order. Patient demographics, including the specific medication administered, its dose, route, and the reason for the medication was part of the uniform dataset used in all nine hospitals. Monthly statistical reports were issued to the hospital system that identified patients who were the highest users of unscheduled psychiatric medications. This information was compared with incident reports of falls, aggression, medication errors, adverse drug reactions, assaults with injury, physical and mechanical restraint use, and seclusion.

Results: The psychiatric use of unscheduled medications in the nine hospital system decreased from 88 per 1,000 days of care in March 2004 to 18 per 1,000 days of care in March 2005. Control measures' including incidents of patient falls, aggression, adverse drug reaction, assaults with injury, and seclusion and restraint all decreased by at least 10% during this study period. Medication errors showed a slight increase during this same period.

Conclusion: Increasing the quality of the decision-making regarding the need to use unscheduled psychiatric medication by requiring a physician's STAT order can have a positive effect on most measures of patient care and decrease patient exposure to unnecessary psychotropic medications.

TARGET AUDIENCE(S):

Psychiatrists, nurses, researchers, policy makers, advocates, state officials, consumers and their family members.

REFERENCES:

1. Thapa P et al: PRN orders and exposure of psychiatric inpatients to unnecessary psychotropic medications. *Psychiatric Services Journal*, September 2003.
2. Szczesny S., Miller M: PRN medications use in inpatient psychiatry. *Journal of Psychosocial Nursing & Mental Health Services*, January 2003.

**Innovative Program 6 Thursday, October 5
1:30 p.m.-3:00 p.m.**

**REDUCING TRAUMA THROUGH THE
REDUCTION AND ELIMINATION OF
SECLUSION AND RESTRAINT**

Gregory M. Smith, M.S., *Chief Executive Officer, Department of Administration, Allentown State Hospital, 1600 Hanover Avenue, Allentown, PA 18109*; Kevin A. Huckshorn, R.N., M.S.N., *Director, National Technical Assistance Center, National Association of Mental Health Program Directors, 66 Canal Center Plaza, Suite 302, Alexandria, VA 22314*; Janice LeBel, Ph.D., *Child and Adolescent Services, Department of Mental Health, Commonwealth of Massachusetts, 25 Staniford Street, Boston, MA 02114*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to appreciate the traumatizing effect the use of seclusion and restraint has on children, adults, and on the staff who support them; describe the strategies used in Massachusetts and Pennsylvania to reduce and eliminate the use of seclusion and restraint; and understand the effective core strategies developed by the staff and faculty of the National Association of State Mental Health Program Directors (NASMHPD) Technical Assistance Center on alternatives to the use of seclusion and restraint.

SUMMARY:

This session focuses on the traumatizing effects the use of seclusion and restraint has on consumers and staff and current strategies to reduce and eliminate the use of these restrictive measures. Representatives from Massachusetts and Pennsylvania will share their varied approaches at discontinuing the use of these practices, including current data on their systems rates of use. Information on the use of response teams, assault deescalation techniques, and patient and staff debriefing procedures are some of the approaches to be discussed. An overview of national emerging best practices for reducing the use of these traumatizing measures will also be included.

TARGET AUDIENCE(S):

Psychiatrists, nurses, researchers, policy makers, advocates, state officials and consumers and their family members.

REFERENCES:

1. *Achieving the Promise: Transforming Mental Health Care in America* (2003) DHHS, New Freedom Commission on Mental Health.
2. Smith G, et al: Pennsylvania State Hospital system's seclusion and restraint reduction program. *Psychiatric Services Journal*, September 2005; 56(9); 1115-1122.
3. Huckshorn, K.A. Reducing seclusion and restraint use in mental health settings: Core strategies for prevention. *Journal of Psychosocial Nursing and Mental Health Services*, September 2004.
4. LeBel, J., et al: Child and adolescent inpatient restraint reduction: A state initiative to promote strength-based care. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43(1).

INNOVATIVE PROGRAMS: SESSION 3**COLLABORATIVE PARTNERSHIPS**

**Innovative Program 7 Thursday, October 5
3:30 p.m.-5:00 p.m.**

**GOOD NEIGHBOR HEALTH CLINIC:
MENTAL AND DENTAL HEALTH
SERVICES FOR THE UNINSURED**

Patricia A. Daly, M.D., *Fellow, Child and Adolescent Psychiatry, Dartmouth-Hitchcock Hospital, 1 Medical Center Drive, Lebanon, NH 03756*; Erica L. O'Neal, M.D., *Resident, Department of Psychiatry, Dartmouth-Hitchcock Hospital, 1 Medical Center Drive, Lebanon, NH 03756*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to understand ways to provide mental and dental health services to the uninsured; and recognize how to overcome barriers to accessing additional services for clients of a clinic when the clients needs exceed what the clinic can provide.

SUMMARY:

The Good Neighbor Health Clinic in White River Junction, Vermont has provided primary care to uninsured residents of a broad geographic area in Vermont and New Hampshire since 1992. For the past two years, the clinic has offered mental health services by utilizing

psychiatry residents from Dartmouth-Hitchcock Medical Center, as well as community psychiatrists who have volunteered to supervise residents and see clients themselves. The psychiatrists working there have noticed that many of their clients have dental problems that are more serious (infection, chronic pain) than their mental health issues. This has led to a new effort to recruit dentists and dental hygienists to address these problems.

This presentation will describe the evolution of the mental health services at the clinic and how services offered to the uninsured are coordinated. The internal referral process will be described and the interfaces with the smoking cessation, nutrition classes, and walking groups will be explained. The latest efforts to access and coordinate dental services will also be addressed. Limitation on what services can be safely offered in a volunteer clinic and how emergencies are handled will also be included. Finally, plans for additional mental health and dental services will be described.

TARGET AUDIENCE(S):

This presentation is geared towards psychiatrists and other clinicians interested in proving well-coordinated services to the uninsured.

REFERENCES:

1. Committee on the Consequences of Uninsurance: A Shared Destiny: Community Effects of Uninsurance. Board on Healthcare Services, Institute of Medicine, 2003.
2. Geyman, J. (2005). *Falling through the Safety Net: Americans without Health Insurance*. Monroe, ME: Common Courage Press.

**Innovative Program 8 Thursday, October 5
3:30 p.m.-5:00 p.m.**

**STATE-UNIVERSITY COLLABORATIONS:
ALTERNATIVE MODELS**

Steven J. Schleifer, M.D., *Professor, Department of Psychiatry, University Medical and Dental of New Jersey, 183 S. Orange Avenue, Newark, NJ 07103*; Margaret Grandison, M.S.W., *Clinical Administration, University Medical and Dental of New Jersey, 99 Central Avenue, Greystone Park, NJ 07950*; Kim T. Mueser, Ph.D., *Professor, Department of Psychiatry, Dartmouth Medical School, New Hampshire-Dartmouth Psychiatric Research Center, 105 Pleasant Street, Concord, NH 03301*; William A. Clayton, M.S.W., *Deputy and Chief Executive Officer, Greystone Park, 99 Central Avenue, Greystone Park, NJ 07950*; Willis Parker, *Section Chief, Greystone Park, 99 Central Avenue, Greystone Park, NJ 07950*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should better understand the potential benefits and challenges associated with implementing a clinically-oriented, multidisciplinary State-University collaboration.

SUMMARY:

Traditional State-University collaborations tend to be structured around education or research and based within single disciplines (often psychiatry). The New Jersey state-funded multidisciplinary collaboration (1999-) is clinically oriented, its team (n=12-15) representing four University Medical and Dental of New Jersey (UMDNJ) entities (Nursing, Psychiatry, Rehabilitation, and Social Work). Implemented sequentially in two state hospitals (>1,200 patients), goals included improved staff competencies, service delivery, implementation of best practices/rehabilitation-recovery, reduced violence/seclusion/restraint, increased discharges, and improved morale and institutional public perception. On-site undergraduate courses, in-service training, new-program development, staff mentoring and organizational/clinical consultations were introduced. Multidisciplinary university teams work with hospital treatment teams. University staff participate in hospital-wide committees and helped develop service-oriented research. Challenges came from custodial/symptom-oriented cultures, interdisciplinary differences (within hospital and university teams), and diffuse team/institutional leadership. Program development occurred in phases: 1) insinuation of the (externally-imposed) university into hospital culture; 2) more open collaboration (years 3-6); and 3) more active partnering with administrative/clinical leadership at multiple levels. Attempts to apply lessons from the first hospital to the second will be discussed. The New Jersey affiliation will be contrasted with models, such as in New Hampshire, that effect change through focused educational/research programs, rather than targeting clinical services directly. Feasibility of the New Jersey model for other settings, including costs/benefits, will be discussed.

REFERENCES:

1. Talbott, JA, Robinowitz, CB (Eds). *Working together: State-University collaboration in mental health*. Washington, DC, American Psychiatric Press, 1986.
2. Fitzgerald E, Caldwell BA, McQuaide T. Working together to improve care: collaboration between a state psychiatric hospital and an academic institution. *J Psychosoc Nurs Ment Health Serv.* 43:31-6, 2005.

**Innovative Program 9 Thursday, October 5
3:30 p.m.-5:00 p.m.**

**DEVELOPMENT OF A HOSPITAL-
UNIVERSITY PARTNERSHIP TO
PREVENT AND TREAT PTSD**

Joseph D. Varley, M.D., *Chairman, Department of Psychiatry, Summa Health System, 444 N. Main Street, Akron, OH 44310*; Holly N. Harris, Ph.D., *Post-Doctoral Fellow, Summa Health System, 444 N. Main Street, Akron, OH 44310*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should understand steps taken to establish an innovative center for research, treatment, and training in traumatic stress, focusing on treatment and prevention of violence in women's lives; and recognize how he/she might evaluate the success of introducing an innovative trauma program.

SUMMARY:

Content: We describe an innovative program to develop psychiatric research, clinical service, and training in traumatic stress.^{1,2} The partnership integrates university and medical system-based faculty for evidence-based treatment, research and training, with a focus on preventing and treatment of violence in women's lives.

Methodology and Results: Within three years, we established 11 M.D./Ph.D. research teams; increased to over 250 patients per year with a success rate of over 85% (achieving at least a 50% decrease in symptoms and falling in below clinical range on PTSD); provided violence and HIV prevention services to over 300 women per year; developed two model intervention programs with high-risk women; integrated doctoral and post-doctoral training in psychology and in psychiatry; received over \$8 million in grants, and published 26 papers (2005).

Conclusion: This innovative program illustrates how a clinical psychiatry department and research university combined their strengths in the area of traumatic stress research, clinical service, and training to create a center with national standing, providing greatly increased community service to prevent and treat violence.

TARGET AUDIENCE(S):

Participants interested in community-based psychiatry and research on PTSD and prevention and treatment of violence in women's lives.

REFERENCES:

1. Foa EB, Keane TM, Friedman MJ et al.: Guidelines for treatment of PTSD. *J Traumatic Stress* 2000; 13: 539-588.

2. William MB, Nurmi LA: Creating a comprehensive trauma center. New York, Plenum, 2001.

INNOVATIVE PROGRAMS: SESSION 4

STABILIZATION AND RECOVERY

**Innovative Program 10 Friday, October 6
8:00 a.m.-9:30 a.m.**

**WASHTENAW COUNTY COMMUNITY
SUPPORT AND TREATMENT SERVICES:
CRISIS STABILIZATION OUTREACH
SERVICES**

Kathryn Blakemore, B.S.N., *Health Services Supervisor, Washtenaw County Community Support and Treatment Services, 2140 E. Ellsworth, Ann Arbor, MI 48108*; Patricia Santy, M.D., *Psychiatrist, Washtenaw County Community Support and Treatment Services, 2140 E. Ellsworth, Ann Arbor, MI 48108*; Ryan Lindsay, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to demonstrate a knowledge of Crisis Stabilization Outreach Services; recognize current gaps in he/she community crisis services; utilize innovative ideas; and understand the cost-saving nature of effectiveness of crisis stabilization outreach services measured through various data points.

SUMMARY:

Crisis Stabilization Outreach Services (CSOS) Team is a new and innovative initiative developed by Washtenaw County to provide crisis stabilization services to individuals in psychological crisis located in various environments. Individuals from multiple disciplines who provide crisis services to the community would benefit from gaining further knowledge of new crisis stabilization services and this unique program. The CSOS are intended to fill the gap in crisis response services and strengthen the entire community crisis response system. Preliminary data from several research studies have supported the cost-effectiveness and efficacy of crisis intervention and outreach services (Bengelsdor, Church, Kaye, & Orłowski, 1993; Scott, 2000). In addition, Guo, Biegel, Johnson, and Dyches (2001) have shown that there is significant increase in likelihood of re-hospitalization of individuals within 30 days post-discharge. Therefore, CSOS are designed to divert clients from the emergency room, shorten hospital and crisis residential stays, and to provide follow-up services to discharged clients. The comprehensive nature of the CSOS team intends to meet the various needs of each client by taking

a multi-disciplinary approach to crisis stabilization and integrating services provided by case-managers, mental health professionals, substance abuse professionals, nurses, and psychiatrists. Data-to-date (June 2004—June 2005) have shown significant support for the cost-effectiveness of these services.

REFERENCES:

1. Bengelsdor, H., Church, J. O., Kaye, R. A., & Orlandski, B. (1993). The cost effectiveness of crisis intervention: Admission diversion savings can offset the high cost of services. *Journal of Nervous and Mental Disease*, 181 (12), 757–762.
2. Guo, S., Biegel, D. E., Johnsen, J. A., & Dyches, H. (2001). Assessing the impact of community-based mobile crisis services on preventing hospitalization. *Psychiatric Services*, 52 (2), 223–228.
3. Scott, Roger L. (2000). Evaluation of a mobile crisis program: effectiveness, efficiency, and consumer satisfaction. *Psychiatric Services*, 51 (9), 1153–1156.

Innovative Program 11 **Friday, October 6**
8:00 a.m.-9:30 a.m.

**COMMUNITY SERVICES NETWORK:
 RECOVERY-ORIENTED CARE FOR
 INDIVIDUALS WITH SERIOUS MENTAL
 ILLNESS**

Thomas H. Styron, Ph.D., *Assistant Professor of Psychology, Department of Psychiatry, Yale University School of Medicine, Community Mental Health Center, 34 Park Street, Room 144, New Haven, CT 06519*; Allison N. Ponce, Ph.D., *Associate Director, Community Services Network, Yale University, 34 Park Street, Room 144, New Haven, CT 06519*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should possess useful information on the development and implementation of an innovative and comprehensive community-based service system for individuals with serious mental illnesses; and develop an appreciation of some of the many challenges associated with the coordinated and oversight of this recovery-oriented system of care.

SUMMARY:

The recent debates about health care reform have focused attention on the need to develop organized systems of care capable of delivering comprehensive services which are coordinated or integrated (Hoge and Howenstine, 1997) and which promote recovery-oriented care (President’s New Freedom Commission, 2003). The Community Services Network (CSN) of

Greater New Haven, funded by the State of Connecticut and for which Yale University School of Medicine, Department of Psychiatry provides administrative oversight and coordination of services, strives to meet this need. A consortium of 16 community-based not-for-profit organizations, the CSN provides psychiatric rehabilitation services to more than 5,000 individuals with serious mental illnesses annually. Services include a broad array of clinical, residential, vocation, social rehabilitation, case management, crisis, respite and family supports, which strive to adhere to recovery-oriented principles of care. This session will provide an overview of the CSN and its services and highlight some of the many associated challenges in the areas of service coordination, program development and quality assurance and improvement.

TARGET AUDIENCE(S):

Individuals who are engaged in direct care or have administrative responsibility for direct care services.

REFERENCES:

1. Hoge M., and Howenstine, R. Organizational development strategies for integrating mental health services. *Community Mental Health Journal* 1997; 33: 175–187.
2. President’s New Freedom Commission on Mental Health. *Achieving the promise: Transforming mental health care in America*, final report (No. Pub. No. SMA-03-3832.) Rockville, MD: U.S. Department of Health and Human Services, 2003.

Innovative Program 12 **Friday, October 6**
8:00 a.m.-9:30 a.m.

**ENHANCING RECOVERY-ORIENTED
 CARE BY PROMOTING CAREER
 DEVELOPMENT**

Allison N. Ponce, Ph.D., *Associate Director, Community Services Network, Yale University, 34 Park Street, Room 144, New Haven, CT 06519*; Thomas H. Styron, Ph.D., *Assistant Professor of Psychology, Department of Psychiatry, Yale University School of Medicine, Community Mental Health Center, 34 Park Street, Room 144, New Haven, CT 06519*; Kyle W. Pedersen, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should possess information about the implementation of an innovative approach to integrating supported employment into an existing system of care, as well as an appreciation of the planning and challenges involved in this process.

SUMMARY:

It is increasingly well accepted that supported employment for individuals in recovery from mental illness and substance use disorders has tremendous benefits. As Substance Abuse and Mental Health Services Administration (SAMHSA) points out in its *Toolkit on Supported Employment* (SAMHSA, 2003), 70% of adults with severe mental illness want to work, and many consumers who are employed experience symptom improvement. The Connecticut Mental Health Center, an urban community mental health center that serves over 5,000 individuals per year, is actively engaged in establishing a flexible, comprehensive array of career development services for those in recovery. This is a cooperative endeavor involving people in recovery, clinical providers, employment providers, administrative leaders and other key stakeholders. A center-wide initiative focuses on action steps including enhancing relationships between clinical and employment providers, improving the flow of information sharing and communication, and developing and utilizing a variety of career development resources, in addition to those already in place. This strategic plan includes innovative methods for collecting data about employment among consumers. This presentation will focus on the challenges and benefits of integrating employment services into the ongoing care provided by this community mental health center and explore the ways in which increased coordination and a focus on consumer choice enhance the services offered.

REFERENCES:

1. Drake RE, Becker DR, Bond GR. Recent research on vocational rehabilitation for persons with severe mental illness. *Current Opinion in Psychiatry* 2003; 16: 451–455.
2. SAMHSA (Substance Abuse and Mental Health Services Administration) (2003). *Supported Employment Workbook*. Retrieved 12/2/05 from <http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/employment/workbook/default.asp>.

INNOVATIVE PROGRAMS: SESSION 5**INNOVATIONS IN CRIMINAL JUSTICE SETTINGS**

**Innovative Program 13 Friday, October 6
10:00 a.m.-11:30 a.m.**

THE MENTALLY ILL SEXUAL OFFENDER: SPECIAL CONSIDERATIONS FOR A SPECIAL POPULATION

Merrill R. Rotter, M.D., *Associate Clinical Professor of Psychiatry, Albert Einstein College of Medicine, 1500*

Waters Place, Bronx, NY 10606; Nicole A. Reid, M.D., Instructor, Department of Psychiatry, Albert Einstein College of Medicine, 1500 Waters Place, Bronx, NY 10461; Jo Ann Rivera, Ph.D., Bronx Psychiatric Center, Albert Einstein College of Medicine, 1500 Waters Place, Bronx, NY 10461; Richard B. Krueger, M.D., Associate Clinical Professor of Psychiatry, Columbia University, 1051 Riverside Drive, #45, New York, NY 10032; Malcolm McCullough, Ph.D., Department of Psychiatry, Bronx-Lebanon Health Center, 1500 Waters Place, Bronx, NY 10461

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to appreciate the need to address both mental illness and sexual offending behavior in patients with both problems, each of which complicates the assessment and treatment of the other; and gain awareness of how to adapt assessment and treatment approaches for the mentally ill sexual offender.

SUMMARY:

The treatment of sexual offenders has been getting increasing attention in clinical, political and legal arenas. While the civil commitment of sexual offenders remains controversial and is only possible in a minority of states, many states have noted the increasing forensic involvement of their mental health population, a significant portion of whom are individuals with traditional mental illnesses and sexual offense histories. The presence of mental illness complicates the presentation, assessment and treatment of sexual offending behavior. In this workshop, we will present a framework for a clinical approach to the mentally ill sexual offender. The focus will be on how these individuals come to our attention, and how traditional approaches to the treatment of mental illness and sexual offender interventions must be adapted to meet the needs of these individuals, while providing greater security for the community after discharge. We will briefly present a dimensional approach to evaluation and categorization, adapting assessment tools to this population, integration of psychological testing, specialized group treatment approaches and psychopharmacologic considerations. Time will be allotted for interactive case presentations with cases brought by panelists and offered by attendees to illustrate the concepts presented.

TARGET AUDIENCE(S):

Mental health practitioners, including physicians and non-physicians, particularly those working in community psychiatry or state health care systems.

REFERENCES:

1. Zonana H, et al: *Dangerous Sex Offenders, A Task Force Report of the American Psychiatric Association*

tion. Arlington, Va, American Psychiatric Publishing, 1999.

2. Krueger, RB, Kaplan, MS: Disorders of Sexual Impulse Control in Neuropsychiatric Conditions. In T. W. McAllister, Guest Ed. Seminars in Clinical Neuropsychiatry: Pharmacological of Neuropsychiatric Syndromes. Vol. 5, No. 4, 2000, pp. 266–274.

**Innovative Program 14 Friday, October 6
10:00 a.m.-11:30 a.m.**

CORRECTIONAL PSYCHIATRY REDUCES VIOLENCE IN AND OUT OF PRISONS

Zebulon C. Taintor, M.D., *Professor of Psychiatry, New York University School of Medicine, 140 Old Orangeburg Road, Orangeburg, NY 10128*; Henry C. Weinstein, M.D., *Clinical Professor of Psychiatry, New York University School of Medicine, 1111 Park Avenue, New York, NY 10128*; Merrill R. Rotter, M.D., *Associate Clinical Professor of Psychiatry, Albert Einstein College of Medicine, 1500 Waters Place, Bronx, NY 10606*; Allison V. Downer, M.D., *Psychiatrist, Sing Sing Correctional Facility, 39 Hudson Terrace, Apt. 308, Yonkers, NY 10701-1995*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to describe the treatment programs for men and women in New York State prisons that have led to marked decreases in violence both within the prisons and on release, including decreased rates of rearrest.

SUMMARY:

Correctional psychiatry involves treatment in prisons, with minimal time spent in prediction and court. The treatment provided can last months or years and uses all of the modalities available to a multidisciplinary treatment team. The authors head programs in male and female prisons that have been designed for patients with severe and persistent mental illness and/or severe behavioral problems (especially violence). Patients discharged from the CORP program at Sing Sing are rearrested only half as much as expected. Progressing through the Behavior Health Units at Great Meadow and Sullivan or the Treatment Behavioral Unit at Bedford results in once violent inmates learning anger management, social and other skills, and reductions in violence. These programs combine skills training and behavioral control with generating insight and alliances with the person against his/her illness. With discharge planning, especially housing and daily activities, treatment benefits can be carried into the community. However, considerable emphasis must be placed on anticipating reentry problems. The programs are run jointly with the Department

of Corrections and have been changed as each component has been evaluated. Cost analyses show that these programs return better than the amount invested in them.

TARGET AUDIENCE(S):

Psychiatrists and mental health professionals.

REFERENCES:

1. Swartz MS, Swanson JW, Hiday VA, Wagner HR: Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial with severely mentally ill individuals *Am J Psychiatry* 1999; 156: 1968–1975.
2. Pataki, GE, Carpinello, SE: Kendra’s Law Final Report on the Status of Assisted Outpatient Treatment. March 2005: 1–60.

**Innovative Program 15 Friday, October 6
10:00 a.m.-11:30 a.m.**

REENTRY FOR PRISONERS: A COORDINATED COMMUNITY RESPONSE

Cinda Cash, M.H.S.A., *Connecticut Women’s Consortium, 205 Whitney Avenue, New Haven, CT 06511*; Derrick M. Gordon, Ph.D., *Department of Psychiatry, Yale University, 205 Whitney Avenue, New Haven, CT 06511*; Alison Cunningham, M.Div., *586 Ella Grass Boulevard, New Haven, CT 06519*; Deborah A. Fisk, M.S.W., *Director, Outreach and Engagement, Community Mental Health Center, Connecticut Mental Health Center, 34 Park Street, New Haven, CT 06511*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to understand how to enhance the motivation and engagement of men involved in reentry planning; establish clear collaborative relationships between the criminal justice system, treatment providers, and community supports; establish continuity of care from the prisons into the community; and provide pre- and post-release supports to individuals, thus resulting in greater successful community transitions.

SUMMARY:

The issue of reentry for individuals coming from jails and or prisons is one that continues to be met with either trepidation or concern. These responses underscore the difficulty faced not only by the individuals who are returning to the community, but those charged with protecting the community from them post-release, and the community to which they will eventually return. This presentation will underscore the development of a program to assist men transitioning from prison successfully reenter their community through a planned community coordinated response. Within this context, this model

builds on strong case management and integrates in its plan recommendations made in the Report of the Reentry Policy Council.

Ideal reentry for individuals moving from prison to the community has been described as having a “seamless set of systems that span the boundaries of prison and community” and “are as close to the community as possible”. Reentry programs are most effective when intensive pre-release services are started in the prison system and are bridged to the community. The promise of the program is to decrease recidivism by facilitating, supporting the release of individuals to their communities, and building partnerships with interested justice, social service and community representatives.

TARGET AUDIENCE(S):

Mental health professionals, consumers, and family members.

REFERENCES:

1. Clear, T.R., Rose, D. R., & Ryder, J.A. (2001). Incarceration and the community: The problem of removing and returning offenders. *Crime and Delinquency*, 47, 335–351.
2. Open Society Institute (2004.) Groundbreaking study identifies crucial factors for successful community reintegration of ex-prisoners in Baltimore. Retrieved June 9, 2004 from the World Wide Web: http://www.soros.org/initiatives/baltimore/press/groundbreaking_20040315.
3. The Council of State Governments (2004). Report of the Re-Entry Policy Council: Charting the Safe and Successful Return of Prisoners to the Community. New York, NY.
4. Travis, J., & Petersilia, J. (2001). Reentry reconsidered: A new look at an old question. *Crime and delinquency*, 47, 291–313.

INNOVATIVE PROGRAMS: SESSION 6

INNOVATIVE TREATMENTS WITH CHILDREN AND ADOLESCENTS

Innovative Program 16 **Friday, October 6**
1:30 p.m.-3:00 p.m.

A REPLICABLE SCHOOL-BASED PROGRAM FOR HIGH-RISK ADOLESCENTS IN TRANSITION

Henry S. White, M.D., *Clinical Director, Department of Psychiatry, Brookline Center, 43 Garrison Road, Brookline, MA 02445*; Sarah J. Henderson, L.C.S.W., *Program Coordinator, Brookline High-Risk Youth Task*

Force, 43 Garrison Road, Brookline, MA 02445; Nancy Langman, R.N., M.S.; Suzanne Donnellan, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to build a system that strengthens coordination among high-risk students, families, teachers, and service providers; understand how to use a collaborative model for program development and operation; and learn how a targeted, school-based, family-centered approach to vulnerable teens can, at modest cost, significantly improve outcomes.

SUMMARY:

This session will describe an innovative, replicable school-based, family-focused program for adolescents returning to school after psychiatric hospitalization or other mental health, medical, or substance abuse crisis. These teens face a high risk of relapse and disruption of their education and socio-emotional development. The program, the Brookline High-Risk Youth Task Force, was developed at an urban high school and has served over 100 students since 2003. It provides brief, intensive care coordination, case management, academic assistance, and social support. It is staffed by two school-based social workers and a classroom aide working in a dedicated classroom. This session will describe the program’s development and operation and present results of the first two years of service.

TARGET AUDIENCE(S):

Mental health professionals who work in or provide consultation to middle and high schools confronted with the challenge of helping students with serious substance abuse, mental health, or medical illness, reintegrate into their school and community.

REFERENCES:

1. Daniel, SS, Goldston, DB, Harris, AE, Kelley AE, Palmes, GK; Review of Literature on Aftercare Services among Children and Adolescents, *Psychiatric Services* 55:901–912; 2004.
2. White, HS, Langman, N, Henderson S, Donnellan, S; An Innovative and Replicable School-Based Program for High-Risk Adolescents in Transition from Hospital to Community; *Frontline Reports*; *Psychiatric Services*; In Press.

Innovative Program 17 **Friday, October 6**
1:30 p.m.-3:00 p.m.

DIALECTICAL BEHAVIOR THERAPY FOR ADOLESCENT GIRLS IN A COMMUNITY MENTAL HEALTH SETTING

Katherine R. Ryan, B.S.W., *Client Services Manager, Washtenaw County Community Mental Health Center,*

2940 Ellsworth, Ypsilanti, MI 48197; Samantha Resnick, L.M.S.W., *Mental Health Professional, Washtenaw County Community Support and Treatment Services, Youth and Family Services, 2940 Ellsworth, Ypsilanti, MI 48197*; Joann Heap, M.S.W.; Karen K. Milner, M.D.

Innovative Program 18

**Friday, October 6
1:30 p.m.-3:00 p.m.**

**FAMILY-FOCUSED, COMPREHENSIVE
CARE FOR TRAUMATIZED CHILDREN**

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should have a greater understanding of the structure, content, and challenges of an outpatient adolescent Dialectical Behavior Treatment program.

SUMMARY:

Youth and Family Services is an outpatient mental health facility serving low-income, severely emotionally disturbed youth. Significant numbers of female adolescent clients display symptoms similar to those of adults with borderline personality disorder: mood and affective instability, interpersonal volatility, and suicidal/parasuicidal behaviors resulting in disproportionately high rates of emergency room visits and psychiatric hospitalizations. In order to address the unique needs of this population and reduce hospital visits, we have developed an innovative program called “Symmetry”, which is an adaptation of Dialectical Behavior Therapy (DBT), pioneered by Marsha Linehan and Behavioral Tech LLC. Research shows that DBT is effective in treating adults with borderline personality disorder; however, there is little research on DBT’s efficacy with adolescent outpatients. “Symmetry” participants attend a weekly skills group with their parent/guardian. Each group is facilitated by two DBT-trained therapists and consists of 45 minutes of skill teaching, followed by 45 minutes of skill sharing and practice. Adolescents also attend weekly individual DBT therapy. Preliminary data suggests that “Symmetry” is effective in reducing hospitalization rates and in teaching skills that are key to symptom reduction.

TARGET AUDIENCE(S):

The target audience for this presentation is providers of child/adolescent mental health services: social workers, psychologists, nurses, direct-care workers and psychiatrists.

REFERENCES:

1. Linehan, M.M. (1993). *Skills Training Manual for Treating Borderline Personality Disorder*. New York: Guilford Press.
2. Miller, A. & Rathus, J. (Summer 2002). *Dialectical Behavior Therapy adapted for suicidal adolescents. Suicide and Life Threatening Behavior*, 32(2), 146–157.

Susan Hansen, L.C.S.W.-R., *NEXIS Program Director, Ulster County Mental Health Department, 239 Golden Hill Lane, Kingston, NY 12401*; James E. Standefer, M.D., *Child and Adolescent Psychiatrist, Ulster County Mental Health Department, 239 Golden Hill Lane, Kingston, NY 12401*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should understand the Trauma Systems Therapy Model of family intervention; and explore the challenges and successes of integrating the cultures of mental health and social services.

SUMMARY:

This session will focus on providing an overview of the Trauma Systems Therapy Model of intervention, which originates from Boston Medical Center under the direction of Dr. Glenn Saxe. The model is a structured family and community-based intervention for children and families struggling with dysregulated emotions and behaviors. The model works to improve child and adolescent behaviors by supporting environmental changes. A primary focus is on skill building and functional enhancement by engaging the families in a mutually agreed upon intervention strategy.

Ulster County’s adaptation of the Trauma Systems Therapy Model involves implementing the model as a joint venture between the Ulster County Mental Health Department, the Ulster County Department of Social Services, and a local not for profit agency, Family of Woodstock. Over the years, the County has struggled to identify a model that could serve to enhance services to the Department of Social Services population in a more effective, focused manner. This model was identified as one that could enhance the mental health service delivery system and also serve to create greater collaboration between the primary service providers, including the Mental Health Department and the Department of Social Services.

The process of integrating two large bureaucracies with different cultures and often very different missions will be discussed. The challenges and the successes will be shared in order to support other agencies who might be considering such a venture.

The preparation for implementing the model, including start up and training will be discussed, as well as the actual implementation of the project at present. The team building process and staff development components will also be discussed.

TARGET AUDIENCE(S):

Those interested in program development serving traumatized children and their social environments.

REFERENCES:

1. Saxe G., MD; Ellis H., PhD; Fogler J.; Hansen S., LICSW, Sorkin B., MS Comprehensive Care for Traumatized Children Psych Annals 34:5 May 05.
2. Trauma Systems Therapy: Treating Child Traumatic Stress from Neurons to Neighborhoods, Saxe G. MD et. al., Guilford Press.

INNOVATIVE PROGRAMS: SESSION 7**INNOVATIVE TREATMENTS OF COMORBID ILLNESS**

Innovative Program 19 **Friday, October 6**
3:30 p.m.-5:00 p.m.

A MODEL FOR TREATING COMBINED MAJOR MENTAL ILLNESS AND SUBSTANCE ABUSE

Marc Galanter, M.D., *Professor of Psychiatry, and Director, Division of Alcoholism and Drug Abuse, New York University School of Medicine, 550 First Avenue, New York, NY 10016*; Stephen Ross, M.D., *Assistant Professor of Psychiatry, New York University School of Medicine, 550 First Avenue, New York, NY 10016*; Jaime L. Grodzicki, M.D.; Helen Dermatis, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to understand options for treating the dually diagnosed; apply these options in clinical facilities; and view such treatment in relation to systems change.

SUMMARY:

Patients with combined general psychiatric and addictive disorders are a major public health problem in the U.S., and are increasingly prevalent in psychiatric facilities. In this presentation, a model treatment system for such patients will be described, one that has been successfully established at Bellevue Medical Center in New York City, in affiliation with the New York University School of Medicine. It is composed of four complementary units: an inpatient ward, a halfway house, a day program, and a consultation service. Treatment is based on integration of peer leadership, conventional psychiatric modalities, contingency management, and 12 step meetings. The program provides multiple levels of care to address the needs of respective patients, with

referral, as appropriate, between units as patients progress in treatment. The patient population is highly economically and socially compromised, suffering from major mental illness and long-term substance dependence, and most patients are members of minority ethnic groups. The units also serve as training sites in addiction for medical students, residents, and addiction fellows. Studies on patient characteristics and attitudes, and clinical outcome will be reviewed, including comparison to conventional care.

TARGET AUDIENCE(S):

Mental health professionals working in institutional settings.

REFERENCES:

1. Galanter M, Kleber HK (eds): Textbook of Substance Abuse Treatment, Third Edition. Washington DC: American Psychiatric Press, 2004.
2. Ross S, Dermatis H, Levounis P, Galanter M: A comparison between dually diagnosed inpatients with and without axis II comorbidity and the relationship to treatment outcome. Am J Drug Alcohol Abuse 29: 263-279, 2003.

Innovative Program 20 **Friday, October 6**
3:30 p.m.-5:00 p.m.

SUBSTANCE ABUSE CONSULTATION AND REFERRAL ON PSYCHIATRIC SERVICES

Jaime L. Grodzicki, M.D., *Assistant Professor of Psychiatry, New York University School of Medicine, 160 Cabrini Boulevard, Apt. 19, New York, NY 10033-1143*; Marc Galanter, M.D., *Professor of Psychiatry, and Director, Division of Alcoholism and Drug Abuse, New York University School of Medicine, 550 First Avenue, New York, NY 10016*; Stephen Ross, M.D., *Assistant Professor of Psychiatry, New York University School of Medicine, 550 First Avenue, New York, NY 10016*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should better understand how a Substance Use Disorder (SUD) consultation can be effectively done in psychiatric settings; and apply a consultation approach to a co-morbid psychiatric and SUD patient in their respective psychiatric facility.

SUMMARY:

Patients' substance use disorders (SUD's) are increasingly recognized as a major problem in achieving proper quality of care on psychiatric services. As many as 50% of psychiatric patients suffer from substance use disorder.

ders, and this clinical problem is often the cause of the presenting illness. This session will address three aspects of developing needed consultation and referral for these patients on psychiatric services. The first deals with drawing on consultation techniques developed in general psychiatry, but tailored to the specific problems presented by co-morbid SUD's. The second is a description of a program developed at Bellevue Hospital, and carried out by a team consisting of a psychiatrist director and five non-physician staff. The specific role of each of the disciplines involved, and data on consultations and their outcome will be presented. The third deals with how the hospital as a whole has been addressed to improve care. Literature in this area will be reviewed. Participants will discuss problems that arise in their respective clinical settings, and how they can be addressed.

TARGET AUDIENCE(S):

Clinicians dealing with consultation services.

REFERENCES:

1. Galanter M, Kleber HK (eds): Textbook of Substance Abuse Treatment, Third Edition. Washington DC: American Psychiatric Press, 2004.
2. Gastfriend DR (ed): Addiction Treatment Matching, New York: Haworth Press, 1994.

**Innovative Program 21 Friday, October 6
3:30 p.m.-5:00 p.m.**

TRAUMA AMONG HOMELESS PERSONS WITH CO-OCCURRING DISORDERS: LESSONS LEARNED

Richard C. Christensen, M.D., M.A., *Clinical Associate Professor, and Director, Community Psychiatry Program, Health Sciences Center, University of Florida College of Medicine, and Former APA/Bristol-Myers Squibb Fellow, 655 West 8th Street, Jacksonville, FL 32209*; Lorrie K. Garces, M.D., *Fellow, Department of Psychiatry, University of Florida College of Medicine; and Former APA/Bristol-Myers Squibb Fellow, P.O. Box 100256, Gainesville, FL 32610*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should obtain a greater understanding of the prevalence of trauma among homeless individuals who suffer from the co-occurring disorders of mental illness and substance use; and gain a greater appreciation for the trauma-based clinical interventions which were implemented in a program designed to provide integrated services to this chronically underserved population.

SUMMARY:

An experience of trauma (i.e., physical or sexual abuse) can be either a cause or consequence of homelessness among individuals with comorbid disorders of substance use and serious mental illness. Although there are a number of programs described in the current literature designed to meet the needs of homeless people with co-occurring disorders, there is a dearth of information which specifically addresses the need for integrating trauma services into the formal treatment of this highly vulnerable population. This presentation will describe a particular program based in Jacksonville, Florida, which has been designed to provide integrated treatment to homeless adults who suffer from co-occurring disorders. The Seeking Treatment and Recovery (STAR) Program was initiated in 2002 upon receiving federal funding for a three-year period. During this time it became abundantly evident that the high prevalence of trauma among those being served called for significant modifications in the program's clinical design. Hence, this presentation will describe the STAR Program and provide an overview of the trauma-based clinical interventions which were implemented to better meet the needs of homeless persons with co-occurring disorders.

TARGET AUDIENCE(S):

Psychiatrists, mental health therapists, social workers, and program administrators.

REFERENCES:

1. Christensen RC, Hodgkins CC, Garces LK, et al.: Homeless, mentally ill and addicted: The need for abuse and trauma services. *Journal of Health Care for the Poor and Underserved*, in press.
2. Fallot RD, Harris M and the Community Connections Men's Trauma Workgroup. Men's trauma recovery and empowerment model: A clinician's guide to working with male trauma survivors in groups. Washington, DC: Community Connections, 2001.

INNOVATIVE PROGRAMS: SESSION 8

MULTIDISCIPLINARY TRAINING

**Innovative Program 22 Saturday, October 7
8:00 a.m.-9:30 a.m.**

INTERDISCIPLINARY TRAINING IN MENTAL HEALTH EDUCATION

Allison N. Ponce, Ph.D., *Associate Director, Community Services Network, Yale University School of Medicine, 34 Park Street, Room 144, New Haven, CT 06519*;

Thomas H. Styron, Ph.D., *Assistant Professor of Psychology, Department of Psychiatry, Yale University School of Medicine, Community Mental Health Center, 34 Park Street, Room 144, New Haven, CT 06519;* Jeanne L. Steiner, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should possess an understanding of the benefits and challenges of integrated interdisciplinary learning for mental health care trainees; and describe what the literature suggests about attitude change among trainees as a result of such training.

SUMMARY:

The psychiatric recovery model has led mental health care practitioners to rely on the strength of interdisciplinary teams to offer the best services to consumers. However, learning to become a member of such a team often happens by default; one accepts a position in which such collaboration is expected, then learns *in vivo*. In order to make explicit the skills required to function well as a member of an interdisciplinary mental health team, a weekly seminar was designed for students from nursing, psychiatry, social work, and psychology at the Connecticut Mental Health Center, which provides community-based, integrated behavioral health services to more than 5,000 patients per year. These trainees from the Department of Psychiatry of Yale University School of Medicine participate in discussions of the interdisciplinary approach to treatment of serious and persistent mental illness (SPMI), the recovery model, and other topics including community integration and the intersection of physical and mental health. Pre- and post-seminar survey data are being collected to learn more about student attitudes toward treating SPMI, perceived challenges and benefits of working on interdisciplinary teams, and perceptions of the roles of different team members. Survey results will be presented, as will a discussion of the predicted changes in attitude regarding roles and comfort in working with the SPMI population.

REFERENCES:

1. Rosen A, Callahy T. Interdisciplinary teamwork and leadership: Issues for psychiatrists. *Australasian Psychiatry* 2005; 13:234–240.
2. Addleton RL, Tratnack SA, Donat DC. Hospital-based multidisciplinary training in the care of seriously mentally ill patients. *Hospital & Community Psychiatry* 1991; 42:60–61.

Innovative Program 23 **Saturday, October 7**
8:00 a.m.-9:30 a.m.

CRISIS INTERVENTION TEAM TRAINING: CORE ELEMENTS, COORDINATION, CONTROVERSY

Ann K. Morrison, M.D., *Associate Professor of Psychiatry, Wright State University, P.O. Box 927, Dayton, OH 45401;* Mark R. Munetz, M.D., *Chief Clinical Officer, Summit County Alcohol, Drug Addiction and Mental Health Services Board; and Professor of Psychiatry and Director, Coordinating Centers of Excellence Project for Mental Health and Criminal Justice, 100 West Cedar Street, #300, Akron, OH 44307*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to name models of law enforcement response to people in mental health crisis; recognize the advantages of the Crisis Intervention Team (CIT) training model and describe dissemination and implementation of this model; and identify the core elements of the CIT model.

SUMMARY:

Law enforcement officers are often the first responders to people experiencing a mental illness crisis. Models for improving the effectiveness of this response have been developed. One model Crisis Intervention Team (CIT) training, or the Memphis Model, has been described, and its adoption encouraged for approximately 20 years. Recently, it has emerged as a dominant model. Barriers to dissemination and implementation persist.

Efforts in Ohio to promote adoption of CIT will be described. These include the early work of the Criminal Justice Coordinating Center of Excellence as a principal training site, and a recent collaboration of the CIT coordinators throughout the state to develop a CIT Core Elements expert consensus document. The current status of CIT across Ohio will be reviewed. The CIT Core Elements document will be described. These elements widely agreed to be essential to the training and those elements which were the most controversial will be discussed.

TARGET AUDIENCE(S):

Mental health professionals who work in emergency settings; law enforcement and mental health administrators; and individuals with mental illness and their family members interested in improved community response to mental health emergencies.

REFERENCES:

1. JS, Ritter JC, Munetz MR: The effects of Crisis Intervention Team training on police disposition of mental disturbance calls. *Psychiatric Services*, in Press.

- Hails J, Borum R. Police training and specialized approaches to respond to people with mental illness. *Crime and Delinquency*, 2003; 49:5261.

- Gray GE, Pinson LA. Evidence based medicine and psychiatric practice. *Psychiatric Quarterly*, 74(4): 387-99, 2003.

**Innovative Program 24 Saturday, October 7
8:00 a.m.-9:30 a.m.**

**THE WEAKEST LINK: A NOVEL
APPROACH TO TEACHING EVIDENCE-
BASED MEDICINE AND
PSYCHOSOMATIC MEDICINE**

Howard Y. Liu, M.D., *Resident, Department of Psychiatry, University of Michigan, 45536 Courtview Drive, Canton, MI 48188*; Lewis P. Krain, M.D., *Geropsychiatry Fellow, Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109*; Michelle B. Riba, M.D., M.S.; Gregory W. Dalack, M.D.; Tracey S. Oppenheim, M.D.; Helen C. Kales, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant will be introduced to an interactive game to stimulate Evidence-Based Medicine (EBM) learning among resident psychiatrists, which introduces a novel approach to encourage mentorship between faculty and residents.

SUMMARY:

This is a fun and innovative method of teaching evidence-based medicine principles to resident psychiatrists. In October 2005, a chief resident at Duke University developed an e-mail forum posing interesting questions to residents. At the University of Michigan, we have expanded this concept into an interactive game for our psychiatry residents. This game encourages faculty to generate questions from their clinical practice where the evidence is controversial. Residents are then challenged to answer these questions and rewarded with prizes designed to encourage mentorship and additional research. Our presentation will explain how to set up this game, present sample questions and answers from previous rounds, and suggest ways that the audience can adapt this game to their training programs.

TARGET AUDIENCE(S):

Residents and faculty in medical education.

REFERENCES:

- Coomarasamy A., Khan KS. What is the evidence that post graduate teaching in EBM changes anything? *BMJ* 329 2004 Oct.

INNOVATIVE PROGRAMS: SESSION 9

CHALLENGING POPULATIONS

**Innovative Program 25 Saturday, October 7
10:00 a.m.-11:30 a.m.**

**ASSERTIVE OUTREACH TO HOMELESS
PERSONS WITH SUBSTANCE USE
DISORDERS: DOES IT MATTER?**

Deborah A. Fisk, M.S.W., *Director, Outreach and Engagement, Community Mental Health Center, Connecticut Mental Health Center, 34 Park Street, New Haven, CT 06511*; Jaak Rakfeldt, Ph.D., *Professor, Department of Social Work, Southern Connecticut State University, 101 Farnham Avenue, New Haven, CT 06515*; Ronald Dunhill, R.N., *Nurse Liaison, Southern Connecticut State University, 400-428 Columbus Avenue, New Haven, CT 06519*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to understand the prevalence of physical and verbal attacks on homeless persons; define the relationship between stigma and “blaming the victim”; and recognize that non-traditional approaches to serving homeless persons with substance use disorders are effective.

SUMMARY:

Over the last several years, harassment and violent assaults on homeless persons have been on the rise. Between 1999 through 2001, there were 110 murders of homeless people by people who were not homeless. In addition, police harassment and community regulations, such as anti-vagrancy and anti-panhandling statutes, have further restricted the independence of homeless persons.

Homeless persons are disenfranchised individuals who are “stigma symbols,” in that they have characteristics that set them apart from others. The mainstream public fears contact with stigmatized individuals and loathes them, with responses that are “visceral.” Public intolerance and resentment toward homeless persons is likely fueled by the high prevalence of untreated substance abuse among homeless persons, and the staggering economic and social costs of untreated substance abuse.

In this session, we describe our frustrating experiences in soliciting a town response to regular attacks on homeless persons with substance use disorders. We also explore nontraditional programs that are effective in engaging homeless persons with substance use disorders into treatment and housing. Finally, we suggest that the limited efforts devoted to engaging homeless substance abusers into treatment results from the view that substance abuse is a problem of “willful misconduct,” rather than a disorder.

TARGET AUDIENCE(S):

Mental health professionals, consumers, and family members.

REFERENCES:

1. Kertesz, S. G., Horton, N.J., Friedmann, P.D., Saitz, R., & Samet, J. H. (2003). Slowing the revolving door: Stabilization programs reduce homeless persons' substance use after detoxification. *Journal of Substance Abuse Treatment*, 24(3), 197–207.
2. Rowe, M., Fisk, D., Frey, J., & Davidson, L. (2002). Engaging persons with substance use disorders: Lessons from homeless outreach. *Administration and Policy in Mental Health*, 29(3), 263–273.

**Innovative Program 26 Saturday, October 7
10:00 a.m.-11:30 a.m.**

THE BOSTON MEDICAL CENTER'S ADVANCED CLINICAL CAPACITY FOR ENGAGEMENT, SAFETY, AND SERVICES PROJECT: THE DUDLEY INN

Alisa K. Lincoln, Ph.D., *Acting Chair, Boston University School of Public Health, 715 Harrison Avenue, Talbot 244W, Boston, MA 02118*; Peggy L. Johnson, M.D., *Vice Chair of Clinical Psychiatry, Boston Medical Center, 85 East Newton, Suite 802, Boston, MA 02118*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to increase their understanding of consumers with chronic homelessness and dual diagnoses; and explore the use of innovative models focused on housing in psychiatric treatment or consumers who are chronically homeless, substance abusing, and have a severe mental illness.

SUMMARY:

The Boston Medical Center Access (Advanced Clinical Capacity For Engagement, Safety and Services) Project is a SAMHSA funded eight-bed enhanced Safe Haven (The Dudley Inn) for women and men with major mental illness, substance abuse and who are chronically

homeless. The Safe Haven Model is a HUD BEST Practice model that is designed to reach the most difficult population of homeless individuals. In 2002, the Boston Medical Center (BMC), Division of Psychiatry, was the first such unit to include Safe Haven services in their continuum of care. Since that time the program has served 16 men and women. We will describe: 1) the core operating philosophy of housing; 2) the expanded clinical services which were necessary to develop; 3) the inter-agency partnership of state, local, and community-based organizations, including consumer run organizations; 4) the unique evaluation design that includes qualitative and quantitative elements, as well as consumer participation; and 5) lessons learned as we implemented and operate this unique and successful program.

TARGET AUDIENCE(S):

Individuals and agencies working with homeless populations with major mental illness or substance abuse.

REFERENCES:

1. Tsemberis S., Gulcur L., Nakae M. Housing First, Consumer Choice, and Harm Reduction For Homeless Individuals with a Dual Diagnosis. *American Journal of Public Health*. 2004; 94:651–656.
2. Bridgman R. Housing Chronically Homeless Women: “Inside” a Safe Haven. *Housing Policy Debate*. 2002; 13(1):51–78.

**Innovative Program 27 Saturday, October 7
10:00 a.m.-11:30 a.m.**

EFFECTS OF HIV INTERVENTION ON MENTALLY ILL SUBSTANCE USING CRIMINAL JUSTICE CLIENTS

Nahama Broner, Ph.D., *Senior Research Psychologist, RTI International, Center for Crime, Violence and Justice Research, 915 Broadway, Suite 1200, New York, NY 10010*; Christopher Krebs, Ph.D.; Kathleen Gates, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to recognize that community-based treatment programs, such as the Treatment Alternatives for Safer Communities (TASC), reduces criminal recidivism through increased access to and retention in community-based treatment programs.

SUMMARY:

Approximately 60–80% of those arrested are drug involved. Seven to 15% have a serious mental illness, almost three-quarters of whom have a substance use disorder. The majority are at risk for HIV, Hepatitis C, and other STDs; about 10% of substance using and 20%

of mentally ill substance using detainees have HIV/AIDS. Criminal justice diversion posits reducing criminal justice recidivism through increased access to and retention in community-based treatment. Treatment Alternatives for Safer Communities (TASC), a criminal justice case management services linkage and monitoring model implemented in New York City for adults with substance use and/or mental health problems, was adapted to provide health interventions targeted to prevent contraction and transmission of HIV/AIDS. This presentation describes this intervention's integration with 600 participants and outcomes based on follow-up interviews, collateral services and criminal justice data. Preliminary findings of this three-site NIDA funded longitudinal comparison study suggest reduction in drug and sexual risk behavior, positive attitude change toward safe sex practices, increased HIV knowledge and increased receipt of HIV services. Relevant to researchers, practitioners and program administrators, implications of initial findings indicate public health in addition to public safety benefits to targeting offenders' health behaviors along with mental health and substance use problems.

TARGET AUDIENCE(S):

Researchers, practitioners and program administrators interested in the intersection of mental illness, substance use and HIV within a criminal justice community supervision population.

REFERENCES:

1. Solomon, P., Marcus, S., Draine, J. (2001). Rates of HIV infection among probationers and parolees with mental illness. *Psychiatric Services*, 52:1658.
2. Broner, N., Lattimore, P.K., Cowell, A.J., Schlenger, W.E. (2005). Effects of diversion on adults with co-occurring mental illness and substance use: Outcomes from a national multi-site study. *Behavioral Sciences and the Law*, 22(4): 519-541.

INNOVATIVE PROGRAMS: SESSION 10

ASSESSMENT TOOLS

**Innovative Program 28 Saturday, October 7
1:30 p.m.-3:00 p.m.**

ASSESSING SYMPTOM SEVERITY WITH THE POSITIVE AND NEGATIVE SYNDROME SCALE (PANSS)

Lewis A. Opler, M.D., Ph.D., *Advocacy Consultant, APA/IPS Scientific Program Committee, and Chief Medical Officer of Mental Health, New York School of Men-*

tal Health, 44 Holland Avenue, Albany, NY 12229; Paul M. Ramirez, Ph.D., Professor, Long Island University, 5400 Fieldston Road, 44-D, Riverdale, NY 10471

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to identify positive, negative, and general psychopathological symptoms in schizophrenia; utilize the structured clinical interview for the Positive and Negative Syndrome Scale (SCI-PANSS) in clinical or research settings; and use the PANSS in rating symptoms.

SUMMARY:

This session will introduce participants to the Positive and Negative Syndrome Scale (PANSS). The PANSS is a 30-item scale which provides a methodology for reliably assessing the presence and severity of positive, negative, and general psychopathological symptoms in psychotic disorders. There are also supplemental items which can be utilized in assessing a patient's dangerousness and for other purposes as well. In order to increase the reliability of obtained data and ratings, the "PANSS Assessment Procedure" provides a structured clinical interview (SCI-PANSS) and an informant questionnaire (IQ-PANSS) to acquire informant information for those 14 PANSS items which require such outside data for rating purposes.

The PANSS has become the most frequently utilized rating scale for psychotic disorders in clinical psychopharmacological trials throughout the world. It is also used in clinical settings for treatment planning purposes and to objectively gauge treatment response and change over time. In this session, participants will learn how to conduct a SCI-PANSS interview, how to use the IQ-PANSS, and how to utilize rating criteria contained in the PANSS manual in order to objectively rate patient video interview vignettes. Participants should have experience working with psychotic patients.

REFERENCES:

1. White L, Harvey PD, Opler LA, Lindenmayer JP, the PANSS Study Group: Empirical assessment of the factorial structure of clinical symptoms in schizophrenia. *Psychopathology* 1997; 30, 263-274.
2. Opler LA, Ramirez PM: Use of the Positive and Negative Syndrome Scale in clinical practice. *Journal of Practical Psychiatry and Behavioral Health* 1998; May, 157-162.

**Innovative Program 29 Saturday, October 7
1:30 p.m.-3:00 p.m.**

ASSESSMENT OF SPIRITUALITY IN PSYCHIATRIC CARE

Michael D. McGee, M.D., *Medical Director, Department of Psychiatry, St. Josephs Hospital, 172 Kinsley*

Street, Nashua, NH 03061; Jennifer Torosian, Program Manager, St. Josephs Hospital, 172 Kinsley Street, Nashua, NH 03061

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to discuss the impact of spiritual functioning on psychiatric outcomes; describe approaches towards the quantitative assessment of domains of spiritual functioning; and describe the actions required to integrate chaplains into a multidisciplinary team in order to address identified spiritual care needs.

SUMMARY:

Numerous studies have shown spirituality to promote both health and healing. The goal of this initiative was to more effectively identify and address patient and family spiritual care needs in order to improve clinical outcomes.

Chaplains were integrated into our multidisciplinary teams. Treatment plans were modified to include a spiritual assessment and intervention component. The admission nursing assessment was modified to include four screening questions adapted from the American College of Physicians Spiritual Assessment to assess appropriateness for spiritual care. Appropriate patients completed six domains of the Fetzer spiritual assessment. The domains measured are: Daily Spiritual Experiences, Meaning, Forgiveness, Private Religious Practices, Religious/Spiritual Coping and Religious Support. Assessment results are entered into a database and a graphical report generated for the patient's record. A spiritual care consult is then requested, and the Chaplain uses the Spiritual Profile report to guide his/her interventions.

This program has facilitated addressing specific areas of relative spiritual weakness that impact on illness and coping. This is the first program we know of to integrate the use of a psychometrically sound spiritual assessment methodology into a multidisciplinary inpatient treatment program to create a "biopsychosocialspiritual" approach to psychiatric treatment.

TARGET AUDIENCE(S):

All clinicians.

REFERENCES:

1. Spirituality in Clinical Practice: New Dimensions in Psychotherapy and Counseling, Len Sperry, M.D., Ph.D. Brunner-Routledge, 2001.
2. Multidimensional Measurement of Religiousness/Spirituality for use in Health Research: A Report of the Fetzer Institute/National Institute on Aging Working Group. John E. Fetzer Institute, Kalamazoo, MI, 2003.

Innovative Program 30 **Saturday, October 7**
1:30 p.m.-3:00 p.m.

ASSESSMENT OF YOUTH ADJUSTMENT TO TRAUMA: CANS-MH SCALE AND POLARIS YOUTH

Jim T. Donoghue, M.S., *Quality Improvement Manager, Magellan Health Services of Iowa, 2600 Westown Parkway, #200, West Des Moines, IA 50266*; Rachel L. Anderson, Ph.D., *Associate Professor, Department of Health Management and Policy, University of Iowa College of Public Health, 200 Hawkins Drive, E202 GH, Iowa City, IA 52242*; Carolyn J. Hejtmanek, M.S.W., *Vice President, Orchard Place Psychiatric Medical Institute for Children, 925 S.W. Porter, Des Moines, IA 50315*; Linda L. Toche-Manley, Ph.D., *Senior Scientist, Polaris Health Division, 446 Lincoln Highway, Fairless Hills, PA 19030*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to demonstrate understanding of the Polaris Youth program and Child Adolescent Needs and Strengths—Mental Health (CANS-MH) Scale and the usefulness of outcomes measurement tools and evidence-based practices to assist clinicians in addressing adjustment to trauma.

SUMMARY:

Magellan Health Services initiated a collaboration to develop an outcomes measurement program and expand use of evidence-based practices. Collaborators (Academic Clinical Researcher, Assessment/ Technology Firm, Treatment Center, and Managed Behavioral Care Organization) will report and demonstrate the implementation for Medicaid - funded youth at a Psychiatric Medical Institute for Children. Presenters will discuss youth trauma and the different assessment tools completed by the youth, the parent/caregiver, and the clinician, and how these tools measure outcomes. Child Adolescent Needs and Strengths (CANS-MH) assessments completed by the clinicians at intake found that 59% of the admissions were judged as moderate or severe in the Problem Presentation of Adjustment to Trauma. Findings will be used to illustrate that the CANS-MH is an affordable, reliable, and valid tool that can be quickly administered by all clinicians and can assist publicly funded settings to respond to youth who experience abuse, trauma or violence. Presenters will discuss youth trauma, the value of collaborations for community-based providers, the increased emphasis by funders and providers on outcomes, and the value of technology. Participants will have the opportunity to observe and discuss the program with the provider, assessment/tech-

nology firm, trainer, and the managed behavioral care organization.

TARGET AUDIENCE(S):

This presentation is targeted to administrators, clinical directors and program managers.

REFERENCES:

1. Anderson, R.L., Lyons, J.S., Giles, D.M., Price, J.A., Estle, G. (2003). Reliability of the Child and Adolescent Needs and Strengths-Mental Health (CANS-MH) Scale. *Journal of Child and Family Studies*, 12:3, 279–289.
2. Toche-Manley, L.L., Nankin, M., Dietzen, L. (2004). Using outcome data to create clinical change: Foundations and example. *Child and Youth Care Forum*, 33:1, 51–67.

INNOVATIVE PROGRAMS: SESSION 11

INNOVATIVE TREATMENTS

**Innovative Program 31 Saturday, October 7
3:30 p.m.-5:00 p.m.**

TF-CBTWEB: A WEB-BASED APPROACH TO LEARNING COGNITIVE BEHAVIORAL THERAPY FOR TRAUMATIZED CHILDREN

Judith A. Cohen, M.D., *Medical Director, Center for Traumatic Stress in Children and Adolescents, Allegheny General Hospital, Four Allegheny Center, 8th Floor, Pittsburgh, PA 15212*; Benjamin Saunders, Ph.D., *Department of Psychiatry, Medical University of South Carolina, 165 Cannon Street, P.O. Box 250852, Charleston, SC 29425*; Daniel Smith, Ph.D.; Esther Deblinger, Ph.D.; Anthony Mannarino, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to describe five innovative features of TF-CBTWeb; and identify how this program assists community practitioners in learning and implementing Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for traumatized children.

SUMMARY:

Many children and adolescents are exposed to traumatic experiences in our communities, including interpersonal traumas such as child abuse, domestic and community violence; vehicular and other types of accidents; natural disasters and acts of war or terrorism. Although most children are resilient in the face of trauma exposure,

some develop long-lasting psychological difficulties including symptoms of post-traumatic stress disorder (PTSD), depression, anxiety, behavioral dysregulation and/or shame. Fortunately, effective treatments are being developed to address these difficulties. Of all of the current treatments which have been tested, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has the strongest evidence of efficacy for resolving the above symptoms in traumatized children and adolescents.

In October 2005, TF-CBTWeb was introduced to provide Web-based TF-CBT training to community therapists. TF-CBTWeb includes the following innovative features: a) each of the ten TF-CBT components teaches specific procedures through the use of streaming video examples; b) each component includes printable scripts that can be used in treatment sessions; c) each component includes suggestions for homework and handouts; d) each component includes discussions regarding cultural considerations when using the technique; and e) each component describes common clinical challenges therapists might encounter.

Preliminary data from the first 100 TF-CBTWeb completers indicate significant pre- to post-course gains in knowledge about all of the TF-CBT components.

TARGET AUDIENCE(S):

Psychiatrists, psychologists, social workers, and mental health professionals.

REFERENCES:

1. Saunders B, Smith D (2005). TF-CBTWeb: A web-based learning course for Trauma-Focused CBT, Charleston, South Carolina: Medical University of South Carolina. Internet training site available at www.musc.edu/tfcbt.
2. Cohen JA, Deblinger E, Mannarino AP, Steer R (2004). A multisite, randomized controlled trial for sexually abused children with symptoms of posttraumatic stress disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43, 393–402.

**Innovative Program 32 Saturday, October 7
3:30 p.m.-5:00 p.m.**

USING FILM CLIPS IN AN INTENSIVE OUTPATIENT TREATMENT PROGRAM

Fuat Ulus, M.D., *Intensive Outpatient Treatment Program, Behavioral Health Services, St. Vincent Hospital, 5976 Southland Drive, Erie, PA 16509*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should understand intensive outpatient treatment programs and use film clips to process the group discussion theme which is designated for each session.

SUMMARY:

St. Vincent Hospital, Behavioral Health Department, Intensive Outpatient Treatment Program, started open-ended groups operational since August 2005, three half-days-a-week. Group movie therapy sessions were coordinated twice a week. The themes of the group sessions include, but are not limited to, Brain Works, Ego Strength, Problem Solving, Stress Management, Communication Skills, and Humor Therapy. Once the patient population is expanded, closed-end groups consisting of six to eight participants for four to six sessions, addressing the themes such as PTSD, OCD, adult ADHD, and others are to be conducted. Patient forms were designed for subjective participant input and therapist forms reflective of objective evaluations are being collected to form a database. An educational grant for research within the line of validity and reliability studies will be sought early next year. Evidence-based practice and information about the program and several film clips are to be shared. Complementary to the meeting theme, "Trauma and Violence in Our Communities," film clips are chosen among the scenes related to the subject and their educational and therapeutic values will be discussed.

TARGET AUDIENCE(S):

Psychiatrists, psychologists, social workers, academicians, instructors, and teachers.

REFERENCES:

1. Dreams in Myth, Medicine and Movies, Sharon Packer, M.D., Praeger Publications, 2002.
2. The Healing Movie Book, Precious Images: The Healing Use of Cinema in Psychotherapy, Michael A. Kalm, M.D., Lulu Publications, 2004.

**Innovative Program 33 Saturday, October 7
3:30 p.m.-5:00 p.m.**

MEDICATION GROUPS: A LOST TRADITION OR NEW SOLUTION?

American Association of Community Psychiatrists

Benjamin Crocker, M.D., *Medical Director, Maine Medical Center, 443 Congress Street, SFU Floor, Portland, ME 04101*; Leslie H. Gise, M.D., *Clinical Professor of Psychiatry, John A. Burns School of Medicine, University of Hawaii, 1035 Na'alah Road, Kula, HI 96790*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to appreciate the advantages of psychiatrist-led group psychotherapy and prescribing for patients with persistent psychiatric symptoms.

SUMMARY:

Psychiatrist-led outpatient group psychotherapy with medication management has been underutilized and understudied. Group psychotherapy is non-threatening, allows more frequent visits, a better therapeutic alliance, and facilitates early intervention. It was hypothesized that group treatment would be associated with less psychiatric hospitalization.

A retrospective cohort study was conducted of all patients (n=608) treated at a community mental health center over three years. Patients attending group were compared to patients receiving usual care. Group patients had significantly (p=.046) shorter duration of hospitalization (14 days per year) compared with controls (25 days per year), especially for those with mood disorders.

The association of retention in treatment and shorter hospitalization with group therapy should be further investigated with a randomized, controlled trial. A mediating factor is likely medication adherence.

TARGET AUDIENCE(S):

Clinicians, patients, and families who are interested in improving access to psychiatric services for patients who may need or desire frequent and flexible scheduling.

REFERENCES:

1. Stone WN, 1993: Group psychotherapy with the chronically mentally ill in Kaplan and Sadock. *Comprehensive Group Therapy* 418-429.
2. Colom, F., Vieta E. et al. 2003, A randomized trial of the efficacy of group psychoeducation in the prophylaxis of recurrences in bipolar patients whose disease is in remission. *Arch Gen Psych* 60: 402-407

INNOVATIVE PROGRAMS: SESSION 12**ISSUES IN RESIDENCY TRAINING**

**Innovative Program 34 Sunday, October 8
8:00 a.m.-9:30 a.m.**

WORKING WITH PSYCHIATRY RESIDENTS AND OTHER TRAINEES ON AN ASSERTIVE COMMUNITY TREATMENT TEAM

Ann L. Hackman, M.D., *Assistant Professor, Department of Psychiatry, University of Maryland Medical School, 630 West Fayette Street, Baltimore, MD 21201*; Curtis N. Adams, M.D., *Assistant Professor, Department of Psychiatry, University of Maryland, 630 West Fayette Street, Baltimore, MD 21201*; Theodora G. Balis, M.D., *Assistant Professor, Department of Psychi-*

atry, University of Maryland Medical School, 630 West Fayette Street, Baltimore, MD 21210

Innovative Program 35

**Sunday, October 8
8:00 a.m.-9:30 a.m.**

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to identify benefits of having psychiatry residents and other trainees involved in Assertive Community Treatment (ACT) teams and apply several approaches to working with trainees in this setting.

SUMMARY:

There is literature on Assertive Community Treatment (ACT) and also on psychiatry residents and trainees in community psychiatry settings. However, there is little which addresses ACT as a training setting for psychiatry residents and other trainees.

The University of Maryland (UMD) has a long tradition of mental health training in the public sector; since the UMD ACT team began in 1990, residents and trainees have worked in the program. The team, started as a research demonstration project evaluating ACT services with homeless patients, and currently serves both homeless and domiciled individuals in an urban setting. This session describes our experiences with trainees including 24 psychiatry residents, 1 medicine resident, 3 psychology interns, and 50 medical, 10 nursing, 8 social work and 12 occupational therapy students. Trainees have had responsibilities appropriate to their disciplines including medication management (residents), patient evaluation and patient care, co-leading groups, crisis and emergency intervention, cross coverage and home visits; all trainees received weekly supervision. Many trainees have gone on to work in the public sector.

After briefly reviewing literature on training in community mental health and describing ACT services, the panel will describe our experience in working with trainees on an ACT team, perspectives of the team, patients and trainees. Participants will then explore the benefits and challenges of ACT as a training experience.

TARGET AUDIENCE(S):

Psychiatry residents, medical students, trainees, psychiatrists, social workers, nurses and other mental health professionals working in community settings.

REFERENCES:

1. Dixon L, Krauss N, Kernan E, et al: Modifying the PACT model for homeless persons with severe mental illness. *Psychiatric Services* 46:684-688, 1995.
2. Weintraub W. The Maryland plan: a decade of university-state collaboration. *New Dir Ment Health Serv* 42: 51-62, 1989.

**TEACHING AND LEARNING
MOTIVATIONAL INTERVIEWING IN A
RESIDENCY TRAINING PROGRAM**

Ali Khadivi, Ph.D., *Chief of Psychology, Department of Psychiatry, Bronx-Lebanon Hospital, 1276 Fulton Avenue, Sixth Floor, Bronx, NY 10456*; Mercedes A. Brito, M.D., *Director of Training, Department of Psychiatry, Bronx-Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10463*; Barbara Kistenmacker, Ph.D., *Department of Psychiatry, Bronx-Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10456*; Kingsley O. Nwokeji, M.D., *Resident, Department of Psychiatry, Bronx-Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10463*; Santokh Singh, M.D., *Resident, Department of Psychiatry, Bronx-Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10463*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to recognize the unique features of Motivational Interviewing and its application to residency training programs.

SUMMARY:

Motivational Interviewing (MI) has been receiving considerable empirical validation. Its efficacy as a psychotherapeutic method has been demonstrated in patients with substance abuse, mental illness, and problems with medication adherence. The objective of this session is to discuss the application of MI as a therapeutic technique in an inner city hospital psychiatric residency program. The session will start with an overview of MI and follow with a discussion about the experience of teaching and learning the method from multiple perspectives. The director of residency training will relate her own experience of learning MI and the processes of becoming an MI instructor. An attending psychiatrist who learned MI in the fourth year of his residency training, will discuss the processes of learning MI from a cultural perspective. In addition, an MI certified psychologist instructor will discuss his teaching methods, including the challenges and rewards of training residents. Finally, there will be a discussion on the application and integration of MI into psychodiagnostic interviewing and psychodynamic-oriented therapy within the residency program. Participants will be strongly encouraged to ask questions and a discussion will follow about utility and application of MI as a method of therapeutic engagement and change in residency program.

TARGET AUDIENCE(S):

Academic psychiatrists, residents, and other mental health professionals involved in training residents.

REFERENCES:

1. Miller, W.R., Benefield, G., & Tonigan, J.S. (1993). Enhancing motivation for change in problem drinking: A controlled comparison of two therapist styles. *Journal of Consulting & Clinical Psychology* 61, 455–461.
2. Miller, W.R., & Rollnick, S(Eds). *Motivational Interviewing: Preparing people to change addictive behaviors*, N.Y. Guilford Press.

**Innovative Program 36 Sunday, October 8
8:00 a.m.-9:30 a.m.**

**RESIDENTS' PERCEPTIONS OF
RECOVERY AND MENTAL HEALTH
TRANSFORMATION**

Daniel Bahmiller, M.D., *Department of Psychiatry, Medical College of Georgia, 1515 Pope Avenue, Augusta, GA 30912*; Courtney A. Kenna, M.S., *Department of Psychiatry, Medical College of Georgia, 1515 Pope Avenue, Augusta, GA 30912*; Peter F. Buckley, M.D., *Professor and Chair, Department of Psychiatry, Medical College of Georgia, 1515 Pope Avenue, Augusta, GA 30912*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to orient residents and other mental health providers toward principles of the Recovery Movement and discuss changes effected in a traditional outpatient setting as a result; and provide a platform for discussion of residents' evaluations of how the Recovery Model could impact their practice and training, as well as the perceived implications of such a paradigm shift.

SUMMARY:

Recovery is emerging as a guiding influence in mental health service delivery and transformation. As a consequence, the expectations and curricular needs of trainees (as future stakeholders in a transformed, recovery-oriented system) are now of considerable importance. To this end, resident-lead focus groups were held at the Medical College of Georgia to obtain perceptions of the Recovery Model. Certified Peer Specialists (CPS) attended and topics covered were the Recovery Model, the CPS training curriculum, and developing a Wellness Recovery Action Plan (WRAP) with consumers. Advantages and disadvantages of the Recovery Model were discussed, with residents generally expressing cautious optimism regarding implementation of these principles, yet concern regarding the potential for diminishing confidence and support for traditional professional services. All residents indicated an interest in obtaining more

information about the Recovery Model, including how to incorporate WRAPS and the role of CPS in Recovery. Approximately 50% of residents selected a recovery-oriented workshop as the best method for further education about these concepts, with less support for other options of didactic handouts and expert lecture.

TARGET AUDIENCE(S):

Medical students/residents, mental health professionals, and consumers.

REFERENCES:

1. Anthony, W., Rogers, E., Farkas, M. (2003). Research on evidence-based practices: Future directions in an era of recovery. *Community Mental Health Journal*, 39, 101–114.
2. Davidson, L., Chinman, M., Kloos, G., Weingarten, R., Stayner, D., & Tebes, J. (1999). Peer support among individuals with severe mental illness: A review of the evidence. *American Psychological Association*, 6, 165–187.

INNOVATIVE PROGRAMS: SESSION 13

**INNOVATIVE APPROACHES TO
SUPPORTED HOUSING**

**Innovative Program 37 Sunday, October 8
10:00 a.m.-11:30 a.m.**

**PARK STREET INN: COMMUNITY RE-
INTEGRATION FOR LONG-TERM STATE
HOSPITAL PATIENTS**

Thomas H. Styron, Ph.D., *Assistant Professor of Psychology, Department of Psychiatry, Yale University School of Medicine, Community Mental Health Center, 34 Park Street, Room 144, New Haven, CT 06519*; Allison N. Ponce, Ph.D., *Associate Director, Community Services Network, Yale University, 34 Park Street, Room 144, New Haven, CT 06519*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should possess useful information on the development and implementation of an innovative, residential-based community re-integration program for individuals being discharged from long-term state psychiatric hospitals in Connecticut and develop an appreciation of some of the many challenges associated with this program model.

SUMMARY:

Supported housing, both permanent and transitional models, has increasingly become the preferred housing approach for persons living with serious mental illnesses and over the last two decades has enabled thousands of individuals to be discharged from long-stay state psychiatric hospitals into the community (Kidd, Styron, Carlson & Hoge, 2004; Rog, 2004). There remains, however, a cohort of long-term patients with particularly complex needs for whom more standard forms of supported housing may not work, thereby limiting their opportunity to return to the community. The Park Street Inn (PSI) is a 15-bed residential living center in New Haven, Connecticut that opened its doors in 2005 with the goal of meeting the needs of this cohort of individuals.

A multidisciplinary collaboration between several organizational entities, including the State of Connecticut and the Yale University School of Medicine, Department of Psychiatry, the PSI offers a comprehensive, interdisciplinary, person-centered approach to each individual's recovery process and integrates clinical, medical, and recovery services, residential case management, and educational and vocational training with peer and natural supports. The program is designed to meet the needs of persons who have not previously been able to access the appropriate combination of resources in the community and require a high level of support to assist them in developing fundamental skills that will allow them to return to their community of origin or community of choice.

TARGET AUDIENCE(S):

Individuals who are engaged in providing or interested in learning more about community-based services for people with severe mental illnesses.

REFERENCES:

1. Rog, D. The evidence on supported housing. *Psychiatric Rehabilitation Journal* 2004; 27, 334-344.
2. Kidd, S., Styron, T., Carlson, S., & Hoge, M. The development of decision tools for residential utilization management: A critical review of the literature. *Administration and Policy in Mental Health* 2004; 31, 435-448.

**Innovative Program 38 Sunday, October 8
10:00 a.m.-11:30 a.m.**

CREATING A FAMILY-LIKE SOCIAL ENVIRONMENT IN SUPPORTIVE HOUSING PROGRAMS

Elizabeth Spring, R.N., M.S., *Washtenaw County Community Support and Treatment Services, 3981 Varsity, Ann Arbor, MI 48108*; Michelle C. Shauger, M.D.,

Washtenaw County Community Support and Treatment Services, 3981 Varsity, Ann Arbor, MI 48108; Daniel J. Healy, M.D.; Kelley Lee, O.T.

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to define the psycho-educational model and treatment components; discover how a family-like social environment improves treatment outcomes and quality of life for adults with schizophrenia; establish this model in supportive housing programs in communities; and recognize the feasibility and effectiveness of this treatment.

SUMMARY:

Adults with schizophrenia who cannot live alone or with family may live in supportive housing programs (SHP). These housing arrangements present challenges that directly impact treatment outcomes and quality of life for residents. In some programs, residents may experience insufficient stimulation with custodial care and low expectations. Residents in other programs may be affected by too much stimulation with too many demands. In either situation there is a risk of unfavorable relationships between staff and residents. Consequently, interactions and communication become confrontational, controlling and punitive. The problematic behaviors that families encounter are prevalent among SHP staff. A delicate balance exists between placing too many demands on residents' verses too few. In 2003, Washtenaw County implemented a model that creates a Family-Like Social Environment in SHP that trains staff in the principles and practices of psychoeducation. This psychoeducational model, originally developed for adults with schizophrenia and their families, is a suitable approach for SHP. The treatment model, developed by Dr. William McFarlane and his staff, utilizes psychoeducational principles with elements of a behavioral approach, primarily focused on problem solving and communication skills. This model provides a framework for creating an optimal social environment for recovery and rehabilitation.

TARGET AUDIENCE(S):

Individuals either working in or have an interest in learning more about community mental health agencies.

REFERENCES:

1. McFarlane, W. (2002). *Multifamily groups in the treatment of severe psychiatric disorders*. The Guilford Press: New York and London.
2. McFarlane, W., Lukens, E., Link, B., Dushay, R., Deakins, S., Newmark, M., Dunne, E., Horen, B., Toran, J. (1995). Multiple-family groups and psychoeducation in the treatment of schizophrenia. *Arch Gen Psychiatry*. 52.

Lecture 1

Thursday, October 5
8:00 a.m.-9:30 a.m.

THE PUBLIC HEALTH CHALLENGE FOR PSYCHIATRY

Neal L. Cohen, M.D., *Associate Clinical Professor of Psychiatry, Mt. Sinai School of Medicine; and Former Commissioner, New York City Department of Mental Health, 29 East 22nd Street, New York, NY 10010-5303*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to recognize the burden of mental illness on health and productivity in the United States and worldwide; and understand the value of a public mental health model that focuses not solely on traditional areas of diagnosis, treatment, and etiology, but also on epidemiological mental health surveillance, mental health promotion, and mental illness prevention.

SUMMARY:

Increasingly, 21st century public health policy and practice is moving toward an agenda that addresses highly prevalent and insidious but non-fatal disorders (e.g. heart disease, strokes, cancer, diabetes) including the huge impact that mental illnesses have on individuals and society as a whole. Additionally, the nation has paid insufficient attention to the connections between mental and physical disorders and how that relationship affects morbidity and mortality.

Building on the groundbreaking reports of the Surgeon General in 1999, any effort to make mental illness an integral part of the nation's public health agenda needs to focus on confronting problems like suicide, depression and anxiety, and the mental health challenges that emerge at specific stages of the life span. Dr. Cohen calls upon psychiatry to assume leadership in advancing the evidence-base that will support public mental health focus within the mainstream of public health practice.

REFERENCES:

1. Cohen, N. & Perl, S. (2003). Integrating behavioral health and social science into a public health agency: a case study of New York City. *Journal of Urban Health*, 80(4), 608–615.
2. United States Public Health Service (1999). *Mental health: A report of the Surgeon General*. Washington, DC.

Lecture 2

Thursday, October 5
10:00 a.m.-11:30 a.m.

BEHAVIORAL GENETICS AND THE PREVENTION AND PUNISHMENT OF CRIME

Paul S. Appelbaum, M.D., *Past President, American Psychiatric Association; Professor of Psychiatry, and*

Director, Division of Psychiatry, Law, and Ethics, Department of Psychiatry, Columbia University College of Physicians and Surgeons, 1051 Riverside Drive, #122, New York, NY 10032-1007

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to understand recent advances in behavioral genetics that relate to antisocial behavior, and their potential implications for adjudication of criminal behavior and preventive interventions.

SUMMARY:

Genetic contributions to behavior have been recognized increasingly in recent years. Most behaviors are likely to be influenced by interactions between genetic and environmental factors, with multiple genes each contributing only small portions of the variance. A striking example comes from findings linking low levels of the enzyme monoamine oxidase A to antisocial behaviors, but only when the person has experienced abuse as a child. In response, it has been suggested that genetic determinants that reduce appreciation of wrongfulness or ability to control behavior should excuse criminal defendants from responsibility for their crimes, or at least lead to mitigation of sentences. Moreover, the genetic findings raise the possibility of early screening to identify persons at increased risk of later criminality, with the double-edged potential for effective interventions and negative stigmatization. Pressure to reduce individual culpability and to screen preventively will increase as effective treatment and prophylactic interventions become available.

REFERENCES:

1. Caspi A, McClay J, Moffitt TE, et al. Role of genotype in the cycle of violence in maltreated children. *Science* 2002; 297:851–854.
2. Appelbaum PS: Behavioral genetics and the punishment of crime. *Psychiatric Services* 2005; 56:25–27.

Lecture 3

Thursday, October 5
10:00 a.m.-11:30 a.m.

THE ANTI-SCREENING MOVEMENT: DECODING THE POLICY AND POLEMICS

Laurie M. Flynn, *Director, Carmel Hill Center, and Department of Psychiatry, Columbia University, 1775 Broadway, Suite 715, New York, NY 10019*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture the participant should be able to: 1) Recognize the problems of untreated mental illness and youth suicide, and be able to identify a variety of ways mental health screening can be easily

implemented in a variety of settings; 2) Understand the history of the TeenScreen Program and the rationale for screening, the research that supports the TeenScreen Program and the way mental health screening works through TeenScreen's screening process; 3) Recognize growing federal, state, and national support for mental health screening and the TeenScreen Program; 4) Demonstrate their understanding of the screening instruments that are available to our local screening sites; 5) Explore strategies through group discussion to take the necessary steps to bring the TeenScreen Programs to their communities, practices, schools, etc.; and 6) Identify the many ways mental health professionals can support TeenScreen Programs in their community and incorporate screening into their own practices.

SUMMARY:

The objective of this presentation is to review current national efforts to move the field of youth suicide prevention and early identification of mental illness from science to service, through the use of public policy efforts and strategies. Topics to be addressed are: 1) Historical perspective on suicide prevention policies and legislation; 2) Review of the current policy and political environment; 3) The national screening program, the Columbia University TeenScreen Program, to promote the public policy effort of suicide prevention; and 4) Campaign-oriented approach to moving suicide prevention and mental health screening from research to national implementation.

REFERENCES:

1. Scott M, Shaffer D, Wilcox H (2004). The Columbia Suicide Screen: Does Screening Identify New Teens at Risk? American Association of Child and Adolescent Psychiatry. Poster Presentation, Washington, DC.
2. Shaffer D, Scott M, Wilcox H, Maslow C, Lucas C, Garfinkel R & Greenwald S (2004). The Columbia SuicideScreen: Validity and reliability of a screen for youth suicide and depression. *The Journal of the American Academy of Child and Adolescent Psychiatry*, 43, 71–79.
3. New Freedom Commission on Mental Health (2003). *Achieving the Promise: Transforming Mental Health Care in America*. Final Report. DHHS Pub No. SMA_03-3832. Rockville, MD.
4. The Carmel Hill Center for Early Diagnosis and Treatment. (2003). *Catch Them Before They Fall: How To Implement Mental Health Screening Programs for Youth as Recommended by the President's New Freedom Commission on Mental Health*.
5. Satcher D (2001). *The National Action Agenda on Children's Mental Health*. www.surgeongeneral.gov/cmh/.

6. Satcher D (1999). The Surgeon General's Call To Action to Prevent Suicide. <http://www.surgeongeneral.gov/library/calltoaction/default.htm>.
7. Shaffer D, Gould M, Fisher P, Trautman P, Moreau D, Kleinman M, and Flory, M. (1996). Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry*; 53:339–348.

Lecture 4

Thursday, October 5
1:30 p.m.-3:00 p.m.

SERVICES AND SCIENCE: SHALL THE TWAIN EVER MEET?

Bernard S. Arons, M.D., *Executive Director, and Chief Executive Officer, National Development and Research Institutes, Inc., 2827 27th Street, N.W., Washington, DC 20008-4129*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should learn about examples of successes of generative interaction of science and services; identify the significant barriers to enhanced interaction of science and services; and learn about three or more immediate actions that would leap over the barriers.

SUMMARY:

Great emphasis is being placed in the behavioral health field on implementation of evidence-based practices, the importance of science in establishing the efficacy and effectiveness of interventions, and the need to stop practices that are not supported by peer reviewed research. This lecture will explore past attempts to address these topics, present programs, barriers to successful integration of science and services and specific steps to overcome those barriers. The role of public and private providers, State and Federal governmental entities, funders, professional guilds, and educational institutions will be analyzed. What is needed and why will be the focus of the discussion period following the lecture.

REFERENCES:

1. Hyde PS, et al., *Turning Knowledge into Practice: A Manual for Behavioral Health Administrators and Practitioners About Understanding and Implementing Evidence-Based Practices*, The Technical Assistance Collaborative, Inc.
2. Sharfstein S: *The Loss of Federal Support for Multisite Demonstrations*. *Psychiatric Services* 56:1185, 2005.

Lecture 5

Thursday, October 5
1:30 p.m.-3:00 p.m.

FUROR THERAPEUTICUS: BENJAMIN RUSH AND THE YELLOW FEVER EPIDEMIC

APA's Benjamin Rush Award

Leon Eisenberg, M.D., *Department of Psychiatry, Harvard University, 9 Clement Circle, Cambridge, MA 02138-2205*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to recognize the importance of an evidence-base for clinical practice; and identify the limitations of outcome measures.

SUMMARY:

In 1793, Philadelphia was engulfed in an epidemic of yellow fever; more than one-third of the population of 50,000 fled to the surrounding countryside; doctors were among those who took flight. From illness and defection, only three physicians were left to treat more than 6,000 cases. After dispatching his wife and children to a safe place, Dr. Rush remained to fill his medical duties. Rush's desperate remedies (bleeding and purging) may have been more fatal to patients than the disease itself. In this episode, we see that devotion to his patients and personal courage were rendered dangerous to public health by his furor therapeutics. In this extreme instance, what cautionary lessons are there for contemporary medical practice.

REFERENCES:

1. Middleton WS (1928) The yellow fever epidemic of 1793 in Philadelphia. *Annals of Medical History* 10:434-450.
2. Eisenberg L (2000) Is psychiatry more mindful or brainier than it was a decade ago? *British Journal of Psychiatry* 176:1-5.

Lecture 6

Thursday, October 5
3:30 p.m.-5:00 p.m.

PREPARE, EDUCATE, EVALUATE: LESSONS FROM A COMMUNITY AGENCY'S FOCUS ON TRAUMA

Paula G. Panzer, M.D., *Associate Director, Center for Trauma Innovation, Jewish Board of Family and Children's Services, and Former Chair, APA/IPS Scientific Program Committee, 142 West End Avenue, Apt. 1-S, New York, NY 10023-6115*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to describe methods for dissemination of trauma informed Evidence-Based Practices relevant to the community.

SUMMARY:

Despite the availability of evidence-based and evidence-informed practices for Post-Traumatic Stress Disorder in adults and children, community agency practice does not usually reflect the methods treatment created in small research settings. Learning collaboratives that address issues of reluctance and access to emerging evidence practices among community agencies are a promising method of ensuring the adaptation and fidelity of Evidence-Based Practices (EBPs). This presentation will highlight the efforts of the Center for Trauma Program Innovation to develop a partnership for system change in conjunction with the National Child Traumatic Stress Network. Areas to be covered include: (1) leadership buy-in and system readiness; (2) clinician education in evidence-informed systems of care for complex trauma in children and teens; (3) careful service modifications to meet the specific communities' need while with attention to treatment fidelity; and (4) program monitoring and evaluation. Lessons learned from this ongoing work will be described.

REFERENCES:

1. Spinazzola, J., Blaustein, M. & van der Kolk, B. (2005) Posttraumatic Stress Disorder Treatment Outcome Research: The Study of Unrepresentative Samples? *Journal of Traumatic Stress*, 18, 425-436.
2. Greenhalgh, T. et al. (2004) Diffusion of Innovations in Service Organizations: Systematic Review and Recommendations. *The Milbank Quarterly*, 82(4).
3. Institute for Health Care Improvement, (1997) *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement*. Boston, MA.

Lecture 7

Friday, October 6
8:00 a.m.-9:30 a.m.

MEETING THE MENTAL HEALTH NEEDS OF NEW YORK CITY

Lloyd I. Sederer, M.D., *Executive Deputy Commissioner, Mental Hygiene Services, New York Department of Mental Health and Mental Hygiene, 93 Worth Street, New York, NY 10013*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to understand how the largest municipal mental health agency in this country works by a description of

the specific functions of the agency and how it goes about performing those functions.

SUMMARY:

This lecture will describe the role of the mental hygiene component of the Department of Health and Mental Hygiene in meeting the mental health needs of New York City. Core agency functions of service planning, purchasing and quality monitoring for mental health, addictions, and mental retardation/developmental disability services throughout the five boroughs will be described. Currently, our work directly reaches over 450,000 New Yorkers.

The lecture will also describe what we call public mental health initiatives where we identify populations for intervention by either gaps in service or major opportunities for improvement, such that we can have a major impact on the mental health of this city. Examples include our work in depression screening and management in primary care and interventions we have introduced for controlling opioid addiction and problem drinking.

REFERENCES:

1. Santora, M. and Carey, B. (2005, April 13). Depressed? New York Screens for People at Risk. *The New York Times*, pp A1, A16.
2. Psych Services editorial by Sederer and Kolodny.

Lecture 8

**Friday, October 6
8:00 a.m.-9:30 a.m.**

BECOMING A RECOVERY-ORIENTED PSYCHIATRIST

Mark Ragins, M.D., *Medical Director, Village Integrated Services, 456 Elm Avenue, Long Beach, CA 90802-2426*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to understand a four-stage development model of recovery analogous to Kubler-Ross' death and dying model; understand the practice and programmatic implications of moving from a medical model to a recovery model; and understand the personnel growth and changes involved in becoming a recovery worker.

SUMMARY:

In this lecture, a four-stage development model of recovery (hope, empowerment, self-responsibility and meaningful roles) will be described. A recovery model is being pushed in many places around the country especially by consumer and rehabilitation groups. This lecture focuses on personal and practice changes psychiatrists and other clinicians can make to become a vital, integral part of recovery-oriented services.

I will be using many stories from my work as a psychiatrist at the Village, one of the foremost recovery-oriented programs in the country, to illustrate the recovery process. I will try to combine both the "inspiration" and the "perspiration" of recovery work. My focus will be on the personal aspects of the work (e.g. reducing professional distance, taking on multiple roles, being empowering, lowering boundaries, promoting risk taking), rather than the administrative aspects.

REFERENCES:

1. Deegan, Patricia. Recovery as a Journey of the Heart. *Psychiatric Rehabilitation Journal*. 1996, 19(3).
2. Harding, Courtenay, et.al. The Vermont Longitudinal Study of Persons with Severe Mental Illness. *American Journal of Psychiatry*, 1987, 144:718-726.

Lecture 9

**Friday, October 6
10:00 a.m.-11:30 a.m.**

ANTIDEPRESSANT MEDICATION AND SUICIDALITY

Health Services Research Track

Mark Olfson, M.D., M.P.H., *Clinical Professor of Psychiatry, Columbia University, 605 Second Street, Brooklyn, NY 11215*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to describe the basic epidemiology of suicide and attempted suicide for children and adults; describe the clinical and epidemiological evidence that antidepressants contribute to an increase in suicide risk in vulnerable patients; and describe the epidemiological evidence that antidepressant use has contributed to an overall decline in suicide.

SUMMARY:

Suicide and suicide attempts, which commonly occur in the context of depressive disorders, present important clinical and public health challenges. Despite the availability of efficacious antidepressant medications, clinical and epidemiological research studies using a variety of methods have yielded mixed and conflicting findings concerning whether these medications help to protect or exacerbate young people and adults from engaging in suicidal behavior. A review will be presented of the basic epidemiology of suicidal behavior in adults and children including known clinical risk and protective factors. This will be followed by a summary and critical assessment of recent key research on the complex association between antidepressant treatment and risk of attempted and completed suicide. The review will highlight promises and pitfalls of various methodological

approaches to this question and offer suggestions for future research directions.

REFERENCES:

1. Olfson M, Shaffer D, Marcus SC, Greenberg T: Relationship of antidepressant medication use to suicide in adolescents. *Arch Gen Psychiatry* 2003; 60:978–982.
2. Olfson M, Marcus SC, Shaffer D: A case control study of antidepressants and suicide in severely depressed children and adults. *Arch Gen Psychiatry* (In Press).

Lecture 10

Friday, October 6
1:30 p.m.-3:00 p.m.

COLLATERAL DAMAGE IN THE WAR ON DRUGS

Sanho Tree, B.A., *Director, Drug Policy Project, Institute for Policy Studies, Washington, DC, 1112 16th Street, N.W., Suite 600, Washington, DC 20036*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to understand the dilemmas that public officials face in trying to combat the war on drugs.

SUMMARY:

This lecture will address the inherent limits and contradictions of our current drug eradication and interdiction policies and show how this is a demand driven problem. The roots of this problem have more to do with issues of poverty, despair, and alienation than with the current scapegoating of “narco-terrorists”. Finally, I will illustrate how these policies play out in the political realm and show why elected officials continue to vote for policies which they privately admit will never work.

REFERENCES:

1. Tree, Sanho. *The War at Home*, May-June 2003 issue of *Sojourners*.
2. Bickel, Warren K., *Drug Policy and Human Nature: Psychological Perspectives on the Prevention, Management and War on Drugs*.

Lecture 11

Friday, October 6
1:30 p.m.-3:00 p.m.

COMPARATIVE EFFECTIVENESS OF ANTIPSYCHOTIC DRUGS: RESULTS OF THE NIMH-CATIE STUDY

Jeffrey A. Lieberman, M.D., *Chair, Department of Psychiatry, College of Physicians and Surgeons, Columbia University; Director, New York State Psychiatric Insti-*

tute; and Director, Lieber Center for Schizophrenia Research, 455 Central Park West, Apt. 9-C, New York, NY 10025-3850

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to understand the historical background related to the development and use of antipsychotics in the treatment of schizophrenia and particularly as it pertains to first generation antipsychotic drugs (FGAs) introduced in the 1950’s and second generation drugs (SGAs) introduced in the 1990’s.

SUMMARY:

Since their introduction in the 1950’s, antipsychotic drugs have become the cornerstone of the treatment of schizophrenia and related psychotic disorders. A second generation of (atypical) antipsychotic drugs (SGA) was introduced in the 1990s that is now preferentially utilized by clinicians and accounts for the vast majority of prescriptions for treating schizophrenia in the United States. The increased use of SGA drugs has resulted in a substantial increase in the amount of money spent on this class of medications in the U.S. with costs of over 10 billion in 2005. The popularity of SGA’s derives from the assumption that they are more effective and safer. However, the relative effectiveness of these new drugs to each other is not fully known, and they have not been definitively proven more effective than the first generation of antipsychotic drugs (FGAs).

To address this question the National Institute of Mental Health initiated the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) program to evaluate the effectiveness of antipsychotic drugs in typical settings and populations so that the study results will be maximally useful in routine clinical situations. The CATIE schizophrenia trial blends features of efficacy studies and large, simple trials to create a pragmatic trial that will provide extensive information about antipsychotic drug effectiveness over at least 18 months. The protocol allows for subjects who receive a study drug that is not effective to receive subsequent treatments within the context of the study. Medication dosages are adjusted within a defined range according to clinical judgment. The primary outcome was all-cause treatment discontinuation because it represented an important clinical endpoint that reflects both clinician and patient judgments about efficacy and tolerability. Secondary outcomes included symptoms, side effects, neurocognitive functioning, and cost effectiveness. Approximately 50 clinical sites across the United States enrolled a total of 1,500 persons with schizophrenia. Phase I was a double-blinded, randomized clinical trial comparing treatment with the second generation antipsychotics olanzapine, quetiapine, risperidone, and ziprasidone to perphenazine, a midpotency first generation antipsychotic. If the

initially assigned medication was not effective, subjects could choose one of the following phase II trials: (1) randomization to open-label clozapine or a double-blinded second generation drug that was available but not assigned in phase I; or (2) double-blinded randomization to ziprasidone or another second generation drug that was available but not assigned in phase I. If the phase 2 study drug was discontinued, subjects could enter phase III, in which clinicians help subjects select an open-label treatment based on individuals' experiences in phases I and II. The initial efficacy and safety results of phases I and II of the trial have been reported (Lieberman et. al. 2005, Stroup et. al. 2006, McEvoy et. al. 2006).

The results of the CATIE study provide the most comprehensive set of data on the pharmacologic treatment of schizophrenia ever assembled. These will guide all doctors in their selection of treatments and clinical management of individual patients. This is because no study has ever examined all marketed drugs in a controlled fashion in this large a number of patients for such a long time period using such extensive measures of efficacy and safety, much less with cost data.

The findings of the CATIE study indicate that these medications work (which we knew from prior research), but also that they have substantial limitations. This is indicated by the fact that 74% of patients elected with their doctors to seek something better, rather than stay on their assigned medication. What this means is that when it comes to the treatment of patients with chronic schizophrenia "the glass is *only* half full". Although the treatments work, patients and their doctors are looking for more, in the way of symptom relief and to enable recovery, and they want this at a lower cost than the side effects that current treatments impose.

The study revealed that all the drugs worked comparably well. Olanzapine, was somewhat better on measures of therapeutic efficacy but it also had the most side effects of weight gain and changes in glucose and lipid metabolism. The biggest surprise of the study was that the older medication, perphenazine, was comparably effective to at least three of the new medications and not much worse than the new drug which did the best, olanzapine. Contrary to expectations, the older medication also did not cause substantially more neurologic side effects than the new drugs. We believe that this is due to the fact that we administered a lower potency APD at moderate doses. Despite, the overall comparability of the treatments, there was variation in the therapeutic and side effects of the antipsychotic drugs which, although not clearly apparent comparing the large groups of patients, can be substantial for individual patients.

In Phase II for patients who discontinued their Phase I medication due to lack of symptom control and went into the clozapine pathway, clozapine was substantially better than all the other atypical medications. The partici-

pants taking clozapine remained on it for an average of ten months compared to an average of three months for those taking any of the three other medications. Those taking clozapine also had greater symptom reduction than those who took any of the other medications.

In Phase II for patients who discontinued their Phase I medication and went into the ziprasidone pathway, it was important to examine the results in phase II separately for those participants who had stopped their phase II medication for different reasons. For those who had stopped phase II medication due to inadequate control of psychotic symptoms, those taking olanzapine or risperidone in phase II stayed on their medication for a significantly longer duration than those taking quetiapine or ziprasidone, results that are similar to the overall results above. However, for the participants who had stopped phase I medication due to side effects, there were no significant differences among the four phase II medications. Thus, which medication works best depends in large part on why a patient was switched to it.

Doctors now have more information to guide the selection of the next antipsychotic medication to try in treating people with schizophrenia if treatment with a first antipsychotic is not successful. The results have shown that the reason why the first medication was stopped is an important consideration in choosing the next medication. Specifically, the success of symptom control and side effects experienced by the patient on the first medication may help predict which medication may be more successful next. The CATIE results show that for patients whose symptoms are not wholly responsive to other antipsychotic medications, clozapine is an effective choice for the next step.

Even with increased support for the use of clozapine, there will still be numbers of patients who need a medication change because their symptoms are not under control who will not want to try clozapine. For those patients, CATIE phase 2 results show that olanzapine and risperidone are more effective than ziprasidone and quetiapine, but side effects must be considered.

For patients who stop their first medication because of side effects, the best strategy is to avoid drugs which are most likely to cause the previously experienced side effects. Olanzapine was associated with substantial weight gain and metabolic problems, more so than the other medications. Ziprasidone was consistently associated with reduction in weight and improvement in metabolic indicators.

REFERENCES:

1. Lieberman JA, Stroup TS, McEvoy JP, Swartz MS, Rosenheck RA, Perkins DO, Keefe RS, Davis SM, Davis CE, Lebowitz BD, Severe J, Hsiao JK: Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. *N Engl J Med* 2005; 353(12):1209–23.

2. McEvoy JP, Lieberman JA, Stroup TS, Davis SM, Meltzer HY, Rosenheck RA, Swartz MS, Perkins DO, Keefe RSE, Davis CE, Severe J, Hsiao JK, for the CATIE Investigators. Effectiveness of Clozapine Versus Olanzapine, Quetiapine, and Risperidone in Patients With Chronic Schizophrenia Who Did Not Respond to Prior Atypical Antipsychotic Treatment. *Am J Psychiatry* 163: 600–610, 2006.
3. Stroup TS, Lieberman JA, McEvoy JP, Swartz MS, Davis SM, Rosenheck RA, Perkins DO, Keefe RSE, Davis CE, Severe J, Hsiao JK, for the CATIE investigators. Effectiveness of Olanzapine, Quetiapine, Risperidone and Ziprasidone in Patients With Chronic Schizophrenia Following Discontinuation of a Previous Atypical Antipsychotic. *Am J Psychiatry* 163: 611–622, 2006.

Lecture 12

**Friday, October 6
1:30 p.m.-3:00 p.m.**

TRAUMA AND RECOVERY: LEARNING AND DOING

A. Kathryn Power, M.Ed., *Director, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 5600 Fishers Lane, Rockville, MD 20857*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to recognize the importance of understanding and treating violence, trauma, and the effects of abuse in women.

SUMMARY:

In this lecture the importance of violence, trauma, and abuse in women's lives will be highlighted. Violence and trauma is far more prevalent than commonly understood, and there is a disconnect between the prevalence of trauma and its recognition in the health, mental health, and substance abuse provider communities. The relationship between trauma and mental health and substance abuse problems is a critical one for providers to identify and treat, and many new individual and community models for integrated trauma counseling have been developed that have been demonstrated to facilitate recovery. The essential features in trauma integrated counseling will be featured in terms of their support for the process of recovery in women's lives. The revitalization that comes with changing the role of service providers in this new paradigm will be presented.

REFERENCES:

1. Akhtar, S. (Ed.) (2001). *Three Faces of Mourning*. Northvale, NJ: Jason Aronson.

2. Barton, A. (1989). *Communities in Disaster*. New York, NY: Doubleday.
3. Roberts, A. (Ed., 2003) *Trauma and Life Stories*. New York, NY: Routledge.

Lecture 13

**Saturday, October 7
8:00 a.m.-9:30 a.m.**

LESBIAN AND GAY FAMILIES

*Association of Gay and Lesbian Psychiatrists
Track*

Ellen Haller, M.D., *Adjunct Professor of Psychiatry, University of California at San Francisco, 401 Parnassus Avenue, San Francisco, CA 94122-2720*; Susan C. Vaughan, M.D., *Assistant Professor of Clinical Psychiatry, Columbia University College of Physicians and Surgeons, 25 West 81st Street, # 1-C, New York, NY 10024-6023*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to understand some of the diversity of pathways for creating families; gain knowledge about how lesbians decide to become pregnant; be familiar with the impact of parenting on the dynamics of a lesbian relationship; learn about myths and stereotypes regarding gay and lesbian parents; and be aware of the evidence in the published literature that refutes these beliefs.

SUMMARY:

Some politicians, conservative organizations, and citizens are quite vocal about their opposition to gay men and lesbians being parents. They believe that children will be harmed somehow if raised by these parents, yet the published scientific literature clearly demonstrates that what matters most to a child's healthy development is the way that child is parented rather than the gender, number or sexual orientation of his or her parents. A growing body of literature addressing these issues has been published in recent years as a "gayby" boom has been happening in the gay and lesbian communities. In this presentation, Dr. Haller will summarize the published literature which refutes myths and stereotypes about the children of gay and lesbian parents.

REFERENCES:

1. Stacey J and Biblarz TJ: (How) Does the Sexual Orientation of Parents Matter? *American Sociological Review*. 2001 Apr; 66, No. (2):159–183.
2. Tasker F: Lesbian mothers, gay fathers, and their children: a review. *J Dev Behav Pediatr*. 2005 Jun; 26(3):224–40.

Lecture 14

**Saturday, October 7
8:00 a.m.-9:30 a.m.**

**DO WE REALLY NEED ANOTHER
SUBSPECIALTY? PSYCHOSOMATIC
MEDICINE: WHAT IS IT AND WHAT
ABOUT THE NAME?**

Thomas N. Wise, M.D., *President and Chair, Board of Directors, American Psychiatric Press, Inc.; and Professor of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, 3300 Gallows Road, Falls Church, VA 22042-3307*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to define the psychiatry subspecialty of Psychosomatic Medicine in terms of clinical and research activities; and review the history of consultation psychiatry as an outgrowth of general hospital psychiatry.

SUMMARY:

Psychosomatic Medicine is the newest subspecialty of psychiatry that has been formally endorsed by the American Board of Medical Specialties and the American Board of Psychiatry and Neurology. This area of psychiatry focuses upon the medically ill, those that think they are medically ill (the somatoform disorders) and medical setting with increasing use of complex technology. It has been previously labelled consultation-liaison psychiatry. The presentation will review the path to formal recognition of Psychosomatic Medicine, as well as the historical roots of both psychosomatics and consultation psychiatry which differ from each other. The lecture will conclude with predictions for the future of this field.

REFERENCES:

1. Lipowski ZJ. Consultation-liaison psychiatry at century's end. *Psychosomatics*. 1992 Spring; 33(2): 128-33.
2. Sollner W, Diefenbacher A, Creed F. Future developments in consultation-liaison psychiatry and psychosomatics. *J Psychosom Res*. 2005 Jan; 58(1):111-2.

Lecture 15

**Saturday, October 7
10:00 a.m.-11:30 a.m.**

**THE EVOLUTION OF PSYCHOSOCIAL
TREATMENT FOR SCHIZOPHRENIA**

APA/APF Alexander Gralnick, M.D., Award for Research in Schizophrenia

Gerard E. Hogarty, M.S.W., (*deceased*) *Emeritus Professor of Psychiatry, Western Psychiatric Institute and Clinic, 2949 Skyline Drive, Allison Park, PA 15101;*

Shaun M. Eack, M.S.W., *Social Work Doctoral Student, University of Pittsburgh, 6001 Saint Marie Street, Apt. 122, Pittsburgh, PA 15206*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture the participant should be able to gain an appreciation of the evolution of psychosocial treatments for schizophrenia, from early treatments based on atheoretical principles to those based on psychosocial biological findings; and understand the methods of Cognitive Enhancement Therapy and the effects of this developmental approach on neurocognitive and social-cognitive functioning in schizophrenia.

SUMMARY:

Psychosocial treatment has evolved from an atheoretical, altruistic form of caring to clinical practice principles reflect an emerging pathophysiology. Our research initiatives demonstrate this transition from Major Role Therapy (case management), Family Psychoeducation, and Personal Therapy to the development and testing of Cognitive Enhancement Therapy (CET). The latter is a performance-based attempt to improve social and neurocognition using a small group curriculum (45 sessions) and 60 hours of computer-oriented training in attention, memory, and problem-solving.

Efficacy among persistently ill persons with schizophrenia has been comprehensive and enduring, with speed of processing arising as a key mediator of CET effects. Preliminary results in an ongoing study of early course patients are showing CET related improvement in brain structure and function, as well as emotional intelligence. The need to implement these efficacious psychosocial treatments in schizophrenia has now become a moral imperative.

REFERENCES:

1. Hogarty GE, Flesher S, Ulrich R, et al: Cognitive enhancement therapy for schizophrenia: effects of a 2-year randomized trial on cognition and behavior. *Archives of General Psychiatry* 61:866-876, 2004.
2. Hogarty GE, Greenwald DP: *Cognitive Enhancement Therapy: The Training Manual*. University of Pittsburgh Medical Center: Authors. Available through www.CognitiveEnhancementTherapy.com.

Lecture 16

**Saturday, October 7
1:30 p.m.-3:00 p.m.**

**PROSPECTS FOR PSYCHIATRIC CARE IN
THE FUTURE**

Herbert Pardes, M.D., *Former President, American Psychiatric Association; and President and Chief Executive Officer, New York Presbyterian/Columbia Hospital, 161*

Fort Washington Avenue, 14th Floor, New York, NY 10032-3713

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to illuminate the implications of government support versus market focus on mental health care; review how psychopharmacological care will fare with tougher scrutiny and reservations regarding the number of people who genuinely benefit from pharmacological care; develop an understanding of what the current political perspective will mean for the care of the chronically mentally ill; and elaborate how the prevailing culture will impact the nature of mental health manpower and education of psychiatrists.

SUMMARY:

Psychiatric care is inevitably influenced by prevailing politics. Psychiatric care has been continually buffeted due to quite different attitudes regarding its significance by federal and state governments.

The United States has moved more toward a market approach to health care. Government support has been under siege. Greater consumer literacy and increased government and public scrutiny regarding psychopharmacology have caused questions regarding the utility of medications.

This is in the context of continued ratcheting down of state facilities nationally and relentless pressure from managed care on dollars for mental health care.

What will be the collective impact on psychiatric care? How can the field marshal efforts to promote optimum care? What is the resulting effect on education and manpower for psychiatric care given movement toward greater market and less government dominance?

This presentation will review these issues and recommend actions to insure the best interests of patients with psychiatric problems.

REFERENCES:

1. Pardes, H.: Psychiatry's Remarkable Journey: The Past 40 Years. *Psychiatric Services*, 54:896-901, 2003.
2. Yedidia, M., Gillespie, C., Bernstein, C.: A Survey of Psychiatric Residency Directors on Current Priorities and Preparation for Public-Sector Care. *Psychiatric Services*, 57:238-243, 2006.

Lecture 17

Saturday, October 7
1:30 p.m.-3:00 p.m.

GAY, PROUD, AND HEALTHY: FROM HERESY TO HUMDRUM

APA's John E. Fryer, M.D., Award and the Association of Gay and Lesbian Psychiatrists Track

Barbara Gittings, *Gay Rights Activist*, 1301 North Harrison Street, Wilmington, DE 19806; Franklin E. Ka-

meny, Ph.D., *Gay Rights Activist*, 5020 Cathedral Avenue, N.W., Washington, DC 20016

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to understand the early gay-rights work and describe how this work has progressed over the past forty years.

SUMMARY:

The sickness label bedevils early gay-rights work. Confrontations begin; gays picket psychiatrist's 1964 public lecture "Homosexuality: A Disease." Gay psychiatrists stay invisible. Activists disrupt 1970 APA session on aversion therapy. APA opens door with 1971 "Lifestyles of Non-Patient Homosexuals." In 1972 APA dialogue on "Psychiatry: Friend or Foe to Homosexuals?" A gay panelist urges adding a gay psychiatrist—if one will appear. Nationwide hunt. Only Dr. H. Anonymous is willing—wearing a mask. He stuns a big APA audience. Gay-run exhibit at same conference shows gay people as normal and happy. Behind scenes, *DSM* committee considers de-listing homosexuality as a mental disorder. Effecting the "cure" in 1973-1974. Some outmoded attitudes linger. Continuing education: fourth gay exhibit (1978) features photos, credentials of five gay psychiatrists. Outside activists bow out. Lesbian and gay psychiatrists now open and organized. APA as potential ally. Honoring John Fryer, "Dr. H. Anonymous."

REFERENCES:

1. Bayer, Ronald. *Homosexuality and American Psychiatry: The Politics of Diagnosis*. New York: Basic Books, 1981.
2. Scasta, David L. MD. "John E. Fryer, MD, and the Dr. H. Anonymous Episode." *Journal of Gay and Lesbian Psychotherapy*, Vol. 6 (4) 2002, pp. 73-84.
3. Weinberg, George. *Society and the Healthy Homosexual*. New York: St. Martins Press, 1972.

Lecture 18

Saturday, October 7
3:30 p.m.-5:00 p.m.

PSYCHIATRY IN THE NEXT MILLENNIUM

APA/NIMH Vestermark Psychiatry Educator Award

Charles B. Nemeroff, M.D., Ph.D., *Reunette W. Harris Professor and Chair, Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine*, 1639 Pierce Drive, #4000, Atlanta, GA 30322

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to understand the mechanism of action of currently used medications to treat psychiatric disorders; list the principles of human genetics in the development of new psychiatric drugs and predictors of treatment response; and recognize how functional brain imaging helps define pathophysiology of psychiatric disorders.

SUMMARY:

Over the past several years, remarkable advances have been made both in our understanding of the central nervous system (CNS) and in the pathophysiology of the major psychiatric disorders, resulting in major breakthroughs in our capacity to treat these devastating illnesses. Since the seminal work of Ramon Y Cajal and Golgi at the turn of the century, new techniques such as fluorescence histochemistry have evolved into immunohistochemistry and more recently *in situ* hybridization. These techniques have permitted, for the first time, the elucidation of chemically defined neural circuits. Such advances in the mapping of neural systems and the visualization of monoaminergic and peptidergic neurons and their receptors in tissue sections have provided the tools for the burgeoning field of neurochemical pathology of psychiatric disorders. Data provided from such studies has served as the basis for the development of novel pharmacological approaches to the treatment of affective and anxiety disorders, as well as schizophrenia. This lecture focuses on two major neural systems implicated in the pathophysiology of depression, serotonin and corticotropin-releasing factor (CRF), with an emphasis on gene-environment interactions and functional brain imaging.

REFERENCES:

1. Jarkas N, Votaw JR, Voll RJ, William L, Camp VM, Owens MJ, Purselle DC, Bremner JD, Kilts CD, Nemeroff CB and Goodman MM. 2005. Carbon-11 HOMADAM: a novel PET radiotracer for imaging serotonin transporters. *Nuclear Med Biol* 32:211–224.
2. Yoshida K, Takahashi H, Higuchi H, Kamata M, Ito K, Sato K, Naito S, Shimizu T, Itoh K, Inoue K, Suzuki T and Nemeroff CB. 2004. Prediction of antidepressant response to milnacipran by norepinephrine transporter gene polymorphisms. *Am J Psychiat* 161:1575–1580.

Lecture 19

**Saturday, October 7
3:30 p.m.-5:00 p.m.**

PSYCHIATRY AND SPIRITUALITY AT THE END OF LIFE

APA's Oskar Pfister Award

Ned H. Cassem, M.D., *Department of Psychiatry, Massachusetts General Hospital, and Professor of Psychia-*

try, Harvard Medical School, 55 Fruit Street, #351, Boston, MA 02114-2621

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to recognize barriers to effective collaboration between psychiatrists and clergy; and demonstrate how to translate an understanding of the patient's unique commitments into a relationship that helps them maintain hope and meaning at the end of life.

SUMMARY:

The antagonism between religion and psychiatry is far from dead. Freud held, and some contemporary psychoanalysts still teach that religion is "a neurotic crutch". People of strong faith still resist seeking psychiatric help, convinced that the doctor will disparage their religious beliefs and practices. At the same time, some religious leaders continue to describe psychoanalysis as an atheistic cult dedicated to wiping out religious belief. Each side can be dogmatic in devaluing the other, inhibiting constructive collaboration.

Psychiatrists are among the essential caregivers for persons at the end of life. Along with other caretakers such as clergy, they need to know how to invite patients and their loved ones into a dialogue about the role of spirituality and faith in their lives. This is true of both those who say that religion and faith are important to them, and those who call themselves agnostics or atheists. This dialogue about deeply meaningful and strongly held values may have nothing to do with organized religion.

It is crucial when patients are entering the last phase of their lives for clinicians to have a practical method of translating this understanding of each unique person into an honest, optimistic, aggressive relationship that helps them maintain hope/meaning.

REFERENCES:

1. Saunders C (ed). *The Management of Terminal Illness*, Chicago: Year Book Medical Publishers, 1978.
2. Cassem NH, Brendel RW. *End of life issues: Principles of Care and Ethics*. Massachusetts General Hospital Handbook of General Hospital Psychiatry. 5th ed. St. Louis: Mosby, 2004, pp. 365–387.

Lecture 20

**Sunday, October 8
8:00 a.m.-9:30 a.m.**

DISPARITIES IN MENTAL HEALTH CARE: WHAT DOES RESEARCH TELL US?

Health Services Research Track

Annelle B. Primm, M.D., M.P.H., *Director, Division of Minority and National Affairs, American Psychiatric*

Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209

Lecture 21

Sunday, October 8
10:00 a.m.-11:30 a.m.

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should understand the nature and breadth of ethnic and racial mental health disparities; identify key aspects of what the research agenda should be in order to elucidate and optimize mental health outcomes in ethnically and racially diverse populations; and delineate strategies for achieving increased research participation among diverse populations.

SUMMARY:

Two major reports, the Institute of Medicine Report, Unequal Treatment and the Surgeon General's Report on Mental Health, Supplement on Culture, Race and Ethnicity introduced and firmly established the existence of health and mental health disparities among African Americans, Asian Americans, Hispanics and Native Americans. This lecture will provide an overview of the recent research literature regarding disparities in disease prevalence, access, utilization, diagnosis, treatment and outcomes in diverse populations. The overview will serve as a foundation upon which to develop a research agenda to fill in the many gaps which preclude optimal quality mental health care for diverse populations. Given the relative lack of diversity among research subjects and clinical investigators, developing an evidence base for diverse populations is a major challenge. In response, the presentation will provide examples of how to eliminate barriers and facilitate participation of members of underrepresented groups in research.

REFERENCES:

1. U.S. Public Health Service. Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Public Health Service; 2001.
2. Smedley BD, Stith AY, Nelson AR, eds. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health care. Washington, DC: National Academies Press; 2003.

PSYCHIATRIC GENETICS: A CURRENT PERSPECTIVE

APA's Judd Marmor Award

Kenneth S. Kendler, M.D., *Banks Distinguished Professor of Psychiatry, Professor of Human Genetics, and Director, Virginia Institute for Psychiatric and Behavioral Genetics, P.O. Box 980126, Richmond, VA 23298-0126*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to understand the four major research paradigms of psychiatric genetics, which includes basic genetic epidemiology, advanced genetic epidemiology, gene finding methods, and molecular genetics.

SUMMARY:

Psychiatric genetics, which is growing in size and influence within psychiatry, employs four major research paradigms: I-basic genetic epidemiology, II-advanced genetic epidemiology, III-gene-finding methods and IV-molecular genetics. Paradigms I and II study aggregate genetic risk factors inferred from patterns of resemblance in relatives. Paradigms III and IV study individual susceptibility genes localized on the human genome. This talk will begin by outlining the strengths and limitations of these various paradigms, emphasizing how they can provide complementary insights into the nature of psychiatric illness. Examples from each of the first three paradigms will be provided to illustrate the kind of results and methods these different perspectives employ. The talk will explore various aspects of genotype x environment interaction, genetic analysis of developmental trajectories and molecular genetics advances in our understanding of schizophrenia and alcoholism.

REFERENCES:

1. Kendler KS (2005). Psychiatric genetics: A methodologic critique. *American Journal of Psychiatry*. 162(1):3-11.
2. Kendler KS, Eaves LJ, (Eds.) (2005) Psychiatric Genetics, Review of Psychiatry, Volume 24. Arlington, Virginia: American Psychiatric Publishing, Inc.

Medical Update 1**Thursday, October 5
8:00 a.m.-9:30 a.m.****PULMONARY DISEASE**

Kenneth Prager, M.D., *Clinical Professor of Medicine, Pulmonary Division, Columbia University College of Physicians and Surgeons, 161 F Washington (Atchley 312), New York, NY 10032*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to present an update on some of the most common pulmonary diseases in the United States, as well as briefly discuss some of the medical ethical issues relating to end-stage lung disease.

SUMMARY:

Recent developments in the diagnosis and treatment of chronic obstructive pulmonary disease (COPD), lung cancer, asthma, and interstitial lung disease will be presented. Rates of COPD continue to rise, and lung cancer claims the greatest number of victims of all cancers in this country. For unclear reasons, the incidence of asthma has risen steadily in industrialized countries for years and continues to impact most severely on the poor, urban population. Interstitial lung diseases are a collection of poorly understood inflammatory and fibrosing conditions of the lung that in their most lethal form cause death within five years of diagnosis. Because all of these diseases may lead in their most severe forms to ICU care and ventilator treatment, they often raise many end-of-life issues of medical ethics.

REFERENCES:

1. Sharma OM P: Current Opinion in Pulmonary Medicine, Volume 12, Number 2; Lippincott Williams & Wilkins, January 2006.

Medical Update 2**Thursday, October 5
10:00 a.m.-11:30 a.m.****HIV AND AIDS**

Joseph Lux, M.D., *Bellevue Hospital and New York University, 201 East 35th Street, Apt. 2-C, New York, NY 10016*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the new DHHS treatment guidelines for the use of antiretroviral agents in adults and adolescents; and gain familiarity with antiretroviral agents and their use in the treatment of subgroups of HIV-infected patients.

SUMMARY:

In the combination antiretroviral therapy era, HIV-infected persons have been living longer with decreasing rates of opportunistic infections. The current HIV guidelines for antiretroviral use reflect the successive introduction of medications with novel mechanisms, increased potency, and decreased pill burdens. With more therapeutic options available and greater awareness about potential side effects and drug interactions, the current guidelines, especially for antiretroviral naive patients, emphasize regimens that minimize side effects and optimize adherence. In addition, HIV resistance testing has become more routine in medical practice, and has helped guide providers in choosing effective treatment regimens.

This presentation will focus on the 2006 DHHS (Department of Health and Human Services) Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents. The guidelines focus on important clinical questions including when therapy should be initiated for asymptomatic HIV infection, preferred regimens for treatment naive patients, safety and toxicity issues with antiretroviral use, the role of resistance testing, goals of therapy for treatment-experienced patients, and recommendations for various subgroups of HIV-infected patients including acute HIV-infection, pregnant women, and hepatitis co-infection.

REFERENCES:

1. DHHS panel on Antiretroviral Guidelines for Adults and Adolescents-A Working Group of the Office of AIDS Research Advisory Council (OARAC): Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents May 2006:1-120.
2. Frieden TR, Das-Douglas M, Kellerman SE, Henning KJ. Applying public health principles to the HIV epidemic. *N Engl J Med* 2005; 353:2397-2402.

Medical Update 3**Thursday, October 5
3:30 p.m.-5:00 p.m.****OPHTHALMOLOGY**

James C. Tsai, M.D., *Associate Professor of Ophthalmology, and Director, Glaucoma Division, Edward S. Harkness Eye Institute, Columbia University College of Physicians and Surgeons, 635 West 165th Street, New York, NY 10032*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand latest advances, diagnosis, and management of patients with glaucoma, ocular hypertension, and glaucoma suspect; and briefly review

the important developments in the treatment of macular degeneration, cataracts, and corneal diseases.

SUMMARY:

Primary open-angle glaucoma (POAG) is diagnosed when a patient has elevated pressure intraocular pressure (IOP) and glaucomatous optic neuropathy (GON). However, a significant number of patients may have elevated IOP and not have GON (i.e., ocular hypertension), as well as normal IOPs and GON (i.e., NTG or Normal Tension Glaucoma). Finally, patients with consistently normal IOPs and suspicious-appearing optic nerves are diagnosed as NTG suspects.

Although elevated IOP may play a significant role in the pathogenesis of POAG and lowering of IOP is the only proven treatment, the definition of POAG is a multifactorial disease characterized by an IOP-sensitive optic neuropathy. Moreover, a thinner corneal thickness value appears to be a significant risk factor in the development of this disease.

Diagnosis of glaucoma has been facilitated by advances in diagnostic structural and functional technologies. Structural detection instruments include the HRT3, GDxVCC, and OCT3, while functional assessment technologies include the SWAP, FDT, PERG, and VEP. In the treatment arena, greater attention has focused on the beneficial effects of enhanced control of diurnal IOP fluctuation, the problems associated with medication adherence, and advancements in laser trabeculoplasty and incisional surgery.

REFERENCES:

1. Medeiros FA, Weinreb RN, Sample PA, et al. Validation of a predictive model to estimate the risk of conversion from ocular hypertension to glaucoma. *Arch Ophthalmol* 2005; 123:1351–1360.
2. Tsai JC. Medication adherence in glaucoma: approaches for optimizing patient compliance. *Curr Opin Ophthalmol* 2006; 17:190–195.

Medical Update 4

**Friday, October 6
10:00 a.m.-11:30 a.m.**

PREVENTIVE HEALTH CARE

Russell Kellogg, M.D., *Chair, Department of Community Medicine, St. Vincent's Catholic Medical Centers of New York; and Assistant Professor of Medicine, New York Medical College, 153 West 11th Street, New York, NY 10011*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand basic concepts of preventive health services including evidence-based criterion for screening immunizations and counseling; controversies in preventive measures; and the efficacy and usefulness of various procedures across the patient's lifespan.

SUMMARY:

The majority of deaths among Americans under age 65 are preventable, many through interventions best provided in a primary care physician's office. Through this talk, I will critically review current scientific evidence for common preventive interventions, including screening, immunizations and counseling maneuvers, as well as offer evidence-based recommendations. Some preventive and screening services, targeting certain infections and diseases, have resulted in significant reductions in mortality and morbidity. For other interventions, however, there is considerable controversy. The value of the routine annual check-up for asymptomatic persons including a full history, physical, and battery of laboratory testing has been discounted. The frequency and content of the periodic health exam should be tailored to the unique health risks of the individual patient, taking into consideration the evidence that specific preventive services are clinically effective. Routine screening tests with inadequate accuracy and applied indiscriminately produce large numbers of false-positive results. This may result in unnecessary further testing, risky interventions, high costs and anxiety. It is recommended that screening tests be performed selectively, targeting conditions most likely to influence the health and well-being of the patient being examined. Such conditions should be among the leading causes of morbidity and mortality for the patient's age group, fit the patient's risk profile, and be known to benefit symptomatic patients through preventive intervention. Additionally, the test must have acceptable accuracy and reliability, be safe, affordable, and acceptable to patients. Beyond testing, the greatest opportunity in prevention of the leading causes of disease and disability are those that address personal health practices such as smoking, physical inactivity, poor nutrition, alcohol and drug abuse. This counseling and patient education has value at least as good as "routine screening."

REFERENCES:

1. Guide to Clinical Preventive Services, 3rd Edition, 2000.
2. Report of the U.S. Preventive Services Task Force.

POSTER SESSION 1

Posters 1–48

FRONTIERS IN RESEARCH: GUIDING PRINCIPLES, INTRIGUING RESULTS, CHANGING PRACTICE

Poster 1

Thursday, October 5
8:30 a.m.-10:00 a.m.

EMPATHY: DO PSYCHIATRISTS AND THEIR PATIENTS AGREE?

Rashi Aggarwal, M.D., *Resident, Department of Psychiatry, Maimonides Medical Center, 43 Stratford Circle, Brooklyn, NY 11219*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the relation between a psychiatrist's self-assessment of empathy with their patient's perception of their empathic skills.

SUMMARY:

Introduction: A psychiatrist's self-perception of empathy may not match the patient's perception of the psychiatrist's empathic skills. The purpose of the present study is to assess the relationship between psychiatrists' self-assessment of empathy and their patients' assessment of their empathy.

Method: Ten outpatient psychiatrists - 6 residents and attending psychiatrists filled out the Jefferson Scale of Physician Empathy (range 20–140). Five patients of each psychiatrist filled out a corresponding questionnaire rating their psychiatrist's empathic skills.

Results: We found no significant correlation between psychiatrist self perception of empathy and their patients' perception of their empathy ($r=0.4, p=0.3$). Mean psychiatrist empathy scores were significantly higher than patient perceived psychiatrist empathy scores (Mean difference =15.3, $df=0, p<.0001$). This difference is most marked between male psychiatrists and female patients (Mean difference=22.4, $df=0, p<.0001$). Differences between how attending psychiatrists rate themselves and their patient ratings of them is less marked than those of residents and their patients.

Conclusions: We did not find any significant correlation between psychiatrists self-assessment of their empathy and their patients' assessments of their empathy. Psychiatrist rate themselves higher than their patients.

TARGET AUDIENCE:

All mental health practitioners.

REFERENCES:

1. Hojat M, Gonnella JS, Nasca TJ, Mangione S, Vergare M, and Magee M.: Physician Empathy: Definition, components, measurement, and relationship to gender and specialty. *Am J Psychiatry* 2002; 159:1563–1569.
2. Kim SS, Kaplowitz S, and Johnston MV. The Effects of physician empathy on patient satisfaction and compliance. *Evaluation & The Health Professions*, Vol 27 No 3, Sep 2004, 237–251.

Poster 2

Thursday, October 5
8:30 a.m.-10:00 a.m.

MEDICATION RESPONSE IN DYSTHYMIC DISORDER: EFFECT OF ALCOHOLISM HISTORY

Bachar Arnaout, M.D., *515 West 59th Street, Apt. 29-R, New York, NY 10019-1031*; Sarai Batchelder, Ph.D.; David J. Hellerstein, M.D.; Steven E. Hyler, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the high comorbidity between alcohol use disorders and dysthymic disorder; and recognize the validity of adequate evaluation and treatment of dysthymic disorder in remitted alcoholic patients.

SUMMARY:

Method: This is a retrospective analysis of data collected through previous outpatient medication trials. Data from 123 subjects with dysthymic disorder (DD) was included. Based on SCID-PI findings, subjects were categorized into two groups: (1) No Lifetime Alcohol Use Disorder (NLAUD) (N = 99); (2) Lifetime Alcohol Use Disorder (LAUD) (N = 24). None of the subjects in the database met criteria for any substance use disorder for six months prior to intake. Rating scales from baseline and after eight weeks of pharmacotherapy for DD were collected. The NLAUD and LAUD groups were compared in terms of response and remission.

Results: After eight weeks of treatment, the NLAUD and LAUD groups did not differ in rates of response or remission, despite significantly higher baseline HDRS-24 scores in the LAUD group. We also found greater decrease in symptoms in the LAUD group, as measured by the HDRS-24.

Conclusions: We conclude that DD in remitted alcoholics is at least as responsive to pharmacotherapy as DD in non-alcoholics. We suspect that remitted alcoholics

might have a more symptomatic form of DD, with greater symptom improvement in response to pharmacotherapy, as compared to nonalcoholic dysthymics.

TARGET AUDIENCE:

All mental health care practitioners.

REFERENCES:

1. Rae AM, Joyce PR, Luty SE, Mulder RT: The effect of a history of alcohol dependence in adult major depression. *J Affect Disord* 2002; 70: 281–90.
2. Regier DA, Farmer ME, Rae DS, Locke BZ, Keith SJ, Judd LL, Goodwin FK; Comorbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiologic Catchment Area (ECA) Study. *JAMA* 1990; 264: 2511–8.

Poster 3

Thursday, October 5
8:30 a.m.-10:00 a.m.

VIOLENCE AND MENTAL ILLNESS

Amel A. Badr, M.D., *Department of Psychiatry, Bergen Regional Medical Center, 230 East Ridgewood Avenue, Paramus, NJ 07652*; Asghar Hossain, M.D., *Department of Psychiatry, Bergen Regional Medical Center, 230 East Ridgewood Avenue, Paramus, NJ 07652*; Moustafa Niazi, M.D.; Masood Jilani, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the socio-demographic and clinical risk factors associated with violence in the mentally ill patients; and identify the risk factors that will help in formulating effective treatment strategies for these patients.

SUMMARY:

Rationale and Background: Recent research established moderate but reliable association between mental disorders and violence. This does not imply that people with mental illness are more likely to commit violent acts compared to general population, however elevated risk is only evident for specific subgroups of psychiatric patients. Identifying risk factors would help in targeting this vulnerable group with assertive community treatment.

Materials and Method: Retrospective chart review was done for admissions in Forensic Psychiatry unit at Bergen Regional Medical Center between January 2003 and December 2005. Admissions related to violent behavior were reviewed. Socio-demographic and clinical data of patients were recorded.

Results: Out of 123 admissions, 66% were related to violent behavior. Mean age was 36+/- 1.3, 85% were males and 77% were homeless and unemployed. Previ-

ous hospitalizations were recorded in 61% and 85% were non compliant with medications, experiencing psychotic symptoms. 40% had dual diagnosis and 26% were diagnosed with antisocial personality disorder.

Conclusion: Risk of violence was associated with young males and low socio-economic attainment. Additional risk factors included prior hospitalizations and non-compliance with medication. Substance abuse was a significant risk factor and family members are mostly targets of violence. Reduction of violence requires carefully targeted community interventions including integrated case management and substance abuse treatment.

REFERENCES:

1. The psychiatric epidemiology of violent behavior. Eronen, M.C. Angermeyer, B. Schulze. *Soc.Psychiatry Psychiatr. Epidemiol.* 1998, 33:S13–S23.
2. Violent behavior by individuals with serious mental illness. E. Fuller Torrey. *Hospital and Community Psychiatry.* July 1994, Vol. 45, NO.7, P.653–662.

Poster 4

Thursday, October 5
8:30 a.m.-10:00 a.m.

ENHANCING QUALITY OF LIFE IN THE ELDERLY WITH SCHIZOPHRENIA

Azziza O. Bankole, M.D., *Psychiatry Resident, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, P.O. Box 1203, Brooklyn, NY 11203*; Carl I. Cohen, M.D.; Ipsit V. Vahia, M.D.; Shilpa P. Diwan, M.D.; Paul M. Ramirez, Ph.D.; Nikhil Palekhar, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the differences in quality of life in the elderly with schizophrenia and the general population and the factors associated with it.

SUMMARY:

There have been few studies on quality of life (QOL) in older schizophrenic adults.

Methods: The schizophrenia (S) group consisted of 198 persons aged 55+ who developed schizophrenia before age 45. A community comparison (C) group (n=113) was recruited. The QOL model consisted of 4 variable sets (demographic, objective, clinical, and subjective) comprising 19 independent variables. The dependent variable was the Quality of Life Index (QLI).

Results: The S group had a significantly lower QLI score than the C group (21.7 vs. 24.2; t=-5.36, DF=362, p=.001). Within the S group, in bivariate analysis, 11 of 19 variables were significantly related to QLI. In regression analysis, 6 variables attained significance, viz., fewer depressive symptoms, more cognitive defi-

cits, fewer acute life stressors, fewer medication side effects, lower financial strain, and better self-rated health. The model explained 55% of the variance in QLI, with the demographic, objective, psychiatric illness, and the subjective variable sets accounting for 6%, 35%, 9%, and 5% of the variance, respectively.

Conclusions: Our findings confirmed earlier reports that older schizophrenic persons had a lower self-reported quality of life than their age matched peers. Our findings suggest that many of the factors impacting on QOL are potentially ameliorable. This is targeted at mental health professionals and those who work with the elderly.

Funded by the National Institute of General Medical Sciences Grant No. SO6GM54650.

TARGET AUDIENCE:

Health care professionals, and mental health professionals.

REFERENCES:

1. Cohen CI, Ramirez PM, Kehn M, Magai C, Eimicke J, Brenner R: Assessing quality of life in older persons with schizophrenia. *Am J Geriatr Psychiatry*. 2003; 11(6):658-66.
2. Lehman, A.F (1988): A Quality of Life Interview for the Chronically Mentally ill. *Evaluation and Program Planning*, 11, 51-62.

Poster 5

**Thursday, October 5
8:30 a.m.-10:00 a.m.**

**ADHD PHARMACY MANAGEMENT:
MANAGING PRESCRIBING OF
PSYCHOTROPICS IN A HIGH-RISK
POPULATION**

Supported by Comprehensive NeuroSciences, Inc.

John E. Byrd, Pharm.D., M.B.A., *Director of Outcomes Research and Pharmacy Services, Comprehensive NeuroSciences, Inc., 1 Copley Parkway, Suite 534, Morrisville, NC 27560*; Joseph J. Parks, M.D., *Medical Director, Missouri Department of Mental Health, 1706 East Elm Street, P.O. Box 687, Jefferson City, MO 65102*; George Oestreich, Pharm.D.; Judith Dogin, M.D.; James Van Halderen, Psy.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will have learned about the extent to which psychotropic prescribing differs from recommended practice and a new initiative for quality improvement and cost management of behavioral medication prescribing in children.

SUMMARY:

Background: Medicaid agencies are experiencing high annual growth in the use of medications for Attention-Deficit/Hyperactivity Disorder (ADHD) with soaring annual cost increases. There is increasing concern about inappropriate medication use in children. **Methods:** We utilized literature reviews and expert consensus to develop 22 child-focused Quality Indicators and recommendations for improving practice, Clinical Considerations™, Nine (9) Quality Indicators (primarily on ADHD prescribing) were chosen to identify high-risk children and their prescribers for intervention. Prescriber intervention occurred December 2005. Four hundred and fifteen (415) prescribers received mailed interventions every other month regarding their prescribing practices with their patients (n=895). **Results:** Missouri claims data reveals that approximately 28,000 children are prescribed behavioral health/opiate medications each quarter. Quality Indicators flagged an average of 3,250 (11.6%) children of the 28,000 each rolling quarter between July 1st and November 30th 2005. The average monthly behavioral health/opiate medication cost per patient (PUPM) for the 28,000 children was \$122. The PUPM of the 3,250 children flagged by our Quality Indicators was \$328, more than 250% higher than the 28,000 patients' average monthly costs. **Discussion:** Medicaid programs need child-focused behavioral health Quality Indicators and expert consensus clinical messages to use for quality improvement and cost management in lieu of restrictive methodologies.

TARGET AUDIENCE:

Psychiatrists and allied health care professionals

REFERENCES:

1. Olfson M, Gameroff MJ, Marcus SC, Jensen PS. National trends in the treatment of Attention Deficit Hyperactivity Disorder. *American Journal of Psychiatry* 2003; 160(2):1071-1077.
2. Chung PJ, Schuster MA. Access and Quality in Child Health Services: Voltage Drops. *Health Affairs*, Vol. 23 No. 5 Sept-Oct 2004.

Poster 6

**Thursday, October 5
8:30 a.m.-10:00 a.m.**

**ADVERSE CHILDHOOD EXPERIENCES
AND UNEXPLAINED MEDICAL
SYMPTOMS**

Daniel P. Chapman, Ph.D., *Psychiatric Epidemiologist, Division of Adult and Community Health, Department of Health Care and Aging, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Buford Highway,*

N.E., Mailstop K-67, Atlanta, GA 30341; Shanta R. Dube, M.P.H., *Epidemiologist, Emergency Investment, Centers for Disease Control and Prevention, 4770 Buford Highway, N.E., Mailstop K-67, Atlanta, GA 30341*; Valerie J. Edwards, Ph.D.; Robert F. Anda, M.D., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the relationship between unexplained medical symptoms and adverse childhood experiences and the implications of the latter for medical care utilization.

SUMMARY:

Objectives: Patients with unexplained medical symptoms (UMS) involving multiple organ systems pose diagnostic and treatment challenges for physicians. Although these patients may be suffering from hypochondriacal, somatization, or conversion disorders, the role that adverse childhood experiences (ACEs) may assume in UMS involving multiple organ systems has not been previously investigated. *Methods:* Data were from the ACE Study, a retrospective cohort investigation of HMO patients receiving biopsychosocial evaluations (N= 17, 337). Patients were assigned an ACE score comprised of the number of eight categories of childhood abuse and household dysfunction they reported. UMS were defined using a review of systems, with no corresponding diagnosis in the patient's medical record. Symptoms across five systems (respiratory, gastrointestinal, central nervous system, cardiovascular, and musculoskeletal) were assessed, as were the number of physician office visits. *Results:* ACE scores were positively associated with the number of organ systems involved in UMS ($p<.001$), the total number of UMS ($p<.001$), and the mean number of doctor visits in the previous year ($p<.001$). *Discussion:* These results suggest assessment for ACEs may promote earlier evaluation of UMS across multiple organ systems, which may underlie increased healthcare utilization.

TARGET AUDIENCE:

Psychiatrists, nonpsychiatric physicians, nurses, and psychologists.

REFERENCES:

1. Chapman DP, Whitfield CL, Felitti VJ, Dube SR, Edwards VJ, Anda RF. Adverse childhood experiences and the risk of depressive disorders in adulthood. *J Affect Disorders* 2004; 82:217-225.
2. Dube SR, Anda RF, Felitti VJ, Chapman DP, Williamson DF, Giles WH. Childhood abuse, household dysfunction, and the risk of suicide throughout the lifespan: findings from the adverse childhood experiences study. *JAMA* 2001; 286:3089-3096.

Poster 7

Thursday, October 5
8:30 a.m.-10:00 a.m.

CONSENT FORM READABILITY AND EDUCATIONAL LEVELS OF POTENTIAL STUDY SUBJECTS

Paul P. Christopher, M.D., *Resident, Department of Psychiatry, Brown University, 665 Hope Street, Providence, RI 02906*; Mary Ellen Foti, M.D.; Paul S. Applebaum, M.D.; Kristen Roy-Bujnowski, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to inform attendees of the poor readability of informed consent forms used in mental health research and highlight the disparity between consent form readability and the educational level of potential study participants.

SUMMARY:

Poor readability of informed consent forms is a problem in clinical research. The low educational attainments of many patients with mental illnesses might suggest a greater problem in mental health settings. We examined whether the informed consent forms used in Massachusetts Department of Mental Health (MA-DMH) research were written at a grade level higher than that achieved by potential study participants. We calculated the readability of 154 consent forms using several formulas. Readability scores were stratified by risk level of the study from which the consent form was taken. We compared these data with the maximum attained grade level of potential participants in MA-DMH approved studies. Mean readability scores for the consent forms ranged between grade level 12 and 14.5. Furthermore, mean readability scores increased with increasing study risk level. Approximately 35% of potential participants had not graduated high school, 37% had graduated high school or obtained a GED and 28% had some education beyond the 12th grade. These data demonstrate poor readability of consent forms used in MA-DMH research and highlight a mismatch between consent form readability and the educational level of potential study participants. These findings suggest that methods of reducing the complexity of forms are much needed.

TARGET AUDIENCE:

Anyone conducting research with mentally ill persons or those interested in the informed consent process.

REFERENCES:

1. Berg JW, Appelbaum PS, Lidz CW, et al: *Informed Consent: Legal Theory and Clinical Practice*, 2nd edition. Oxford University Press, New York, NY, 2001.

2. Sentell TL, Shumway MA: Low literacy and mental illness in a nationally representative sample. *Journal of Nervous & Mental Disease* 191:549-52, 2003.

2. Mega MS; Cerebral Correlates of psychotic symptoms in Alzheimer's disease. *J. Neurol Neurosurg Psychiatry* 2000.

Poster 8

**Thursday, October 5
8:30 a.m.-10:00 a.m.**

DELUSIONAL SYMPTOMS IN ALZHEIMER'S DISEASE WITH 99M TC-HMPAO SPECT IMAGING

Supported by the Korean Ministry of Health and Welfare

Maeng-Je Cho, M.D., Ph.D., *Professor, Department of Psychiatry and Behavioral Science, Seoul National University Hospital, 28 Yongun-Dong, Chongno-Gu, Seoul, South Korea 110-744*; Hong-Jin Jeon, M.D., *Department of Psychiatry, Seoul National University Hospital, 28 Yongon-Dong Chong No-Gu, Seoul, South Korea*; Kim Shin-Kyum, M.D.; Chang Sung-Man, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the symptoms of dementia and understand the brain imaging of SPECT.

SUMMARY:

Delusional symptoms are common among the Behavioral and Psychological Symptoms of Dementia (BPSD) in patients with Alzheimer's disease. The correlations between regional cerebral blood perfusion (rCBF) and delusional symptoms were evaluated with functional SPECT imaging. This study compared 99m TC-hexamethyl propyleneamine oxime (HMPAO) SPECT images of a group of patients with Alzheimer's disease with (n = 13) and without delusional symptoms (n = 29). The SPECT data were compared using a statistical parametric mapping technique (the Voxel-Based Morphometry, VBM). The Alzheimer's disease group with delusional symptoms had a significant area of hypoperfusion in the both left (Z = 4.08) and right parahippocampal gyrus (Z = 3.72). Among thirteen Alzheimer's disease patients with delusional symptoms, 'stopping of their possessions' (n = 6) and 'invasion by others' (n = 4) were most common. This result suggests that delusions in AD are associated with the functional impairment of the parahippocampal gyri which handle memory.

This study was supported by Korea Science Engineering Foundation Grant No. R01-2001-000-10178-0.

REFERENCES:

1. Moran M.; Syndromes of behavioral and psychological symptoms in mild Alzheimer's disease. *Int. J. Geriatr Psychiatry* 2004.

Poster 9

**Thursday, October 5
8:30 a.m.-10:00 a.m.**

FUNCTIONING OF ADULT OFFSPRING OF DEPRESSED PARENTS: A 23-YEAR FOLLOW-UP

Supported by Eli Lilly and Company

Ruth C. Cronkite, Ph.D., *Palo Alto Veterans Administration, 795 Willow Road, Menlo Park, CA 94025*; Christine Timko, Ph.D.; Ralph Swindle, Ph.D.; Rebecca L. Robinson, M.S.; Patricia Turrubiarres, B.A.; Rudolf H. Moos, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize that offspring of depressed parents are at risk for poor psychosocial functioning into adulthood, especially if the parent had a more severe course of depression, while offspring of parents who reached long-term remission are doing relatively well.

SUMMARY:

We compared adult offspring of depressed (DPOs) and control (CPOs) parents on psychosocial functioning, and examined associations between the severity and course of parental depression and functioning of offspring. We followed parents of 143 DPOs and 197 CPOs prospectively for 23 years (80% response rate). At baseline and/or follow-ups, parents and offspring completed the Health and Daily Living Form (Moos et al., 1990). Depression Symptom Severity was based on DSM-IV criteria (American Psychological Association, 1994). At the 23-year follow-up, compared to CPOs (51% female; mean age = 34), DPOs (58% female; mean age = 35) reported: (1) higher levels of depressive symptoms, (2) a greater family history of depression, (3) more physical symptoms, pain, and disability, (4) more use of antidepressant medications and mental health and non-mental health professional sources, (5) fewer friends, and more reliance on a avoidance coping. A more severe course of parental depression was associated with poorer functioning among DPOs at 23 years. Parental depression, especially more severe depression, is associated with offspring's depression and poorer psychosocial functioning in adulthood. Efforts to prevent and treat parental depression and offspring's dysfunction should improve the well-being of adult offspring and their families.

This project was funded by the Department of Veterans Affairs Medical Research and Health Services Research and Development Services, National Institute of

Alcoholism and Alcohol Abuse, and Eli Lilly and Company.

REFERENCES:

1. Lieb R, Isensee B, Hofler M, Wittchen HU: Parental depression and depression in offspring: evidence for familial characteristics and subtypes? *J Psychiatr Res* 2002; 36:237–246.
2. Timko C, Cronkite RC, Berg EA, Moos RH: Children of parents with unipolar depression: a comparison of stably remitted, partially remitted, and nonremitted parents and nondepressed controls. *Child Psychiatry Hum Dev* 2002; 32:165–185.

Poster 10

Thursday, October 5

8:30 a.m.-10:00 a.m.

PSYCHOMETRIC EVALUATION OF PATIENT-RATED TROUBLING SYMPTOMS SCALE FOR ANXIETY

Supported by Janssen Pharmaceutica, Inc.

Luella Engelhart, M.A., *Director, Outcomes Research, Ortho-McNeil Janssen Scientific Affairs, LLC, 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Gahan J. Pandina, Ph.D., *Assistant Director of Medical Affairs, Janssen Pharmaceutica Products, L.P., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Dennis A. Revicki, Ph.D.; Leah Kleinman, Ph.D.; Ibrahim Turkoz, M.S.; Jacquelyn D. McLemore, M.D.; Georges M. Gharabawi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate the reliability and validity of the Patient-Rated Troubling Symptoms Scale for Anxiety in patients with generalized anxiety disorder; and demonstrate the clinical responsiveness of the Patient-Rated Troubling Symptoms Scale for Anxiety in patients with generalized anxiety disorder.

SUMMARY:

Background: Psychometric properties and clinical responsiveness of the Patient-Rated Troubling Symptoms Scale for Anxiety (PaRTS-A) were examined in patients with generalized anxiety disorder (GAD).

Methods: In a 6-week trial of adjunctive risperidone, data were available from 385 patients at baseline and weeks 4 and 6 on PaRTS-A; Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q); and Sheehan Disability Scale (SDS). Clinicians completed the HAM-A and Clinical Global Impressions-Severity (CGI-S) scale. Descriptive exploratory factor item response (IRT) and ANCOVA analyses were conducted using SAS version 8.2.

Results: Patients were predominantly women with a mean 14.9=12.6-year history of anxiety. Strong evidence for a single factor (eigenvalue=3.54; 51% variance explained), strong correlation of items ($r=0.48-0.85$), ability of items to assess anxiety severity (IRT), and high reliability (>0.7) were found. Validity correlations were moderate and supportive (Q-LES-Q: -0.59) SDS: 0.62; SDS chief complaint: 0.65) at baseline. PaRTS-A discriminated between high and low HAM-A ($p<.0001$) and CGI-S ($p=0.027$) ratings. MCID (minimal clinically important difference) score of 4 points indicated stable and slight improvement in clinical responsiveness.

Conclusions: PaRTS-A provides reliable and internally consistent scores, good construct validity, discriminant validity, and responsiveness over time in a GAD sample.

TARGET AUDIENCE:

Psychiatrists, and other mental health professionals.

REFERENCES:

1. Wittchen HU, Kessler RC, Geesdo K, et al. Generalized anxiety and depression in primary care: prevalence, recognition and management. *J Clin Psychiatry* 2002; 63 Suppl 8:24–34.
2. Brawman-Mintzer O, Knapp RG, Nietert PJ. Adjunctive risperidone in generalized anxiety disorder: a double-blind, placebo-controlled study. *J Clin Psychiatry*. 2005; 66:1321–1325.

Poster 11

Thursday, October 5

8:30 a.m.-10:00 a.m.

TWENTY-FOUR HOURS IN THE PSYCHIATRIC EMERGENCY ROOM

Alisa K. Lincoln, Ph.D., M.P.H., *Associate Professor, Department of Social and Behavioral Sciences, Boston University School of Public Health, 715 Albany Street, Talbot 248A, Boston, MA 02118*; Andrew W. White, M.A., *Project Coordinator, Public Health, Boston University School of Public Health, 715 Albany Street, Boston, MA 02118*; Peggy L. Johnson, M.D.; Nancy P. Benedict, B.A.; Lee Stronin, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand and report on the general activities of staff in a psychiatric emergency room, as well as understand a method for identifying and quantifying these activities.

SUMMARY:

This poster presents the first data from a three year NIMH grant examining staff perspectives on working in a psychiatric emergency room (PER). Little information

exists in the literature about day-to-day staff operations in the PER and the amount of time staff spend on different activities. We developed a protocol allowing for unobtrusive staff observation to collect information on the amount of time spent doing various types of job tasks, such as clinical tasks and administrative tasks. This protocol was implemented at a busy urban safety-net PER which historically sees more than 4,300 patients per year (about 360 patients per month). 24 hours of observations were completed during different shifts on weekdays as well as weekends. In total, 22 staff with six different job titles (nurses, psychiatrists, medical students, mental health workers, psychologists, residents) were observed. On average, staff spent 53% on administrative tasks, 20% on other activities, 18% of their time in direct face-to-face clinical contact, and 9% on the phone. These findings will increase knowledge about workflow and staff functions in the PER and provide a unique perspective from which to develop further research questions.

TARGET AUDIENCE:

Individuals engaged in mental health services research, as well as mental health administrators, clinicians, and consumers with interests in emergency services.

REFERENCES:

1. Brown, J. (2005). Psychiatric Emergency Services: A review of the literature and a proposed research agenda. *Psychiatric Quarterly*, 76(2) 139–165.
2. Pasic, J., Russo, J., & Roy-Byrne, P. (2005). High utilizers of psychiatric emergency services. *Psychiatric Services*, 56(6), 678–684.

Poster 12

**Thursday, October 5
8:30 a.m.-10:00 a.m.**

EXAMINING THE RELATIONSHIP BETWEEN MENTAL ILLNESS AND LITERACY

Dennis B. Espejo, M.P.H., *Research Coordinator, Department of Social and Behavioral Sciences, Boston University School of Public Health, 715 Albany Street, Talbot 248A West, Boston, MA 02118*; Alisa K. Lincoln, Ph.D., M.P.H., *Associate Professor, Department of Social and Behavioral Sciences, Boston University School of Public Health, 715 Albany Street, Talbot 248A, Boston, MA 02118*; Terri Webber, M.P.H.; Jeanne L. Speckman, M.S.C.; Peggy L. Johnson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to learn about the prevalence of literacy

problems among people seeking outpatient mental health services at a public urban teaching hospital; and understand the relationship between literacy level and psychiatric symptoms and diagnoses.

SUMMARY:

Little is known about the relationship between mental illness and literacy despite both being prevalent problems in the United States with tremendous consequences. This study explores the relationship between literacy, education, psychiatric symptoms and diagnoses. Interviews and chart reviews (N=100) were conducted in a public, urban behavioral-health outpatient clinic. The relationship among sociodemographics, Rapid Estimate of Adult Literacy in Medicine (REALM), cognitive status, and psychiatric symptoms and diagnoses was examined. Forty-five percent of the sample had limited literacy (a REALM score \leq 60 indicates an 8th grade or below reading level). Psychotic disorder was associated with limited literacy ($p=.026$). However, higher literacy was associated with substance abuse ($p=.0033$) and PTSD ($p=.068$). Multivariate analyses demonstrate that these relationships remain in adjusted models. Limitations include the small sample size and the over-representation of people with high levels of education. Increasing our understanding of the relationships between health literacy, education and psychiatric symptoms and disorders will help inform the development of appropriate psychiatric care and better outcomes for people seeking care. This project was supported by a faculty research development grant from the Boston University School of Public Health.

TARGET AUDIENCE:

Mental health researchers and clinicians.

REFERENCES:

1. Parikh, N.S., Ruth M. Parker, R.M., Nurss, J.R., Baker, D.W., & Williams, M.V. (1996). Shame and Health Literacy: the unspoken connection. *Patient Education and Counseling* 27(1), 33–39.
2. Currier, G.W., Sitzman, R., & Trenton, A. (2001). Literacy in the Psychiatric Emergency Service. *The Journal of Nervous and Mental Disease*, 189(1), 56–58.

Poster 13

**Thursday, October 5
8:30 a.m.-10:00 a.m.**

THE UTILITY OF ATYPICAL NEUROLEPTICS IN SUBSTANCE USE DISORDERS: A REVIEW

Kia Faridi, M.D., *Resident, Department of Psychiatry, McGill University, 4547 De Bullioni, Montreal, Quebec, Canada H2T 1Y7*; Kathryn Gill, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to critically appraise the literature concerning the effectiveness of atypical neuroleptics in the treatment of substance use disorders.

SUMMARY:

Dopamine is hypothesized to play a central role in the creation and maintenance of addictions. Accordingly, dopamine antagonists have been found in animal studies to block many of the conditioning effects of drugs of abuse. Given the difficulty in treating drug addictions in humans, and the significant burden of these disorders, there has been enormous interest in evaluating the dopamine-blocking neuroleptic drugs for their effects on substance abuse. This poster, intended for all clinicians, presents a critical review of the available literature concerning the utility of atypical neuroleptic drugs on substance abuse. A comprehensive literature search, including extensive bibliographic review, was completed. All studies examining substance-abuse measures in the context of atypical neuroleptic treatment in humans were reviewed, with the exception of case reports. These included retrospective or cross-sectional analyses of clinical data, open-label trials, laboratory experiments, and blinded clinical trials. In summary, the review revealed that, though analysis of naturalistic clinical data and open-label trials show promise for atypical neuroleptics, and laboratory experiments clearly demonstrate that atypical neuroleptics can attenuate the acute effects and craving in the laboratory setting, the few published clinical trials have not demonstrated any efficacy of atypical neuroleptics in substance abuse treatment.

TARGET AUDIENCE:

All clinicians.

REFERENCES:

1. Sattar SP, Bhatia SC, Petty F. 2004. Potential benefits of quetiapine in the treatment of substance dependence disorders. *Journal of Psychiatry & Neuroscience*. 29(6):452-7.
2. Littrell KH, Petty RG, Hilligoss NM, Peabody CD, Johnson CG. 2001. Olanzapine treatment for patients with schizophrenia and substance abuse. *Journal of Substance Abuse Treatment*. 21(4):217-21.

Poster 14

Thursday, October 5
8:30 a.m.-10:00 a.m.

VIOLENCE RISK APPRAISAL GUIDE/SEX OFFENDER RISK APPRAISAL GUIDE ITEMS IN DEVELOPMENTALLY DELAYED AND NON-DELAYED SEX OFFENDERS

Supported by the Canadian Institute of Health Research

J. Paul Fedoroff, M.D., *Research Unit Director, University of Ottawa, Forensic Division 1145 Carling, Ottawa, Ontario, Canada K1Z 7K4*; Susan Curry; Gina Madri-grano; Chanie Cunningham; John M. Bradford, M.B.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should be able to describe ways in which the VRAG and SORAG may need to be modified for use with men with developmental delay.

SUMMARY:

Accurate prediction of whether an offender will commit subsequent acts of violence or sexual aggression has been a primary concern in forensic research. Over the course of the past 20 years, extensive research has been conducted to assess the validity and effectiveness of various risk appraisal instruments with sexual and violent offenders. Despite the fact that developmentally delayed populations were not adequately represented in the development of these risk assessment measures, they have nonetheless been used to assess the developmentally delayed population. The purpose of this study was to compare the scores of two groups of convicted child molesters on the Sex Offender Risk Appraisal Guide (SORAG) and the Violence Risk Appraisal Guide (VRAG) (Quinsey et al, 1998).

Assessment items and total scores on the VRAG and SORAG were compared for thirty-eight developmentally delayed men and 38 without developmental delay. This study did not replicate previous findings (Fedoroff et al., 2001), as no significant differences were found on the total scores between the groups on either the VRAG or the SORAG. However, there were significant differences on a number of the individual scale items. This study was supported by a grant from the Canadian Institutes of Health Research (CIHR).

TARGET AUDIENCE:

Forensic psychiatrists.

REFERENCES:

1. Barbaree, H.E., Seto, M.C., Langton CM, & Peacock EJ. (2001). Evaluating the predictive accuracy of six

- risk assessment instruments for adult sex offenders. *Criminal Justice and Behavior*, 28(4), 490–521.
2. Quinsey VL, Harris GT, Rice ME, & Cormier CA. (1998). *Violent offenders: Appraising and managing risk*. Washington, DC: American Psychological Association.

Poster 15 **Thursday, October 5**
8:30 a.m.-10:00 a.m.

RISK ASSESSMENT FOR MEN WITH PROBLEMATIC SEX ACTS AND DEVELOPMENTAL DELAY

Supported by the Canadian Institute of Health Research

J. Paul Fedoroff, M.D., *Research Unit Director, University of Ottawa, Forensic Division 1145 Carling, Ottawa, Ontario, Canada K1Z 7K4*; Susan Curry; Gina Madri-grano; Chanie Cunningham; Soula Korovessis; John M. Bradford, M.B.; Deborah Richards; Dorothy Griffiths

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should be able to appreciate the unique factors that may influence risk assessment in this specific offender population.

SUMMARY:

Participants consented to their charts being reviewed, and information being collected in order to score the VRAG and the SORAG, as well as being administered the WASI (Wechsler Abbreviated Scale of Intelligence) to obtain an estimate of their IQ. Care providers completed the SDRS, an eight item dynamic risk scale, on a monthly basis. Event reporting forms, including information regarding the event type, date, location, victim or target, degree of damage/injury and consequence of events, were completed by the care providers when a reportable event occurred. Neither VRAG nor SORAG scores accurately predicted violent or sexual misbehaviour over a 2 month follow-up. In contrast, means SDRS score for the month prior to an event—without an event, was significantly higher than the mean SDRS score for those men who had no events reported during follow-up. These results support the study hypothesis that VRAG and SORAG scores are unreliable indicators of future difficulties in men with developmental delay at least in the short term. The SDRS is a valuable tool to detect changes in the behaviour of developmentally delayed men that may predict mis-behaviour in the short term. This study was supported by the Canadian Institutes of Health Research (CIHR).

TARGET AUDIENCE:

Forensic psychiatrists.

REFERENCES:

1. Griffiths DM, Richards D, Fedoroff JP, & Watson S. (2002) *Ethical Dilemmas: Sexuality and Developmental Disability*. Kingston, NY: NADD Press.
2. Quinsey VL, Book A. & Skilling TA (2004). A follow-up of deinstitutionalized men with intellectual disabilities and histories of antisocial behaviour. *Journal of Applied Research in Intellectual Disabilities*, 17, 243–253.

Poster 16 **Thursday, October 5**
8:30 a.m.-10:00 a.m.

PREDICTORS OF PSYCHIATRIC INPATIENTS' LEVEL OF DEPRESSION AT DISCHARGE: CLINICAL AND RESEARCH IMPLICATIONS

Robert Friedberg, Ph.D., *Associate Professor, Department of Psychiatry, Hershey Medical Center, 22 Northeast Drive, Hershey, PA 17033*; Adam G. Biuckians, M.D., *Resident, Department of Psychiatry, Hershey Medical Center, 22 Northeast Drive, Hershey, PA 17033*; Donald J. Viglione, Jr., Ph.D.; Bobby L. Stinson, Psy.D.; Raymond A. Fidaleo, M.D.; Manling Chen, M.S.; Kathleen G. Beal, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate understanding of what factors predicted inpatients' depression scores at discharge; identify clinical implications of the research findings; and recognize promising future directions for continued research.

SUMMARY:

This was a third study in a three-part project examining Beck Depression Inventory Scores in psychiatric inpatients hospitalized on a Cognitive Therapy Unit. More specifically, the study examined predictors of discharge in these depressed inpatients. Method: Data on approximately Caucasian psychiatric inpatients were collected in the first six months of 1994. BDI scores and scores on social perception measure designed for this study were culled from the patients' charts along with demographic information and data on their length of stay (LOS). Results: As hypothesized, statistically significant gender differences were found on the BDI at both admission ($t=2.49$, $df=144$, $p<.05$) and at discharge ($t=2.58$, $df=107$, $p<.01$). A weighted least square regression analysis was employed to test which variables best predicted discharge depression. Depression at ad-

mission, gender, and length of stay powerfully predicted depression at discharge accounting for 41% of the variance in the discharge depression scores ($R^2=.41$, $df=41$, $p<.001$). Admission BDI scores were the most powerful predictor scores explaining 23% of the variance with length of stay accounting for 11% and gender contributing 7% to the variance. Discussion: Clinical, methodological and administrative implications of the results are discussed.

An earlier version of this poster was originally presented at the 2006 American Psychiatric Association Annual Meeting, held in Toronto, Canada.

REFERENCES:

1. Clark DA, Beck AT, & Alford BA. (1999). Scientific foundations of cognitive theory and therapy of depression. New York: Guilford.
2. Friedberg RD, Viglione DJ, Stinson BL, Beal KG, Fidaleo RA, & Celeste B. (1999). Perceptions of treatment helpfulness and depressive symptomology in psychiatric inpatients on a cognitive therapy unit. *Journal of Rational-Emotive and Cognitive Behavior Therapy*, 17, 33–50.

Poster 17

Thursday, October 5
8:30 a.m.-10:00 a.m.

DECREASING THE USE OF RESTRAINT AND SECLUSION AMONG PSYCHIATRIC INPATIENTS

David J. Hellerstein, M.D., *Associate Professor of Clinical Psychiatry, Columbia University, 180 Fort Washington Avenue, HP#256, New York, NY 10032*; Amy Bennett-Staub, *Director, Quality Management, Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032*; Elizabeth R. LeQuesne, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe ways in which an academic urban psychiatric hospital was able to decrease use of restraint and seclusion without a concomitant increase in adverse outcomes.

SUMMARY:

Objective: Restraint and seclusion (R/S) of psychiatric patients are “last resort” measures used when a patient presents an imminent risk to self or others. R/S episodes may cause emotional trauma, even physical harm or death. Clinical and ethical considerations and external regulations stipulate that R/S should be used as seldom as possible. We describe a hospital-wide effort to decrease R/S, with the hypotheses that interventions could:

1) reduce the number of patients in R/S, 2) reduce patient hours in R/S, 3) without an increase in adverse outcomes (fights/assaults, staff injuries).

Method: Study was performed at an urban academic psychiatric hospital (NY State Psychiatric Institute) with 3 inpatient units totaling 57 beds. Interventions included 1) decreased initial time in R/S from 4 to 2 hours before new order was required; 2) staff education to identify patients at risk of R/S and provide early interventions to avoid crises; 3) a coping questionnaire to assess patient preferences for dealing with agitation. Data was assessed 18 months before and 66 months following these interventions.

Results: Mean number of patients restrained went from 0.35 to 0.32 patients/month, and hours of restraint decreased from 0.05 to 0.03 hours per 1000 patient hours. Mean number of patients secluded decreased from 3.18 to 1.13 patients/month. Mean hours of seclusion decreased markedly, from 1.28 to 0.09 hours per 1000 patient hours. There was no increase in patient-related staff injuries or in fights/assaults.

Conclusions: Interventions were successful in decreasing R/S usage over five year follow-up. Such interventions may be adapted to other settings.

TARGET AUDIENCE:

Clinical psychiatrists, mental health professionals, and health services researchers.

REFERENCES:

1. Schreiner GM, Crafton CG, Sevin JA: Decreasing the use of mechanical restraints and locked seclusion. *Adm Policy Ment Health* 31:449–63, 2004.
2. Fisher WA: Elements of successful restraint and seclusion reduction programs and their application in a large, urban, state psychiatric hospital. *J Psychiatr Pract* 9:7–15, 2003.

Poster 18

Thursday, October 5
8:30 a.m.-10:00 a.m.

ASSESSING HEALTH AND NUTRITION STATUS OF URBAN PSYCHIATRIC OUTPATIENTS

David J. Hellerstein, M.D., *Associate Professor of Clinical Psychiatry, Columbia University, 180 Fort Washington Avenue, HP#256, New York, NY 10032*; Goretti Almeida, M.B.A., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032*; Michael J. Devlin, M.D.; Nathaniel Mendelsohn, A.B.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe health and nutritional issues related to outpatients treated in urban psychiatric settings, with particular reference to the needs of Hispanic patients with chronic mental disorders.

SUMMARY:

Objective: Individuals with chronic mental disorders often suffer from health problems, including obesity, hypertension, and diabetes, which may be exacerbated by psychotropic medications, and may result in excess mortality. This study assessed the health status of predominantly Hispanic outpatients in an urban psychiatric day program.

Method: 69 patients (of 105 enrollees) were assessed by chart review, interview and somatic measurements, for blood pressure, weight, girth, body mass index (BMI), glucose and lipid levels, as well as nutritional habits and medical care.

Results: Patients were 51% female, 78% Hispanic, and predominantly between the ages of 25 and 64 years. 57% were diagnosed with schizophrenia-spectrum disorders. 86% were on antipsychotic medications, and 25% were on two or more antipsychotics. Only 11% of women and 41% of men had normal weight, 29% of women and 18% of men were overweight (BMI = 25–29.9); and 60% of women and 41% of men were obese (BMI ≥ 30). Atypical antipsychotic treatment was significantly associated with obesity (BMI ≥ 30) ($\chi^2 = 5.5, df = 1, p < .025$). Waist measurements showed significant abdominal obesity among female patients, according to American Heart Association criteria. Blood pressure was elevated in 77% of patients (45% were pre-hypertensive [with BP 120–139/80–89]; and 32% were hypertensive [with BP ≥ 140/90]), and 53% had elevated random blood glucoses (>110 mg/dL). Patients generally had had recent medical follow-up, and most had adequate cooking facilities.

Conclusions: These predominantly Hispanic chronically mentally ill individuals are at high risk for cardiac illness, highlighting the need for developing culturally-sensitive interventions in urban outpatient psychiatric settings.

This study was supported by a Health Promotions Funding Award grant from the New York State Office of Mental Health Bureau of Health Services, and a grant from the Frontier Fund of the Department of Psychiatry, Columbia University College of Physicians and Surgeons

TARGET AUDIENCE:

Clinical psychiatrists, other mental health professionals, and health services researchers.

REFERENCES:

1. Marder SR, Essock SM, Miller AL, et al. Physical health monitoring of patients with schizophrenia. *Am J Psychiatry* 2004; 161:1334–1349.
2. Hellerstein DJ, Almeida G, Devlin MJ, et al. Naturalistic study of obesity and other related health problems of chronic mentally ill Hispanic patients in an urban outpatient setting. *Psychiatric Quarterly* 2006; in press.

Poster 19

**Thursday, October 5
8:30 a.m.-10:00 a.m.**

PREVALENCE OF INTIMATE PARTNER VIOLENCE IN INPATIENTS WITH SUICIDAL INTENT

Alison M. Heru, M.D., (Clinical), *Associate Professor, Department of Psychiatry, Brown Medical School, 345 Blackstone Boulevard, Providence, RI 02906*; Patricia R. Recupero, M.D., *Clinical Professor of Psychiatry, Brown University; and President and Chief Executive Officer, Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906*; Gregory L. Stuart, Ph.D.; Samara Rainey, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the prevalence of intimate partner violence and relational dysfunction among suicidal inpatients.

SUMMARY:

Objective: To identify the prevalence of intimate partner violence (IPV) in psychiatric inpatients, with suicidal ideation. *Method:* Eligible patients, aged 18–65, living with partner for at least six months, who were admitted with suicidal ideation completed a demographics questionnaire and self-report assessment measures. *Results:* Over 90% reported IPV perpetration and victimization with no gender differences noted. Poor general relational functioning was correlated with IPV for both genders. Relational functioning was equally poor across all domains for both genders. When the sample was divided into good and poor relational functioning, a gender difference emerged. For women, poor relational functioning was correlated with psychological abuse by respondent and partner, physical assault by respondent and partner physical injury by respondent. For men, a correlation was present only for physical injury by respondent and partner. Gender differences were also found in the correlations between the FAD subscales and the 2 major CTS2 subscales: physical violence and psychological violence, with greater correlation for women than men. *Conclusion:* Suicidal inpatients report very high levels

of bidirectional IPV with equal rates for each gender. Poor relational functioning is associated with IPV for both genders although the patterns of dysfunction are different.

TARGET AUDIENCE:

Inpatient psychiatrists, and family therapists.

REFERENCES:

1. Heru AM, Stuart GL, Eyres J, Rainey S, Recupero PR. Prevalence and Severity of Intimate Partner Violence and Associations with Family Functioning and alcohol Abuse in Psychiatric Inpatients with Suicidal Intent. *Journal of Clinical Psychiatry*; 2006; 67:23–29.
2. Straus MA, Hamby SL, Boney-McCoy S, Sugarman DB: The Revised Conflict Tactic Scales (CTS2): Development and preliminary psychometric data. *Journal of Family Issues*, 1996; 17 (3):283–316.

Poster 20

Thursday, October 5
8:30 a.m.-10:00 a.m.

IMPLICATIONS OF CYP2D6 ULTRA-RAPID METABOLISM IN THE TREATMENT OF MANIA

Brenda L. Jensen, M.D., *Resident, Department of Psychiatry, University of California at Irvine, 2 Chinaberry, Irvine, CA 92618-7009*; Charles S. Nguyen, M.D.; Gerald Maguire, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that genotype testing of CYP2D6 can potentially improve clinical response by influencing the selection and dosing of psychiatric medications.

SUMMARY:

Introduction: CYP2D6 enzymes metabolize many psychiatric medications and can potentially impact a patient's clinical response. In this case report, we describe a patient with bipolar disorder who did not respond to numerous psychotropic medications and was later found to have ultra-rapid metabolism of CYP2D6.

Case Report: AG was a 23 year old Hispanic female hospitalized for worsening manic symptoms. She was started on olanzapine and divalproex ER. After 2 weeks of no response, she was switched from divalproex to lithium and started on chlorpromazine. AG's symptoms continued. Chlorpromazine was discontinued, while aripiprazole and haloperidol were added. After AG's agitation increased, aripiprazole was stopped, haloperidol was increased, and quetiapine and oxcarbazepine were

started. This resulted in significant clinical improvement. Near the end of her 64 day hospitalization, AG was found to be an ultra-rapid metabolizer of CYP2D6.

Conclusion: This case suggests that a patient's CYP2D6 ultra-rapid metabolism phenotype is important in guiding medication choices and dosing, even when combination therapies only include a limited number of medications that are CYP2D6 substrates. The patient did not have a clinical recovery until several medications not metabolized by CYP2D6 were initiated and a medication metabolized by CYP2D6 was increased in dose.

TARGET AUDIENCE:

All psychiatrists who treat patients with medications metabolized by CYP2D6.

REFERENCES:

1. Leon J, Armstrong S, Cozza K. Med-Psych Drug-Drug Interactions Update: Clinical Guidelines for Psychiatrists for the Use of Pharmacogenetic Testings for CYP450 2D6 and CYP250 2C19. *Psychosomatics* 2006; 47:75–85.
2. Chou WH, Yan FX, Robbins-Weilert DK, et al: Comparison of two CYP2D6 genotyping methods and assessments of genotype-phenotype relations. *Clinical Chemistry* 2003; 49:542–551.

Poster 21

Thursday, October 5
8:30 a.m.-10:00 a.m.

THE EFFECT OF PERSONALITY TRAITS ON THE PROPHYLACTIC EFFICACY OF SSRI'S IN RECOVERED DEPRESSIVES

Sabrina J. Khan, M.D., *Resident, Department of Psychiatry, New York University School of Medicine, 344 Third Avenue, #17F, New York, NY 10010*; Eric D. Peselow, M.D., *Medical Director, Freedom From Fear, 32 Bassett Avenue, Brooklyn, NY 11234-6724*; Borboro Orlovski, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand whether the presence or absence of personality traits/disorders affects the long-term course of patients treated with antidepressants who completely recovered from a depressive episode.

SUMMARY:

Objective: With research showing a 30–70% prevalence of personality disorders in samples of depressed individuals, there is clear evidence for the comorbidity of personality disorders and unipolar depression. One major issue is the difficulty in assessing the effect personality traits/disorders has on the long-term course of

depression. For instance, do individuals who receive prophylactic SSRIs have a differential long-term course in preventing depression if they have deviant personality traits. It is the purpose of this poster to evaluate the long-term course of recovered depressives treated prophylactically with SSRIs who either do or do not have deviant personality traits.

Method: Over a 10 year period, we measured personality traits/disorder in 168 patients during who had recovered from a depressive episode after receiving SSRI treatment. We used the Structured Interview for DSM-IV Personality Disorder (SIDP) was used to measure maladaptive personality traits. The SIDP measures ratable traits of the 10 DSM-IV personality disorders. All traits within a disorder are rated on a 0–3 point scale.

Results: The higher the dimensional personality trait score for the 10 total personality disorders the quicker the relapse ($r=-.378$ $p<.0001$) The average number of months stable for the group that was diagnosed with at least one categorical personality diagnosis ($n=95$) was 29.82 vs. 43.81 for the group with no categorical personality disorder diagnosis ($n=73$). This difference was highly significant ($p<.0004$).

Conclusion: The presence of deviant personality traits and/or categorical diagnosis in recovered depressives led to a quicker relapse despite prophylactic SSRI use.

TARGET AUDIENCE:

Clinical psychiatrists, psychiatric nurses, and psychologists.

REFERENCES:

1. Mulder RT. Personality pathology and treatment outcome in major depression: a review. *American Journal of Psychiatry*, 2002; 159:359–371.
2. Weissman MM, Prusoff BA, Klerman GL. Personality and the prediction of long-term outcome of depression. *American Journal of Psychiatry*, 1978 Jul; 135(7):797–800.

Poster 22

Thursday, October 5
8:30 a.m.-10:00 a.m.

AUTISM, ASPERGER’S, AND SCHIZOPHRENIA: COMMON ENDOPHENOTYPIC AND GENETIC CHARACTERISTICS OF NEGATIVE SYMPTOM SPECTRUM DISORDERS

Supported by Janssen Pharmaceutica, Inc.

Donna L. Londino, M.D., *Assistant Professor of Psychiatry, Medical College of Georgia, 1515 Pope Avenue, Augusta, GA 30904-5843*; Benjamin Carr, M.D., *Resident, Department of Psychiatry, Medical College of*

Georgia, 1515 Pope Avenue, Augusta, GA 30912; Elizabeth Sirota, M.D.; Jeffrey L. Rausch, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify regions of the genome associated with common endophenotypic symptomatology.

SUMMARY:

Negative symptoms have been associated almost exclusively with schizophrenia; however, there are social deficits and cognitive/behavioral stereotypes in autism, Asperger’s disorder, schizoid and schizotypal personality disorder. Theoretically, these disorders may have overlapping genetic diatheses that contribute to overlapping endophenotypes. Substantial information is available for genetic markers in schizophrenia, autism, and Asperger’s disorder, but not for schizoid and schizotypal personality disorders. We mapped markers with significant linkage disequilibrium and found 9 regions of overlap. One region on the X chromosome was reported for Asperger’s disorder and autism, but not schizophrenia. The results for the X chromosome are intriguing considering the male predominance of Asperger’s and autism as composed to schizophrenia. The findings could be consistent with the 9 chromosomal regions being linked to common endophenotypes and 1 X-linked area coding for unique aspects of autism and Asperger’s disorder or a gene protective against the positive symptoms of schizophrenia. More information is needed since the studies classified linkage disequilibrium with the disorders as a whole and not by endophenotypes. The results suggest that cross-disorder endophenotyping of specific symptoms should receive more emphasis in whole genome mapping to identify regions of the genome associated with common endophenotypic symptomatology.

Funded by Janssen Pharmaceutica, Inc..

TARGET AUDIENCE:

Psychiatrists, pediatricians, and beneficists.

REFERENCES:

1. Rasch JL, Asperger’s disorder as a negative symptom spectrum disorder a comparison with schizophrenia & schizotypal and schizoid personality to Submitted for publication <http://www.ncbi.nlm.nih.gov/mapview>.

Poster 23

Thursday, October 5
8:30 a.m.-10:00 a.m.

PSYCHOPHARMACOLOGICAL TREATMENTS AND CHANGES IN BODY MASS INDEX IN ADOLESCENTS

Robert J. Love, D.O., *Chief Resident, Department of Psychiatry, University of Texas, 9502 Fallen Willow,*

San Antonio, TX 78254; Ashley Love, D.P.H., Assistant Professor, Department of Health, University of Texas, 6900 North Loop 1604, West, San Antonio, TX 78249

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the lack of statistically significant association between exposure to various classes of psychopharmacological agents and weight gain in terms of Body Mass Index (BMI), as well as BMI Z-score that was observed in a sample of child and adolescent psychiatric patients treated in an outpatient clinic setting.

SUMMARY:

Objective: To determine if any associations would be observed between change in BMI/BMI Z-score, psychotropic medication administration, and several potentially confounding variables in clinical sample of child and adolescent psychiatric outpatients.

Method: Retrospective analyses of 250 charts of patients who received treatment in an outpatient clinic during 18 month period prior to these analyses were performed. Of these charts, 204 contained adequate follow-up information. Multiple comparisons were performed using repeated measures analyses of covariance.

Result: There was significant change in BMI ($p = .05$), but not a statistically significant change in BMI Z-score on all the children from baseline to follow-up. The mean and median number of days on stable regimen was 721.7 and 460.5 respectively. There were no statistically significant effects on the change in BMI/BMI Z-score that were revealed when comparison was performed with: age; gender; class of psychotropic medication used (including: atypical antipsychotic, antidepressant, mood stabilizer, and stimulant medications); total number of medications; total time of exposure; or exposure to psychotropic medication prior to observation period.

Conclusions: After comparing the changes in BMI/BMI Z-score between patients differentiated by various parameters, we did not find any statistically significant associations between any of these factors and change in BMI/BMI Z-score.

TARGET AUDIENCE:

Mental health professionals working with children and adolescents

REFERENCES:

1. Vieweg WVR, Kuhnley LJ, Kuhnley EJ, Antm EA, Socd B, Panduzangi A, and Silverman JJ. Body mass index (BMI) in newly admitted child and adolescent psychiatric inpatients. *Progress in Neuropsychopharmacology & Biological Psychiatry* 2005; 29:51.
2. Ratzoni G, Gothelf D, Brand-Gothelf A, Reidman J, Kikinzon L, Gal G, Phillip N, Apter A, Weizman

R. Weight Gain Associated With Olanzapine and Risperidone in Adolescent Patients. A Comparative Prospective Study. *J. Am. Acad. Child Adolesc Psychiatr.*

Poster 24

Thursday, October 5
8:30 a.m.-10:00 a.m.

FACTORS ASSOCIATED WITH PSYCHIATRIC SERVICE USE IN LATINO ADOLESCENTS

Karen G. Martinez, M.D., Assistant Professor, Department of Psychiatry, University of Puerto Rico, 170 Avenue Arterial Hostos, Apt. B-6, San Juan, PR 00918-5041; Katyna Rosario, M.D.; Lelis L. Nazario, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the need for better access to mental health services in Latino children and adolescents, and identify factors that may play a role in improving service access in this population.

SUMMARY:

Access to mental health services, in addition to being a problem for children and adolescents with psychiatric disorders, has also been described in Latino populations (Alegria, 2002; Kataoka SH, 2002). For these reasons, we attempt to describe the individual, socioeconomic and family factors that play a role in accessing treatment in Latino adolescents. All patients admitted to the Intensive Ambulatory Program at the University Pediatric Hospital of Puerto Rico from January to December 2005 were evaluated to assess reasons and diagnosis for admission as well as psychosocial risk factors for mental health problems. The profile of the patients showed that they were most frequently females, from 15 to 17 years old, above poverty level and living only with their mothers. The most common initial diagnosis was mood disorders. Referral was from their ambulatory psychiatrist due to aggression towards others and the most frequently identified stressor was family conflicts. Most patients did not present a history of abuse but did present family psychiatric history and school problems. Analysis revealed that statistically significant factors associated with more prolonged length of stay were having a private health plan, high-income level and having comorbid diagnosis, especially mood disorder comorbid with disruptive disorder.

TARGET AUDIENCE:

Psychiatrists who treat Latino children and adolescents and health services administrators.

REFERENCES:

1. Alegria M, Canino G, Lai S et al. Understanding caregiver's help-seeking for Latino children's mental health care use. *Medical Care*. 2004; 42(5):447-455.
2. Kataoka SH, Zhang L, Wells KB. Unmet need for mental health care among US children: variation by ethnicity and insurance status, *Am J Psychiatry*. 2002; 159(9):1548-1555.

Poster 25

**Thursday, October 5
8:30 a.m.-10:00 a.m.**

PREVALENCE OF PTSD IN PREGNANT WOMEN WITH PRIOR PREGNANCY COMPLICATIONS

Melanie Y. McKean, D.O., Ph.D., *Resident Physician, Department of Psychiatry, Yale University, 5142 North Paulina Street, Apt. 2, Chicago, IL 60640-2742*; Urania Magriples, M.D.; Naamit Kurshan, M.D.; Kathryn A. Czarkowski, M.A.; Linda Mayes, M.D.; C. Neill Epperson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will be aware of the incidence of post-traumatic stress disorder (PTSD) in pregnant women who have experienced a previous pregnancy complication. In addition, clinicians will become familiar with a method to assess pregnant women with prior pregnancy complications for PTSD.

SUMMARY:

Objective: Post-traumatic stress disorder (PTSD) involves the development of characteristic symptoms following a traumatic event, including re-experiencing the event, avoidance of stimuli associated with the event, and symptoms of increased physiologic arousal. As a pregnancy loss or other complication can be considered traumatic and severity of PTSD has been linked to the frequency of traumatic reminders, we sought to examine the prevalence of full and partial PTSD in a group of pregnant women who have experienced a previous pregnancy loss or serious complication.

Methods: Forty-two pregnant women referred to a university-based maternal fetal medicine program who experienced a previous pregnancy loss or complication completed a self-rated pregnancy complication questionnaire (PCQ) based on the Clinician-Administered PTSD Scale (CAPS-1). Another 24 women underwent a clinical interview to assess presence of PTSD due to a pregnancy-related trauma.

Results: Of the 42 women who provided self-rated assessments, the prevalence of PTSD meeting DSM-IV criteria was 5/42, while an additional 10/42 met criteria for partial PTSD. Of the 24 women who underwent

clinician-rated assessments, 2/24 met criteria for full PTSD and 6/24 met criteria for partial PTSD.

Conclusions: The prevalence of full and partial PTSD in women who are pregnant subsequent to a pregnancy-related trauma is considerable. Given anxiety during pregnancy is not without risks to both mother and fetus, women who have experienced a previous pregnancy loss should be screened for the presence of clinically meaningful symptoms of PTSD.

TARGET AUDIENCE:

Clinicians treating pregnant women.

REFERENCES:

1. Blanchard EB, Hickling EJ, Taylor AE, Forneris CA, Loos W, and Jaccard J. (1995). Effects of varying scoring rules of the Clinician Administered PTSD Scale (CAPS) for the diagnosis of post-traumatic stress disorder in motor vehicle accident victims. *Behaviour Research & Therapy*, 33 (4), 471-475.
2. Blake DD, Weathers FW, Nagy LM, Kaloupek DG, Gusman FD, Charney DS, Kean TM. (1995). The development of a Clinician-Administered PTSD Scale. *Journal of Traumatic Stress*, 8, 75-90.

Poster 26

**Thursday, October 5
8:30 a.m.-10:00 a.m.**

MORTALITY AND MEDICAL COMORBIDITY IN PATIENTS WITH SERIOUS MENTAL ILLNESS: PART TWO

Brian J. Miller, M.D., M.P.H., *Psychiatry Resident, Medical College of Georgia, 1961 Long Creek Falls, Grovetown, GA 30813*; C. Bayard Paschall III, Ph.D., *Chief, Office of Quality Improvement, Ohio Department of Mental Health, 30 East Broad Street, Columbus, OH 43215*; Dale P. Svendsen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to gain an improved understanding of the leading causes of death and medical co-morbidities among SMI patients admitted to the Ohio Department of Mental Health-licensed psychiatric units and the need to target interventions that improve quality of life outcomes for this population.

SUMMARY:

Objectives: We recently documented excess mortality and examined leading causes of death and medical co-morbidities among patients with serious mental illness (SMI) discharged from Ohio public psychiatric hospitals. The purpose of this study was to extend our previous work to examine a larger psychiatric inpatient popula-

tion. *Methods:* Medicaid pre-admission screening records from 177,000 inpatient admissions to Ohio Department of Mental Health-licensed psychiatric units between 1998 and 2004 were matched against state death records, identifying 2819 deaths. Deaths were further stratified by age, gender, race, and primary diagnosis. Leading causes of death and medical co-morbidities, years of potential life lost (YPLL), and the time interval between discharge and death were calculated for this population. *Results:* Heart disease (N=629, 22%) and cancer (N=335, 12%) were the leading causes of death. Decedents had a mean YPLL of 28.5 +/- 13.6 years. Hypertension (N=559, 20%) and diabetes mellitus (N=486, 17%) were the most prevalent medical co-morbidities. There were 143 deaths within 31 days post-discharge. *Conclusions:* Our study demonstrated excess mortality among patients with SMI. This study reinforces the need to integrate the delivery of currently fragmented mental and physical health services and to target interventions that improve quality of life outcomes for this population.

REFERENCES:

1. Felker B, Yazel JJ, Short D: Mortality and Medical Comorbidity Among Psychiatric Patients: A Review. *Psychiatric Services: 1356-1363, December 1996.*
2. Dembling BP, Chen DT, Vachon L: Life Expectancy and Causes of Death in a Population Treated for Serious Mental Illness. *Psychiatric Services 50: 1036-1042, August 1999.*
3. Miller BJ, Paschall CB, Svendsen DP: Mortality and Medical Comorbidity in Patients with Serious Mental Illness. *Psychiatric Services: Accepted for publication 12/2005. Publication date 10/2006.*

Poster 27

**Thursday, October 5
8:30 a.m.-10:00 a.m.**

UNDERSTANDING AND IMPLEMENTING COMMUNITY RESEARCH PARTNERSHIPS

Joan Nandlal, Ph.D., *Manager, Centre for Addiction and Mental Health, 1001 Queen Street, Room 2075, Admin., Toronto, Ontario, Canada M6J 1H4;* Melanie Ollenber, B.H.S., *Research Analyst, Centre for Addiction and Mental Health, 1001 Queen Street, Room 2075, Admin., Toronto, Ontario, Canada M6J 1H4;* Kate MacDonnell, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this poster presentation, the participant should be able to recognize various community research partnership theories, principles and processes,

as well as strategies to foster improved partnerships between researchers and community agencies.

SUMMARY:

A strong link between practice and research is crucial to create research projects that have applicability at the clinical and policy levels. Partnerships between community agencies and researchers facilitates the maintenance of this link. Our aim in this poster is to share insights with researchers and community agency decision-makers, regarding the development of partnerships serving persons with mental health issues and other marginalized populations. Drawing on tenets of participatory action research, Fetterman's (1999) view of *empowerment evaluation*, Nelson, Prilleltensky and MacGillivray's (2001) *value-based partnership framework*, and Fawcett et al.'s (1995) strategies for successful partnerships, we describe and examine different types of partnerships that we have forged over the past six years. We compare and contrast principles for ideal partnerships as reflected in these theories with the realities of the partnerships we have been involved in. We then offer 'lessons learned' regarding: the different manifestations of partnerships, the ways in which partner agencies have different needs from those of researchers, ways of addressing these different needs, the strategies used to build trust in an attempt to overcome partners' concerns in working with hospital-based/academic researchers. We complete the poster with suggestions for how to foster partnerships with community-based agencies.

TARGET AUDIENCE:

Researchers and community agency decision-makers (e.g., Executive Directors, Managers).

REFERENCES:

1. Fawcett SB, Paine-Andrews A, Francisco VT, Schultz JA, Richter KP, Lewis RK, Williams EL, Harris KJ, Berkley JK, Fisher JL, & Lopez CM. (1995). Using empowerment theory in collaborative partnerships for community health and development. *American Journal of Community Psychology, 23(5), 677-697.*
2. Fetterman DM. (1999). Reflections on empowerment evaluation: Learning from experience. *Canadian Journal of Program Evaluation, Special Issue, 5-38.*
3. Nelson G, Prilleltensky I, & MacGillivray H. 2001. Building value-based partnerships: Toward solidarity with oppressed groups. *American Journal of Community Psychology 29(5):649-677.*

Poster 28

**Thursday, October 5
8:30 a.m.-10:00 a.m.**

**ATYPICAL ANTIPSYCHOTIC
POLYPHARMACY RATES: A
COMPARISON OF DIFFERENT METHODS**

Supported by Eli Lilly and Company

Allen W. Nyhuis, M.S., *Associate Senior Statistician, Outcomes Research Department, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285*; Trina J. Clark, R.Ph., M.S.; Bridget M. Olson, Pharm.D., M.S.; Danielle L. Loosbrock, M.H.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize that there are different methods for calculating polypharmacy rates, which will result in very different results. Further, it should be recognized that polypharmacy rates are increasing over time, and are greater in the Medicaid population.

SUMMARY:

Objective: Atypical antipsychotic (AAP) polypharmacy is a growing clinical concern and target for decreasing pharmacy budgets. This study's purpose was to examine varying results when using different retrospective methodologic approaches to assess polypharmacy.

Method: AAP polypharmacy rates, both annual and point prevalence, were calculated and compared over time using different polypharmacy definitions and data sources. These sources included a privately insured population [PharMetrics®, 2000–2004] and a Medicaid population [large western state, 2000–2002]. Prescription records were used to create drug episodes, from which polypharmacy rates were computed for each calendar date and year of study. Descriptive statistics and general linear modeling were utilized.

Results: Using a 30-day persistence definition, annual AAP polypharmacy rates increased in the Medicaid (9.0% to 15.2%) and insured (3.4% to 7.8%) samples. In both, year-to-year rates increased significantly ($p=0.018$). The average difference between Medicaid and insured annual rates was 5.8% ($p=0.002$). The 30-day point prevalence rates remained at a consistent ratio (59%) of the corresponding annual rates.

Conclusion: AAP polypharmacy rates were higher for Medicaid patients versus insured patients, increasing over time. Point prevalence polypharmacy rates averaged 59% of annual rates. Decision-makers should consider the impact of different approaches when estimating polypharmacy.

Funding provided by Eli Lilly and Company.

TARGET AUDIENCE:

Payers, practicing clinicians, schizophrenia researchers, mental health decision makers, and advocacy groups.

REFERENCES:

1. Stahl SM. (2002). "Antipsychotic polypharmacy: squandering precious resources?" *Journal of Clinical Psychiatry* 63(2):93–94.
2. Kingsbury SJ, D Yi, et al. (2001). "Rational and Irrational Polypharmacy." *Psychiatric Services* 52(8):1033–1036.

Poster 29

**Thursday, October 5
8:30 a.m.-10:00 a.m.**

**META-ANALYSIS OF
NEUROPSYCHIATRIC INVENTORY
DOMAINS IN THREE, SIX-MONTH
TRIALS OF MEMANTINE IN MODERATE
TO SEVERE ALZHEIMER'S DISEASE**

Supported by Forest Laboratories, Inc.

Jason T. Olin, Ph.D., *Director, Clinical Development, Forest Laboratories, Inc., Harborside Financial Center Plaza V, Jersey City, NJ 07311*; Jeffrey L. Cummings, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to assess the efficacy of memantine on behavioral disturbances in patients with moderate to severe Alzheimer's disease.

SUMMARY:

Objective: Memantine, a moderate affinity, uncompetitive N-methyl-D-aspartate (NMDA) receptor antagonist, is approved in the US and in Europe for the treatment of moderate to severe Alzheimer's disease (AD). To assess the effects of memantine on behavioral disturbances in AD, a meta-analysis of three large-scale, randomized, placebo-controlled clinical trials was performed.

Methods: NPI total scores and individual domains from three, 6-month memantine trials in moderate to severe AD patients were analyzed (MEM-MD-01, van Dyck et al, in preparation; MEM-MD-02, Tariot et al, 2004; MRZ 90001-9605, Reisberg et al, 2003). All trials were randomized, double-blind, parallel-group designs comparing memantine (10 mg BID) to placebo. MEM-MD-02 allowed concomitant donepezil therapy (6 months, stable for 3 months). Standardized mean differences (SMD) were calculated using fixed-effect models; random effects models were used when evidence of heterogeneity was observed ($\text{Chi}^2 P \leq 10$). Analyses

were based on Intention-to-Treat populations using a last observation carried approach for replacement of missing values.

Results: Change from baseline on NPI total score at study endpoint for each trial revealed a statistically significant advantage of memantine over placebo in the MEM-MD-02 study only ($P=.002$). When data from all three trials were combined and analyzed, the NPI total score showed a homogeneous effect size in favor of memantine treatment ($\text{Chi}^2=3.32$, $P=.19$; $\text{SMD}=-0.17$ [95%CI -0.30 , -0.04], $P=.01$). Additionally, several NPI domains demonstrated statistically significant treatment differences in favor of memantine and all were homogeneous: delusions ($\text{Chi}^2=2.33$, $P=.31$; $\text{SMD}=-0.14$ [95%CI -0.27 , -0.02], $P=.03$), agitation/aggression ($\text{Chi}^2=2.48$, $P=.29$; $\text{SMD}=-0.24$ [95%CI -0.37 , -0.11], $P=.0003$), and irritability/lability ($\text{Chi}^2=3.49$, $P=.17$; $\text{SMD}=-0.13$ [95%CI -0.26 , 0.0], $P=.05$). Heterogeneity was seen on hallucinations and depression/dysphoria.

Conclusions: These findings suggest that memantine treatment of 6-months duration can provide a reduction in specific behavioral disturbances in patients with moderate to severe AD, including agitation/aggression, delusions, and irritability/lability.

REFERENCES:

1. Reisberg B, Doody R, Stöffler A, et al. Memantine in moderate-to-severe Alzheimer's disease. *N Engl J Med.* 2003; 348(14):1333–1341.
2. Tariot PN, Farlow MR, Grossberg GT, et al. Memantine treatment in patients with moderate to severe Alzheimer disease already receiving donepezil: a randomized controlled trial. *JAMA.* 2004; 291(3):317–324.

Poster 30

Thursday, October 5
8:30 a.m.-10:00 a.m.

NEUROPSYCHIATRIC INVENTORY SUBSCALE ANALYSIS OF MEMANTINE/ DONEPEZIL TREATMENT IN MODERATE TO SEVERE ALZHEIMER'S DISEASE

Supported by Forest Laboratories, Inc.

Jason T. Olin, Ph.D., *Director, Clinical Development, Forest Laboratories, Inc., Harborside Financial Center Plaza V, Jersey City, NJ 07311*; Jeffrey L. Cummings, M.D.; Pierre N. Tariot, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the potential for memantine to provide specific benefits for mood- and psychosis-related behavioral symptoms in Alzheimer's Disease.

SUMMARY:

Objective: Memantine, a moderate affinity, uncompetitive N-methyl-D-aspartate (NMDA) receptor antagonist, is approved in the US and in Europe for the treatment of moderate to severe Alzheimer's disease (AD). To assess the effects of memantine on behavioral disturbances in AD, a post hoc analysis of behavioral outcomes from a previously published trial of memantine in moderate to severe AD patients receiving stable donepezil treatment was performed.

Methods: Neuropsychiatric Inventory (NPI) individual items were aggregated into four subscales based on a modification to a previously reported factor analysis. Subscales were defined as follows: Mood (depression/dysphoria, anxiety, irritability/lability, night-time behavior disturbances, appetite/eating change), Psychosis (delusions, hallucinations, agitation/aggression), Frontal (euphoria/elation, disinhibition), or Other (apathy, aberrant motor behavior). The efficacy analysis was based on the Intention to Treat population, using the Last Observation Carried Forward approach to missing data.

Results: Baseline characteristics between the placebo treatment group and memantine treatment group were comparable. The total NPI score was significantly lower for the memantine group as compared to the placebo group at week 24 ($P=.002$), representing fewer behavioral disturbances and psychiatric symptoms in memantine-treated patients. On the Mood subscale, memantine/donepezil treated patients demonstrated improvement at study endpoint whereas placebo/donepezil treated patients worsened by 1.6 points ($P=.002$). Although symptoms of psychosis increased in both groups, the increase was significantly attenuated in memantine/donepezil treated patients compared to placebo/donepezil treated patients ($P=.008$). Frontal symptoms and Other symptoms were not significantly different between treatment groups.

Conclusions: These findings suggest that 6-months of memantine treatment in patients receiving stable donepezil significantly reduces behavioral symptoms in patients with moderate to severe AD, with a benefit for behaviors associated with mood and psychosis.

REFERENCES:

1. Tariot PN, Farlow MR, Grossberg GT, et al. Memantine treatment in patients with moderate to severe Alzheimer disease already receiving donepezil: a randomized controlled trial. *JAMA.* 2004; 291(3):317–324.
2. Frisoni GB, Rozzini L, Gozzetti A, et al. Behavioral syndromes in Alzheimer's disease: description and correlates. *Dement Geriatr Cogn Disord.* Mar-Apr 1999; 10(2):130–138.

Poster 31

Thursday, October 5
8:30 a.m.-10:00 a.m.

**THE EFFECT OF MEMANTINE ON
DISTINCT BEHAVIOR SYNDROMES IN
MODERATE TO SEVERE ALZHEIMER'S
DISEASE PATIENTS**

Supported by Forest Laboratories, Inc.

Jason T. Olin, Ph.D., *Director, Clinical Development, Forest Laboratories, Inc., Harborside Financial Center Plaza V, Jersey City, NJ07311*; Jeffrey L. Cummings, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the potential for memantine to provide specific benefits to Alzheimer's Disease patients for mood- and psychosis-related behavioral symptoms based on the Neuropsychiatric Inventory.

SUMMARY:

Objective: In a previously reported 24-week placebo-controlled, double-blind clinical trial in moderate to severe AD patients on concomitant donepezil treatment, memantine-treated patients performed significantly better on the Neuropsychiatric Inventory (NPI) than placebo-treated patients. The current study is a post hoc analysis in which NPI individual items were aggregated into four subscales (modified from a previously reported factor analysis) to determine whether memantine has specific effects on one or more subscales. Memantine is a moderate affinity, uncompetitive N-methyl-D-aspartate (NMDA) receptor antagonist approved in the US and in Europe for moderate to severe AD.

Methods: Behavioral subscales were defined as follows: Mood (depression/dysphoria, anxiety, irritability/lability, night-time behavior disturbances, appetite/eating change), Psychosis (delusions, hallucinations, agitation/aggression), Frontal (euphoria/elation, disinhibition), or Other (apathy, aberrant motor behavior). A positive response for each subscale was defined as no net change or net improvement on the NPI items constituting the subscale. *P* values were based upon a CMH test controlling for study center.

Results: Results (OC) indicate that memantine had a significant effect over placebo upon symptoms in the Mood subscale at both weeks 12 ($P=.034$) and 24 ($P=.033$), with 65.5% of patients in the memantine group showing a positive response at week 24. Memantine also had a significant effect over placebo (OC) upon symptoms of Psychosis at both weeks 12 ($P=.006$) and 24 ($P<.001$), with 80.7% of patients in the memantine group showing a positive response in this domain at week 24. The response difference (OC) between memantine and placebo patients at week 24 was 12.2% and

18.9% for Mood and Psychosis subscales, respectively. LOCF analysis yielded comparable results. Effects of memantine on Frontal symptoms were not significant, while the effects on Other symptoms were significant at week 24 using LOCF analysis ($P=.037$), but not OC analysis ($P=.058$).

Conclusions: Taken together, these results suggest that memantine provides specific behavioral benefits for mood and psychosis-related symptoms associated with AD.

REFERENCES:

1. Frisoni GB, Rozzini L, Gozzetti A, et al. Behavioral syndromes in Alzheimer's disease: description and correlates. *Dement Geriatr Cogn Disord.* Mar-Apr 1999; 10(2):130-138.
2. Tariot PN, Farlow MR, Grossberg GT, et al. Memantine treatment in patients with moderate to severe Alzheimer disease already receiving donepezil: a randomized controlled trial. *JAMA.* 2004; 291(3):317-324.

Poster 32

Thursday, October 5
8:30 a.m.-10:00 a.m.

**PERSONAL AND SOCIAL PERFORMANCE
SCALE IN PATIENTS WITH ACUTE
SCHIZOPHRENIA**

*Supported by Johnson & Johnson
Pharmaceutical Services*

Donald Patrick, Ph.D., *Professor, University of Washington, P.O. Box 357660, 1959 N.E. Pacific, Seattle, WA 98195*; Dennis D. Gagnon, M.A., MABF, *Director of Health, Economics, and Pricing, Johnson & Johnson Pharmaceutical Services, L.L.C. 700 U.S. Highway 202, South, P.O. Box 670, Raritan, NJ 08869*; Ines Adriaenssen, M.S.C.; Pier L. Morosini, M.D.; Margaret Rothman, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should understand that the Personal and Social Performance Scale is a reliable and valid measure of personal and social function in patients with acute schizophrenia with good construct validity and sensitivity to clinical change.

SUMMARY:

The Personal and Social Performance scale (PSP) addresses 4 domains of personal and social functioning and has shown good reliability and validity in patients with stabilized schizophrenia¹. This research presents data on validity, reliability, responsiveness and mini-

mally important difference (MID) of the PSP in patients with acute schizophrenia.

Data from a cross-sectional validation study (n=299) and three pooled clinical antipsychotic trials (n=1692), including patients with acute psychotic symptoms (baseline mean PANSS>90), were analyzed. Intraclass correlation coefficients (ICC) were derived to assess inter-rater and test-retest reliability. Convergent and discriminant validity, sensitivity of the PSP to clinical change and MID were evaluated.

The test-retest and inter-rater ICCs exceeded 0.80, indicating good reliability. PSP was more highly correlated with PANSS items expected to have an impact on social function (active social avoidance [p=-0.26], emotional withdrawal [p=-0.23], passive/apathetic social withdrawal [p=-0.24]). PSP was able to discriminate between different levels of CGI severity (p<0.005). Regression analyses showed that PSP is sensitive to change in PANSS total score (p<0.0001). Based on a 1 category improvement in CGI-S, the observed between-group MID for PSP in acute patients was 7 points.

These data support the PSP as a valid, reliable clinician-reported measure of personal and social function in acute schizophrenia patients.

TARGET AUDIENCE:

Psychiatrist and other mental health professionals.

REFERENCES:

1. Morosini PL et al. *Acta Psychiatr Scand* 2000; 101(4):323-329.

Poster 33

**Thursday, October 5
8:30 a.m.-10:00 a.m.**

CONTINUOUS ELIGIBILITY CONSTRAINT MAY UNDERESTIMATE COST IN CLAIMS DATA

Supported by Eli Lilly and Company

Glenn A. Phillips, Ph.D., *Outcomes Research Consultant, Eli Lilly and Company, Lilly Corporate Center, DC 4133, Indianapolis, IN 46285*; Baojin Zhu, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand that continuous eligibility requirements in claims data analysis may underestimate health care cost, and be aware of some cost components that are affected by the requirement.

SUMMARY:

When conducting claims data analyses, a common requirement is that patients have continuous eligibility for some timeframe to enter the analysis sample. This

constraint may exclude more severe patients who temporarily lose eligibility for reasons related to their illness. As a result, patients diagnosed with schizophrenia with 12 months eligibility for one fiscal year may have lower non-medication psychiatric cost for that year than those with fewer eligible months. Using the Pennsylvania Medicaid database for the fiscal years 1999 through 2003 we compared yearly psychiatric cost for patients with varying levels of eligibility. In the 2002 fiscal year data, patients who had 12 months of eligibility had significantly lower annual psychiatric cost (mean=\$6348.35, SD=\$13317.12, median=\$1925.00, N=26529) than those with 6 to 11 months of eligibility (mean=\$9960.37, SD=\$16098.56, median=\$4240.00, N=2083) (p<0.0001). Total psychiatric cost for those with less than 6 months of eligibility did not significantly differ from those with full 12 month eligibility (mean=\$5462.00, SD=\$8826.96, median=\$1719.54, N=614) (p=0.2282), and was significantly lower than those with 6 to 11 months eligibility (p<0.0001). The pattern was similar for other fiscal years. Excluding patients with less than 12 months of eligibility may exclude a group of patients that are more costly to treat.

Funding provided by Eli Lilly and Company.

TARGET AUDIENCE:

Payers, practicing clinicians, schizophrenia researchers, mental health decision makers, and advocacy groups.

REFERENCES:

1. Motheral BR, and Fairman KA, The use of claims databases for outcomes research: Rationale, challenges, and strategies. *Clinical Therapeutics*. 1997; 19:346-366.
2. Strom BL and Carson JL. Use of automated databases for pharmacoepidemiology research. *Epidemiologic Reviews*. 1990; 12:87-107.

Poster 34

**Thursday, October 5
8:30 a.m.-10:00 a.m.**

VIOLENCE IN COLOMBIA: THE DECADE OF THE 90'S

Mauricio Romerogonzalez, M.D., M.P.H., *Advisor, Mental Health Program, Connecticut Department of Mental Health, 1165 Forest Road, New Haven, CT 06515*; Gerardo Gonzalez, M.D., *Assistant Professor, Department of Psychiatry, Yale University, 950 Campbell Avenue, 116A-4, West Haven, CT 06516*; Ramon Rodriguez-Santana, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the socio-economical cir-

cumstances that are generating most of the violent deaths in Colombia.

SUMMARY:

Colombia has been under an internal armed conflict during at least the last 45 years. This armed conflict is one of the largest wars in the modern history. During the decade of the 90's, Colombia had the highest rate of death by violence in the world. These rates were higher than in those countries in Africa, Central America or Europe that had a declared civil war. The purpose of this study was to describe if the high rates of violent deaths in Colombia were directly related to the armed conflict. Methods: Data from violent death during the decade of the 90's were collected from the national and international sources that included the National Forensic Institute, Ministry of Health, the National Department of Statistic and United Nations. Findings: The data showed that only 20% of all violent-deaths were attributable to the internal conflict, and that most violent deaths (80%) occurred in circumstances not related to the internal conflict. Conclusion: The peace efforts of the Colombian government may help reduce the rates of violent deaths. However, the government and Colombian society should consider increasing the efforts to reduce the socio-economical circumstances that may be generating the majority of the violent deaths.

TARGET AUDIENCE:

Social and behavioral researchers, and human rights workers.

REFERENCES:

1. Franco S. 2003. A social-medical approach to violence in Colombia. *Am J Public Health*. 93, 2032–2036.
2. Garfield R, and Llanten Morales CP, 2004. The public health context of violence in Colombia. *Rev Panam Salud Publica*. 16, 266–271.

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**Thursday, October 5
8:30 a.m.-10:00 a.m.**

TRAUMA HEALING VIA COGNITIVE BEHAVIOR THERAPY IN CHRONICALLY HOSPITALIZED PATIENTS

Brian Trappler, M.D., *Director, Department of Psychiatry, Kingsboro Psychiatric Center, 501 Montgomery Street, Brooklyn, NY 11225-3009*; Stephen M. Goldfinger, M.D., *Vice Chair, APA/IPS Scientific Program Committee; and Chair, Department of Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, Brooklyn, NY 11203*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the standard approach to coping and its challenges in schizophrenia; and describe a new framework of coping and its relation to outcome in schizophrenia.

SUMMARY:

Background and objectives: Problem-focused coping, as compared with emotion-focused coping, is considered to have beneficial effects on outcome in stressful conditions. This has not been strongly corroborated for schizophrenia. We attempted to generate new factors of coping and to examine their relation to symptom severity and to quality of life in schizophrenia.

Methods: 58 adult outpatients, diagnosed with schizophrenia as per SCID, tested cross-sectionally on the Ways of Coping Checklist (WCC), on the Positive and Negative Symptom Scale (PANSS), and on the Wisconsin Quality of Life Index (W-QLI). Principal components analysis was performed on the WCC, and the resulting coping factors were correlated with PANSS and with W-QLI scores.

Results: 6 coping factors were found. Of these, intellectual coping was inversely correlated with general symptoms, coping by direct problem solving was inversely correlated with negative symptoms, active coping was directly correlated with the social domain of quality of life, and negative emotion coping was inversely correlated with four domains of quality of life as well as with total quality of life.

Conclusion: Intellectual coping may be a newly discovered factor that moderates comorbidity in schizophrenia. Further study of this topic is needed.

TARGET AUDIENCE:

Mental health care professionals and trainees, and consumers of psychiatric services.

REFERENCES:

1. Lysaker PH, Johannesen JK, Lancaster RS, Davis LW, Zito W, Bell MD. Assessing coping in schizophrenia—a rationally devised scoring scheme to assess coping in schizophrenia. *International Journal of Psychosocial Rehabilitation* 2004; 8:73–83.
2. Rudnick A. The impact of coping on the relation between symptoms and quality of life in schizophrenia. *Psychiatry* 2001; 64:304–308.

Poster 36

Thursday, October 5
8:30 a.m.-10:00 a.m.

**QUALITY OF CARE ASSESSMENT:
RESULTS OF A PATIENT SATISFACTION
QUESTIONNAIRE IN AN INPATIENT
CARE UNIT IN SPAIN**

Natalia Sartorius, M.D., *Department of Psychiatry, Octubre Hospital, Orellana 4, Madrid, Spain 28004*; Enrique Garcia Bernardo, M.D., *Department of Psychiatry, Gregorio Maranon, Orellana 4, Madrid, Spain 28004*; Javier Sanz, M.D.; Roberto Perez, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the importance of measuring patient satisfaction and how to perform it.

SUMMARY:

There is a growing concern in recent years about the importance of patient opinion and satisfaction with psychiatric services. Many scales and questionnaires have been developed for this purpose. The aim of this poster is to review this topic and show the results of a research questionnaire developed by our team and passed to 96 inpatients after their discharge. Variables related to age, sex, demographic and social status, as well as clinical characteristics were studied. It was performed ten days after discharge and completed by patients in an anonymous way. The study was confidential, voluntary and blind to the researchers. 86 out of 96 patients filled out the questionnaire meaning an 88% participation rate. The items studied could be tested in three categories from best to poor satisfaction in five aspects of care. Preliminary results suggests an overall satisfaction with care ranging from 63,9% in Safety to 77% to staff management. Only a 2% answered negatively in illness handling to a 5% in security sense. No differences were found regarding to sex, age and diagnostic categories. Men were less satisfied in general with care. Global results are very close to those observed in other studies in the sense of high levels of satisfaction with no differences related to demographic variables. Further and specific research is needed.

TARGET AUDIENCE:

Clinicians interested in quality assessment of their clinical practice.

REFERENCES:

1. Eytan A, Bovet L et al. Patients satisfaction with hospitalization in a mixed psychiatric and somatic unit. *Eur Psychiatry* 2004. Dec; 19(8):499-501.
2. Greenwood N, Key A. Satisfaction with inpatient-psychiatric services. Relationship to patient and

treatment factors. *Br J Psychiatry* 1999 Feb; 174:159-163.

Poster 37

Thursday, October 5
8:30 a.m.-10:00 a.m.

**DISPARITY IN RATES OF DEPRESSION
AND ANTIDEPRESSANT USE BY
ETHNICITY/RACE**

Supported by Washington State University

David A. Sclar, Ph.D., *Professor of Health Policy and Administration, Pharmacy Department, Washington State University, P.O. Box 646510, Pullman, WA 99164-6510*; Linda M. Robison, M.D., *Research Coordinator, Pharmacy Department, Washington State University, P.O. Box 646510, Pullman, WA 99164-6510*; Tracy L. Skaer, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the disparity in rates of depression and antidepressant use for its treatment by ethnicity/race.

SUMMARY:

Purpose: To discern ethnic/race-specific (black; Hispanic; white) population-adjusted rates of U.S. office-based physician visits documenting a diagnosis of depression, or a diagnosis of depression in concert with the prescribing of antidepressant pharmacotherapy. Methods: Data from the National Ambulatory Medical Care Survey for the time-period 1992-97, and 2003-04 were partitioned into four, two-year time intervals. In each time interval, data were extracted to evaluate: (1) ethnic/race-specific rates of office-based visits per 100 U.S. population age 20-79 years documenting a diagnosis of depression (ICD-9-CM codes 296.2-296.36; 300.4; or 311), and (2) a diagnosis of a depression and the prescribing of an antidepressant. Results: From 1992-93 to 2003-04, the rate of office-based visits documenting a diagnosis of a depression increased 41.3% for whites (from 10.9 to 15.4 per 100), 81% for blacks (from 4.2 to 7.6 per 100), and 45.8% for Hispanics (from 4.8 to 7.0 per 100). The rate of office-based visits with both a recorded diagnosis of depression and an antidepressant prescription increased from 6.5 to 11.4 per 100 for whites; from 2.6 to 5.2 for blacks; and from 3.0 to 5.6 for Hispanics. Conclusion: By 2003-04, diagnostic and treatment rates were comparable among blacks and Hispanic, but were less than half the observed rates for whites.

This project was funded by the Pharmacoeconomics and Pharmacoepidemiology Research Unit, Washington State University.

TARGET AUDIENCE:

Psychiatrists, policy makers, and payers.

REFERENCES:

1. Skaer TL, Sclar DA, Robison LM, Galin RS. Trends in the rate of depressive illness and use of antidepressant pharmacotherapy by ethnicity/race. An Assessment of Office-Based Visits in the United States, 1992–1997. *Clinical Therapeutics: The International Journal of Drug Therapy* 2000; 22(12):1575–1589.
2. Sclar DA, Robison LM, Skaer TL, Galin RS. Ethnicity and the prescribing of antidepressant pharmacotherapy: 1992–1995. *Harvard Review of Psychiatry* 1999; 7(1):29–36.

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**Thursday, October 5
8:30 a.m.-10:00 a.m.**

DIAGNOSIS AND TREATMENT OF ADHD IN ADULTS: 2001–2004

Supported by Washington State University

Linda M. Robison, M.D., *Research Coordinator, Pharmacy Department, Washington State University, P.O. Box 646510, Pullman, WA 99164-6510*; David A. Sclar, Ph.D., *Professor of Health Policy and Administration, Pharmacy Department, Washington State University, P.O. Box 646510, Pullman, WA 99164-6510*; Tracy L. Skaer, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the upward trend in the rate of adult ADHD and the use of stimulant and nonstimulant medications for its treatment.

SUMMARY:

Purpose: To evaluate whether the trend in adults seeking medical care for the treatment of ADHD reflects the upward pattern seen among children. Methods: Data from the U.S. National Ambulatory Medical Care Survey for years 2001 through 2004, were extracted to evaluate: (1) the number and rate of office-based physician visits resulting in a diagnosis of ADHD (ICD-9 CM code 314.00 or 314.01) among patients ≥ 20 years old; and (2) the rate of a diagnosis of ADHD and the prescribing of stimulant or nonstimulant (atomoxetine; available since late 2002) pharmacotherapy for its treatment. Results: Between 2001 and 2004, national estimates of the number of office-based visits documenting a diagnosis of ADHD doubled, increasing from 1,394,639 to 2,771,101. Adjusted for population growth, the rate per year of office visits per 1,000 U.S. population ≥ 20 years old resulting in a diagnosis of ADHD increased from 6.8 per 1,000 in 2001, to 13.1 in 2004 ($p < 0.05$). The

vast majority of these visits documented a prescription for stimulant or nonstimulant pharmacotherapy for the treatment of ADHD (range: 70.9%–83.1%). Conclusion: As with children, the rate of adults seeking medical care for ADHD has increased dramatically. Over all years, 79% of patients were being treated with a stimulant or nonstimulant medication.

This project was funded by the Pharmacoeconomics and Pharmacoepidemiology Research Unit, Washington State University.

TARGET AUDIENCE:

Psychiatrists, policy makers, and payers.

REFERENCES:

1. Robison LM, Sclar DA, Skaer TL. Trends in ADHD and stimulant use among adults: 1995–2002. *Psychiatric Services* 2005; 56(12):1497.
2. Robison LM, Skaer TL, Sclar DA. Is attention-deficit hyperactivity disorder (ADHD) diagnosed in adults? An examination of US office-based visits, 1995–2000. *International Journal of Pharmaceutical Medicine* 2004; 18(6):337–341.

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**Thursday, October 5
8:30 a.m.-10:00 a.m.**

IMPACT AND IMPLICATIONS OF INDUSTRY SUPPORT UPON PSYCHIATRIC RESEARCH

Chandresh Shah, M.D., *Associate Clinical Professor of Psychiatry, University of Southern California, 350 E. Temple Street, Los Angeles, CA 90012*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to appreciate the impact and understand the implications of support from pharmaceutical industries upon psychiatric research.

SUMMARY:

The pharmaceutical industry has become a major source of funding for medical research. This has led to suggestion that there may a pro-industry bias in such “industrialized” research. The American Psychiatric Association (APA), along with many other national and international scientific organizations has adopted a policy of public disclosure of any relationship between the industry sponsorship and authorship. To study the impact of this policy, all abstracts (N=889) of the New Research published at the 158th annual meeting of the APA were reviewed. There were 292 abstracts (32.85%) which appeared to have some relationship with the industry. Out of these abstracts, there were 225 (77.05%) abstracts

which were labeled as “Supported by Industry”. The rest of the abstracts (N=67, 22.95%) were first-authored by an employee of the industry in addition to 40 of the 225 “Supported by Industry” abstracts. There were 62 (21.23%) abstracts studying non-pharmaceutical subjects. In 194 abstracts (66.44%), the outcome favored the study drug in contrast to only 6 abstracts (2.05%) showing the study drug to be inferior, and 30 abstracts (10.28%) showing the study drug to be no better or worse (P<0.005). These observations show that the industry has a significant financial impact upon psychiatric research. There is a tendency to report favorable outcome for a particular study drug. This shows that the APA policy works in making the potential of pro-industry bias transparent. But the policy falls short on evaluating for such bias on abstracts first-authored by an employee of the industry.

TARGET AUDIENCE:

Psychiatric research scientists, the pharmaceutical industry, and policy makers.

REFERENCES:

1. Perlis RH, Perlis CS, Wu Y et al: Industry sponsorship and financial conflict of interest in reporting of clinical trials in psychiatry. *Am J Psychiatry* 2005; 162:1957–60.
2. Buchkowsky SS, Jewesson PJ: Industry sponsorship and authorship of clinical trials over 20 years. *Ann Pharmacother*. 2000; 38:579–85.

Poster 40

Thursday, October 5
8:30 a.m.-10:00 a.m.

CONCOMITANT MEDICATION USE AND COST FOR INDIVIDUALS WITH BIPOLAR DISORDER TREATED WITH OLANZAPINE OR QUETIAPINE

Supported by Eli Lilly and Company

Michael D. Stensland, Ph.D., *Outcomes Research Consultant, Department of Neuroscience, Eli Lilly and Company, Lilly Corporate Center, DC-4133, Indianapolis, IN 46285*; Allen W. Nyhuis, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe differences in concomitant medication use and cost of medications for individuals with bipolar disorder initiating treatment with olanzapine or quetiapine.

SUMMARY:

Objective: To compare the concomitant medication use, cost of psychotropic medications, and total cost of

treatment for individuals with bipolar disorder initiated on olanzapine or quetiapine.

Methods: We identified individuals in PharMetrics Integrated Outcomes Database who had at least one inpatient discharge diagnosis or 2 outpatient diagnoses for bipolar disorder and initiated treatment with either olanzapine (N=763) or quetiapine (N=676) between 1-1-2003 and 6-1-2004. All patients were continuously enrolled for 6 months prior through 6 months following the initiation of olanzapine or quetiapine. Propensity scores based on demographic and resource use variables from 6 months prior to initiation were used to adjust significance tests for baseline differences.

Results: Although the average 6-month cost of olanzapine (\$824) was significantly higher than that for quetiapine (\$532), the cost of concomitant psychotropic medications during the 6-month post period were significantly higher for quetiapine-treated patients (\$873) than olanzapine treated patients (\$708). Total healthcare costs were similar for olanzapine- (\$6840) and quetiapine-treated (\$7744) patient, partially due to less frequent emergency room use for olanzapine patients.

Conclusions: Although olanzapine has a higher acquisition cost than quetiapine, patients with bipolar disorder treated with olanzapine use fewer concomitant psychotropic medications and have similar total healthcare costs. Funding provided by Eli Lilly and Company.

TARGET AUDIENCE:

Payers, prescribers, and patients.

REFERENCES:

1. Yatham LN. Atypical antipsychotics for bipolar disorder. *Psychiatr Clin North Am*. Jun 2005; 28(2):325–347.
2. Chengappa KN, Suppes T, Berk M. Treatment of bipolar mania with atypical antipsychotics. *Expert Rev Neurother*. Nov 2004; 4(6 Suppl 2):S17–25.

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Thursday, October 5
8:30 a.m.-10:00 a.m.

DEPRESSION IN TYPE 2 DIABETES: CORRELATION AND QUALITY OF LIFE

Senthil A. Subramanian, M.D., *Department of Psychiatry, Stanley Medical College, 8 New Singles Accommodation, South Tyneside Hospital, United Kingdom NE3 40P2*; Lena K. Palaniyappan, *Department of Psychiatry, Stanley Medical College, 9 Mirberry Mews, Nottingham, United Kingdom NAF 2PR*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognise the co-occurrence of depres-

sion in diabetes and to identify it; understand the importance of treating it early; and understand the burden it places on the quality of life of the diabetic.

SUMMARY:

Depression and diabetes coexist frequently but not often recognised. The knowledge of associated factors and treatment strategies is limited. We determined the factors associated with depression in patients with type 2 diabetes and compared the quality of life of the depressed with the non depressed diabetic patients. This is a cross sectional study of 150 consecutive type 2 diabetic patients attending diabetology outpatient clinic at a teaching hospital (Stanley medical college, Chennai) in urban India. Structured instrument was designed to elicit factors associated with depression; these were categorised into 3 groups as disease measures, socioeconomic measures and family measures. Diabetes specific quality of life index was used to measure the quality of life. Socioeconomic factors and family measures were found to be more significantly associated with depression than disease measures. Quality of life is more significantly affected in the depressed group than in the non depressed group and it is possible to identify associated factors. The possibility of enjoying a good quality of life for diabetics is made further far-fetched by the co-occurrence of depression. This study emphasizes a holistic patient focussed approach rather than a disease orientation in approaching this combination.

TARGET AUDIENCE:

Consultant psychiatrists, trainees, and psychologists.

REFERENCES:

1. Lustman P J, Anderson RJ, Freedland KE, de Groot M, Carnet RM: depression and poor glycaemic control: a meta-analytic review of the literature. *Diabetes care* 23: 434-442, 2000.
2. De Groot M, Anderson RJ, Freedland KE, Clouse RE, Lustman PJ: Association of diabetes complications and depression in type 1 and type 2 diabetes: a meta-analysis, *Diabetes* 49: A63, 2000.

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**Thursday, October 5
8:30 a.m.-10:00 a.m.**

MEDICAL SCREENING OF PSYCHIATRIC INPATIENTS ON EMERGENCY ADMISSION

Benjamin K.P. Woo, M.D., *Resident, Department of Psychiatry, UCLA, 1830 Flower Street, Room 3057, Bakersfield, CA 93305*; Shamala Jeevarakshagan, B.S.; Richard T. Lieu, B.A.; Conrado C. Sevilla, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to recognize the high prevalence of medical co-morbidity in psychiatric inpatients; and understand that while routine laboratory testing may not be indicated in all psychiatric inpatients, a subset of labs consisting of BMP, LFT, and urine toxicology appears useful as a screening tool.

SUMMARY:

Objective: The ACEP published an evidence-based clinical policy in 2006 that states routine laboratory testing is of very low yield and needs not be performed as part of the ED assessment in psychiatric patients with normal vital signs, a noncontributory history and physical examination. In this study we sought to determine the utility of routine laboratory investigations in psychiatric admissions.

Method: Subjects included 934 consecutively admitted psychiatric inpatients to UCLA-Kern Medical Center in 2005. Charts were reviewed for demographic data, laboratory and imaging studies, and clinical diagnoses.

Results: The prevalence of medical co-morbidity was 45.6%, the most common being: hyperglycemia, hypertension, and asthma. The prevalence of abnormal laboratory findings was 18.2% among a total of 6612 tests. 356 (41.3%) of 861 basic metabolic panels (BMP), 140 (31.9%) of 439 liver function tests (LFT), and 235 (30.0%) of 783 urine toxicology were abnormal. Both thyroid stimulating hormone (TSH) and rapid plasma regain (RPR) were considered low yield with only 62 (7.7%) of 808 and 3 (0.5%) of 623 abnormal results.

Conclusions: BMP, LFT, and urine toxicology appear useful as screening laboratory examination. RPR and TSH should only be ordered based on clinical suspicions.

TARGET AUDIENCE:

Professionals diagnosing and treating in emergency psychiatric settings.

REFERENCES:

1. Gregory RJ, Nihalani ND, Rodriguez E. Medical screening in the emergency department for psychiatric admissions: a procedural analysis. *Gen Hosp Psychiatry*. 2004 Sep-Oct; 26(5):405-10.
2. Lukens TW, Wolf SJ, Edlow JA, et al. Clinical policy: critical issues in the diagnosis and management of the adult psychiatric patient in the emergency department. *Ann Emerg Med*. 2006 Jan; 47(1):79-99.

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Thursday, October 5
8:30 a.m.-10:00 a.m.

ASSESSING THE VALIDITY OF THE QUALITY OF LIFE ENJOYMENT AND SATISFACTION QUESTIONNAIRE IN ADULTS WITH ADHD

Supported by Ortho-McNeil Pharmaceuticals, Inc.

Huabin F. Zhang, M.D., M.P.H., *Associate Director, Outcomes, McNeil Pediatrics, 7050 Camp Hill Road, Fort Washington, PA 19034*; Eric Mick, Sc.D.; Joseph Biederman, M.D.; Stephen V. Faraone, Ph.D.; Thomas Spencer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the validity of Quality of Life Enjoyment and Satisfaction Questionnaire in adults with ADHD.

SUMMARY:

Objective: Despite documentation of robust clinical response to pharmacotherapy of attention-deficit hyperactivity disorder (ADHD) in adults, the impact of treatment on overall quality of life has not been fully addressed. We assessed the psychometric properties of the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q) in ADHD adults.

Methods: 179 ADHD and 117 non-ADHD adults from a case control study and 112 adults randomized to placebo or methylphenidate were assessed the Q-LES-Q and the Social Adjustment Scale (SAS). Internal consistency of the 16 individual items Q-LES-Q was assessed with Chronbach's alpha statistic and concurrent validity was assessed via correlation with the SAS total T-score. Response to change was estimated by comparing change in Q-LES-Q scores in responders and non-responders in our randomized clinical trial.

Results: There was no difference in ADHD cases and controls in sex (53% and 44% male, $p=0.1$) but controls were significantly younger than cases (30.1+/-8.8 vs. 36.1+/-10.7 years, $p<0.001$). ADHD clinical trial patients were comparable to ADHD family study cases (52% male and 37.2+/-9.5 years of age). Internal consistency of the Q-LES-Q items was excellent in ADHD cases ($\alpha=0.90$) and ADHD clinical trials patients ($\alpha=0.91$ at endpoint). Correlation between the Q-LES-Q total score and the SAS total T-score were high in ADHD cases (0.71) and ADHD clinical trial patients (0.61). Compared to non-ADHD controls, ADHD cases had statistically significantly poorer scores on the QLES-Q (52.1+/-10.6 vs. 61.7+/-6.8, $p<0.001$). These values were comparable in the non-responders and responders

from the controlled trial of methylphenidate (57.4+/-8.3 vs. 64.2+/-7.2, $p<0.001$).

Conclusions: These results support the validity of the Q-LES-Q as a measure of quality of life in samples of adults with ADHD. Thus, the Q-LES-Q is an appropriate tool to measure quality of life in clinical trials of ADHD adults.

REFERENCES:

1. Endicott J, Nee J, Harrison W, Blumenthal R: Quality of life enjoyment and satisfaction questionnaire: A new measure. *Psychopharmacology Bulletin* 1993; 29(2):321-326.
2. Spencer T, Biederman J, Wilens T, Faraone SV, Doyle RD, Surman C, Prince J, Mick E, Aleardi M, Herzig K: A large, double-blind, randomized clinical trial of methylphenidate in the treatment of adults with attention-deficit/hyperactivity disorder. *Biological Psychiatry* 2005; 57(5):456-63.

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Thursday, October 5
8:30 a.m.-10:00 a.m.

THE THREE-YEAR COURSE OF SCHIZOPHRENIA AMONG PERSONS WITH AND WITHOUT TARDIVE DYSKINESIA

Supported by Eli Lilly and Company

Haya Ascher-Svanum, Ph.D., *Research Advisor, U.S. Health Outcomes, Eli Lilly and Company, Lilly Corporate Center, DC 4133, Indianapolis, IN 46285*; Baojin Zhu, Ph.D.; Douglas E. Faries, Ph.D.; Bruce J. Kinon, M.D.; Nina A. Thomas, M.P.H.; Mauricio Tohen, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should recognize the course of schizophrenia significantly differs between persons with and without tardive dyskinesia (TD). Persons with TD appear to have a more severe illness profile and more refractory course of illness, suggesting poorer prognosis and need for specialized targeted interventions.

SUMMARY:

Objective: To compare the 3-year course of schizophrenia between persons with tardive dyskinesia (TD) and persons without.

Methods: Data were drawn from a large, prospective, naturalistic study of persons treated for schizophrenia in the US, conducted between 7/1997 and 9/2003. Treatment outcomes were assessed at 12-month intervals using standard psychiatric measures and medical record abstraction. Using repeated measures analyses, partici-

pants with probable TD at enrollment (fulfilling Schooler-Kane criteria, N=621, 29.5%) were compared with participants who did not (N=1482), on clinical and functional measures across the 3-year study.

Results: Participants with TD had, across the 3-year study, significantly more severe psychopathology (PANSS total score, negative symptoms, positive symptoms, general psychopathology), were less likely to experience symptom remission, had more severe EPS, and poorer level of functioning (eg, productivity level, employment, daily activity, GAF, Quality of Life Scale and its 4 domains). Results were essentially unchanged following adjustments for known correlates of TD and when using a subgroup of participants with persistent TD (at enrollment and at 1 year).

Conclusions: In the long-term treatment of schizophrenia, persons with TD have a significantly more severe and more refractory course of illness than persons without TD, suggesting poorer prognosis and need for specialized interventions. Funding provided by Eli Lilly and Company.

TARGET AUDIENCE:

Practicing clinicians, schizophrenia researchers, mental health decision makers, and advocacy groups.

REFERENCES:

1. Miller DD, McEvoy JP, Davis SM, et al. Clinical correlates of tardive dyskinesia in schizophrenia: Baseline data from the CATIE schizophrenia trial. *Schizophr Res.* 2005 Sep 17.
2. Browne S, Roe M, Lane A. et al. Quality of life in schizophrenia: relationship to sociodemographic factors, symptomatology and tardive dyskinesia. *Acta Psychiatr Scand.* 1996 Aug; 94(2):118-24.

Poster 45

**Thursday, October 5
8:30 a.m.-10:00 a.m.**

EARLY RESPONSE TO ANTIPSYCHOTICS AS PREDICTOR OF LATER RESPONSE IN THE NATURALISTIC TREATMENT OF SCHIZOPHRENIA

Supported by Eli Lilly and Company

Haya Ascher-Svanum, Ph.D., *Research Advisor, U.S. Health Outcomes, Eli Lilly and Company, Lilly Corporate Center, DC 4133, Indianapolis, IN 46285*; Douglas E. Faries, Ph.D.; Allen W. Nyhuis, M.S.; Nina A. Thomas, M.P.H.; Bruce J. Kinon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should recognize that in the naturalistic treatment of schizophrenia, lack of early minimal response to antipsy-

chotic medication appears to accurately predict subsequent non-response to treatment. Findings suggest that early non-responders may benefit from changing antipsychotic regimens to avoid prolonging exposure to sub-optimal treatment.

SUMMARY:

Objective: To assess whether early response to antipsychotic medication (at 2 weeks) accurately predicts later response (at 8 weeks) in the naturalistic treatment of schizophrenia.

Methods: Data were drawn from a randomized, open-label, trial (N=664) of olanzapine, risperidone, and typical antipsychotics in the treatment of schizophrenia, completed in September 2002. Treatment response was defined as at least 20% improvement on the PANSS total score from baseline (“minimal improvement”). Sensitivity, specificity, positive predictive value (PPV), negative predictive value (NPV), and overall predictive accuracy were calculated for response/non-response at 2 weeks and subsequent response/non-response at 8 weeks. Analyses were repeated using mild or better scores on 4 PANSS psychotic items to define response.

Results: Early response/non-response predicted subsequent response/non-response with high overall accuracy (72.8%), moderate PPV (69.4%), high NPV (73.8%), moderate sensitivity (42.4%), and high specificity (89.7%). Results were similar when 4 PANSS psychotic items defined response/non-response.

Conclusions: In the naturalistic treatment of schizophrenia, early response/non-response to treatment with antipsychotics appears to accurately predict subsequent response/non-response to treatment. Findings suggest that early non-responders may benefit from change in antipsychotic regimens to avoid prolonging exposure to sub-optimal treatment alternatives. Findings are consistent with previous research on early prediction of antipsychotic response in schizophrenia.

Funding provided by Eli Lilly and Company.

TARGET AUDIENCE:

Practicing clinicians, schizophrenia researchers, mental health decision makers, and advocacy groups.

REFERENCES:

1. Correll CU, Malhotra AK, Kaushik S. et al. Early prediction of antipsychotic response in schizophrenia. *Am J Psychiatry* 2003; 160:2063-2065.
2. Kapur S, Arenovich T, Agid O et al. Evidence for onset of antipsychotic effects within the first 24 hours of treatment. *Am J Psychiatry* 2005; 162:939-946.

Poster 46

Thursday, October 5
8:30 a.m.-10:00 a.m.

COST AND EFFECTIVENESS OF SWITCHING FROM RISPERIDONE TO OLANZAPINE IN THE TREATMENT OF SCHIZOPHRENIA

Supported by Eli Lilly and Company

Haya Ascher-Svanum, Ph.D., *Research Advisor, U.S. Health Outcomes, Eli Lilly and Company, Lilly Corporate Center, DC 4133, Indianapolis, IN 46285*; Douglas E. Faries, Ph.D.; Allen W. Nyhuis, M.S.; Nina A. Thomas, M.P.H.; Bruce J. Kinon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize that during the long-term treatment of patients with schizophrenia, switching from risperidone to olanzapine, when clinically warranted, appears to be a cost effective “rescue” option.

SUMMARY:

Objectives: To assess changes in cost and effectiveness parameters following switch from risperidone to olanzapine during the long-term treatment of schizophrenia patients.

Methods: Patients were participants in a randomized, open-label, 1-year cost-effectiveness trial of olanzapine, risperidone, and typical antipsychotics in the treatment of schizophrenia. Study protocol permitted antipsychotic switching when clinically warranted. Resource utilization was systematically abstracted from medical records. Treatment outcomes were assessed with standard psychiatric measures. Statistical analyses assessed changes from pre-to-post switch among patients who were randomized to risperidone, but later switched to olanzapine for any cause.

Results: Sixty of the 218 (27.5%) patients randomized to risperidone switched antipsychotics—with 43 (72%) switching to olanzapine. Average duration on risperidone before switching to olanzapine was 86.1 days (mean maximum dose 4.5 mg/day). Most of these switchers (86%) completed the 1-year study on olanzapine (average maximum dose 13.3 mg/day). Following switch to olanzapine, patients experienced significant improvements on clinical and social parameters (both, $p < .001$), with 35.7% of the prior non-remitters achieving remission status. Mean total daily costs changed from \$49.5/day pre-switch, to \$44.4/day post-switch (non-significant difference).

Conclusions: Olanzapine appears to be a cost effective “rescue” option for patients who require switching from risperidone in the long-term treatment of schizophrenia.

Funding provided by Eli Lilly and Company.

TARGET AUDIENCE:

Practicing clinicians, schizophrenia researchers, mental health decision makers, and advocacy groups.

REFERENCES:

1. Tunis SL, Kinon BJ, Faries DE, Ascher-Svanum H, Nyhuis AW, Aquila R. Cost-Effectiveness of Olanzapine as First-Line Treatment for Schizophrenia: Results From a Randomized, Open-Label, One-Year Trial. *Value in Health*, in press.
2. Hargreaves WA, Gibson PJ. Effectiveness and cost of risperidone and olanzapine for schizophrenia: a systematic review. *CNS Drugs* 2005; 19:393–410.

Poster 47

Thursday, October 5
8:30 a.m.-10:00 a.m.

RAMIFICATIONS OF SWITCHING ANTIPSYCHOTICS IN THE TREATMENT OF SCHIZOPHRENIA

Supported by Eli Lilly and Company

Haya Ascher-Svanum, Ph.D., *Research Advisor, U.S. Health Outcomes, Eli Lilly and Company, Lilly Corporate Center, DC 4133, Indianapolis, IN 46285*; Douglas E. Faries, Ph.D.; Allen W. Nyhuis, M.S.; Nina A. Thomas, M.P.H.; Bruce J. Kinon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize that switching antipsychotics is an effective “rescue” option, but it is also costly in personal and economic terms. The optimal treatment strategy is to begin treatment with the antipsychotic most likely to lead to effective treatment for each individual patient.

SUMMARY:

Objectives: To assess the clinical, functional, and economic ramifications of switching antipsychotics for any cause during treatment of schizophrenia.

Method: We used outpatient data from a randomized, open-label, 1-year cost-effectiveness trial of olanzapine, risperidone, and typical antipsychotics in the treatment of schizophrenia. Study protocol permitted switching of antipsychotics when clinically warranted. Resource utilization was abstracted from medical records. Treatment outcomes were assessed with standard psychiatric measures. Changes from pre-to-post switch were assessed among patients who switched from randomized antipsychotics. Switchers and non-switchers were compared on risk for crisis-related events (e.g., hospitalization).

Results: About one-third of the patients (30.2%, 185/612) were switched from randomized antipsychotics: 14.9% from olanzapine, 27.9% from risperidone, and

48.5% from typical antipsychotics. Following antipsychotic switch, switchers experienced significant improvements in symptoms and social relations ($p < .001$), and numerical cost reductions (\$3.72 per day less, $p = .320$). Compared to non-switchers, switchers were at significantly higher risk for crisis-related events ($p = .006$), experienced them sooner ($p = .004$), and accrued higher crisis-related service costs ($p < .05$).

Conclusions: Although switching antipsychotics is an effective “rescue” option, it is costly in personal and economic terms. The optimal treatment strategy is to begin treatment with the antipsychotic most likely to lead to effective treatment for each individual patient.

Funding provided by Eli Lilly and Company.

TARGET AUDIENCE:

Practicing clinicians, schizophrenia researchers, mental health decision makers, and advocacy groups.

REFERENCES:

1. Tunis SL, Kinon BJ, Faries DE, Ascher-Svanum H, Nyhuis AW, Aquila R. Cost-Effectiveness of Olanzapine as First-Line Treatment for Schizophrenia: Results From a Randomized, Open-Label, One-Year Trial. *Value in Health*, in press.
2. Hugenholtz GW, Heerdink ER, Nolen WA, et al. Less medication switching after initial start with atypical antipsychotics. *European Journal of Neuropsychopharmacology* 2002; 14:1–5.

Poster 48

**Thursday, October 5
8:30 a.m.-10:00 a.m.**

MEDICATION USE PATTERNS AND COSTS ASSOCIATED WITH ATYPICAL ANTIPSYCHOTICS IN THE TREATMENT OF BIPOLAR DISORDER

Supported by Eli Lilly and Company

Baojin Zhu, Ph.D., *Assistant Senior Statistician, Eli Lilly and Company, Lilly Corporate Center, Drop Code 4025, Indianapolis, IN 46285*; Pandurang Kulkarni, Ph.D.; Michael D. Stensland, Ph.D.; Haya Ascher-Svanum, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize how atypicals antipsychotics differ in their medication use patterns and costs associated with the use of atypical antipsychotics in the treatment of bipolar disorder.

SUMMARY:

Objective: The objective of this study was to determine the medication use patterns and costs associated

with atypical antipsychotics in the treatment of bipolar disorder.

Method: Data for this retrospective study were obtained from private payer administrative claims. Bipolar patients were identified based on 1 inpatient or 2 outpatient diagnoses of bipolar disorder. Those who initiated on olanzapine, risperidone, quetiapine, or ziprasidone during 2003, had not used the initiated medication during the prior 3-months, and met eligibility criteria in prior 6-months and post 1-year were included.

Results: Among the 1516 bipolar patients in this study, olanzapine (N=507) was more likely to be initiated as the primary bipolar medication (50.9%) than risperidone (39.9%, N=424), quetiapine (36.1%, N=463) or ziprasidone (25.4%, N=122). During the post 1-year, olanzapine was used as the only primary bipolar medication for more days (73.5) than risperidone (53.7), quetiapine (56.3), and ziprasidone (36.6). Overall, olanzapine and risperidone initiated patients incurred lower total annual costs (\$15208 & \$14216 respectively) than quetiapine (\$18087) and ziprasidone (\$18729) initiated patients.

Conclusion: Among the atypical antipsychotics studied, olanzapine was used more often as a primary bipolar medication while quetiapine and ziprasidone were used more in conjunction with other bipolar medication for bipolar disorder.

Funding provided by Eli Lilly and Company

TARGET AUDIENCE:

Practicing clinicians, schizophrenia researchers, mental health decision makers, and advocacy groups.

REFERENCES:

1. Woods SW. The economic burden of bipolar disease. *J. Clin Psychiatry* 2000; 61:38–41.
2. Zhu Baojin, Sandra Tunis, Zhongyun Zhao, Robert W. Baker, Maureen J. Lage, Lizheng Shi, Mauricio Tohen. Service Utilization and Costs of Olanzapine versus Divalproex Treatment for Acute Mania: Results from a Randomized, 47-Week Clinical Trial. *Current Medical Research and Opinion* 2005; 21:555–564.

POSTER SESSION 2

Posters 49–96

EFFICACY, SAFETY, AND TOLERABILITY IN THE TREATMENT OF SCHIZOPHRENIA, DEMENTIA, AND DEVELOPMENTAL DISORDERS

Poster 49

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

PALIPERIDONE EXTENDED-RELEASE IN PATIENTS WITH SCHIZOPHRENIA PREVIOUSLY TREATED WITH RISPERIDONE

Supported by Ortho-McNeil Janssen Scientific Affairs, Inc.

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to describe the efficacy and safety of the investigational drug paliperidone extended-release during the treatment of adults with schizophrenia who had prior treatment with risperidone.

SUMMARY:

Objective: To assess the effects of paliperidone extended-release (ER) tablets in subjects with acute symptoms of schizophrenia who received prior treatment with risperidone.

Method: Pooled data from an intent-to-treat (ITT) subpopulation from three 6-week, double-blind, placebo-controlled trials were evaluated. Subjects included in this exploratory analysis were randomized to fixed doses of paliperidone ER 3–12mg/day or placebo and had received oral risperidone within 2 weeks prior to randomization.

Results: 285 subjects (paliperidone ER n=207, placebo n=78) met the inclusion criteria. Baseline characteristics were similar to the pooled ITT population. The median duration of prior risperidone was 95 days; median risperidone dose was 4.0mg/day. The completion rate was 59.9% for paliperidone ER and 41.0% for placebo.

Significant improvement on PANSS total score were observed with paliperidone ER vs placebo (-15.1 ± 19.9 , -4.7 ± 23.5 [$P < 0.001$]). Personal and Social Performance scores improved for paliperidone ER vs placebo ($+8.0 \pm 14.2$, -2.2 ± 16.1 [$P < 0.001$]). AEs in $\geq 10\%$ of subjects were (paliperidone ER vs placebo); headache (13.0% vs 14.1%), agitation (6.8% vs 11.5%), insomnia (11.6% vs 15.4%), and anxiety (6.3% vs 11.5%).

Conclusions: Paliperidone ER appeared effective in improving acute symptoms of schizophrenia and personal and social performance in subjects previously treated with risperidone.

This project was funded by Janssen L.P.; Johnson & Johnson Pharmaceutical Research and Development, LLC.

TARGET AUDIENCE:

Clinical psychiatrists.

REFERENCES:

1. Kane J, et al. ACNP. 2005 December; 30:(Supplement):S191–S192.
2. Marder S, et al. ACNP. 2005 December; 30:(Supplement):S200.

Poster 50

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

PALIPERIDONE EXTENDED-RELEASE IN SEVERELY ILL PATIENTS WITH SCHIZOPHRENIA

Supported by Janssen, L.P.

Bryan Dirks, M.D., M.S., *Associate Director, Research Physician, Janssen Pharmaceutica, Inc., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Eriene Youssef, Pharm.D., *Manager, Medical Affairs, Janssen Pharmaceutica, 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Ibrahim Turkoz, M.S.; Dean Najarian, Pharm.D.; P. Bouhours, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the efficacy of paliperidone extended-release (paliperidone ER) tablets, an investigational psychotropic, in patients with particularly severe symptoms of schizophrenia.

SUMMARY:

Objective: To evaluate the efficacy of paliperidone extended-release (ER) in subjects with marked to severe symptoms of schizophrenia.

Methods: This post-hoc analysis used data pooled from three 6-week, double-blind, placebo-controlled

studies. Subjects with baseline Positive and Negative Syndrome Scale (PANSS) scores ≤ 105 were included, reflecting marked to severe illness. Subjects received fixed doses of paliperidone ER 3–12 mg/day or placebo. Assessments included PANSS, Clinical Global Impressions-Severity scale (CGI-S), Personal and Social Performance scale (PSP), Simpson-Angus Rating Scale (SAS), and adverse events (AEs).

Results: 217 subjects were included. Mean baseline PANSS total scores were 111.4 ± 5.74 for paliperidone ER and 110.9 ± 4.27 for placebo. At endpoint, significant improvements ($P < 0.05$) were observed compared with placebo in mean PANSS total (-26.65 vs -5.74), CGI-S (-1.17 vs -0.14), and PSP ($+11.46$ vs -3.05) scores. Significant improvements were also seen on all PANSS factor scores compared to placebo ($P < 0.05$). Changes in SAS were not statistically different from placebo. Most common AEs with paliperidone ER and placebo included headache (17.0% vs 8.6%), agitation (6.1% vs 12.9%), and insomnia (14.3% vs 14.3%).

Conclusions: These results suggest that paliperidone ER treatment is effective and well-tolerated in improving clinical symptoms and functioning in markedly to severely ill schizophrenia subjects.

TARGET AUDIENCE:

Clinical psychiatrists.

REFERENCES:

1. Csernansky JG. Treatment of schizophrenia: preventing the progression of disease. *Psychiatr Clin North Am* 2003; 26(2):367–379.
2. Davidson L, McGlashan TH. The varied outcomes of schizophrenia. *Can J Psychiatry* 1997; 42(1):34–43.

Poster 51

**Thursday, October 5
3:00 p.m.-4:30 p.m.**

EFFECTS OF PALIPERIDONE EXTENDED-RELEASE ON NEGATIVE SYMPTOMS OF SCHIZOPHRENIA

Supported by Janssen, L.P.

Bryan Dirks, M.D., M.S., *Associate Director, Research Physician, Janssen Pharmaceutica Inc., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Ibrahim Turkoz, M.S., *Medical Affairs, Janssen Pharmaceutica Products, L.P., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Dean Najarian, Pharm.D.; Georges M. Ghara-bawi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the direct and indirect effects of the investigational psychotropic, paliperidone extended-

release (ER) tablets, on negative symptoms in patients with schizophrenia.

SUMMARY:

Objective: Investigational paliperidone extended-release (ER) tablets significantly reduced negative symptoms in three double-blind, placebo-controlled studies of subjects with schizophrenia. This post-hoc analysis evaluates direct and indirect effects of paliperidone ER on negative symptoms, using a path analytical approach.

Methods: Data were pooled from three 6-week, double-blind, placebo-controlled studies in 937 paliperidone ER-treated subjects with schizophrenia experiencing an acute exacerbation. Regression analyses explored the relationship between demographic and clinical characteristics, including Personal and Social Performance (PSP) scale scores and negative symptoms. Path analysis was used to determine direct/indirect effects of paliperidone ER on negative symptom change. Factors evaluated as indirect modulators were changes in positive and depressive symptoms per PANSS and movement disorders per SAS.

Results: Regression models found that duration of paliperidone ER exposure and change in PSP score were significantly ($P < 0.001$) associated with change in negative symptoms. Path analysis indicated that up to 33% of negative symptom improvement was a direct effect of treatment. Indirect effects were mediated through change in positive (51%) and depressive (18%) symptoms. Changes in movement disorder ratings had a 2.1% inverse effect on negative symptoms.

Conclusions: Post-hoc path analysis suggests that paliperidone ER has direct and indirect effects on the negative symptoms of schizophrenia.

TARGET AUDIENCE:

Clinical Psychiatrists.

REFERENCES:

1. Moller HJ, Muller H, Borison RL, et al. A path-analytical approach to differentiate between direct and indirect drug effects on negative symptoms in schizophrenic patients. A re-evaluation of the North American risperidone study. *Eur Arch Psychiatry Clin Neurosci* 1995; 245(1):45–49.
2. Tandon R. Quetiapine has a direct effect on the negative symptoms of schizophrenia. *Hum Psychopharmacol* 2004; 19(8):559–563.

Poster 52

**Thursday, October 5
3:00 p.m.-4:30 p.m.**

PALIPERIDONE EXTENDED-RELEASE TABLETS IN RECENTLY DIAGNOSED PATIENTS WITH SCHIZOPHRENIA

Supported by Janssen Pharmaceutica, L.P.

Dusan Kostic, Ph.D., *Medical Affairs, Janssen Pharmaceutica Products, L.P., 1125 Trenton-Harbourton Road,*

Titusville, NJ 08560; Carla M. Canuso, M.D., Associate Director, Central Nervous System Clinical Development, Janssen Pharmaceutica Products, L.P., 1125 Trenton-Harbourton Road, Titusville, NJ 08560; Cynthia A. Bossie, Ph.D.; Ibrahim Turkoz, M.S.; Dean Najarian, Pharm.D.; P. Bouhours, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the impact of the investigational psychotropic, paliperidone extended-release (ER) tablets, on symptoms and functioning in schizophrenia patients who entered the study within five years of initial schizophrenia diagnosis.

SUMMARY:

Objective: Early pharmacotherapy in patients recently diagnosed with schizophrenia may improve long-term outcomes. The efficacy and safety of treatment with paliperidone extended-release (ER) tablets within 5 years of diagnosis was investigated.

Methods: Data for this post-hoc analysis were pooled from three 6-week, double-blind, placebo-controlled studies of investigational paliperidone ER (3–12 mg/day) in subjects experiencing an acute exacerbation of schizophrenia. Subjects diagnosed in the 5 years preceding study entry were included in the analysis. Assessments included the Positive and Negative Syndrome Scale (PANSS), Clinical Global Impressions-Severity (CGI-S) scale, Personal and Social Performance (PSP) scale, the Simpson-Angus Rating Scale (SAS), and adverse events (AEs).

Results: Among 384 subjects identified, mean time since diagnosis was 2.8 years for both the paliperidone ER and placebo groups. At endpoint, mean PANSS total scores, CGI-S scores, and PSP scores improved significantly ($P < 0.05$) in paliperidone ER compared to placebo-treated subjects. A small but statistically significant change in SAS scores was seen compared to the placebo group. AEs in 10% of subjects taking paliperidone ER included headache (11.6% vs 10.0% with placebo) and insomnia (15.5% vs 22.0% with placebo).

Conclusions: This post-hoc analysis suggests that paliperidone ER significantly improves symptoms and functioning for recently diagnosed subjects with schizophrenia.

TARGET AUDIENCE:

Clinical psychiatrists.

REFERENCES:

1. Liberman RP, Kopelowicz A, Ventura J, et al. Operational criteria and factors related to recovery from schizophrenia. *Int Rev Psych* 2002; 14:256–272.
2. Lieberman JA, Perkins D, Belger A, et al. The early stages of schizophrenia: speculations on pathogene-

sis, pathophysiology, and therapeutic approaches. *Biol Psych* 2001; 50(11):884–897.

Poster 53

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

PALIPERIDONE EXTENDED-RELEASE FOR PREDOMINANT NEGATIVE SYMPTOMS IN SCHIZOPHRENIA

Supported by Janssen Pharmaceutica, L.P.

Cynthia A. Bossie, Ph.D., Director, Analysis & Publications, Medical Affairs Department, Janssen Pharmaceutica Inc., 1125 Trenton-Harbourton Road, Titusville, NJ 08560; Dusan Kostic, Ph.D., Medical Affairs, Janssen Pharmaceutica Products, L.P., 1125 Trenton-Harbourton Road, Titusville, NJ 08560; Cynthia A. Bossie, Ph.D.; Marielle Eerdeken, M.D., M.B.A.; Ibrahim Turkoz, M.S.; Dean Najarian, Pharm.D.; Carla M. Canuso, M.D.; Bryan Dirks, M.D., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the efficacy and tolerability of the investigational psychotropic, paliperidone extended-release (ER) tablets in patients with schizophrenia and predominant negative symptoms.

SUMMARY:

Objective: To evaluate investigational paliperidone extended-release (ER) in subjects with schizophrenia and predominant negative symptoms.

Methods: This post-hoc analysis used pooled data from three 6-week, double-blind, placebo-controlled studies. Subjects with predominant negative symptoms [40% of the maximum negative factor score and <40% of the maximum positive factor score of the Positive and Negative Syndrome Scale (PANSS)] at baseline were included. Subjects included in the analysis received fixed doses of paliperidone ER 3–12 mg/day or placebo. Assessments included the total PANSS, PANSS negative factor score, Personal and Social Performance Scale (PSP), the Simpson-Angus Rating Scale (SAS) and adverse events (AEs).

Results: 270 subjects with predominant negative symptoms were identified (paliperidone n=195; placebo n=75). There were significant improvements ($P < 0.05$) for paliperidone ER vs placebo ($P < 0.05$) on the PANSS total (–16.09 vs –5.75), PANSS negative factor (–5.27 vs –2.80), and PSP (+8.66 vs –0.69). SAS score changes were similar to placebo. AEs reported in >10% of subjects (paliperidone ER vs placebo) were headache (14.4% vs 6.7%), insomnia (13.8% vs 21.3%), and sinus tachycardia (10.3% vs 1.3%).

Conclusions: Paliperidone ER was effective and well-tolerated in subjects with predominant negative symptoms, with notable improvement in negative symptoms and functioning.

TARGET AUDIENCE:

Clinical psychiatrists.

REFERENCES:

1. Csernansky JG. Treatment of schizophrenia: preventing the progression of disease. *Psychiatr Clin North Am.* 2003; 26:367-379.
2. Milev P, Ho BC, Arndt S, et al. Predictive values of neurocognition and negative symptoms on functional outcome in schizophrenia: a longitudinal first-episode study with 7-year follow-up. *Am J Psychiatry.* 2005; 162:495-506.

Poster 54

**Thursday, October 5
3:00 p.m.-4:30 p.m.**

FACTORS ASSOCIATED WITH REMISSION IN SCHIZOPHRENIA WITH LONG-ACTING RISPERIDONE

Supported by Janssen Pharmaceutica, L.P.

Cynthia A. Bossie, Ph.D., *Director, Analysis & Publications, Medical Affairs Department, Janssen Pharmaceutica, Inc., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Mary J. Kujawa, M.D., Ph.D., *Senior Director, Medical Affairs Department, Janssen Pharmaceutica, Inc., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Georges M. Gharabawi, M.D.; Ibrahim Turkoz, M.S.; Richard Druckenbrod, Pharm.D.; Henry A. Nasrallah, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the relationship between different patient variables and the expectation for achieving remission in patients with schizophrenia receiving long-acting risperidone.

SUMMARY:

Objective: To explore variables associated with fulfilling remission criteria in patients with schizophrenia receiving risperidone long-acting injectable (RLAI).

Methods: This post-hoc analysis examined the intent-to-treat population (N=323) in a 1-year study of RLAI (25 or 50 mg IM every 2 weeks) in patients with schizophrenia or schizoaffective disorder. At entry, patients were clinically stable, with no psychiatric hospitalizations for 4 months, and on a stable dose of oral antipsychotic for 4 weeks. In this analysis, remission was defined by symptom severity and duration criteria (An-

dreasen, 2005). Correlation and regression analyses explored the relationship between meeting remission and baseline demographic and clinical variables.

Results: Significant correlations were noted between meeting remission criteria during the study and baseline scores on the PANSS disorganized-thought factor (Pearson coefficient=-0.20; $P<0.001$), insight (-0.14; $P=0.0121$), PSP total score (0.24; $P<0.001$), some LOF items, and some cognitive domains. The multiple logistic model identified a significant relationship between meeting remission and the baseline factors: sex (odds ratio [OR]=0.50; $P=0.052$); PANSS disorganized-thought factor score (OR=0.92; $P=0.038$) and LOF item 7 (OR=1.57; $P=0.045$).

Conclusion: These findings suggest that female sex, lower PANSS disorganized-thought factor score, and higher overall functioning are associated with achieving remission in stable patients receiving RLAI.

TARGET AUDIENCE:

Clinical psychiatrists.

REFERENCES:

1. Andreasen NC, Carpenter WT Jr, Kane JM, et al. Remission in schizophrenia: proposed criteria and rationale for consensus. *Am J Psychiatry* 2005; 162:441-449.
2. Rodriguez S, Lasser R, Turkoz I, et al. A 52-week randomized trial of long-acting risperidone maintenance therapy in schizophrenia. Poster presented at: the 45th Annual NCDEU Meeting; June 6-9, 2005; Boca Raton, FL.

Poster 55

**Thursday, October 5
3:00 p.m.-4:30 p.m.**

TREATMENT OF TARDIVE DYSKINESIA WITH GALANTAMINE

Supported by Ortho-McNeil Neurologics, Inc.

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EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should become aware of the cholinergic deficit hypothesis of tardive dyskinesia; and be able to discuss the evidence on use of cholinesterase inhibitors in tardive dyskinesia.

SUMMARY:

Objective: Recent evidence suggests that tardive dyskinesia (TD) may result from antipsychotic-induced damage to striatal cholinergic neurons. To test whether cholinesterase inhibitors might compensate for diminished cholinergic activity, we conducted a 30-week randomized, double-blind, placebo-controlled crossover trial of galantamine in patients with TD. *Method:* After a 2-week baseline period, 35 male schizophrenic patients, on stable doses of antipsychotics, were randomized to receive galantamine (8-24 mg) or placebo for 12-weeks separated by a 4-week washout period. Patients were evaluated bi-weekly for changes in extrapyramidal symptoms, and before and after each treatment for effects on psychiatric symptoms and cognition. *Results:* Galantamine showed a trend toward reduced mean AIMS scores compared with placebo ($p = 0.08$). Furthermore, patients initially randomized to galantamine showed a reversal of AIMS scores after switching to placebo. SAS ratings of parkinsonism were significantly higher with galantamine than placebo ($p < 0.0005$), and correlated with age. There were no significant differences between groups in akathisia, cognition or psychiatric symptoms. More patients dropped out while receiving galantamine, but this did not significantly influence the results. *Conclusions:* In contrast to previous reports, reductions in TD associated with galantamine were not significant compared with placebo in this trial. However, galantamine was associated with an apparent delayed rebound in dyskinesia scores after discontinuation, and clinically minor but statistically higher ratings of parkinsonism. These findings support the need for further investigations of cholinergic mechanisms underlying TD, and the effect of cholinesterase inhibitors in combination with antipsychotics on extrapyramidal function in susceptible patients.

TARGET AUDIENCE:

Psychiatrists, psychopharmacologists, neurologists, geriatricians, and psychiatric residents

REFERENCES:

1. Caroff SN, Mann SC, Campbell EC, et al. Movement disorders associated with atypical antipsychotic drugs. *J Clin Psychiatry* 2002; 63(suppl 4):12-19.
2. Caroff SN, Campbell EC, Havey J, et al. Treatment of tardive dyskinesia with donepezil: a pilot study. *Journal of Clinical Psychiatry* 2001; 62: 772-75.

Poster 56

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

**OBSERVATIONAL STUDY OF
INTRAMUSCULAR OLANZAPINE IN THE
TREATMENT OF ACUTE AGITATION IN
PATIENTS WITH BIPOLAR MANIA/
MIXED MANIA OR SCHIZOPHRENIA/
SCHIZOAFFECTIVE DISORDERS**

Supported by Eli Lilly and Company

Stephanie L. Cincotta, B.A., *Clinical Research Assistant, Department of Schizophrenia, McLean Hospital, 115 Mill Street, Belmont, MA 02478*; Franca Centorrino, M.D.; Leslie Zun, M.D.; Adam L. Meyers, M.S.; Jonna Ahl, Ph.D.; Elisabeth Degenhardt, M.S.N.; Angela H. Gulliver, Pharm.D.; Bruce J. Kinon, M.D.; John P. Houston, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will have an understanding of the efficacy of IM olanzapine in usual clinical practice treatment of severely agitated patients with bipolar I disorder (manic or mixed-episode) or schizophrenia/schizoaffective disorders.

SUMMARY:

The objective of this open-label, multicenter, 1-week observational study was to evaluate IM olanzapine treatment in acutely agitated patients ($n=74$) with bipolar I disorder, manic or mixed-episode ($n=22$), or schizophrenia/schizoaffective disorder ($n=52$), who were hospitalized inpatients or presented to emergency departments. Agitation assessed with the Positive and Negative Syndrome Scale-Excited Component (PANSS-EC) at baseline and during the first 2 hours of treatment. Categorical response was a rating of mild or less (≤ 3) on each item (tension, uncooperativeness, hostility, impulsivity, and excitement) of the PANSS-EC. Sedation was assessed by the Agitation Calmness Evaluation Scale.

Results: Two hours after first injection of olanzapine (mean dose = 9.9 mg), agitation was significantly reduced by 19.2 ± 0.98 points ($p < .001$) from baseline (mean=29.0) with a mean level of sedation consistent with mild calmness. Over 90% of the patients required only one injection in the first 24 hours, and 50% of patients had a categorical response within 30 min. Treatment-emergent adverse events that occurred in 4% of patients included insomnia (9.5%), arthralgia (7.9%), and headache (6.3%).

Conclusions: Severely agitated patients responded rapidly to usual clinical practice treatment with a single injection of intramuscular olanzapine without excessive sedation or serious treatment-emergent adverse events.

Funding provided by Eli Lilly and Company.

TARGET AUDIENCE:

Psychiatrists who practice in psychiatric emergency settings and acute care psychiatric facilities.

REFERENCES:

1. Breier A, Meehan K, Birkett M, et al: A double-blind, placebo-controlled dose-response comparison of intramuscular olanzapine and haloperidol in the treatment of acute agitation in schizophrenia. *Arch Gen Psychiatry* 2002; 59: 441-448.
2. Meehan K, Zhang F, David S, Tohen M, Janicak P, Small J, Koch M, Rizk R, Walker D, Tran P, Breier A. A double-blind, randomized comparison of the efficacy and safety of intramuscular injections of olanzapine, lorazepam, or placebo in treating acutely agitated patients diagnosed with bipolar mania. *J Clin Psychopharmacol*, 2001; 21(4):398-97.

tolerated and effective in the treatment of pediatric attention deficit hyperactivity disorder. OROS methylphenidate employs the advanced trilayer formulation to maintain efficacy for 12 hours. Paliperidone extended-release tablet (paliperidone ER), an investigational psychotropic, uses the trilayer formulation to ensure a gradual rise in plasma concentrations, and minimal fluctuations in levels at steady state. Paliperidone ER has been shown to be efficacious and generally well tolerated in three 6-week schizophrenia trials. OROS hydromorphone, under development for the management of chronic pain, uses the push-pull osmotic delivery system for steady drug release over a 24-hour period.

OROS delivery technology can result in stable drug levels, once-daily dosing and the use of an effective starting dose without the need for dose titration for safety.

This project was funded by Johnson & Johnson Pharmaceutical Services, LLC and Johnson & Johnson Pharmaceutical Research and Development.

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**Thursday, October 5
3:00 p.m.-4:30 p.m.**

OSMOTIC-CONTROLLED RELEASE ORAL DELIVERY SYSTEM: USE IN CENTRAL NERVOUS SYSTEM DISORDERS

*Supported by Johnson & Johnson
Pharmaceutical Services*

Robert Conley, M.D., *Department of Psychiatry, Maryland Psychiatric Research Center, 919 Leeswood Road, Bel Air, MD 21014*; Suneel K. Gupta, Ph. D., *Alza Corporation, 1900 Charleston Road, Mountain View, CA 94043*; Gayatri Sathyan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have an understanding of the evolution of OROS delivery technology, its application to several therapeutic areas, in particular central nervous disorders, and the impact of the technology on treatment outcome.

SUMMARY:

The osmotic-controlled-release oral delivery system, OROS[®], is an advanced drug-delivery technology used for once-daily pharmacotherapy. This literature review considers its evolution and impact on treatment outcome in several therapeutic areas, focusing on central nervous system (CNS) disorders.

A Medline/EMBASE search used keywords 'OROS' and 'osmotic delivery' for January 1990-June 2005. Data were also obtained from the manufacturers' website and associated publications.

Among marketed products, OROS technology is employed in four therapeutic areas: cardiovascular medicine, endocrinology, urology and CNS. CNS drugs include OROS methylphenidate, shown to be well

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**Thursday, October 5
3:00 p.m.-4:30 p.m.**

EFFECTIVITY OF ORAL OLANZAPINE ON AGGRESSIVENESS IN ACUTELY PSYCHOTIC PATIENTS

Supported by Eli Lilly and Company

Manuel Delgado, M.D., *Department of Psychiatry, Hospital Severo Ochoa, Los Yébenes 60 #5-D, Madrid, Spain*; Carlos A. Gonzalez, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to determine that olanzapine prescribed in orally disintegrating tablets can reduce hostile/aggressive behavior in schizophrenic or manic acute inpatients.

SUMMARY:

Objective: Antipsychotics are known to reduce aggressive behavior in schizophrenia. This naturalistic, open study evaluated the effectiveness of olanzapine in the treatment of aggressive or hostile behavior in acutely ill schizophrenic or manic inpatients. Orally disintegrating tablets were used to achieve a faster response, and facilitate compliance.

Method: Inclusion criteria were a diagnosis of schizophrenia, schizoaffective, or manic episode, 18-65 years old, and scoring 3 or higher in the hostility/aggressiveness scale. Treatment was initiated in the first 24 hours after admission.

Results: From 48 inpatients included in the study, 44 completed follow-up. Mean onset of illness was 8.87 years before entering the study. Mean daily dose was

19.06 mg. After 5 days, we obtained a mean reduction of 12.15 points in the BPRS agitation subscale (64% reduction), and of 3.63 points in the hostility/aggressiveness scale (82% reduction). We also obtained a reduction of 1.35 points in the CGI (27% of the mean baseline score).

Conclusion: We conclude that olanzapine prescribed in orally disintegrating tablets for aggressive/hostile schizophrenic or manic acute inpatients can substantially reduce hostile/aggressive behavior during the initial treatment period of five days.

Research funded by Lilly S.A.—Spain.

TARGET AUDIENCE:

Psychiatrists practicing in hospital and emergency settings.

REFERENCES:

1. Baker RW, et al. Effectiveness of rapid initial dose escalation of up to forty milligrams per day of oral olanzapine in acute agitation. *J Clin Psychopharmacol* 2003 Aug; 23(4):342–8.
2. Bitter I, et al. Effectiveness of clozapine, olanzapine, quetiapine, risperidone, and haloperidol monotherapy in reducing hostile and aggressive behavior in outpatients treated for schizophrenia: a prospective naturalistic study (IC-SOHO). *Eur Psychiatry* 2005 Aug; 20(5–6):403–8.

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

REHOSPITALIZATION AND RESOURCE USE IN SCHIZOPHRENIA WITH LONG-ACTING RISPERIDONE

Supported by Ortho-McNeil Janssen Scientific Affairs, LLC.

Scott C. Flanders, Ph.D., Associate Director, Outcomes Research, Ortho-McNeil Janssen Scientific Affairs, Inc., 740 Waterford, Grayslake, IL 60030; K. Shermock, Pharm.D.; M. Secic, M.S.; Susan M. Vallow, R.Ph., M.B.A.; M. Fuller

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the clinical and economic impact of risperidone long-acting injection in a U.S. based veterans population.

SUMMARY:

Objective: Examine hospitalization rates and resource utilization in schizophrenia patients following initiation of risperidone long-acting injection (RLAI) in a US-based veterans population.

Methods: Healthcare claims data (2003–2006) were analyzed from adult schizophrenia patients in the Ohio Veterans Affairs (VA) Healthcare System (VISN10). Eligible patients had continuous enrollment and ≥ 4 injections of RLAI. Primary analyses were psychiatric-related hospitalizations and other healthcare resource use for an equal period prior to and following initiation of RLAI. Statistical analyses included descriptive statistics and paired *t*-tests to compare psychiatric-related hospitalizations during the pre- and post-RLAI periods.

Results: 106 patients in VISN10 were eligible. Patients were 52.0 ± 10.2 years old, 93% male and 58% White. Mean duration on RLAI was 309 ± 196 days and patients received a mean of 14 ± 9.7 doses. While patients were on RLAI, the mean number of psychiatric hospitalizations decreased from 1.9 ± 2.0 to 1.1 ± 1.8 ($P < 0.001$); mean psychiatric-related inpatient days per month decreased from 5.1 ± 6.1 to 2.0 ± 3.8 days ($P < 0.001$); while the mean psychiatric-related outpatient visits per month increased from 3.9 ± 3.5 to 5.0 ± 3.6 visits ($P < 0.001$).

Conclusions: Results from this study suggest that VA patients with schizophrenia treated with RLAI have fewer hospitalizations and psychiatric-related inpatient days per month compared with their previous experience on other treatments.

TARGET AUDIENCE:

Clinical psychiatrists.

REFERENCES:

1. Kane JM, Eerdekens M, Lindenmeyer JP, et al. Long-acting injectable risperidone: efficacy and safety of the first long-acting atypical antipsychotic. *Am J Psychiatry* 2003; 160:1125.
2. Locklear J, Lasser R, Zhu Y, et al. "Hospitalization during long-term treatment with long acting risperidone" [poster] 2004 Institute on Psychiatric Services' Scientific Program, October 6–10, 2004, Atlanta, GA.

Poster 60

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

RESPONDER/NUMBERS NEEDED TO TREAT ANALYSIS OF ACAMPROSATE IN ALCOHOL DEPENDENCE IN THE CONTEXT OF CURRENT CENTRAL NERVOUS SYSTEM THERAPY

Supported by Forest Laboratories, Inc.

Allyson Gage, Ph.D., Assistant Director, CNS Department, Forest Laboratories, Inc., Harborside Financial Center Plaza V, Jersey City, NJ 07311; Khalil Saikali, Ph.D.; James Perhach, Ph.D.; Daozhi Zhang, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the efficacy of acamprosate across pivotal trials using various definitions of response in the context of other CNS pharmacotherapies.

SUMMARY:

Background: Despite availability of pharmacologic options for the treatment of alcohol dependence, the use of such agents lags behind that for other CNS disorders which report NNTs in the range of 3–7. Acamprosate is indicated for the maintenance of abstinence from alcohol in the treatment of alcohol dependence in combination with psychosocial support. Multiple placebo-controlled clinical trials have demonstrated the efficacy and safety of acamprosate in maintaining complete abstinence in alcohol-dependent patients. The current ad-hoc analyses examine the efficacy data across three pivotal trials of acamprosate using clinically relevant definitions of response.

Methods: Intent-to-treat (ITT) data from three double-blind, placebo-controlled pivotal European trials were retrospectively pooled to examine the proportion of patients who responded to treatment with acamprosate 1998 mg/day or placebo using different responder definitions. Number needed to treat (NNT) analysis was carried out using more stringent responder definitions than for other NNT analyses.

Results: 372 acamprosate and 375 placebo patients comprised the ITT population. The percentage of responders was significantly greater with acamprosate compared to placebo, using any one of the three criteria of response: patients abstinent at two thirds or more study visits (45% vs. 28%, respectively, $P < .0001$); patients with percent days abstinent (PDA) $\geq 90\%$ (41% vs. 22%, $P < .0001$); and patients with PDA $\geq 90\%$ and Clinical Global Impression of Improvement (CGI-I) scores of 1 (very much improved) or 2 (much improved) (36% vs. 15%, $P < .0001$). Depending on the specific definition of clinical response used, between 5 and 6 patients would need to be treated with acamprosate to achieve therapeutic response in one additional patient.

Conclusion: Acamprosate is an effective medication for the treatment of alcohol dependence, with a magnitude of treatment effect comparable to that of other psychopharmacologic therapies.

Supported by funding from Forest Laboratories, Inc.

TARGET AUDIENCE:

Addiction psychiatrists.

REFERENCES:

1. Paille FM, Guelfi JD, Perkins AC, Royer RJ, Steru L, Parot P. Double-blind randomized multicentre trial of acamprosate in maintaining abstinence from alcohol. *Alcohol Alcohol*. 1995;30:239–247.

2. Sass H, Soyka M, Mann K, Zeiglgansberger W. Relapse prevention by acamprosate. Results from a placebo-controlled study on alcohol dependence. *Arch Gen Psychiatry*. 1996; 53:673–680.

Poster 61

**Thursday, October 5
3:00 p.m.-4:30 p.m.**

METABOLIC IMPACT AND PSYCHIATRIC OUTCOME OF SWITCHING ANTIPSYCHOTIC THERAPY TO ARIPIPRAZOLE AFTER WEIGHT GAIN

Supported by Bristol-Myers Squibb Company and Otsuka Pharmaceuticals, Inc.

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EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand and manage metabolic effects of atypical antipsychotics for patients with schizophrenia.

SUMMARY:

Objective: This study had 2 objectives - 1) an investigation of metabolic issues associated with the use of atypicals (SGAs), and 2) to determine if patients who had gained weight and were stable, would/could switch to aripiprazole, and what would happen to their weight and insulin-resistance measures.

Methods: This was an open-label, pilot study with 20 overweight patients with schizophrenia, who had stabilized on an SGA. Patients were evaluated with a standard psychiatric battery plus SSPG and OGTT metabolic tests. Following baseline evaluation, the patients were slowly tapered from their antipsychotic and started on flexible dosing of aripiprazole (15–30 mg) and evaluated monthly for four months.

Results: We enrolled 20 patients. Of these, 5 were early dropouts and 5 could not be tapered off their SGA. The remaining 10 did as well, or improved, on aripiprazole compared to their prior antipsychotic. Metabolically, 3 patients lost weight, 5 showed no change and 2 gained weight. Only 1 of 10 patients showed enhanced insulin sensitivity. No benefit on other metabolic abnormalities were seen.

Summary and Conclusions: Most overweight patients on atypicals, including clozapine and olanzapine, can be switched to aripiprazole without loss of efficacy.

Insulin resistance was only marginally related with degree of obesity.

Greatest clinical benefit in patients with schizophrenia may come from identifying and aggressively treating those risk factors for CVD and type 2 diabetes rather than focusing solely on weight loss or switching from effective agents. Supported in part by funding from BMS-Otsuka and the CCRC from the NIH (to Stanford University).

TARGET AUDIENCE:

Clinical psychiatrists.

REFERENCES:

1. Davis JM, Chen H, Glick ID: A meta-analysis of the efficacy of second-generation anti-psychotics. *Archives of General Psychiatry* 2003; 60:553–564.
2. Nasrallah HA, Newcomer JW: Atypical antipsychotics and metabolic dysregulation: evaluating the risk/benefit equation and improving the standard of care. *J Clin Psychopharm* 2004; 24:S7–S14.

Poster 62

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

PHARMACOECONOMICS: DIVALPROEX SODIUM AND SCHIZOPHRENIA SPECTRUM DISORDERS

Supported by Abbot Laboratories

Lisa H. Guzik, B.A., *Department of Psychiatry, Greater Los Angeles VA Medical Center, 11301 Wilshire Boulevard, Building 210, Los Angeles, CA 90073*; Shirley Mahgerefteh, B.A., *Researcher, Greater Los Angeles VA Medical Center, 11301 Wilshire Boulevard, Building 210, Los Angeles, CA 90073*; William C. Wirshing, M.D.; Jennifer A. Boyd, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should better understand the economic impact of the adjunctive use of divalproex sodium in patients with schizophrenia spectrum disorders.

SUMMARY:

Objective: Using a retrospective chart review method with the pretreatment period as a comparator, we examined economic impact as reflected in bed days of hospital care of the adjunctive use of divalproex sodium (DIV).

Method: A chart review was conducted on over 350 charts of patients identified from pharmacy records as receiving at least one prescription of DIV. Of these, 48 carried a chart diagnosis of schizophrenia spectrum disorders, and had satisfactory evaluable pre and post initiation epochs (i.e., one year before and two years after DIV).

Results: Exactly 39.6% schizophrenia 60.4% schizoaffective; 6.3% women 93.8% men. Average dose of DIV was 1452.23 mg/day (SD=695.75) Average days of hospitalization per year increased from 15.48 (SD=28.59) to 31.96 (SD=46.99) after initiating DIV—this is a statistically significant increase (p=.001). There was no difference in hospital days between year 1 and year 2 with DIV (p=0.303), or between the number of patients on antidepressants (p=0.689) and mood stabilizers (p=0.813) before and during treatment of DIV. Cost of hospitalization increased from \$12,800.00/year/patient to \$25,600.00.

Conclusion: This retrospective chart review analysis suggests that initiation of adjunctive DIV is either a marker for impending clinical instability or of limited therapeutic and negative economic consequences.

REFERENCES:

1. Moringo A, Martin J, Gonzales S, Mateo I. Treatment of resistant schizophrenia with valproate and neuroleptic drugs. *Hillside K Clin Psychiatry* 1989; 11:199–207.
2. McElroy SL, Keck PE, Pope HG. Sodium valproate: its use in primary psychiatric disorders. *J Clin Psychopharmacol* 1987; 7:16–24.

Poster 63

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

DIVALPROEX MONOTHERAPY AND IN COMBINATION WITH ATYPICAL ANTIPSYCHOTICS IN THE MANAGEMENT OF AGITATION AND AGGRESSION IN PATIENTS WITH DEMENTIA

Supported by Abbott Laboratories

Joan Hyde, Ph.D., *Department of Research, Hearststone, 23 Warren Avenue, Woburn, MA 01801*; Mark Vaneui, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

Objective: To identify behavioral symptoms of dementia responsive to divalproex and to provide clinical guidance to physicians prescribing divalproex (Depakote ER and sprinkles) alone and in combination with atypical antipsychotics.

Background: Behavioral disturbances in dementia are common and disabling to both patient and caregiver. Pharmacotherapy studies have been primarily limited to monotherapy trials.

Methods: This was a six-week, open-label naturalistic pilot study of 12 subjects recruited from a geriatric psychiatry inpatient unit, community assisted living and

nursing home facilities. The primary outcome measure was the Cohen Mansfield Agitation Inventory (CMAI).

Results: Significant reductions were observed on the CMAI aggregate score at week 1 (-7.2, SE = 1.8, $p < .001$), week 3 (-8.2, SE = 1.8, $p < .001$), and week 6 (-6.5, SE=2.4, $p=0.02$), and in the aggression subscale at week 3 (-3.0, SE=0.9, $p < 0.01$) and week 6 (-3.1, SE=0.7, $p < 0.01$). At week 6, physically non-aggressive (-1.3, SE=0.9, $p > .05$) and verbally agitated behavior (-2.1, SE = 1.6, $p > 0.05$) were not significantly improved. There was no significant difference in CMAI change and adverse events in divalproex alone vs. in combination with atypical antipsychotic.

At week 6, the dose of divalproex ranges from 250mg/day to 1250mg/day, and the mean dose and serum level of divalproex are lower for subjects on atypicals (607mg/day and 44.9mg/L) vs. for divalproex alone (938mg/day and 60.9mg/L) though the differences are not significant.

Safety: Divalproex was well tolerated with somnolence (3/12), gait disturbance (1/12) reported as adverse events at week 6 in 12 patients.

Conclusions: Interim results suggest divalproex may selectively help treat the physical aggression associated with dementia, but not verbal agitation and physical non-aggression (such as wandering). Divalproex doses and serum levels were lower than those used to treat bipolar disorder. Divalproex monotherapy and in combination with atypical antipsychotics was well tolerated.

TARGET AUDIENCE:

Geriatric/dementia psychiatrists.

REFERENCES:

1. Tariot et al. Divalproex Sodium in Nursing Home Residents with Possible or Probable Alzheimer's Disease Complicated by Agitation: a Randomized Controlled Trial. *Am J Geriatr Psychiatry* 2005; 13:942-949.
2. Ichikawa J. et al. Valproic Acid Potentiates both Typical and Atypical Anti-psychotic induced prefrontal cortical Dopamine release. *Brain Research* 2005; 1052-52:62.

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

COMPARISON OF BODY MASS INDEX INCREASE IN VETERANS RECEIVING ANTIPSYCHOTICS MEDICATIONS

Supported by Bristol-Myers Squibb Company

Teresa J. Hudson, Pharm.D., *Co-Director, South Central VA Health Care Network, Central Arkansas Health Care Services, 2200 Fort Roots Drive, North Little Rock, AR 72114;* Richard R. Owen, M.D., *Co-Director, South*

Central VA Health Care Network, Central Arkansas Health Care Services, 2200 Fort Roots Drive, North Little Rock, AR 72114-1709; A. Vickie Tuomari, Pharm.D.; Patricia K. Corey-Lisle, Ph.D., R.N.

EDUCATIONAL OBJECTIVES:

After viewing this poster, the participant will be able to identify factors associated with BMI increase among veterans who receive antipsychotic medications; discuss the differences in odds ratios for BMI increase among users of different antipsychotic medications; and recognize clinically significant increases in BMI among users of antipsychotic medications

SUMMARY:

We used a VA database to examine factors associated with weight gain among veterans whose first antipsychotic prescription in that VA network was between 10/1/03 and 5/30/05. Bivariate analyses and logistic regression were used to evaluate the relationship between increase BMI ℓ 7% and factors such as antipsychotic dose, mental health diagnosis and concomitant diagnoses of diabetes mellitus.

BMI increase was more likely to occur in patients receiving olanzapine ($X^2=23.89$, Df=5, $p=0.0002$); olanzapine, aripiprazole or ziprasidone patients were more likely to have a psychotic diagnosis ($X^2=117.39$, DF=5, $p < .0001$) and be dosed within the VA guideline-recommended range ($X^2=691.79$, DF=10, $p < .0001$). Aripiprazole or ziprasidone patients were more likely to have a concomitant diagnosis of diabetes ($X^2=19.80$, DF=5, $p=.0014$). In a logistic regression model, olanzapine, higher antipsychotic dose and psychotic diagnosis were associated with risk of increased BMI (OR=1.92 95% CI=1.013 - 3.634, OR=1.001, 95% CI=1.00-1.001, OR=1.39, 95% CI=1.12-1.72 respectively). Diabetes was associated with less risk of BMI increase (OR = .67, 95%CI=0.52-0.86 respectively).

Olanzapine, dose and psychotic diagnosis were associated with increased BMI; patients with diabetes were less likely to have BMI increase. These findings may represent prescribing patterns that minimize adverse effects of 2nd generation antipsychotics rather than identifying factors associated with BMI.

REFERENCES:

1. Koro CE, Fedder DO, L'italien GJ, Weiss SS, Magder LS, Kreyenbuhl J et al Assessment of independent effect of olanzapine and risperidone on risk of diabetes among patients with schizophrenia: Population based nested case-control study. *Br Med Journal* 2002; 325(3):243-248.
2. Newcomer J. Second-Generation (Atypical) Antipsychotics and Metabolic Effects. A comprehensive Literature Review. *CNS Drugs* 2005; 19 suppl:1-93.

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

DELAYING SYMPTOM RECURRENCE IN SCHIZOPHRENIA PATIENTS WITH PALIPERIDONE EXTENDED-RELEASE

*Supported by Johnson & Johnson
Pharmaceutical Services*

Michelle Kramer, M.D., *Director, Clinical Research and Development, CNS Janssen and Johnson & Johnson, 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Stuart F. Kushner, M.D.; Ujjwala Vijapurkar, Ph.D.; Pilar Lim, Ph.D.; Marielle Eerdeken, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have an understanding of the effectiveness of the investigational drug, paliperidone extended-release tablets, in delaying the recurrence of symptoms of acute schizophrenia.

SUMMARY:

To evaluate maintained efficacy, safety and tolerability of the investigational paliperidone extended-release tablets (paliperidone ER), patients with acute schizophrenia (n=530) entered an 8-week open-label (OL) run-in (RI) phase (paliperidone ER flexible 3mg-15mg once daily). This was followed by a 6-week OL stabilization (ST) phase (n=312) and a double-blind (DB) phase (paliperidone ER or placebo; n=207).

Study was terminated at preplanned interim analysis (time of 43rd recurrence event). In the ITT set (DB phase, n=205), 52% on placebo experienced recurrence events versus 22% on paliperidone ER (p<0.001). The time point at which 25% of patients experienced recurrence in placebo and paliperidone ER treated groups was 23 and 83 days, respectively. Final analysis showed mean±SD exposure=74.1±78.1 days (paliperidone ER) and 56.1±66.3 days (placebo) (DB phase). TEAEs occurred in 73% patients in RI/ST phases and in 40% (placebo) and 35% (paliperidone ER) of patients in DB phase. EPS-related AEs occurred in 7% of patients with paliperidone ER versus 3% with placebo (DB phase).

Paliperidone ER delayed symptom recurrence in patients with schizophrenia. Consistent with short-term data¹⁻³, paliperidone ER was well tolerated in this longer-term study.

This project was funded by Johnson and Johnson Pharmaceutical Services, LLC and Johnson and Johnson Pharmaceutical Research and Development.

REFERENCES:

1. Kane J, et al. *Neuropsychopharmacol* 2005; 30: S191-2.

2. Marder S, et al. *Neuropsychopharmacol* 2005; 30: S200.
3. Davidson M, et al. *Schizophr Res* 2006; 81:S43.

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

ONSET OF ACTION OF INVESTIGATIONAL PALIPERIDONE EXTENDED-RELEASE TABLETS

*Supported by Johnson & Johnson
Pharmaceutical Services*

Michelle Kramer, M.D., *Director, Clinical Research and Development, CNS Janssen and Johnson & Johnson, 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Dean Najarian, Pharm.D., *Employee, Ortho-McNeil Janssen Scientific Affairs, LLC, 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Isaac Nuamah, Ph.D.; Pilar Lim, Ph.D.; Marielle Eerdeken, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have an understanding of the onset of therapeutic effect, efficacy, and safety of the investigational drug, paliperidone extended-release tablets.

SUMMARY:

Abstract: This pooled analysis assessed time of onset of therapeutic effect of investigational paliperidone extended-release tablets (paliperidone ER) in patients with acute schizophrenia.

Pooled data from three 6-week, multicenter, double-blind, randomized, placebo-controlled, parallel-group, dose-response studies¹⁻³ in patients (n=1192, aged 18 years) treated with fixed-doses of paliperidone ER (3mg, 6mg, 9mg and 12mg) or placebo daily were analyzed. Onset of therapeutic effect (first time point at which change from baseline in PANSS total score with paliperidone ER was significantly different from placebo) was determined.

ITT population (n=1192): mean±SD age=38.4±11.0 years, baseline PANSS total score=93.6±11.7. Significant improvement in mean±SE PANSS total score was observed on the first observation point (Day 4) for paliperidone ER 3mg, 6mg, 9mg and 12mg versus placebo (-5.8±0.95, -5.6±0.64, -5.1±0.62 and -5.8±0.63, -2.9±0.49, respectively; p<0.05) with sustained improvement for trial duration (p<0.001 vs placebo). TEAEs occurred in 66%, 72%, 66%, 70% and 76% of patients treated with placebo and paliperidone ER 3mg-12mg, respectively.

This analysis demonstrated that paliperidone ER (3mg, 6mg, 9mg, and 12mg) is a rapidly effective treat-

ment option, within 4 days, for patients with acute schizophrenia with an early onset of action.

Johnson & Johnson Pharmaceutical Services, LLC and Johnson & Johnson Pharmaceutical Research and Development.

REFERENCES:

1. Kane J, et al. *Neuropsychopharmacol* 2005; 30: S191-2.
2. Davidson M, et al. *Schizophr Res* 2006; 81:S43.
3. Marder S, et al. *Neuropsychopharmacol* 2005; 30: S200.

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**Thursday, October 5
3:00 p.m.-4:30 p.m.**

OLANZAPINE, QUETIAPINE, AND RISPERIDONE IN FIRST-EPI­SODE SCHIZOPHRENIA

Supported by AstraZeneca Pharmaceuticals

Arthur L. Lazarus, M.D., M.B.A., *Senior Director, Clinical Research, AstraZeneca Pharmaceuticals, 1800 Concord Pike, B3B-425, Wilmington, DE 19850*; Dennis Sweitzer, Ph.D.; Joseph P. McEvoy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the similarities and differences between olanzapine, quetiapine, and risperidone in the treatment of first-episode schizophrenia based on the rates of all-cause treatment discontinuation and secondary outcome measures in this study.

SUMMARY:

Objective: Compare the effectiveness of olanzapine, quetiapine, and risperidone in a subset of first-episode patients with schizophrenia from the CAFE study.

Methods: *Post-hoc* analysis of 224 patients with schizophrenia (³18 years of age) included in a 52-week, randomized, double-blind, flexible-dose study of first-episode patients with psychosis randomized to olanzapine (2.5–20 mg/d), quetiapine (100–800 mg/d), or risperidone (0.5–4 mg/d). Non-inferiority between quetiapine and olanzapine or risperidone in all-cause treatment discontinuation rates up to 52 weeks (primary outcome measure) was tested using a 20% non-inferiority margin.

Results: Patients received mean modal doses of 11.1, 514.1, or 2.5 mg/d of olanzapine, quetiapine, or risperidone, respectively. All-cause treatment discontinuation rates did not differ significantly between quetiapine (65.3%) and olanzapine (66.3%) or risperidone (76.4%). Psychopathology rating scale scores indicated symptom improvements for all treatments at Week 52, with no

significant differences between groups. Treatment groups differed in their safety and tolerability profiles.

Conclusions: Olanzapine, quetiapine, and risperidone, at mean modal doses of 11.1, 514.1, or 2.5 mg/d, demonstrated similar effectiveness in the treatment of first-episode schizophrenia.

The CAFE research program was coordinated by the University of North Carolina. Funding for this academic center was provided by AstraZeneca Pharmaceuticals LP.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. Lieberman J, McEvoy JP, Perkins D, Hamer R. *Eur Neuropsychopharmacol* 2005; 15(Suppl 3):S525.
2. Lieberman JA, Stroup TS, McEvoy JP, et al. CATIE Investigators. *N Engl J Med*, 2005; 353:1209–1223.

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**Thursday, October 5
3:00 p.m.-4:30 p.m.**

PALIPERIDONE EXTENDED-RELEASE: SYMPTOM SEVERITY/SOCIAL FUNCTIONING-MEDIATION ANALYSIS

Supported by Johnson & Johnson Pharmaceutical Services

Pilar Lim, Ph.D., *Director, Clinical Biostatistics, Johnson & Johnson, 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Isaac Nuamah, Ph.D., *Clinical Biostatistics, Johnson & Johnson, 1125 Trenton-Harbourten Road, Titusville, NJ 08560*; Allan Sampson, M.D.; Dennis D. Gagnon, M.D.; Margaret Rothman, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the effect of paliperidone extended release treatment on symptom severity and social functioning.

SUMMARY:

Both symptom severity and social function can improve with treatment, however, the association does not imply complete causality. A post-hoc analysis of pooled data from three paliperidone extended-release (ER) RCTs¹ investigated the mediating role² of the Positive and Negative Syndrome Scale (PANSS), a measure of symptom severity, on the relationship between treatment and the Personal and Social Performance scale (PSP), a measure of social functioning.

Two equivalent statistical formulations were used. One showed that the change in PANSS was only a partial mediator of the effect of paliperidone ER upon

the change in PSP; similarly, the other demonstrated that the change in PANSS was not a complete surrogate variable for the change in PSP in assessing the effect of paliperidone. Analysis of covariance was used to assess the mediation effect. The conditional treatment effect was assessed by an overall treatment F-statistic and by a 1-degree-of-freedom contrast between placebo and the paliperidone ER dose groups.

Significant effects of paliperidone ER on the change in both PANSS total score and PSP score was demonstrated ($p < 0.001$). The mediation analysis demonstrated a statistically significant positive effect of paliperidone ER on social functioning (PSP), which was over and above and independent from the effect on symptoms (PANSS) ($p < 0.02$). This research relates to an investigational pharmaceutical product.

This project was funded by Johnson & Johnson Pharmaceutical Services, Division of Janssen Pharmaceutica, Beerse, Belgium and Johnson & Johnson Pharmaceutical Research and Development, Titusville, U.S.

REFERENCES:

1. Meltzer H, Kramer M, Gassmann-Mayer C, Lim P, Bobo W, Eerdeken M. Efficacy and tolerability of oral paliperidone extended-release tablets in the treatment of acute schizophrenia: Pooled data from three 6-week placebo controlled studies. Presented at CINP, Chicago, July 9–13.
2. Baron RM and Kenny DA. The moderator-mediator variable distinction in social psychological research: conceptual, strategic and statistical considerations. *Journal of Personality and Social Psychology*. 1986; 51(6):1173–1182.

Poster 69

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

COMPARATIVE EFFECTS OF ZIPRASIDONE AND OLANZAPINE ON MARKERS OF INSULIN RESISTANCE: RESULTS OF A SIX-WEEK, RANDOMIZED STUDY IN PATIENTS WITH ACUTE SCHIZOPHRENIA

Supported by Pfizer Inc.

Antony D. Loebel, M.D., *Medical Director, Pfizer Inc., 235 East 42nd Street, 8th Floor, New York, NY 10017*; Jonathan M. Meyer, M.D.; Gary Ellenor, Pharm.D.; Henry A. Nasrallah, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to see that olanzapine, not ziprasidone, was associated with a change in sensitive markers of insulin resistance.

SUMMARY:

Objective: To highlight the importance of insulin resistance as a medical risk factor in patients with schizophrenia and to show the differing effects of ziprasidone and olanzapine on laboratory markers of insulin resistance.

Methods: Changes in TG:HDL-C ratio and serum insulin levels were analyzed using data from a randomized, double-blind, 6-week trial of patients treated with ziprasidone or olanzapine.

Results: At baseline, median TG:HDL-C ratios were similar in both drug cohorts (ziprasidone, 2.67; olanzapine, 2.91). At end point there was a significant increase in median TG:HDL-C ratios for olanzapine- (0.60; $P = 0.0001$) but not ziprasidone-treated patients (0.13; $P = 0.435$). After adjustment for baseline differences, the increase in TG:HDL-C ratio was significantly greater for patients randomized to olanzapine than for patients randomized to ziprasidone ($P = 0.006$). Median change in serum insulin levels from baseline was also significant for the olanzapine (3.30 $\mu\text{U/mL}$; $P < 0.0001$) but not the ziprasidone group (0.25 $\mu\text{U/mL}$; $P = 0.328$).

Conclusions: Olanzapine, but not ziprasidone, was associated with a change in sensitive markers of insulin resistance. These findings are consistent with the American Diabetes Association/American Psychiatric Association Consensus Statement citing a greater risk for diabetes and hyperlipidemia during treatment with olanzapine than with ziprasidone.

TARGET AUDIENCE:

Psychiatrists, primary care physicians, physician assistants, and nurse practitioners.

REFERENCES:

1. McLaughlin T, Abbasi F, Cheal K, et al. Use of metabolic markers to identify overweight individuals who are insulin resistant. *Ann Intern Med*. 2003; 139:802–809.
2. Consensus development conference on antipsychotic drugs and obesity and diabetes. *Diabetes Care*. 2004; 27:596–601.
3. Meyer JM, Koro CE. The effects of antipsychotic therapy on serum lipids: a comprehensive review. *Schizophr Res*. 2004; 70:1–17.

Poster 70

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

WEIGHT EFFECTS ASSOCIATED WITH ZIPRASIDONE: A COMPREHENSIVE DATABASE REVIEW

Supported by Pfizer Inc.

Antony D. Loebel, M.D., *Medical Director, Pfizer Inc., 235 East 42nd Street, Eighth Floor, New York, NY 10017*; Bruce Parsons, M.D., *Senior Director, Pfizer*

Inc., 235 East 42nd Street, New York, NY 10017; Kathryn Williams, Ph.D.; Earl L. Giller, Jr., M.D., Ph.D.; Cynthia Siu, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants will have a greater understanding of the long-term effects of ziprasidone on weight gain and loss.

SUMMARY:

Objective: Weight gain and obesity are associated with increased risk for cardiovascular disease and diabetes. Some antipsychotics produce significant weight gain.¹ We examined ziprasidone’s clinical trial database to characterize weight change in 21 placebo- or active-controlled studies.

Methods: Post-hoc integrated analyses were performed. Subjects (N=3391) were classified into three groups: weight unchanged (within 7% of baseline), weight increased or decreased (>7% of baseline).

Results: In short- and long-term studies, the incidence of weight increase observed in the ziprasidone (9.1% and 15% of subjects, respectively) or haloperidol (9.6% and 33%) groups was not significantly different from placebo (4.3% and 10%). Olanzapine (48% and 53%) and risperidone (17% and 38%) had significantly greater incidences of weight increase. At 12 months, weight remained unchanged for 57% ziprasidone-treated subjects, 28% had >7% weight loss, and 15% had >7% weight gain. Overall, no relationship was observed between the distribution of weight change and ziprasidone dose, treatment duration, or gender.

Conclusions: This comprehensive analysis confirms that ziprasidone is associated with an overall weight neutral profile,² and with some evidence for weight loss in long-term treatment.

REFERENCES:

1. Allison DB, et al. Antipsychotic-Induced Weight Gain: A Comprehensive Research Synthesis. *Am J Psychiatry.* 1999; 156:1686–1696.
2. Lieberman JA, Stroup TS, McEvoy JP et. al. Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. *N Engl J Med* 2005; 353:1209–1223.

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**Thursday, October 5
3:00 p.m.-4:30 p.m.**

ANALYSIS OF REMISSION IN A SIX-MONTH, DOUBLE-BLIND CONTINUATION STUDY OF ZIPRASIDONE VERSUS OLANZAPINE

Supported by Pfizer Inc.

Antony D. Loebel, M.D., *Medical Director, Pfizer Inc., 235 East 42nd Street, 8th Floor, New York, NY 10017;* Prakash S. Masand, M.D.; Francine Mandel, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to emphasize the importance of using remission as a clinically relevant outcome variable, and to assess remission rates in a long-term trial of ziprasidone and olanzapine in patients with schizophrenia.

SUMMARY:

Objective: To assess rates of remission in patients with schizophrenia treated with ziprasidone and olanzapine in a 6-month, double-blind continuation study.

Methods: Data were drawn from a 6-month, double-blind controlled extension trial of olanzapine and ziprasidone in the treatment of an acute exacerbation of schizophrenia. The primary definition of remission was based on the BPRS criteria proposed by the Remission in Schizophrenia Working Group, as BPRS was the primary outcome measure for the study. A secondary definition of remission was based on the PANSS criteria proposed by the same group.

Results: At 6 months, evaluable data were available for 25 (44.6%) ziprasidone- and 28 (42.4%) olanzapine-treated patients. Of these, 80% of the ziprasidone patients and 46.4% of the olanzapine patients met BPRS remission criteria for 6 months ($P=0.02$). Using PANSS criteria, 64% of patients on ziprasidone and 50% of patients on olanzapine were in remission for 6 months ($P=0.41$).

Conclusions: In this analysis from a controlled, 6-month trial of continuation treatment of an acute exacerbation of schizophrenia, ziprasidone-treated patients achieved higher remission rates at the 6-month study endpoint than did olanzapine-treated patients. Further study is needed to better characterize the relationship of remission to cognitive improvement and functional capacity.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. Simpson GM, Weiden P, Pigott T, et al. Six-month, blinded, multicenter continuation study of ziprasidone versus olanzapine in schizophrenia. *Am J Psychiatry.* 2005; 162:1535–1538.
2. Andreasen NC, Carpenter WT Jr, Kane JM, et al. Remission in schizophrenia: proposed criteria and rationale for consensus. *Am J Psychiatry.* 2005; 162:441–449.

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**Thursday, October 5
3:00 p.m.-4:30 p.m.**

IMPACT OF FOOD ON ABSORPTION OF ZIPRASIDONE

Supported by Pfizer Inc.

Ilise D. Lombardo, M.D., *Medical Studies Department, Pfizer Inc., 235 East 42nd Street, New York, NY 10017;* Jeffrey Alderman, Ph.D.; Jeffrey Miceli, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the effect of food on the pharmacokinetic profile of ziprasidone.

SUMMARY:

Background: Current recommendations for ziprasidone include dosing with food (1). These studies examine the impact of food on the absorption of ziprasidone.

Methods: The impact of food on absorption of ziprasidone across a range of 3 clinically relevant doses (20, 40, and 80 mg single doses) was evaluated in both fasting and fed states. A separate study explored the impact of fat content on ziprasidone absorption using a 40 mg steady state regimen administered under 3 separate conditions: fasting, with an FDA standard meal (60% fat content), and with a lower fat meal (30% fat content).

Results: The AUC_{0-inf} was greater in the fed state than in the fasting state at each dose tested (20 mg, +48%; 40 mg, +87%; 80 mg, +101%). The increase in AUC_{0-inf} with dose was nonlinear in the fasting state but linear in the fed. Decreasing the fat content of the meal (using the 40 mg dose) had modest impact on ziprasidone absorption. Compared with the fasting state, there was a 100% increase in AUC for the high-fat meal and an 80% increase for the moderate-fat meal.

Conclusions: These results demonstrate that the administration of ziprasidone with meals is crucial for effective medication absorption.

REFERENCE:

1. Geodon[®] (ziprasidone) prescribing information. Physician's Desk Reference. 59th ed. Montvale, NJ: Thompson PDR; 2005:2609–2615.

Poster 73

**Thursday, October 5
3:00 p.m.-4:30 p.m.**

**PALIPERIDONE EXTENDED-RELEASE
TABLETS: EFFECTS ON SLEEP IN
SCHIZOPHRENIA**

*Supported by Johnson & Johnson
Pharmaceutical Services*

Remy Luthringer, M.D., *Executive Director, Forenap Pharma, 27 Rue Du 4eme RSM, Rouffach, France 68250*; Luc Staner, M.D., *Department of Research and Development, Forenap Pharma, 27 Rue Du 4eme RSM, Rouffach, France 68250*; Nadine Noel, Ph.D.; Muriel Muzet, M.D.; Cristiana Gassmann-Mayer, Ph.D.; Krishna K. Talluri, M.D.; Adriaan Cleton, Ph.D.; Joseph M. Palumbo, M.D.; Marielle Eerdeken, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have an understanding of the effects of investigational paliperidone extended-release tablets on changes in sleep architecture in patients with schizophrenia-related insomnia, and patient-rated changes in quality of sleep and daytime drowsiness in patients with acute schizophrenia.

SUMMARY:

Investigational paliperidone extended-release tablets (paliperidone ER) have been examined for effects on sleep in schizophrenia in two independent datasets. In dataset 1, effects on schizophrenia-related insomnia were evaluated (multicenter, double-blind, 3-week, randomized, placebo-controlled study; stable schizophrenia; paliperidone ER 9mg/placebo daily). In dataset 2, patient-rated Visual Analog Scale changes in quality of sleep/daytime drowsiness were investigated (pooled analysis; three 6-week double-blind, controlled studies; acute schizophrenia; paliperidone ER 3–15 mg/placebo daily).

Analysis of dataset 1 (n=36; mean±SD age=32.2y±7.3; baseline PANSS=62.9±11.2) showed that paliperidone ER produced relevant, statistically significant (2-sided, 10% level) improvements in sleep versus placebo: decreased latency to persistent sleep (−26.1±64.4 versus 14.9±47.3 minutes) and sleep onset latency (−22.5±52.2 versus +12.8±37.2 minutes). Sleep Efficiency Index (+6.0±13.5% versus −5.0±16.2%), total sleep time (+28.5±64.4 versus −24.4±78.0 minutes), duration of Stage II sleep (+35.4±57.7 versus −15.3±48.3 minutes) and REM sleep (+7.4±27.8 versus −10.9±27.9 minutes) were enhanced without significant effects on slow-wave sleep.

Analysis of dataset 2 (n=1306; mean±SD age=38.3y±10.9, baseline PANSS=93.5±11.8) showed significant improvements (2-sided, 5% level) in quality of sleep with paliperidone ER without an increase in daytime drowsiness versus placebo. Safety data will be reported in the poster. These results in schizophrenia and schizophrenia-related insomnia suggest that paliperidone ER treatment may produce favorable effects on sleep in schizophrenia.

This project was funded by Johnson & Johnson Pharmaceutical Services, LLC and Johnson & Johnson Pharmaceutical Research and Development.

REFERENCES:

1. Hofstetter JR, Lysaker PH, Mayeda AR Quality of sleep in patients with schizophrenia is associated with quality of life and coping. *BMC Psychiatry*. 2005; 5:13.
2. Monti JM, Monti D. Sleep in schizophrenia patients and the effects of antipsychotic drugs. *Sleep Med Rev* 2004; 8:133–48.

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

USE OF LEVETIRACETAM IN ASPERGER'S DISORDER SUBJECTS

Supported by Pfizer Inc.

Arnold W. Mech, M.D., *Psychiatrist, Department of Research, The Mech Center, 7500 San Jacinto, Plano, TX 75024*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate the use of levetiracetam in the treatment of subjects with Asperger's Disorder.

SUMMARY:

Asperger's Disorder is syndrome consisting of severe and sustained impairment in social interaction and the development of restricted, repetitive patterns of behavior, interests and activities. Other specific aspects include diminished social cuing, impaired non-verbal communication, and lack of emotional reciprocity, unusually restricted interests and stereotyped and repetitive motor mannerisms.

The primary objective of this study was to evaluate the effect of open label, flexible dose of levetiracetam in outpatients diagnosed with Asperger's Disorder with The Australian Scale for Asperger's Syndrome, Barkley ADHD Inventory (Barkley). Clinical Global Impression-Severity (CGI-S) and Clinical Global Impression-Improvement (CGI-I). Reynolds Childhood Depression Scale (RCDS) was performed for subjects 6–11, Beck Depression Inventory Youth (BDI) for subjects 12–16, and Beck Depression Inventory Adult (BDI) for subjects 17–19.

The study was a single center, 6 week, open label, flexible dosing trial examining safety, tolerability and effectiveness associated with the use of levetiracetam in children and adolescents between the ages of 6–19 years diagnosed with Asperger's Disorder, 20 subjects were enrolled in the study.

Results: 75% of subjects demonstrated improvement of the Australian Scale for Asperger's Syndrome. There was a 24 point improvement with a mean starting score of 102 to 78 mean ending score. 15% of subjects demonstrated worsening with a 10 point increase with a mean starting score of 97 to 107 mean ending score. 45% of subjects demonstrated improvement in attention and 50% showed improvement in hyperactivity on the Barkley ADHD Inventory. 71% of subjects demonstrated improvement on the Reynolds Childhood Depression scale, and 50% showed an improvement on the Beck Depression Inventory. Reported improvements seen with the medication included less impulsivity, improved comprehension, focus and concentration. Socially, im-

provements included being more outgoing and talkative. Overall, the medication was well-tolerated.

TARGET AUDIENCE:

Psychiatrists and other physicians.

REFERENCES:

1. Attwood, Tony, Wing, Lorna. Asperger's Syndrome: A Guide for Parents and Professionals. Jessica Kingsly Publishers, 1997.
2. Ruginio TA, Samscock TC, Levetiracetam in Autistic Children: An Open Label Study: Developmental and Behavioral Pediatrics. Vol, 23, No. 4, August 2002.

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**Thursday, October 5
3:00 p.m.-4:30 p.m.**

PALIPERIDONE EXTENDED-RELEASE TABLETS: EFFICACY AND TOLERABILITY

Supported by Johnson & Johnson Pharmaceutical Services

Herbert Y. Meltzer, M.D., *Department of Psychiatry, Vanderbilt Medical Center, 1601 23rd Avenue, South, #306, Nashville, TN 37212-8645*; Richard Druckenbrod, Pharm.D., *Scientific Affairs Liaison, Ortho-McNeil Janssen Scientific Affairs, LLC, 3836 Somerset Drive, Durham, NC 27707*; Michelle Kramer, M.D.; Cristiana Gasmann-Mayer, Ph.D.; Pilar Lim, Ph.D.; William Bobo, M.D.; Marielle Eerdeken, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have an understanding of the efficacy, safety and tolerability of the investigational drug, paliperidone extended-release, and the effects on functioning in patients with schizophrenia as assessed using the Personal and Social Performance Scale.

SUMMARY:

This pooled analysis evaluated the efficacy and safety of investigational paliperidone extended-release tablets (paliperidone ER) in patients with acute schizophrenia.

Pooled data from three international, 6-week, multicenter, double-blind, randomized, placebo-controlled, parallel-group, dose-response studies¹⁻³ in patients (n=1326, aged 18 years) treated with fixed-doses of paliperidone ER (3, 6, 9, 12 or 15mg) or placebo daily were analyzed.

Mean age=38.3y±10.9 in the intent-to-treat population. Mean PANSS total score (93.5±11.8 at baseline) improved at end point for paliperidone ER versus placebo (3mg=-15.0±19.6, 6mg=-16.9±20.7, 9mg=

-16.8±21.0, 12mg=-20.6±20.2, 15mg=-19.9±18.4, placebo=-4.8±22.0; p<0.001). Patient functioning, assessed using the Personal and Social Performance scale, improved at end point for paliperidone ER versus placebo (3mg=8.3±17.1, 6mg=9.0±14.8, 9mg=7.8±14.3, 12mg 9.5±15.0, 15mg=12.2±15.7, placebo=0.5±15.0; p<0.001). Treatment-emergent adverse events (TEAEs) occurring >3% more with paliperidone ER than placebo were extrapyramidal disorder, akathisia, headache, somnolence and tachycardia. TEAE-EPS rates were comparable for paliperidone ER 3mg, 6mg and placebo, and increased with paliperidone ER 9mg, 12mg and 15mg. Serious AEs with paliperidone ER (all doses combined) were comparable with placebo (6% each group).

In this analysis, paliperidone ER showed significant efficacy, although the lowest dose (3mg) was less effective than the higher doses. All doses were well tolerated and associated with improvements in personal and social functioning.

This project was funded by Johnson & Johnson Pharmaceutical Services, LLC and Johnson & Johnson Pharmaceutical Research and Development.

REFERENCES:

1. Kane J, et al. *Neuropsychopharmacol* 2005; 30: S191-2.
2. Marder S, et al. *Neuropsychopharmacol* 2005; 30: S200.
3. Davidson M, et al. *Schizophr Res* 2006; 81:S43.

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

TWO-YEAR METABOLIC OUTCOMES OF DOUBLE-BLIND OLANZAPINE VERSUS RISPERIDONE

Supported by Eli Lilly and Company

Douglas L. Noordsy, M.D., *Associate Director, Department of Psychiatry, Dartmouth Medical Center, 1 Medical Center Drive, Lebanon, NH 03756*; Stephen R. Marder, M.D., *Professor of Psychiatry, David Geffen School of Medicine, UCLA, 11301 Wilshire Boulevard, Los Angeles, CA 90073*; Shirley Glynn, Ph.D.; Christopher O'Keefe, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize metabolic outcomes associated with long-term treatment with olanzapine or risperidone among stable patients with schizophrenia.

SUMMARY:

Abstract: We randomized 101 stable outpatients with schizophrenia or schizoaffective disorder to double-blind olanzapine vs risperidone, and to 2 forms of vocational rehabilitation. Participants were weighed monthly, and blood tested at baseline, 3, 6, 12, 18 and 24 months. At study entry, 37% were taking olanzapine, 34% risperidone, 12% quetiapine, 5% clozapine, and 11% first-generation antipsychotics. All cause discontinuation was 29% vs. 31% at 12 months, and 61% vs. 52% at 24 months for olanzapine vs. risperidone respectively. Olanzapine treatment was associated with a significantly greater increase in BMI relative to risperidone at 12 months only. Entering the study on a first-generation antipsychotic, or randomization to change medication, was associated with significant increase in BMI. We were unable to detect an effect of medication assignment on change in fasting glucose, HgA1c, cholesterol, LDL or triglyceride levels across the study. However, olanzapine treatment was associated with higher total cholesterol levels at 3 and 18-month assessments, and with less increase in mean HDL cholesterol levels across the study period than risperidone treatment. Our finding of relatively less weight gain and metabolic derangement than that reported in CATIE may reflect the impact of the frequent metabolic assessment schedule used in this study.

This study was funded by NIMH; a supplement from Eli Lilly supported laboratory testing.

TARGET AUDIENCE:

Psychiatrists, nurse practitioners, and researchers.

REFERENCES:

1. Lieberman JA, Stroup TS, McEvoy JP, et al. Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. *NEJM* 2005; 353: 1209-23.
2. Newcomer JW, Haupt DW, Fucetola R, et al. Abnormalities in glucose regulation during antipsychotic treatment of schizophrenia. *Arch Gen Psychiatry*; 2002:337-345.

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

ANTIPSYCHOTIC AND METABOLIC SCREENING: A FOUR-STATE, MEDICAID STUDY

Elaine H. Morrato, Dr.PH., *Outcomes Research Fellow, University of Colorado, 4200 E. Ninth Avenue, C-238, Denver, CO 80262*; John W. Newcomer, M.D.; Richard R. Allen, M.S.; Robert J. Valuck, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize the prevalence of glucose and lipid monitoring associated with the usage of atypical antipsychotic medications.

SUMMARY:

Some atypical antipsychotic (AA) drugs have been associated risk of hyperglycemia and dyslipidemia, with recent recommendations that all treated patients undergo blood glucose and lipid monitoring. The prevalence of monitoring associated with AA prescription is understudied.

This retrospective cohort study used Medicaid claims data from California, Oregon, Tennessee, and Utah to evaluate 50,372 patients who received an antipsychotic drug between 1998 and 2003. Laboratory testing was identified with CPT-4 codes. Multivariate logistic regression determined likelihood of baseline glucose testing (BGT) adjusting for drug, year, and clinical characteristics. Initiation of AA treatment was associated with a 5% increase in glucose testing ($p < 0.001$) and 2% increase in lipid testing ($p < 0.001$) over background test levels. Combining AA-related increases plus background rate, the overall prevalence of baseline testing (-14 days/+28 days) was 18% (glucose) and 6% (lipid). Compared to risperidone, BGT was higher with olanzapine (OR=1.13, 95% CI: 1.08-1.19) and lower with ziprasidone (OR=0.84, 95% CI: 0.71-1.01). BGT was higher in 2003 vs. 1998 (OR=2.51, 95% CI: 2.24-2.81).

Metabolic screening prevalence remained low over the time period of observation. Research is needed to evaluate monitoring prevalence following FDA warnings and medical recommendations for baseline and ongoing monitoring.

TARGET AUDIENCE:

Mental health policy decision makers and practicing clinicians prescribing atypical antipsychotic drugs.

REFERENCES:

1. ADA, APA, AACE, NAASO: Consensus development conference on antipsychotic drugs and obesity and diabetes. *J Clin Psychiatry*. 2004; 65:267-272.
2. Newcomer JW, Nasrallah HA, Loebel AD: The atypical antipsychotic therapy and metabolic issues national survey. *J Clin Psychopharmacol*. 2004; 24:S1-S6.

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**Thursday, October 5
3:00 p.m.-4:30 p.m.**

ASENAPINE SAFETY AND TOLERABILITY IN ACUTE SCHIZOPHRENIA

Supported by Organon Pharmaceuticals, Inc. and Pfizer Inc.

John Panagides, Ph.D., *Senior Director, Organon International, Inc., 56 Livingston Avenue, Roseland, NJ 07068*; Steven G. Potkin, M.D.; Miriam Cohen, Ph.D.; Anil S. Jina, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to compare the safety and tolerability profiles of asenapine and risperidone in patients with an acute exacerbation of schizophrenia; and assess the relative risks of extrapyramidal symptoms and weight gain with asenapine versus risperidone.

SUMMARY:

Objective: To evaluate the safety and tolerability of asenapine in acute schizophrenia.

Methods: In a double-blind trial, patients with acute schizophrenia were randomly assigned to 6 weeks of treatment with sublingual asenapine 5 mg twice daily plus oral placebo, oral risperidone 3 mg twice daily plus sublingual placebo, or double placebo twice daily. Adverse events (AEs) were assessed weekly and 30 days after study exit.

Results: Among 180 patients who received study medication (asenapine, n=59; risperidone, n=59; placebo, n=62), 151 (84%) had ≥ 1 AE. The most frequently reported AEs were headache and agitation (placebo and risperidone), followed by transient sleep disturbances (active medications). Hypertonia and hyperkinesia were more frequent with risperidone (12% and 7%, respectively) than with asenapine (0%, 0%) or placebo (3%, 0%). Weight gain $\geq 7\%$ over baseline occurred more often with risperidone (17%) than with asenapine or placebo (4% and 2%; both $P < 0.05$). The incidence of hyperprolactinemia was higher with risperidone (79%) than with asenapine or placebo (9% and 2%; both $P < 0.0001$).

Conclusions: Asenapine was well tolerated by patients with acute schizophrenia, with a low incidence of extrapyramidal symptoms, hyperprolactinemia, and weight gain.

This study was supported by Organon USA Inc. and Pfizer Inc.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. Lehman AF, Lieberman JA, Dixon LB, McGlashan TH, Miller AL, Perkins DO, Kreyenbuhl J: Practice

guideline for the treatment of patients with schizophrenia, second edition. *Am J Psychiatry* 2004; 161:1–56

2. Leucht S, Wahlbeck K, Hamann J, Kissling W: New generation antipsychotics versus low-potency conventional antipsychotics: a systematic review and meta-analysis. *Lancet* 2003; 361:1581–1589.

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**Thursday, October 5
3:00 p.m.-4:30 p.m.**

ASENAPINE EFFICACY IN ACUTE SCHIZOPHRENIA

Supported by Organon Pharmaceuticals, Inc. and Pfizer Inc.

John Panagides, Ph.D., *Senior Director, Organon International, Inc., 56 Livingston Avenue, Roseland, NJ 07068*; Steven G. Potkin, M.D.; Miriam Cohen, Ph.D.; Anil S. Jina, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to compare the efficacy of asenapine versus risperidone and placebo in treating an acute exacerbation of schizophrenia.

SUMMARY:

Objective: To evaluate the efficacy of asenapine in acute schizophrenia.

Methods: In a double-blind trial, patients with acute schizophrenia were randomly assigned to 6 weeks of sublingual asenapine 5 mg twice daily plus oral placebo, oral risperidone 3 mg twice daily plus sublingual placebo, or double placebo twice daily. The primary efficacy measure was change from baseline in Positive and Negative Syndrome Scale (PANSS) total score. Secondary measures included changes on the Clinical Global Impression (CGI) severity of illness and on the PANSS positive, negative, and general psychopathology subscales.

Results: Among 58, 56, and 60 patients in the asenapine, risperidone, and placebo groups, respectively, mean change at week 6 on PANSS total score was –15.9 with asenapine versus –5.3 with placebo ($P < 0.005$). Asenapine was also significantly better than placebo on all secondary measures. On the PANSS negative subscale, change with asenapine (–3.2) was significantly greater than with placebo (–0.6; $P = 0.01$) or risperidone (–1.05; $P < 0.05$).

Conclusions: Asenapine is effective in the treatment of acute schizophrenia and may represent an advance in the treatment of negative symptoms.

This study was supported by Organon USA Inc. and Pfizer Inc.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. Wong EHF, Shahid M: Asenapine has a unique human receptor binding signature [abstract]. *World J Biol Psychiatry* 2005; 6:360
2. Moller HJ, Bottlender R, Wegner U, Wittmann J, Strauss A: Long-term course of schizophrenic, affective and schizoaffective psychosis: focus on negative symptoms and their impact on global indicators of outcome. *Acta Psychiatr Scand* 2000; 102(suppl 407):54–57

Poster 80

**Thursday, October 5
3:00 p.m.-4:30 p.m.**

LONG-TERM RISPERIDONE TREATMENT AND GROWTH AND MATURATION IN CHILDREN AND ADOLESCENTS WITH DISRUPTIVE BEHAVIOR DISORDERS

Supported by Janssen Pharmaceutica, L.P.

Gahan J. Pandina, Ph.D., *Director CNS Clinical Development, Medical Affairs Department, Janssen Pharmaceutica, Inc., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Magali Reyes, M.D., Ph.D., *Senior Clinical Director, Johnson & Johnson Pharmaceutical Research, 1125 Trenton-Harbourton Road, Titusville, NJ 08560-0200*; Ilise Augustyns; Jacquelyn D. McLemore, M.D.; Robert L. Findling, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss endocrine adverse events associated with risperidone in children and adolescents with disruptive behavior disorders; and discuss long-term effects of treatment with risperidone on growth and sexual maturation in children and adolescents with disruptive behavior disorders.

SUMMARY:

Method: Subjects (5–17 years) with diagnosis of disruptive behavior disorders (DBD) who had responded to 12 weeks of open-label (OL) risperidone entered a 6-month double-blind (DB) and a 1-year OL extension.

Results: Of the 527 patients (OL), 335 responders entered DB and received risperidone or placebo. During OL extension 115 continued on risperidone and 117 were switched to risperidone. Median risperidone dose was 0.75 mg/day (<50 kg) or 1.5 mg/day (50 kg). Subjects' height increased during all study phases. Prolactin levels increased during OL ($+403.0 \pm 414.6$ mU/L) and decreased during DB (-215.0 ± 454.3 mU/L in risperidone and -420 ± 415.1 mU/L in placebo). During OL

extension, levels decreased further on risperidone and increased in patients switched from placebo. Potentially prolactin-related adverse events were low across all study phases (risperidone DB = 2.9%). Testosterone levels remained stable during OL and DB in risperidone and increased slightly in placebo ($+0.7 \pm 3.1$ nmol/L). During OL extension, levels increased in both groups ($+3.3 \pm 5.3$ nmol/L and $+1.5 \pm 4.2$ nmol/L respectively). No potentially testosterone-related adverse events were noted.

Conclusions: Analyses of growth and development measures in children and adolescents treated with risperidone for up to 21 months suggested a normal pattern of sexual maturation and growth.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. Reyes M, Olah R, Csaba K, Augustyns I, Eerdeken M. Long-term safety and efficacy of risperidone in children with disruptive behaviour disorders. Results of a 2-year extension study. *Eur Child Adolesc Psychiatry*. 2006; 15:97-104.
2. Croonenberghs J, Fegert JM, Findling RL, De Smedt G, Van Dongen S. Risperidone in children with disruptive behavior disorders and subaverage intelligence: a 1-year, open-label study of 504 patients. *J Am Acad Child Adolesc Psychiatry*. 2005; 44(1):64-72.

Poster 81

**Thursday, October 5
3:00 p.m.-4:30 p.m.**

EVALUATION OF LONG-ACTING, INJECTABLE RISPERIDONE FOR OLDER ADULT INPATIENTS WITH CHRONIC PSYCHOSIS

Supported by Janssen Pharmaceutica, Inc.

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EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the potential role of risperidone in treating older adults considered to be unstable inpatients with psychosis.

SUMMARY:

Introduction: The treatment of the older adult patient with chronic psychosis with the long-acting formulation of risperidone in the inpatient setting has not been fully evaluated to date. The authors report a naturalistic pilot study evaluating the effectiveness of risperidone long-acting injection in such a psychiatric treatment setting.

Objective: To assess the effectiveness of long-acting injectable risperidone in an older adult inpatient population with psychosis.

Methods: This is a retrospective assessment of patients aged 50 years and older admitted to an inpatient psychiatric facility for severe and unstable psychosis. Clinical judgment prompted the initiation of the long-acting injectable form of risperidone. Per hospital policy, baseline and follow-up assessments utilizing the Positive and Negative Syndrome Scale (PANSS) was done. Physician clinical assessment of response is reflected using the Clinical Global Impression Scales for Severity and Improvement (CGI-S/I).

Results: These are the preliminary findings of twenty-five older adults who were treated with risperidone long-acting injection for at least 2 months in an inpatient setting. Schizophrenia was the diagnosis for 76% (n=19) of the patients. Other patients were diagnosed with either bipolar disorder with psychotic features or with schizo-affective disorder. The mean age was 59.5 years (range: 50-76 yrs). The mean of the total PANSS scores at baseline was 102.5 (SD +/-26.6, range: 65-149, n=19). The mean total PANSS scores at last follow-up was 84.1 (SD +/-25.9, range: 53-134, n=19). The difference in total PANSS scores was statistically significant (p<0.01). For the patients receiving a CGI-Improvement assessment (n=25), 56% were either much improved or very much improved at last follow-up. The mean dose of risperidone long-acting injection was 36.5 mg (n=25). Further descriptions and sub-analyses of this evaluation will be presented.

Conclusions: Long-acting risperidone was associated with clinically and statistically significant improvements in a group of older adults considered to be unstable inpatients with psychosis.

TARGET AUDIENCE:

Clinical practitioners working in inpatient settings.

REFERENCES:

1. Kane JM, et. al. *AM J Psychiatry* 2003; 160:1125-32.
2. Fleischmacker WW et al. *J Clin Psychiatry* 2003; 64:1250-57.

Poster 82

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

**ADJUNCT EXTENDED-RELEASE
DIVALPROEX IN LATE-LIFE
SCHIZOPHRENIA**

Supported by Abbott Laboratories

Martha Sajatovic, M.D., *Associate Professor of Psychiatry, Case Western Reserve University, 11100 Euclid Avenue, Cleveland, OH 44106*; Nicole Coconcea, M.D., *Northeast Ohio Health Service, 23210 Chagin Boulevard, Suite 400, Beachwood, OH 44122*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should gain familiarity with challenges in the treatment of older adults with schizophrenia.

SUMMARY:

Anticonvulsant medications in combination with antipsychotic compounds may provide benefit to some individuals with schizophrenia, however data on adjunct anticonvulsants in older adults with schizophrenia is limited. This prospective, 12-week open label study of adjunct extended-release divalproex included older adults (age 50 and older) with a diagnosis of schizophrenia confirmed by the Mini International Neuropsychiatric Inventory (MINI) who were receiving treatment with either typical or atypical antipsychotic medications. Individuals with active substance use disorders or active significant medical comorbidity were excluded. Divalproex sodium (valproate) was dosed to a target of 750–1500 mg/day. Primary outcome measures included the Positive and Negative Symptom Scale (PANSS), Geriatric Depression Scale (GDS) and Global Assessment Scale (GAS).

In this preliminary analysis, fifteen older adults (mean age 61.1 years, range 50–78 years) had significant reductions in psychosis scores (mean baseline PANSS = 78.7, SD \pm 3.5, mean endpoint PANSS (LOCF) = 59.7, SD \pm 16.7, $p < .001$), as well as in global functioning (GAS change from baseline to endpoint mean, $p = .003$). There was no change in depression scores. Mean dose of extended-release divalproex was 687.5 mg/day SD \pm 263.8. Extended-release divalproex was well tolerated in this older adult population. The primary adverse effect was sedation, which appeared to be relatively dose and titration-speed dependent. While extended release divalproex appears efficacious and well tolerated in older adults with schizophrenia, data from larger, controlled trials is needed.

TARGET AUDIENCE:

Physicians, nurses, and other mental health clinicians.

REFERENCES:

1. Citrome L, Levine J, Allingham B. Changes in use of valproate and other mood stabilizers for patients with schizophrenia from 1994–1998. *Psychiatric Services* 2000; 51(5):634–8.
2. Casey DE, Daniel DG, Wassef AA, Tracey KA, Wozniak P, Sommerville KW. Effect of divalproex combined with olanzapine or risperidone in patients with an acute exacerbation of schizophrenia. *Neuropsychopharmacology* 2003; 28(1):182–92.

Poster 83

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

**LAMOTRIGINE THERAPY IN THE
ELDERLY WITH BIPOLAR DISORDER,
EPILEPSY, OR DEMENTIA**

Supported by GlaxoSmithKline

Martha Sajatovic, M.D., *Associate Professor of Psychiatry, Case Western Reserve University, 11100 Euclid Avenue, Cleveland, OH 44106*; Kevin P. Nanry, B.S., *Employee, GlaxoSmithKline, Five Moore Drive, Research Triangle Park, NC 27709*; Eugene Ramsay, M.D.; Thomas R. Thompson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand elderly patient response and tolerability to lamotrigine treatment.

SUMMARY:

Objective: In spite of wide clinical use, there is a paucity of data on anticonvulsant drugs in elderly patients with psychiatric and neurological disorders. The authors conducted a systemized analysis of the literature on lamotrigine (LTG) therapy in elderly patients with BD, epilepsy, or dementia.

Methods: The search included electronic databases, meeting abstracts and presentations.

Results: Fourteen reports included controlled trials, retrospective analyses, and case studies. Reports of LTG in geriatric BD suggest improvement in depression, core manic symptoms and delay in mood relapse. Mean dose in larger samples was 182–240 mg/day.^{1,2} Controlled trials in geriatric epilepsy demonstrated efficacy and tolerability comparable to gabapentin. Compared to carbamazepine, there were fewer treatment withdrawals and fewer cases of somnolence or rash in the lamotrigine group. Preliminary reports in dementia note improvement in cognition, agitation and depression. While elimination of LTG can be affected by increasing age, dispo-

tion is more directly impacted by concurrent anticonvulsant therapy. There is extensive variability in LTG concentration/dose (C/D) ratios across the age-span, but as a group C/D ratios increase through adulthood.

Conclusion: LTG appears effective and was well tolerated in older adults with BD, epilepsy and dementia. Incidence and severity of adverse events appears similar to that established in younger patient populations.

REFERENCES:

1. Sajatovic M. Maintenance treatment outcomes in older patients with bipolar I disorder. *Am J Geriatr Psychiatry* 2005; 13(4):305-11.
2. Marcotte DB. Long-term use of lamotrigine for bipolar disorder in patients over 55 years of age. Poster presentation at the 157th Annual Meeting of the American Psychiatric Association, New York, NY, May 1-6, 2004.

Poster 84

**Thursday, October 5
3:00 p.m.-4:30 p.m.**

ACAMPROSATE DECREASES THE SEVERITY AND DURATION OF RELAPSE AND AIDS IN POST-RELAPSE RECOVERY OF ABSTINENCE IN ALCOHOL-DEPENDENT PATIENTS

Supported by Forest Laboratories, Inc.

Eugene J. Schneider, M.D., *Associate Director, Clinical Development and Medical Affairs, Forest Laboratories, Inc., Harborside Financial Center Plaza V, Jersey City, NJ 07311*; Khalil Saikali, Ph.D.; Daozhi Zhang, Ph.D.; Allyson Gage, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the efficacy of acamprosate in reducing relapse severity in alcohol-dependent individuals who return to drinking, as measured by quantity/frequency of alcohol consumption and duration of relapse episodes.

SUMMARY:

Background: A major goal of alcohol dependence treatment is relapse prevention. Acamprosate, with psychosocial support, is effective in aiding alcohol-dependent patients maintain abstinence and regain abstinence after relapse. In the current analysis, the effect of acamprosate on severity of relapse in patients who returned to drinking was examined and their post-relapse recovery assessed.

Methods: The intent-to-treat (ITT) population from three controlled pivotal trials (13, 48, and 52 weeks)

receiving acamprosate 1998 mg/day (n=372) or placebo (n=375), in combination with psychosocial therapy, was evaluated on the quantity of alcohol consumption during relapse (at Days 0, 30, 60, 90, and last visit). Weekly frequency of alcohol consumption (13-week study) and duration of individual relapse episodes (48-week study) were also reported. In an ITT population subset with ℓ 1 documented relapse before last study visit, the rate of complete abstinence, percent days abstinent, time to first drink, and time to complete abstinence were analyzed for post-relapse time intervals.

Results: Of 747 patients, 616 relapsed over the course of the studies (placebo, 89%; acamprosate, 76%). Pooled data showed that during relapse a significantly smaller proportion of acamprosate vs. placebo patients reported consuming ℓ 5 standard drinks/day during the interval preceding Day 30, 60, 90 and last study visit ($P<.01$). Acamprosate was statistically superior to placebo ($P<.05$) with respect to frequency of alcohol consumption during relapse (13-week study) and for relapse duration (48-week study). Post-relapse recovery, evaluated in patients who relapsed before the last study visit (n=587), showed that a significantly greater proportion of acamprosate-treated patients, compared to placebo-treated patients, regained abstinence following initial relapse and maintained it for the remainder of the trial (13% vs. 5%, respectively; $P<.01$).

Conclusions/Discussion: In addition to helping alcohol-dependent patients maintain abstinence, acamprosate reduces relapse severity in patients who return to drinking and aids in abstinence recovery.

TARGET AUDIENCE:

Addiction psychiatrists.

REFERENCES:

1. Pelc I, Verbanck P, Le Bon O, Gavrilovic M, Lion K, Lehert P. Efficacy and safety of acamprosate in the treatment of detoxified alcohol-dependent patients. A 90-day placebo-controlled dose-finding study. *Br J Psychiatry*. 1997; 171:73-77.
2. Sass H, Soyka M, Mann K, Zieglgansberger W. Relapse prevention by acamprosate. Results from a placebo-controlled study on alcohol dependence. *Arch Gen Psychiatry*. 1996; 53:673-680.

Poster 85

**Thursday, October 5
3:00 p.m.-4:30 p.m.**

PHARMACOGENETIC TESTING OF CYP2D6 MAY PREDICT EXTRAPYRAMIDAL REACTIONS WITH ARIPIRAZOLE

Anton A. Subuh Surja, M.D., *Department of Psychiatry, University of Louisville, 10946 Symington Circle, Louis-*

ville, KY 40241-1344; Kristen K. Reynolds, Ph.D.; Rif S. El-Mallakh, M.D.; Roland Valdes, Jr.; Mark W. Linder

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize several cases of aripiprazole-induced EPS in children and adolescents; recognize that individual differences in CYP2D6 are important in the efficacy and tolerability of second-generation antipsychotics in general, and aripiprazole in particular; develop an awareness of the importance of pharmacogenetic testing as a powerful tool to predict adverse drug reactions; and incorporate pharmacogenetic considerations into medication selection and dosing.

SUMMARY:

Background: Aripiprazole is a new antipsychotic medication that has the unique mechanism of partial agonism at the dopamine D2 receptor. Because of this agonist effect, extrapyramidal reactions (EPS) other than akathisia are quite rare. We observed several cases of children who developed EPS following aripiprazole administration. Aripiprazole is metabolized by the polymorphic Cytochrome P450-2D6 (CYP2D6) enzyme. Individuals with a genetic deficiency of CYP2D6 (poor metabolizers, PMs) have an 80% increase in aripiprazole exposure and twice the elimination half-life compared to subjects with normal CYP2D6 activity (extensive metabolizers, EMs). The consequence of the PM phenotype is increased risk of adverse drug reactions at standard doses of CYP2D6 substrates. This data together with increasing numbers of reports indicating the clinical utility of pharmacogenetic testing led us to examine the CYP2D6 genotype of these patients. **Objective:** To determine whether genetic deficiency of CYP2D6 contributed to increased aripiprazole exposure and development of EPS in these children. **Methods:** Four consecutive children who developed EPS within 1 week of either dose titration or initial aripiprazole administration at standard doses were genotyped. The children (1 female, 3 male) aged 6–15 years, exhibited a variety of EPS including drooling, stiffness, tongue protrusion, cogwheeling, rigidity, Parkinsonism, and NMS-like reactions. These patients were not taking other medications known to interact with aripiprazole. CYP2D6 genotyping was performed in a CLIA-certified clinical laboratory using genomic DNA extracted from patient buccal swabs. **Results:** Two children who developed EPS were found to be CYP2D6 poor metabolizers (no active gene copies), while the other two children were intermediate metabolizers (one active gene copy). **Conclusion:** All of the children who developed EPS following aripiprazole administration were found to have a dysfunctional CYP2D6 enzyme. Pharmacogenetic testing for CYP2D6 may be useful in predicting which patients are at in-

creased risk of aripiprazole-induced adverse drug reactions.

TARGET AUDIENCE:

Psychiatrists, psychiatric nurses, and pharmacists.

REFERENCES:

1. Mrazek DA. New tool: Genotyping makes prescribing safer, more effective. *Current Psychiatry* 2004; 3 (9): 11–23.
2. Abilify product information. In: *Physicians' Desk Reference* 2006; 60: 916–922.

Poster 86

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

EARLY-ONSET ANTIPSYCHOTIC ACTION IN THE TREATMENT OF AGITATED PATIENTS

Supported by Pfizer Inc.

Cynthia Siu, Ph.D., *Statistician, Department of Statistics, Data Power, Inc., One Palomino Court, Ringoes, NJ 08551*; Lewis E. Warrington, M.D.; Anthony D. Loebel, M.D.; David C. Mamo, M.D.; Shitij Kapur, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize these research data will contribute to the participant's understanding of the rapid onset of antipsychotic action in patients with acute agitation.

SUMMARY:

Objective: To evaluate early response (within the first 24 hours) in a psychosis and agitation symptoms with ziprasidone IM treatment.

Methods: In two 24-hour, double-blind studies, hospitalized patients with psychotic disorder and acute agitation were randomized to treatment with fixed doses of ziprasidone 2 mg IM (N=94), 10 mg IM (N=64, Study 1), or 20 mg IM (N=40, Study 2). Efficacy evaluation was based on the PANSS scale at baseline, 4 hours, and 24 hours. Results: Ziprasidone IM showed a significant ($p<0.05$) dose-related effect (20 mg vs. 2 mg) on the PANSS early psychosis factor score (conceptual disorganization, hallucinatory behavior, and unusual thought content)¹ and PANSS positive subscale, at the first post-baseline time point (4 hours) and at 24 hours. Dose-related response in overall psychopathology ($p=0.02$) and reduction of acute agitation symptoms ($p=0.02$) were also observed as early as 4 hours. No statistically significant difference in these outcome measures was observed between the 10 mg and 2 mg groups during the first 24 hours of treatment.

Conclusions: Our findings suggest that in addition to reduction in acute agitation, ziprasidone IM may be associated with a more rapid improvement in psychotic symptoms than has been previously reported.

REFERENCE:

1. Kapur S et al. Evidence for onset of antipsychotic effects within the first 24 hours of treatment. *Am J Psychiatry* 2005; 162: 1–8.

Poster 87

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

**REMISSION IN SCHIZOPHRENIA:
RESULTS FROM A 196-WEEK, DOUBLE-
BLIND STUDY**

Supported by Pfizer Inc.

Cynthia Siu, Ph.D., *Statistician, Department of Statistics, Data Power, Inc., One Palomino Court, Ringoes, NJ 08551*; Lewis E. Warrington, M.D., *Medical Director, U.S. Medical Department, Pfizer Inc., 235 East 42nd Street, New York, NY 10017*; Antony D. Loebel, M.D.; Jeffrey A. Lieberman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants will have a greater understanding of the long-term effectiveness of atypical antipsychotics compared with conventional agents, including differential effects on remission and quality of life.

SUMMARY:

Objective: To compare the effectiveness of two ziprasidone dose regimens (80–160 mg/d given BID, N=72; or 80–120 mg/d given QD, N=67) with haloperidol (5–20 mg/d, N=47), in subjects who had completed a 40-week, double-blind core phase and were enrolled in this double-blind, 3-year continuation study.

Methods: Efficacy evaluation was based on recently proposed remission criteria for schizophrenia.¹ Cross-sectional remission rates (excluding the time component) and Quality-of-Life Scale (QLS) scores over time were analyzed using Generalized Estimating Equations.

Results: Overall, 63% of subjects discontinued study medication in the continuation study. Ziprasidone treatment was associated with a greater proportion of patients meeting full remission criteria (p<0.05) in the 6 months preceding the last visit (Week 196 or early termination). Longitudinal assessment of cross-sectional remission and QLS in the continuation phase demonstrated superior improvement in the ziprasidone BID (all p<0.015) and QD (all p<0.04) groups compared with haloperidol. Significant association between remission and QLS improvement over time was observed (p<0.001).

Conclusions: In this double-blind, long-term (40-week core and 3-year continuation) study, ziprasidone was associated with continued improvement in remission and quality of life, in contrast to haloperidol.

REFERENCES:

1. Andreasen NC, Carpenter WT, Kane JM, Lasser RA, Marder SR, Weinberger DR. Remission in Schizophrenia: Proposed criteria and rationale for consensus. *Am J Psychiatry* 2005; 162:441–449.

Poster 88

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

**MAINTENANCE OF RESPONSE TO
MEMANTINE TREATMENT IN
MODERATE TO SEVERE ALZHEIMER'S
DISEASE PATIENTS RECEIVING STABLE
DONEPEZIL TREATMENT**

Supported by Forest Laboratories, Inc.

Michael Tocco, Ph.D., *Senior Clinical Scientist, CNS Clinical Development, Forest Laboratories, Inc., Harborside Financial Center Plaza V, Jersey City, NJ 07311*; Jason T. Olin, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the value of maintaining memantine treatment based on measures of cognition, function, behavior, and global measures.

SUMMARY:

Objective: Memantine is a moderate affinity, uncompetitive NMDA receptor antagonist approved in the US and in Europe for the treatment of moderate to severe Alzheimer's disease (AD). Post hoc analyses were performed using data from a previously conducted 24-week, double-blind, placebo-controlled trial of memantine (20 mg/day) in moderate to severe AD patients (N=404) treated with ongoing donepezil therapy (Tariot et al, 2004). These analyses assessed the maintenance of response on cognitive, functional, behavioral and global measures individually in a moderate to severe AD patient population.

Methods: The Severe Impairment Battery (SIB) was used to assess cognitive abilities. Functional and behavioral outcomes were measured with the Alzheimer's Disease Cooperative Study—Activities of Daily Living (ADCS-ADL₁₉) and Neuropsychiatric Inventory (NPI). Global status was assessed using the Clinician's Interview-Based Impression of Change Plus Caregiver Input (CIBIC-Plus). Maintenance of response for each outcome measure was defined as either no change or improvement above baseline scores for both weeks 12 and

24. Cochran-Mantel-Haenszel tests controlling for study center were performed on the Intention-to-Treat populations (OC and LOCF).

Results: Compared to patients receiving placebo, a significantly greater percentage of memantine-treated patients who responded at week 12 maintained their response at week 24 (OC analyses) on the SIB (52% vs. 39.5%, $P=.015$), the ADCS-ADL₁₉ (36.6% vs. 25.8%, $P=.037$), the NPI (50.9% vs. 36.8%, $P=.009$), and the CIBIC-Plus for OC (48.5% vs. 37.1%, $P=.036$). LOCF analyses yielded similar results, however maintenance of response on the CIBIC-Plus did not reach significance ($P=.054$).

Conclusions: These analyses indicate that, compared to placebo, a significant proportion of patients treated with memantine showed an early treatment response that was maintained for the duration of the 6-month study on all efficacy measures. These findings support the value of maintaining memantine treatment.

REFERENCES:

1. Tariot PN, Farlow MR, Grossberg GT, et al. Memantine treatment in patients with moderate to severe Alzheimer disease already receiving donepezil: a randomized controlled trial. *JAMA*. 2004; 291(3):317–324.
2. Schmitt FA, Ashford W, Ernesto C, et al. The severe impairment battery: concurrent validity and the assessment of longitudinal change in Alzheimer's disease. *The Alzheimer's Disease Cooperative Study*. *Alzheimer Dis Assoc Disord*. 1997; 11(Suppl 2): S51–S56.

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

FUNCTIONING IMPROVEMENTS IN SCHIZOPHRENIA PATIENTS WITH LONG-ACTING RISPERIDONE

Supported by Ortho-McNeil Janssen Scientific Affairs, LLC

Susan M. Vallow, R.Ph., M.B.A., *Manager, Clinical Operations, Janssen Pharmaceutical Products, L.P., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Stephen C. Rodriguez, M.S., *Manager, Clinical Operations, Janssen Pharmaceutica Products, L.P., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; L. Mao; Earle Baine, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand clinical characteristics of patients with schizophrenia initiated on long-acting risperidone; and understand the clinical and functional

improvements for patients with schizophrenia initiated on long-acting risperidone from these interim results.

SUMMARY:

Objective: Examine interim results of an ongoing, 2-year observational study in schizophrenia patients on risperidone long-acting injection (RLAI; Risperdal® CONSTA®).

Methods: Adult schizophrenia patients requiring treatment with RLAI were eligible. Patient demographics, treatment history, Clinical Global Impressions of Severity (CGI-S), Global Assessment of Functioning (GAF), Personal and Social Performance (PSP), Strauss-Carpenter Levels of Functioning (LOF), quality of life (SF-36), and resource utilization are collected at baseline and prospectively every 3 months for 2 years.

Results: Baseline data are available for 270 patients; 6-month data are available for 53 patients. Mean age (\pm SD) is 44.2 ± 12.4 years, 65.2% are male, and mean length of illness is 19.8 ± 12.4 years. Most patients (73.0%) initiated on RLAI 25 mg. Average duration between RLAI injections is 16.5 ± 5.6 days. Improvements from baseline to 6 months were shown: CGI-S improved from 4.5 ± 1.3 to 3.5 ± 1.2 ($P < 0.0001$); mean PSP scores improved from 48.1 ± 17.3 to 59.2 ± 14.3 ($P < 0.0001$); mean GAF scores improved from 48.7 ± 15.2 to 56.6 ± 12.9 ($P < 0.001$). Functioning and limited health-related quality-of-life improvements at month 6 were also observed. 10.7% of patients reported at least 1 adverse event.

Conclusions: Interim data suggest that schizophrenia patients treated with RLAI experience improvements in clinical and functional status.

TARGET AUDIENCE:

Clinical psychiatrists.

REFERENCES:

1. Kennedy L, Craig A. Global registries for measuring pharmaco-economic and quality-of-life outcomes. *Pharmacoeconomics*. 2004; 22:551–568.
2. Franciosa JA. The potential role of community-based registries to complement the limited applicability of clinical trial results to the community setting: heart failure as an example. *Am J Manag Care*. 2004; 10:487–492.

Poster 90

**Thursday, October 5
3:00 p.m.-4:30 p.m.**

COMPARATIVE EFFICACY AND SAFETY OF ZIPRASIDONE AND CLOZAPINE IN TREATMENT-REFRACTORY SCHIZOPHRENIA: RESULTS OF A RANDOMIZED, DOUBLE-BLIND, 18-WEEK TRAIL

Supported by Pfizer Inc.

Lewis E. Warrington, M.D., *Medical Director, U.S. Medical Department, Pfizer Inc., 235 East 42nd Street, New York, NY 10017*; Emilio Sacchetti, M.D.; A. Gal-luzzo, M.D.; P. Valsecchi, M.D.; Fabio Romeo, M.D.; B. Gorini, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to contribute to the participant's understanding of the safety and efficacy of difficult-to-manage patients diagnosed with schizophrenia who do not respond to, and/or are intolerant of, serial antipsychotic treatment.

SUMMARY:

Objective: To evaluate the efficacy and safety of ziprasidone and clozapine in patients with treatment-refractory schizophrenia.

Methods: This was a double-blind, parallel-group study of patients who had treatment-refractory schizophrenia (nonresponse in ≤ 3 adequate trials in the past 5 years) and/or were unable to tolerate antipsychotic treatment. All patients had a PANSS total score of ≥ 80 . Following a 3- to 7-day screening period, patients were randomized to receive ziprasidone, 80–160 mg/day ($n = 73$) or clozapine, 250–600 mg/day ($n = 74$) for up to 18 weeks.

Results: In the primary ITT-LOCF analysis, the baseline-to-end point decrease in mean PANSS total score was similar for the ziprasidone (-25.0 ± 22.0 ; 95% CI: -30.2 to -19.8) and clozapine (-24.5 ± 22.5 ; 95% CI: -29.7 to -19.2) groups. Mean end point improvement was also similar with both drugs on the CDSS, CGI, and GAF. Ziprasidone-treated patients had fewer treatment-related adverse events and a significantly more favorable metabolic profile than the patients given clozapine, showing significant ($P < 0.05$) reductions in weight, median total cholesterol, LDL cholesterol, and triglycerides.

Conclusions: In this study of treatment-refractory schizophrenia patients, ziprasidone demonstrated comparable efficacy but superior tolerability and metabolic safety in comparison with clozapine.

Supported by funding from Pfizer Italy.

TARGET AUDIENCE:

Clinical psychiatrists who evaluate and treat patients diagnosed with schizophrenia.

REFERENCES:

1. Conley RR, Buchanan RW. Evaluation of treatment-resistant schizophrenia. *Schizophr Bull* 1997; 23:663-674.
2. Newcomer JW, Schatzberg AF, Kilts CD, et al. From clinical research to clinical practice: a 4-year review of ziprasidone. *CNS Spectr* 2005; 10(suppl 17):1–19.

Poster 91

**Thursday, October 5
3:00 p.m.-4:30 p.m.**

ZIPRASIDONE IN THE TREATMENT OF SCHIZOPHRENIA: EVIDENCE FOR A LINEAR DOSE-RESPONSE RELATIONSHIP

Supported by Pfizer Inc.

Lewis E. Warrington, M.D., *Medical Director, U.S. Medical Department, Pfizer Inc., 235 East 42nd Street, New York, NY 10017*; Antony D. Loebel, M.D.; Ruoyong Yang, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to look at data that will clarify current understanding of the dose-response relationship for ziprasidone in the treatment of schizophrenia.

SUMMARY:

Objective: To examine the dose-response relationship of ziprasidone in patients with acute exacerbations of schizophrenia or schizoaffective disorder.

Methods: Data were pooled from two 6-week, fixed-dose, placebo-controlled trials of ziprasidone. Patients with acute exacerbations of schizophrenia or schizoaffective disorder received ziprasidone, 40 ($n = 86$), 80 ($n = 104$), 120 ($n = 76$), or 160 mg/day ($n = 103$), or placebo ($n = 71$). Change from baseline to end point in PANSS total score, subscales, and items, and MADRS were analyzed by group. Treatment effect size for each group was obtained and statistical testing for dose-response relationship applied.

Results: There was a significant linear dose-response relationship for PANSS total score, subscales, and items, and MADRS (subjects with baseline MADRS ≥ 14). Treatment effect sizes were consistently greatest in the 120–160 mg/day group. Analysis of PANSS items showed linear dose-response relationships for 28 of 30 items, with the greatest treatment effect size in the 160 mg/day group for 19 items and in the 120 mg/day group for nine items.

Conclusions: Analysis of PANSS and MADRS scores demonstrated a significant linear dose-response relationship for ziprasidone in the management of schizophrenia and schizoaffective disorder, with the largest clinical benefits observed with 160 mg/day.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. Keck P Jr, Buffenstein A, Ferguson J, et al. Ziprasidone 40 and 120 mg/day in the acute exacerbation of schizophrenia and schizoaffective disorder: a 4-week placebo-controlled trial. *Psychopharmacology (Berl)* 1998; 140:173–184.
2. Daniel DG, Zimbroff DL, Potkin SG, et al. Ziprasidone 80 mg/day and 160 mg/day in the acute exacerbation of schizophrenia and schizoaffective disorder: a 6-week placebo-controlled trial. Ziprasidone Study Group. *Neuropsychopharmacology* 1999; 20:491–505.

Poster 92

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

ZIPRASIDONE IN THE TREATMENT OF SCHIZOAFFECTIVE DISORDER: DOSE-RESPONSE ANALYSIS

Supported by Pfizer Inc.

Lewis E. Warrington, M.D., *Medical Director, U.S. Medical Department, Pfizer Inc., 235 East 42nd Street, New York, NY 10017*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the dose-response relationship for ziprasidone in the treatment of schizoaffective disorder.

SUMMARY:

Background: Schizoaffective disorder is an important but understudied psychotic illness, with a potentially different treatment response compared to schizophrenia. We sought to assess the dose-response relationship for ziprasidone in the acute treatment of schizoaffective disorder.

Methods: This analysis was limited to schizoaffective disorder subjects, taken from 2 similarly designed, fixed-dose, placebo-controlled trials of ziprasidone in the treatment of acute psychotic illness. Dosage groups were ziprasidone 40 mg/day (n=29), 80 mg/day (n=24), 120 mg/day (n=21), 160 mg/day (n=25), and placebo (n=50). Change from baseline to endpoint in PANSS total, CGI-S, and MADRS were analyzed by dosage group.

Treatment effect size (Cohen's *d*) for each group was obtained and statistical testing for dose response was applied.

Results: A significant linear dose-response relationship was found for PANSS total (F statistic 14.35 [*P*=0.0002]). Treatment effects were consistently greatest in the 160 mg/day group (effect sizes of 1.0, 1.1, and 0.77 for PANSS total, CGI-S, and MADRS, respectively).

Conclusion: The results of these analyses suggest that ziprasidone is associated with a linear dose response with the largest clinical benefits observed at 160 mg/day.

TARGET AUDIENCE:

Psychiatrists, primary care physicians, clinical nurse specialists and nurse practitioners, physician assistants, and pharmacists.

REFERENCE:

1. Daniel DG, Zimbroff DL, Potkin SG, et al. Ziprasidone 80 mg/day and 160 mg/day in the acute exacerbation of schizophrenia and schizoaffective disorder: a 6-week placebo-controlled trial. *Neuropsychopharmacology* 1999; 20:491–505.

Poster 93

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

DO FIRST-EPISODE SCHIZOPHRENIA PATIENTS ACCEPT A RECOMMENDATION OF A LONG-ACTING ANTIPSYCHOTIC?

Supported by Janssen Pharmaceutica, Inc.

Peter J. Weiden, M.D., *Director, Schizophrenia Research, Department of Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203*; Ayako Sunakawa, M.A., *Department of Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203*; Amjad Hindi, M.D.; Nina R. Schooler, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to learn that it is possible to use a strategy of long-acting atypical antipsychotic for the majority of first episode patients who accept a recommendation of maintenance antipsychotic therapy after their acute episode has responded.

SUMMARY:

Overview: Clinicians generally limit the use of long acting, "depot" antipsychotics to persistently ill patients. A long-acting atypical antipsychotic has theoretical advantages for first-episode schizophrenia patients,

who have the very high rates of nonadherence, and tend to have the most to lose from an otherwise preventable relapse. One important question is whether a long-acting injection would be accepted by first-episode patients when it is recommended in an informed, voluntary manner.

Methods: First-episode patients were invited into a two phase study. Phase I was a diagnostic and treatment assessment phase. Patients meeting inclusion criteria for maintenance antipsychotic therapy were invited to Phase II. Patients entering Phase II were then randomized to: a *recommendation* of long-acting risperidone vs a recommendation of oral atypical antipsychotic in a 2:1 ratio.

Results: As of May 1, 2006, 27 patients entered into Phase II, with 18 randomized to a recommendation of long-acting atypical antipsychotic (long-acting risperidone) and 9 to a recommendation of any first-line oral antipsychotic medication. Of the 18 offered long-acting risperidone, 14 patients (78%) did accept this recommendation as defined by receiving at least one injection of long-acting risperidone.

Conclusion: Our preliminary results show that the majority of first-episode patients who agree to maintenance antipsychotic therapy will accept a long-acting injection version of the medication, as long as the recommendation is provided in an integrated fashion.

TARGET AUDIENCE:

Clinicians treating first-episode schizophrenia patients and their families.

REFERENCES:

1. Robinson DG, Woerner MG, McMeniman M, Mendelowitz A, Bilder RM. Symptomatic and functional recovery from a first episode of schizophrenia or schizoaffective disorder. *Am J Psychiatry*. Mar 2004; 161(3):473-479.
2. Valenstein M, Copeland LA, Owen R, Blow FC, Visnic S. Adherence assessments and the use of depot antipsychotics in patients with schizophrenia. *J Clin Psychiatry*. Jul 2001; 62(7):545-551.

Poster 94

**Thursday, October 5
3:00 p.m.-4:30 p.m.**

REDUCING POLYPHARMACY WITH RISPERIDONE LONG ACTING INJECTION

Supported by Janssen Pharmaceutica, Inc.

William H. Wilson, Ph.D., *Research Professor, Department of Psychiatry, Duke University, Box 3930, Durham, NC 27705*; Joseph P. McEvoy, M.D., Matthew J. Byerly, M.D.; Prakash S. Masand, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants will be familiar with the prevalence of polypharmacy (more than one antipsychotic and/or more than one adjunctive medication) in the treatment of psychotic disorders; and understand the effects of switching to assured antipsychotic treatment with Risperidone Consta on polypharmacy.

SUMMARY:

Background: When a patient with a psychotic disorder has an incomplete therapeutic response to an antipsychotic, the treating clinician may add a second antipsychotic or adjunctive medication (mood stabilizer, antidepressant, etc.) in an effort to better control the psychopathology. However, the incomplete therapeutic response may reflect poor medication adherence, a problem that will not be corrected by additional medications. We examined whether assured antipsychotic treatment through Risperidone allowed for the tapering away of other antipsychotics and adjunctive medications.

Method: We switched recently admitted patients with a psychotic disorder and incomplete adherence and/or polypharmacy to treatment with Risperidone. Over a 6-month follow-up, we attempted to reduce polypharmacy and assess clinical course. *Results:* Of 28 subjects who completed at least 2 months of treatment, 24 completed 6 months, 4 completed 4 months. Of 13 taking more than one antipsychotic 7 (54%) had a reduction by 6 months (or time of ending participation). Of the 23 taking one or more adjunctive medications, 15 (65%) had a reduction and 2 (8.6%) had an increase in number of adjunctive medications. *Conclusion:* These results support the hypothesis that assured treatment may permit a reduction in polypharmacy.

TARGET AUDIENCE:

Psychiatrists, psychologists, and other mental health professionals.

REFERENCES:

1. Reducing Nonadherence: New Formulations of Antipsychotic Medications, John M. Kane, *Psychiatric Times* Feb. 2006 Vol. XXV Issue 2.
2. Practical Application of Pharmacotherapy With Long-Acting Risperidone for Patients With Schizophrenia. S.J. Keith; *Psychiatric Services*, Sept 2004 Vol. 55 No. 9 997.

Poster 95

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

**ASENAPINE IMPROVES COGNITIVE
FUNCTION IN MONKEYS EXPOSED TO
PHENCYCLIDINE**

*Supported by Organon International, Inc. and
Pfizer Inc.*

Erik H.F. Wong, Ph.D., *Director, Pfizer Inc., 2800 Plymouth Road, Ann Arbor, MI 48105*; J. David Jentsch, Ph.D.; Mohammed Shahid, Ph.D.; Robert H. Roth, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the model of PCP-induced cognitive impairment in monkeys and its usefulness in determining the efficacy of psychopharmacologic agents for cognitive dysfunction; and discuss the effects of asenapine on cognitive function in monkeys with PCP-induced cognitive impairment.

SUMMARY:

Objective: To explore the effects of short- and long-term asenapine dosing on reversal learning and object retrieval in normal and chronic phencyclidine (PCP)-exposed monkeys.

Methods: Forty-eight monkeys were trained in object discrimination and reversal learning before twice-daily dosing with PCP (0.3 mg/kg intramuscular) or saline for 14 days. A baseline test confirmed cognitive deficits in PCP-exposed animals before beginning twice-daily subcutaneous administration of saline (control) or asenapine (50, 100, or 150 µg/kg).

Results: In the reversal task, PCP-exposed monkeys made more perseverative errors than did controls, evidence of poor capacity to switch responses. On average, PCP-treated monkeys made twice as many errors as did control monkeys under these conditions. Asenapine facilitated reversal learning in PCP-exposed monkeys. Improvements in reversal learning were at the trend level in week 1 and significant in weeks 2–4. In week 4, asenapine 150 µg/kg significantly improved reversal learning in PCP-exposed monkeys ($P=0.01$), rendering their performance indistinguishable from that of controls.

Conclusions: Asenapine produced substantial and lasting gains in executive functions in this model of PCP-induced cognitive impairment.

TARGET AUDIENCE:

Psychiatrists

REFERENCES:

1. Jentsch JD, Redmond DE, Elsworth JD, Taylor JR, Youngren KD, Roth RH: Enduring cognitive deficits

and cortical dopamine dysfunction after long-term administration of phencyclidine to monkeys. *Science* 1997; 277:953–955.

2. Jentsch JD, Taylor JR, Redmond DE, Elsworth JD, Youngren KD, Roth RH: Dopamine D4 receptor antagonist reversal of subchronic phencyclidine-induced object retrieval/detour deficits in monkeys. *Psychopharmacology* 1999; 142: 78–84.

Poster 96

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

**ASENAPINE: A
PSYCHOPHARMACOLOGIC AGENT
WITH A UNIQUE HUMAN RECEPTOR
SIGNATURE**

*Supported by Organon Pharmaceuticals, Inc. and
Pfizer Inc.*

Erik H.F. Wong, Ph.D., *Director, Pfizer Inc., 2800 Plymouth Road, Ann Arbor, MI 48105*; Mohammed Shahid, Ph.D.; Glenn B. Walker; Anil S. Jina, M.D.; Stevin Zorn, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the receptor signature of asenapine in terms of relative potency of interactions at serotonergic, dopaminergic, alpha-adrenergic, and muscarinic receptors; and compare the receptor signature of asenapine with those of currently available antipsychotic drugs.

SUMMARY:

Objective: To explore the mechanism of action of asenapine by comparing its human receptor signature with the receptor-binding profiles of antipsychotic drugs.

Methods: We determined the binding affinities of asenapine under comparable assay conditions for cloned human serotonergic, alpha-adrenergic, dopaminergic, histaminic, and muscarinic receptors.

Results: The rank order of receptor affinity for asenapine at various receptors was different from that of olanzapine, risperidone, quetiapine, aripiprazole, ziprasidone, clozapine, and haloperidol. Asenapine exhibited higher affinity (K_i in nM) for 5-HT_{2C} (0.03), 5-HT_{2A} (0.07), 5-HT₇ (0.11), 5-HT_{2B} (0.18), and 5-HT₆ (0.25) receptors compared with D₂ (1.3) receptors. Receptor affinities for the antipsychotic drugs tested were generally in agreement with published data. Compared with antipsychotics, asenapine showed more potent interaction with 5-HT_{2C}, 5-HT₇, 5-HT₆, 5-HT₅ (1.6) and D₃ (0.42) receptors and alpha₁ (1.2) and alpha₂ (0.33–1.2) adrenoceptors. Unlike olanzapine, clozapine, and queti-

pine, asenapine has much lower affinity for muscarinic receptors relative to its D₂ affinity.

Conclusions: The human receptor signature of asenapine differs from that of the antipsychotics tested, with potent interactions at an ensemble of serotonergic, dopaminergic, and alpha-adrenergic receptors but no significant interaction at muscarinic receptors.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. Kongsamut S, Kang J, Chen XL, Roehr J, Rampe D: A comparison of the receptor binding and HERG channel affinities for a series of antipsychotic drugs. *Eur J Pharmacol* 2002;450: 37–41.
2. Potkin SG, Cohen M, Baker RA, et al: Asenapine, a novel psychopharmacologic agent with efficacy in positive and negative symptoms during acute episodes of schizophrenia: a randomized placebo- and risperidone-controlled trial. Presented at: 44th Annual Meeting of the American College of Neuropsychopharmacology; December 11–15, 2005; Waikoloa, Hawaii.

POSTER SESSION 3

Posters 97–143

TRANSFORMING PSYCHIATRY: HOW SYSTEMS OF CARE RESPOND TO CHALLENGING POPULATIONS

Poster 97

**Friday, October 6
3:00 p.m.-4:30 p.m.**

TRAINING ACROSS LANGUAGES AND CULTURES USING THE NEGATIVE SYMPTOM ASSESSMENT SCALE

Supported by Organon International, Inc., and Pfizer Inc.

Larry Alphas, M.D., Ph.D., *Executive Director, Pfizer Inc., 2800 Plymouth Road, Ann Arbor, MI 48105*; David G. Daniel, M.D.; Dawn I. Velligan, Ph.D.; John Bartko, Ph.D.; John Panagides, Ph.D.; John M. Davis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the Negative Symptom Assessment (NSA) scale; and compare results of training on the NSA versus the Positive and Negative Syndrome Scale in terms of achieving acceptable agreement among raters across different nationalities and languages.

SUMMARY:

Objective: To analyze level of agreement among raters of different nationalities and languages using the 16-item Negative Symptom Assessment scale (NSA-16) versus the Positive and Negative Syndrome Scale (PANSS).

Methods: Two cohorts of raters were enrolled: 120 from the US and 180 from 18 other countries. Participants viewed ℓ1 training lecture, rated ℓ1 videotaped NSA-16 interview of a schizophrenic patient, and received feedback on rating methods. Training for the PANSS was similar. Participants were then evaluated on their ratings of another videotaped interview. Acceptable agreement was a score within 1 point of the modal score on ℓ80% of the items on each rating instrument.

Results: Using the NSA-16, acceptable agreement was achieved by 85/90 (94%) of US raters versus 174/180 (97%) of non-US raters (*P*=0.38). Using the PANSS, agreement was achieved by 104/120 (87%) of US raters versus 168/173 (97%) of non-US raters (*P*=0.0009).

Conclusions: Both cohorts achieved comparable success in NSA-16 training but showed a significant difference with the PANSS. This suggests that raters from differing cultures can be more effectively trained to assess negative symptoms using the NSA-16.

This study was supported by Organon International Inc., and Pfizer Inc., based on independent research.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. Axelrod BN, Goldman RS, Alphas, LD: Validation of the 16-item Negative Symptom Assessment. *J Psychiatr Res* 1993; 27: 253–258.
2. Eckert SL, Diamond PM, Miller AL, Velligan DI, Funderburg LG, True JE: A comparison of instrument sensitivity to negative symptom change. *Psychiatry Res* 1996; 63: 67–75.

Poster 98

**Friday, October 6
8:30 a.m.-10:00 a.m.**

ASSOCIATION BETWEEN CHANGES IN NEGATIVE SYMPTOMS AND FUNCTIONAL OUTCOMES

Supported by Organon International, Inc., and Pfizer Inc.

Larry Alphas, M.D., Ph.D., *Executive Director, Pfizer Inc., 2800 Plymouth Road, Ann Arbor, MI 48105*; Dawn I. Velligan, Ph.D.; Mai Wang, M.S.; George M. Haig, Pharm.D.; Scott E. Lancaster, M.S.; Tom N. Taylor

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate familiarity with several standard measures of functional outcome in patients with schizophrenia; and describe the degree of correlation between changes in several measures of functional outcome and scores on the Negative Symptom Assessment scale.

SUMMARY:

Objective: To correlate changes in scores on the 16-item Negative Symptom Assessment scale (NSA-16) with changes in scores on various functional outcome scales.

Methods: 99 stable outpatients with schizophrenia or schizoaffective disorder participating in 1 of 3 medication or psychosocial treatment intervention studies were assessed at baseline and 9 months with the NSA-16, the Quality of Life Scale (QLS), Multnomah Community Ability Scale (MCAS), Global Assessment of Functioning (GAF), Social and Occupational Functioning Assessment Scale (SOFAS), Frontal Systems Behavioral Scale (FrSBe), Functional Needs Assessment (FNA), and Life Skills Profile (LSP). Associations between change scores were assessed using Pearson's correlation coefficients.

Results: Changes on the NSA-16 showed significant correlations with changes on all of the functional outcome scales, including structured assessments (QLS, $r = -0.423$, $P < 0.0001$; MCAS, $r = -0.338$, $P = 0.0008$), global assessments (GAF, $r = -0.521$, $P < 0.0001$; SOFAS, $r = -0.497$, $P < 0.0001$), performance-based assessments (FrSBe, $r = 0.414$, $P = 0.0003$; FNA, $r = -0.231$, $P = 0.0247$), and an observational assessment (LSP, $r = -0.367$, $P = 0.0003$).

Conclusions: Improvements in negative symptoms are associated with improvements in clinician- and patient-assessed functional outcome measures.

This study was supported by Organon International Inc., and Pfizer Inc., based on independent research.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. Eckert SL, Diamond PM, Miller AL, Velligan DI, Funderburg LG, True JE: A comparison of instrument sensitivity to negative symptom change. *Psychiatry Res* 1996; 63:67-75.
2. Axelrod BN, Goldman RS, Alphas LD: Validation of the 16-item Negative Symptom Assessment. *J Psychiatr Res* 1993; 27:253-258.

Poster 99

Friday, October 6
8:30 a.m.-10:00 a.m.

INVOLUNTARY MEDICATION IN PSYCHIATRIC INPATIENT TREATMENT

Amel A. Badr, M.D., *Department of Psychiatry, Bergen Regional Medical Center, 230 East Ridgewood Avenue, Paramus, NJ 07652*; Asghar Hossain, M.D., *Department of Psychiatry, Bergen Regional Medical Center, 230 East Ridgewood Avenue, Paramus, NJ 07652*; Arthur E. Middleton, M.D.; M. Javed Jobal, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to examine the demographic and clinical risk factors associated with forced medication in psychiatric inpatient treatment.

SUMMARY:

Rationale and Background: The right of committed psychiatric patients to refuse medication and the procedures to determine when refusal can be overridden continues to be a debate. The justification of compulsory treatment however rests on the idea that treatment refusal had negative effects on the hospital milieu and on the patient. Involuntary medication could also help to enhance insight or cooperation helping in rapid return to the community. Identifying the risk factors would allow early recognition and effective intervention to prevent or limit the use of forced medication.

Materials and Method: Retrospective chart review of the records of involuntarily medicated patients admitted in the time period 1/1/04-5/31/06 was done. Date of admission, legal status and demographic and clinical data of the patients were recorded.

Results: Involuntary medication events were found to occur in average on fourth day of admission. All patients had involuntary legal status. DSMIV diagnoses included Schizophrenia 41%, schizoaffective bipolar 25% and bipolar manic 20%. Only four patients had to be proceeded from 72 hours procedure to three-step procedure.

Conclusion: Significant relationship was found between treatment refusal and psychotic, recently admitted patients. This is the group of patients who are expected to be mistrustful of the treatment team and less insightful into their psychiatric illness.

REFERENCES:

1. A prospective multicenter study of patient's refusal of antipsychotic medication. Hoge SK, Appelbaum PS, et al. *Arch. Gen. Psychiatry*, 1990 Oct; 47(10): 949-956.
2. Prospective study of patients' refusal of antipsychotic medication under a psychiatric discretion review procedure. John A. Kasper, Steven K. Hoge et al. *Am J Psychiatry* 1997, 154; 483-489.

Poster 100

Friday, October 6
8:30 a.m.-10:00 a.m.

**BIPOLAR DISORDER: MANAGING
PRESCRIBING OF PSYCHOTROPICS IN A
HIGH-RISK POPULATION**

Supported by Comprehensive NeuroSciences, Inc.

John E. Byrd, Pharm.D., M.B.A., *Director of Outcomes Research and Pharmacy Services, Comprehensive NeuroSciences, Inc., 1 Copley Parkway, Suite 534, Morrisville, NC 27560*; Joseph J. Parks, M.D., *Medical Director, Missouri Department of Mental Health, 1706 East Elm Street, P.O. Box 687, Jefferson City, MO 65102*; George Oestreich, Pharm.D.; Judith Dogin, M.D.; James Van Halderen, Psy.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will have learned about the extent to which psychotropic prescribing for the treatment of bipolar disorder can differ from recommended practice and learn about a new initiative for quality improvement and cost management of behavioral medication prescribing.

SUMMARY:

Background: Bipolar disorder is difficult and expensive to treat. Individuals with bipolar disorder are often misdiagnosed leading to ineffective treatment or go undiagnosed. *Methods:* Patients were selected from Medicaid claims data from October 2003 through October 2005. All patients were 18–64 years old, had a diagnosis of bipolar disorder, were continuously eligible during entire period, were not dually eligible (Medicare-Medicaid), had no diagnosis of schizophrenia. A subset of patients was selected for intervention based on high medical services, high pharmacy utilization and severity of disease. Three Main *Objectives:* (1) analyze the pharmacological history of a patient with Bipolar Disorder to ascertain patterns of care outside of best practice; (2) develop proxy measures to assess potential inappropriate prescribing; (3) create patient-focused reports for treating physicians containing patient’s pharmacological history and Clinical Considerations™. *Discussion:* Twelve bipolar-focused Quality Indicators were developed to be applied to Medicaid claims in search of prescribing practices indicating risky and/or redundant treatments and problems with coordination/continuity of care. The goal is to develop interventions for high risk bipolar patients whose treatment is inconsistent with best practice. A patient centered approach could determine if improving quality of prescribing can also improve quality of care as well as reduce costs.

TARGET AUDIENCE:

Psychiatrists and allied health care professionals.

REFERENCES:

1. Keck PE, Perlis RH, Otto MW et al. Treatment of Bipolar Disorder 2004 Postgraduate Medicine—A Special Report, December 2004.
2. Hirschfeld RMA & Vornik LA. Bipolar Disorder—Costs and Comorbidity. *American Journal of Managed Care*, 2005; 11:S85–S90.

Poster 101

Friday, October 6
8:30 a.m.-10:00 a.m.

**ELDERLY PAIN AND DEPRESSION:
ANALYSIS OF POTENTIALLY
INAPPROPRIATE PRESCRIBING IN A
MEDICAID POPULATION**

Supported by Comprehensive NeuroSciences, Inc.

John E. Byrd, Pharm.D., M.B.A., *Director of Outcomes Research and Pharmacy Services, Comprehensive NeuroSciences, Inc., 1 Copley Parkway, Suite 534, Morrisville, NC 27560*; Joseph J. Parks, M.D., *Medical Director, Missouri Department of Mental Health, 1706 East Elm Street, P.O. Box 687, Jefferson City, MO 65102*; George Oestreich, Pharm.D.; William Jones, M.D.; James Van Halderen, Psy.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will have learned about the extent to which psychotropic prescribing for health conditions in the elderly population differ from recommended practice and be able to examine a new initiative for quality improvement and cost management of behavioral medication prescribing.

SUMMARY:

Background: Concurrent presence of chronic pain and depression in elderly patients can result in negative lifestyle and economic consequences. Treating chronic pain and depression in the elderly is complex as many medications are contraindicated or require dosing modifications. *Methods:* Quality Indicators™ were developed to identify potentially inappropriate prescribing in elderly patients with pain and depression using published expert-consensus guidelines, Beers criteria and nationally-recognized geriatricians. The indicators were applied to Missouri Medicaid pharmacy claims from January to December 2005. Elderly patients, over 65, were identified with chronic pain if they received two consecutive 30-days supply of an opiate or COX-II inhibitor (n=27,972). *Results:* Forty percent (n=11,274) were prescribed opiates or psychotropics outside of best practice guidelines. The most common high-risk prescribing

practices were: use of daily fluoxetine (n=1182), use of SSRI at lower than recommended dose for more than 60 days (n=2524), use of benzodiazepines for more than 30 days (n=7407), and concurrent use of benzodiazepines and opiates for 60 or more days (n=2441). There was also a high rate of discontinuation of newly prescribed antidepressants (n=2056). *Discussion:* Inappropriate use of medications can result in negative health and economic consequences. It is important to develop physician interventions around appropriate medication prescribing.

TARGET AUDIENCE:

Psychiatrists and allied health care professionals.

REFERENCES:

1. Fick DM, Cooper JW, Wade WE, et al. Updating the Beers criteria for potentially inappropriate medication use in older adults. *Arch Intern Med.* 2003; 163: 2716–24.
2. Fu AZ, Liu GG, Christensen DB. Inappropriate medication use and health outcomes in the elderly. *J Am Ger Soc.* 2004; 52: 1934–39.

Poster 102

Friday, October 6
8:30 a.m.-10:00 a.m.

TREATMENT BARRIERS FOR LOW-INCOME, URBAN AFRICAN AMERICANS WITH UNDIAGNOSED PTSD

Supported by the National Institutes of Mental Health

Regina G. Davis, Ph.D., *Post-Doctoral Fellow, Department of Psychiatry and Behavioral Sciences, Emory University Medical School, 923 Clairemont Avenue, #6, Decatur, GA 30030*; Kerry J. Ressler, M.D., Ph.D.; Rebekah G. Bradley, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will recognize those low-income, urban-dwelling African Americans who are at highest risk for PTSD; examine the most prevalent barriers to low-income, urban-dwelling African Americans accessing mental health services; and learn specific strategies to implement culturally sensitive and relevant mental health services for African Americans needing PTSD treatment.

SUMMARY:

Sample/Method: Two hundred and twenty low-income, urban-dwelling African Americans, recruited from hospital waiting areas, completed self-report measures examining the interrelationship between the prevalence of traumatic events and (1) PTSD and the (2) need

for and barriers to clinical services. *Findings:* Almost 50% had relatives/friends who were murdered, and 42.5% (males 58%; females 36%) had been attacked with a lethal weapon. Females (36.4%) were more likely than males (8.9%) to be attacked sexually. Twenty-two percent met the criteria for PTSD, yet only 4.1% reported prior treatment for PTSD symptoms. A PTSD diagnosis was predictive of greater desire (53.3% vs. 39.87% with no diagnosis) for mental health services. The most endorsed barriers to mental health services were (1) no transportation; (2) limited funds; (3) family disapproval; (4) unfamiliarity with accessing mental health services; (5) negative therapy experiences of others. *Conclusion:* Many low-income, urban-dwelling African Americans are at great risk for violence and undiagnosed PTSD. They are also unlikely to receive mental health services due in part to intrapersonal (e.g., limited funds), institutional (e.g., resource capacity), and cultural (e.g., family disapproval) barriers. *Implications:* Remedial interventions should be aimed at providing culturally-sensitive and culturally-relevant PTSD psychoeducation, routine PTSD screens, and user-friendly clinical services.

This research was funded by an NIH-NIMH Grant (#MH071537)

TARGET AUDIENCE:

Professionals interested in low-income, urban-dwelling African Americans exposed to high violence rates that result in post traumatic stress disorder (PTSD) symptoms.

REFERENCES:

1. Hines-Martin V, Malone M, Kim S, & Brown-Piper, A. (2003). Barriers to mental health care access in an African American population. *Issues in Mental Health Nursing*, 24, 237–256.
2. Lecrubier, Y. (2004). Posttraumatic Stress Disorder in Primary Care: A Hidden Diagnosis. *Journal of Clinical Psychiatry*, 65, (Suppl. 1), 49–54.

Poster 103

Friday, October 6
8:30 a.m.-10:00 a.m.

MEDICARE D UTILIZATION MANAGEMENT SPREADSHEET PROJECT

Benjamin Crocker, M.D., *Medical Director, Maine Medical Center, 443 Congress Street, SFU Floor, Portland, ME 04101*; Stevan Onessitt, M.D.; Edward B.K. Pontius, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize an easy and accessible way of monitoring posted utilization management proposed

for medicare PDP's in a format that allows for plan comparison regarding different classes of medication.

SUMMARY:

The Medicare D spreadsheet project began under the auspices of the Maine Association of Psychiatric Physicians, in order to try to track proposed utilization management edits posted on the Medicare Formual Finder and PDP plan formularie for psychiatric medications in plans for dual eligible and special help beneficiaries. Because the UM edits are the major differentiators of this group of plans, it was felt to be essential that patients and providers be able to compare plans easily in each region. The authors worked together to develop the formatting of the spreadsheets, and by January 2006, several classes of medications used in general medicine as well as psychotropics were posted on the website of the Maine District Branch of the APA at www.mainepsych.org. In preparation for the APA annual meeting, an inventory of plans serving the dual eligible population revealed that the bulk of the plans across the 34 US PDP regions were provided by 21 companies, using the same formularies in each region. This made it possible to quickly create spreadsheets concerning psychotropic medications for all PDP regions. These spreadsheets are now being posted on various national and regional websites. We will review the progress of this project and display examples of the spreadsheets.

TARGET AUDIENCE:

Prescribing clinicians and consumers.

REFERENCES:

1. Medicare Drug Plans: Restrictions on Access to Formulary Drugs. United States House of Representatives Committee on Government Reform-Minority Staff Special Investigations Division, March 2006.
2. MedPAC Report to the Congress: Increasing the Value of Medicare, Chapter 7, Part D Plan offerings, June 2006.

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Friday, October 6
8:30 a.m.-10:00 a.m.

A MODEL OF LONG-TERM CHANGE IN DIABETES AND CORONARY HEART DISEASE RISK: EFFECTS OF METABOLIC CHANGE IN PHASE I OF THE CATIE STUDY

Supported by Pfizer Inc.

Brian Cuffel, Ph.D., *Director, U.S. Outcomes Research, Pfizer Inc., 235 East 42nd Street, New York, NY 10017;*
Ilise D. Lombardo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate the long-term risks for diabetes and CHD associated with the use of atypical antipsychotic medications, as estimated from data on metabolic risk factors from the CATIE study.

SUMMARY:

Background: A published study using baseline fasting laboratory values from the CATIE study indicated increases in CHD risk, vs age- and sex-matched controls. We used mathematical modeling to determine whether metabolic changes observed in the CATIE study following atypical antipsychotic treatment translated into further, long-term increases in CHD and diabetes risk.

Methods: Risk equations were used to estimate 10-year rates of diabetes and CHD using baseline and follow-up data from CATIE. Exposure-adjusted mean change from baseline was used to estimate the increase in risk relative to treatment with ziprasidone or no treatment.

Results: Relative to ziprasidone, olanzapine and quetiapine substantially elevated the risk for diabetes and for a primary CHD event among men and women (range of relative risk=1.06–1.26 for men and 1.03–1.09 for women). To a lesser extent, risperidone elevated the risk for diabetes and CHD in men and for CHD in women. Ziprasidone treatment did not increase risk for diabetes or CHD in the CATIE study.

Conclusions: Olanzapine and quetiapine substantially increased the risk for diabetes and CHD above that of ziprasidone and above that of the patient's baseline risk, as calculated using exposure-adjusted metabolic changes observed in the CATIE study. These results suggest serious long-term safety concerns for olanzapine, quetiapine, and, to a lesser extent, risperidone.

TARGET AUDIENCE:

Psychiatrists, primary care physicians, clinical nurse specialists, nurse practitioners, and physician assistants.

REFERENCES:

1. Lieberman JA, Stroup TS, McEvoy JP, et al. Rosenheck RA, Perkins DO, Keefe RS, Davis SM, Davis CE, Lebowitz BD, Severe J, Hsiao JK. Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. *N Engl J Med.* 2005; 353:1209–1223.
2. Goff DC, Sullivan LM, McEvoy JP, Meyer JM, Nasrallah HA, Daumit GL, et al. A comparison of ten-year cardiac risk estimates in schizophrenia patients from the CATIE study and matched controls. *Schizophr Res.* 2005; 80(1):45–53.

Poster 105

Friday, October 6
8:30 a.m.-10:00 a.m.

LIPID AND GLUCOSE MONITORING DURING ATYPICAL ANTIPSYCHOTIC TREATMENT: EFFECTS OF THE 2004 ADA/APA CONSENSUS STATEMENT

Supported by Pfizer Inc.

Brian Cuffel, Ph.D., *Director, U.S. Outcomes Research, Pfizer Inc., 235 East 42nd Street, New York, NY 10017*; John Martin, M.P.H.; Amie T. Joyce, M.P.H.; Stephen J. Boccuzzi, Ph.D.; Antony D. Loebel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to increase physician awareness of the need to monitor metabolic risk factors in patients treated with atypical antipsychotic medication as recommended by ADA/APA guidelines.

SUMMARY:

Objective: Concerns about the metabolic effects of atypical antipsychotic medications and the elevated rate of medical morbidity in patients treated with these medications (1) led the ADA and the APA to publish a consensus statement regarding specific recommendations for medical management (2). The recommendations include lipid and glucose testing at the start of atypical antipsychotic treatment and 12 weeks later. To assess the impact of these guidelines on monitoring rates, we evaluated laboratory testing rates before and after publication of the guidelines.

Methods: Patients initiating treatment with an atypical antipsychotic before (n=21,848) and after (n=8,166) guideline publication were identified from the Pharmetrics claims database. Lipid and glucose testing was assessed at treatment initiation and 12 weeks after.

Results: Testing rates were low at baseline and at 12 weeks both before guideline publication (lipids: 7.8% and 6.2%; glucose: 20.6% and 16.0%, respectively) and after (8.5% and 7.1%; 22.5% and 17.6%). Stratification by age or atypical antipsychotic did not change the pattern of results.

Conclusions: Adherence to consensus recommendations for lipid and glucose monitoring in patients receiving atypical antipsychotic therapy is poor suggesting that publication and dissemination of guidelines is insufficient by itself to change physician practice.

TARGET AUDIENCE:

Psychiatrists, primary care physicians, clinical nurse specialists and nurse practitioners, physician assistants, pharmacists.

REFERENCES:

1. Goff DC, Cather C, Evins AE, et al. Medical morbidity and mortality in schizophrenia: guidelines for psychiatrists. *J Clin Psychiatry.* 2005; 66(2):183-194.
2. Consensus development conference on antipsychotic drugs and obesity and diabetes. *J Clin Psychiatry.* 2004; 65(2):267-272.

Poster 106

Friday, October 6
8:30 a.m.-10:00 a.m.

INITIAL DOSE AND DISCONTINUATION FOR FIVE MAJOR ATYPICAL ANTIPSYCHOTIC MEDICATIONS

Supported by Pfizer Inc.

Brian Cuffel, Ph.D., *Director, U.S. Outcomes Research, Pfizer Inc., 235 East 42nd Street, New York, NY 10017*; C. Daniel Mullins, Ph.D.; Nour Obeidat, M.S.; John Naradzay, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to highlight the relationship between initial atypical antipsychotic dose and time-to-discontinuation in using a naturalistic Medicaid pharmacy claims data base. This relationship was examined for atypical antipsychotics as a class, as well as for each drug individually.

SUMMARY:

Objective: To determine the relationship between initial atypical antipsychotic dose and treatment discontinuation in patients with schizophrenia.

Methods: Adult Medicaid recipients with schizophrenia, having prescription claims for any of the major atypical antipsychotics (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) between July 2001 and September 2003, were categorized by initial dose (low, medium, high). Treatment discontinuation was defined as a 14-day gap between expected refill dates. Using multivariate Cox proportional hazards regression analysis, we explored the impact of initial dose, controlling for age, gender, race, hospitalization prior to initiation of drug therapy, and concurrency in psychotropic medications for the five drugs pooled together (n = 3523) and for each drug separately. A sensitivity analysis was conducted, allowing a 29-day gap between refills.

Results: In the pooled analysis, high initial dose was significantly associated with a lower hazard of discontinuation (hazard ratio [HR], 0.872; *P* = 0.0045). When the drugs were considered separately, only ziprasidone showed this significant association (HR, 0.808; *P* = 0.0191).

Conclusions: In contrast to other antipsychotics, time-to-discontinuation with ziprasidone is generally greater when patients are initiated on a high rather than a low dose. Our results are consistent with results of a prior study in commercially insured ziprasidone users.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. Mullins CD, Shaya FT, Zito J, et al. Effect of initial ziprasidone dose on treatment persistence in schizophrenia. *Schizophrenia Research* 2006; 83:277–284.
2. Joyce AT, Harrison DJ, Loebel AD, et al. Effect of initial ziprasidone dose on length of therapy in schizophrenia. *Schizophrenia Research* 2006; 83:285–292.

deficiency has been in the development of intermediate community services and programs to rehabilitate and resettle patients in the community. This has been the cause of an insufficient deinstitutionalization of the patients in long-term and medium-term care units of the old psychiatric hospital, which is still open.

TARGET AUDIENCE:

This poster is intended for psychiatrists, primary care physicians, mental health professionals, health care professionals, health administrators and hospital managers.

REFERENCES:

1. The World Health Report 2001—Mental Health: New understanding, new hope. (WHO, 2001).
2. “Deinstitutionalization and psychiatric reform in Spain”. Vazquez-Barquero JL, Garcia J. (*Eur. Arch. Psychiatry Clin. Neurosci.* 1999; 249 (3):128–35).

Poster 107

**Friday, October 6
8:30 a.m.-10:00 a.m.**

DEVELOPING COMMUNITY MENTAL HEALTH SERVICES IN BALEARIC ISLANDS, SPAIN

Miguel Echevarria, M.D., *Mental Health Director of Balearic Islands, Reina Esclaramunda, 9, Palma De Mallorca, Spain 07003*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to examine how the development and improvement of mental health services affects patient care.

SUMMARY:

The Balearic Islands form one of the 19 autonomous regions of Spain. Comprising of the islands of Majorca, Minorca, Eivissa, Formentera and various other small islands. The population is 1,000,000 inhabitants approximately.

The transformation of psychiatric care has been carried out in Spain since the 1980s under the name of “Psychiatric Reform” however it was not clearly initiated in the Balearic Islands until 1998. Thanks to it a much better organized mental health care structure has been made, the ratio of mental health professionals has increased, an extensive community network of mental health centres has been build up and most of the mental health problems are attended in the community, most of the psychiatric units are located in general hospitals instead of psychiatric hospitals, and the majority of psychiatric patients have being integrated in the general health care system. New legislation has also improved the care and civil rights of patients. However, the main

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**Friday, October 6
8:30 a.m.-10:00 a.m.**

CARDIAC RISK FACTORS AND SCHIZOPHRENIA: AN ANALYSIS OF 18,094 PATIENTS ENROLLED IN AN INTERNATIONAL COMPARATIVE TRIAL OF OLANZAPINE AND ZIPRASIDONE

Supported by Pfizer Inc.

Sybil Eng, Ph.D., *Director, Global Epidemiology, Pfizer Inc., 235 East 42nd Street, New York, NY 10017*; Brian L. Strom; Gerald Faich; Robert F. Reynolds, Sc.D.; John M. Kane, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to increase awareness among psychiatrists of the elevated cardiac risk factors present in schizophrenia patients, based on data obtained at baseline from a very large sample of patients enrolled in an international comparative trial of ziprasidone and olanzapine

SUMMARY:

Introduction: Ziprasidone has modest QT_c-prolonging effects, but it is not known if this translates to increased risk of cardiovascular events. The Ziprasidone Observational Study of Cardiac Outcomes (ZODIAC), a large (N>18,000), international, open-label, randomized, postmarketing study, has been conducted to address this issue.

Methods: A physician-administered questionnaire collected baseline information on demographics, medical and psychiatric history, and concomitant medication use. Data were self-reported by patients or reported by

enrolling physicians. Selected baseline data on 18,094 patients are presented here.

Results: ZODIAC enrolled a total of 18,240 schizophrenia patients (mean age, 41.6 years; 55.1% male; 60.0% white), primarily from the U.S. or Brazil (73.0%). Approximately 18% of patients had hypertension, 14.8% hyperlipidemia, 46.5% currently smoked, 28.9% had a body mass index of ≥ 30 kg/m², and 7.7% had diabetes at baseline. Mean time since schizophrenia diagnosis was 10.4 years, and average Clinical Impression Score was 5.2 (range, 1 to 8). At baseline, 71% of patients were using antipsychotics. Almost 80% of patients were using concomitant medications, yet less than 3% were using antihypertensives or statins.

Conclusions: ZODIAC baseline data suggest that this study population has a substantial prevalence of cardiovascular risk factors and that hyperlipidemia and hypertension may be undertreated.

TARGET AUDIENCE:

Psychiatrists, primary care physicians and clinical nurse practitioners.

REFERENCES:

1. Hennekens CH, Hennekens AR, Hollar D, Casey DE. Schizophrenia and increased risks of cardiovascular disease. *Am Heart J.* 2005; 150:1115–1121.
2. Glassman AH. Schizophrenia, antipsychotic drugs, and cardiovascular disease. *J Clin Psychiatry.* 2005; 66(suppl 6):5–10.

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Friday, October 6
8:30 a.m.-10:00 a.m.

THE MAKING OF A PSYCHIATRIC DIAGNOSIS IN PRIMARY CARE

Hector Foncerrada, M.D., *Research Assistant, B.U.A.P. Medical School, 13 SUR #2702 Colonia Volcanes, Puebla, Mexico 72410*; Carmen Lara, Ph.D., *Chair, Department of Psychiatry, B.U.A.P. Medical School, 13 SUR #2702 Colonia Volcanes, Puebla, Mexico 72410*; David Mota, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to improve the diagnosis of depression by primary care physicians.

SUMMARY:

The objective of this study was to identify the symptoms that are relevant for a diagnosis of depression by primary care physicians. Material and methods: Males and females between 18 and 65 years old, who attended a primary care physician's office. They completed the CES-D. After consultation, the clinical charts were re-

viewed and the physician-made diagnosis was registered. The ratings of CES-D items were compared among the patients identified as depressed and those who were not. Results: 10 patients out of 1094 were diagnosed as depressed. The items that did not show any difference between the groups were those related to physiological, cognitive and interpersonal symptoms. The items in which a greater difference was observed were: "I felt that I could not shake off the blues, I felt hopeful about the future, I was happy, I felt lonely, I enjoyed life and I had crying spells". Conclusion: The number of patients diagnosed with depression is lower than that reported in the literature. The diagnosis of depression by primary care physicians rests mainly upon affective symptoms. Does this reflect a lack of knowledge about the clinical manifestations of depression?

TARGET AUDIENCE:

Clinical investigators.

REFERENCES:

1. Montano C. Recognition and treatment of Depression in a primary care setting. *J Clin Psychiatry* 55 (12, suppl) 18–34, 1994.
2. Reyes-OM, Soto-HA, Milla KJ, García RA, Hubard VI, Mendoza SH, Mejía GL et al. Actualización de la escala de Depresión del Centro de Estudios Epidemiológico (CES-D). *Salud Mental* 26 (1):59–68, 2003.

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Friday, October 6
8:30 a.m.-10:00 a.m.

NOVEL WAYS FOR ANALYZING HIGHLY-SKEWED LONGITUDINAL REHABILITATION OUTCOMES

Paul B. Gold, Ph.D., *Assistant Professor, Department of Psychiatry, Medical University of South Carolina, 1320 Battery Hill Court, Mount Pleasant, SC 29466*; Haiyi Xie, Ph.D.; Kim T. Mueser, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that most patients' psychiatric rehabilitation outcomes are highly skewed and require novel statistical analysis; acquire initial understanding about novel statistical techniques developed specifically for skewed distributions with mostly 0 values; visually see how these statistical techniques vividly reveal patients' responses to psychiatric rehabilitation over time.

SUMMARY:

Effectiveness of psychiatric rehabilitation programs for persons with severe mental illness (SMI) are frequently measured prospectively and longitudinally by outcomes distributed as highly positively skewed with clumping at 0. Examples include hours and income earned from jobs in supported employment programs, episodes and length of hospitalizations in assertive community treatment, and days of substance misuse in integrated treatment of co-occurring SMI/addiction. These distributions complicate analysis and interpretation of longitudinal program impact. To minimize frequency of zero values, evaluators typically sum up values on these outcomes across entire project periods and then conduct cross-sectional between-group endpoint parametric statistical analyses. Results from endpoint analyses obscures identifying which patients benefit (or not) from which intervention over time. Instead, we demonstrate that, for supported employment (SE) programs, using mixed-effects, mixed distribution models for estimating trajectories of patients' work activity over time, permits more refined inferences about patient and program effects on work activity. To make this analytic approach accessible to psychiatric rehabilitation researchers and practitioners, we illustrate its elements with visual displays, and by comparing patient work outcomes from two recently completed 24-month SE randomized trials: urban Hartford (N=204) and rural Sumter, SC (N = 143). SAMHSA grants UD7SM51823 and UD7SM51818 supported this study.

TARGET AUDIENCE:

Psychiatric rehabilitation researchers and practitioners serving persons with severe mental illness; research methodologists.

REFERENCES:

1. Xie H, McHugo GJ, Sengupta A, Clark RE, Drake RE. A method for analyzing longitudinal outcomes with many zeros. *Mental Health Services Research*. 2004; 6:239–246.
2. Gold PB, Meisler N, Santos AB, Carnemolla MA, Williams OH, Keleher J. Randomized trial of supported employment integrated with assertive community treatment for rural adults with severe mental illness. *Schizophrenia Bulletin*. 2006; 32:378–395.

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Friday, October 6
8:30 a.m.-10:00 a.m.

DETERMINANTS OF OUTCOME FOR ADOLESCENTS TRANSITIONING TO INDEPENDENT LIVING

Dusan Hanidziar, M.D., *Department of Psychiatry, Safarik University, Gen Svobodu 350, Uranov Nad Toplou,*

Slovenia 09301; C.D. Hanson, M.D., Medical Director, SBS Consulting, 131 Daniel Webster Highway, #106, Nashua, NH 03060; Scott Dufour; Amanda Tang

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to appreciate factors associated with successful involvement in a residential program for adolescents.

SUMMARY:

Background: Adolescents whose families are so dysfunctional as to require government intervention to remove the individuals from their homes, or who have been discharged from successful completion of residential treatment for adolescent substance abusers or from psychiatric inpatient units, often need assistance in developing independent living skills.

Objectives: The identification of factors associated with success in a residential program for adolescents was the objective of a chart review of the records of fifty-one individuals who had been admitted to the program.

Methods: Records were examined from a transitional group home program providing residential care for a maximum of twelve adolescents (16 to 20 years old), either homeless or at risk of becoming homeless. The adolescents normally reside for approximately one year and then, transitioning into the community, reside in their own apartments while receiving case management and supportive services. For fifty-one adolescents admitted consecutively, records were reviewed with regard to age, gender, diagnoses, previous history of psychiatric hospitalization, history of involvement with the juvenile justice system, and history of previous drug and alcohol use, and with regard to the work, educational, and therapeutic programs provided for each adolescent. Differences with respect to these variables were sought among three groups: those successfully completing the program, those voluntarily withdrawing, and those involuntarily discharged.

Results: More than sixty per cent of those admitted to the program successfully completed the program; the remainder were voluntarily or involuntarily discharged for reasons which were tabulated. Several differences among the groups were found.

Conclusion: A group home for adolescents can foster transition to successful independent living for a variety of adolescents who are homeless or at risk of becoming homeless, with success varying in association with several factors.

REFERENCES:

1. Lyons JS, Mintzer LL, Kisiel CL, et al: Understanding the mental health needs of children and adolescents in residential treatment. *Professional Psychology: Research and practice* 29:582–587, 1998.

2. Lyman RD, Prentice-Dunn S, Gabel S, eds: Residential and Inpatient Treatment of Children and Adolescents. New York: Plenum; 1989.

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**Friday, October 6
8:30 a.m.-10:00 a.m.**

**SYMPTOM WORSENING ASSOCIATED
WITH TREATMENT DISCONTINUATION
IN SCHIZOPHRENIA TRIALS**

Supported by Eli Lilly and Company

Hassan Jamal, *Scientific Communications Associate, Department of Neuroscience, Eli Lilly and Company, Lilly Corporate Center, DC4133, Indianapolis, IN 46285*; Haya Ascher-Svanum, Ph.D.; Lei Chen, M.S.; Glenn A. Phillips, Ph.D.; Bruce J. Kinon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to get a better understanding of the relationship between schizophrenia treatment discontinuation and symptom improvement as measured by PANSS.

SUMMARY:

Introduction: Treatment discontinuation, common in antipsychotic trials for the treatment of schizophrenia, may be associated with symptom worsening

Methods: Data from 4 randomized, double-blind studies (n=1627; 24–28 weeks duration) were used in this pooled post-hoc analysis. Patients with schizophrenia or a related disorder were treated with olanzapine (n=822), risperidone (n=167), quetiapine (n=175), or ziprasidone (n=463). Changes in PANSS total scores (PTS) were analyzed by ANOVA, while generalized estimating equations (GEE) were used to model discontinuation status versus concurrent PTS changes.

Results: A total of 865 (53%) patients discontinued treatment over the entire study. Mean PTS decreased from 91 to 71 during the study (LOCF; completers from 91 to 59; discontinuers from 91 to 85). Early in treatment (Weeks 0–4), discontinuers had no significant change in mean PTS from their previous visit, and 21% of discontinuers (versus 61% of completers) achieved clinical response, defined as 20% or more PTS reduction from baseline. Overall, discontinuers had symptom worsening or less improvement on PTS in a given interval. Similarly, individuals who discontinued due to adverse events experienced symptom worsening, or insignificant decreases in PTS compared to their previous visit. Overall, there was a 70% estimated increase in odds for discontinuation for every 10-point PTS increase, within any given visit interval.

Conclusions: Findings from post-hoc analyses of a large pooled sample of patients suggest that failure to

establish early treatment response, as well as recent loss of previous symptom improvement, may lead to treatment interruption and discontinuation.

TARGET AUDIENCE:

Schizophrenia treatment teams, including primary caregivers and psychiatrists.

REFERENCES:

1. Nose M, Barbui C, Tansella M: How often do patients with psychosis fail to adhere to treatment programmes? A systematic review. *Psychol Med* 2003, 33:1149–1160.
2. Perkins DO: Predictors of noncompliance in patients with schizophrenia. *J Clin Psychiatry* 2002, 63:1121–1128.

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**Friday, October 6
8:30 a.m.-10:00 a.m.**

**TREATMENT DISCONTINUATION IN
ANTIPSYCHOTIC TRIALS AND CHANGE
IN SCHIZOPHRENIA SYMPTOMS**

Supported by Eli Lilly and Company

Lisa Jatton, *Medical Liaison Consultant, Department of Neuroscience, Eli Lilly and Company, Lilly Corporate Center, DC4133, Indianapolis, IN 46285*; Adam L. Meyers, M.S.; David H. Adams, Ph.D.; Haya Ascher-Svanum, Ph.D.; Bruce J. Kinon, M.D.; Hassan Jamal

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss reasons for antipsychotic treatment discontinuation in clinical trials and the association between improvement in specific symptom domains and treatment discontinuation.

SUMMARY:

Objective: To examine the association between treatment discontinuation in antipsychotic trials and change in schizophrenia symptoms.

Methods: A post hoc, pooled analysis of 4 randomized, 24–28 week, double-blind, head-to-head trials of atypical antipsychotics for treatment of schizophrenia spectrum disorders (N=1627) compared trial completers with non-completers on improvements in positive, negative, and depressive symptoms, measured by the Positive and Negative Syndrome Scale. Symptom severity and change were used to predict trial discontinuation.

Results: Fifty-three percent (866/1627) of patients discontinued early. Poor response or symptom worsening was the most frequent reason for discontinuation (36%; 315/866). Non-completers showed significantly less depressive, positive, and negative symptom improvement

compared with completers. Patients with less severe baseline depressive symptoms (hazard ratio [HR]=0.95; 95% Confidence Interval [CI] 0.93, 0.97; $p<.001$) and positive symptoms (HR=0.97; 95% CI 0.95, 0.98; $p<.001$) were less likely to discontinue. Patients with improvements in depressive symptoms (HR=0.94 for a unit-point change; 95% CI 0.92, 0.96; $p<.001$) and positive symptoms (HR=0.95; 95% CI 0.93, 0.96; $p<.001$) were less likely to discontinue at a subsequent visit independent of baseline severity. A 20% improvement in depressive and positive symptoms in the first 2 weeks was associated with a 50% (odds ratio [OR]=1.52; 95% CI 1.22, 1.90) and 70% (OR=1.71; 95% CI 1.35, 2.16) greater likelihood of completion, respectively. Baseline or change in negative symptoms did not significantly predict discontinuation.

Conclusions: Poor response or symptom worsening was the most frequent reason for treatment discontinuation. In particular, poor improvement of depressive and positive symptoms predicted treatment discontinuation.

Funding provided by Eli Lilly and Company.

TARGET AUDIENCE:

Psychiatrists and other mental health professionals who treat patients with schizophrenia.

REFERENCES:

1. Lieberman JA, Stroup TS, McEvoy JP, et al. Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. *The New England Journal of Medicine* 2005; 353:1209–1223.
2. Dunayevich E, Zhao F, Ascher-Svanum H, Mitchell CP, Phillips GA, Deliva MA, Green A. Increased time to all-cause antipsychotic trial discontinuation is associated with better schizophrenia treatment outcomes. Abstract. *Biol Psychiatry* 2005;57; 107.

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**Friday, October 6
8:30 a.m.-10:00 a.m.**

A SEMINAL ARTICLES COURSE FOR RESIDENTS

Lindsay Jordan, M.D., *Resident, Department of Psychiatry, Maimonides Medical Center, 920 48th Street, Brooklyn, NY 11219*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate the effectiveness of a resident organized course on noteworthy articles in psychiatry that was directed at potentially broadening residents exposure to evidence-based learning.

SUMMARY:

Objective: A Seminal Articles Course was developed by a resident for twenty-seven psychiatric residents to ascertain the impact of a course focusing on landmark articles.

Method: Thirteen psychodynamic and psychopharmacologic articles were selected from a list of sixty articles obtained through faculty inquiry and Medline searching. The course consisted of a syllabus and thirteen lectures led by both a resident and a rotating faculty facilitator. Evaluations were filled out after each session and at the end of the course.

Results: Major issues involved in developing the course were 1) arranging the course’s logistics, 2) establishing the thirteen articles to be reviewed, 3) obtaining commitments from the participating faculty, 4) organizing the content of the lectures, and 5) developing the evaluation instruments. The course had an average attendance of 70%. The same average rating of 92% was given concerning the content of the articles, the adequacy of the resident instructor, and the clarity of the faculty facilitators.

Conclusion: Residents indicated through their attendance and evaluations that the course was worthwhile and useful. Residents gained from the ample discussion time allocated for reviewing critical articles in the field of psychiatry.

TARGET AUDIENCE:

Educators of psychiatric residents.

REFERENCES:

1. Abrahams MB, Friedman CP: Preclinical course-evaluation methods at U.S. and Canadian medical schools. *Acad. Med.* 1996; 71:371–374.
2. Anderson DC, Harris IB, Allen S, Satran L, Bland C, Davis-Feockert JA, Poland GA, Miller WJ: Comparing students’ feedback about clinical instruction with their performances. *Acad. Med.* 1991; 66:29–34.

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**Friday, October 6
8:30 a.m.-10:00 a.m.**

EVALUATING THE ROLE OF RADIO FREQUENCY IDENTIFICATION IN IMPROVING PATIENT ADHERENCE TO PRESCRIBED MEDICATION

Supported by Janssen Pharmaceutica, Inc., and Johnson & Johnson

Stan Kachnowski, M.P.H., *Professor of Public Health, Columbia University, 3960 Broadway, Fourth Floor, New York, NY 10032*; JiJo James, M.D., *Consultant, Department of Public Health, Columbia University, 3960 Broadway, Fourth Floor, New York, NY 10032*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the functions and capabilities of Radiofrequency Identification Technology as it pertains to prescription medication compliance. Additionally, participants will grasp the patient health care and economic benefits that a mass implementation of this technology can yield.

SUMMARY:

Background Patient compliance is a longstanding issue that has hampered the practice of medicine and the health of patients. Because studies have shown that the cost of partial compliance in Schizophrenia and Bi-Polar Disorders accounts for a considerable 40% of the annual costs of re-hospitalization, we will concentrate on this group.

Hypothesis The use of RFID enabled product [such as: Risperdal®] blister packs will lead to improved medication compliance when compared to regular blister packs.

Methodology 60 subjects with Schizophrenia currently on Risperdal® will be recruited from various hospitals in Europe. In a controlled trial setting lasting nine months, these individuals will be randomized to receive RFID enabled Risperdal® blister packs or regular blister packs. The frequency and consistency of medication intake, number of prescription refills, emergency room visits, and hospitalizations will determine success.

Objective The aims are to examine the role of RFID-enabled blister packs in improving patient compliance, evaluate the feasibility of commercial deployment of technology, and validate an economic model that will support industry-wide adoption.

Funding Janssen.

REFERENCES:

1. Subjective Response to Antipsychotic Treatment and Compliance in Schizophrenia Garcia-Cabeza, Ignacio and Gomez, Juan-Carlos.
2. Embedded Microelectronic Chip Enhances RFID Tracking-Coppola, Doreen R.

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**Friday, October 6
8:30 a.m.-10:00 a.m.**

**TREATMENT PERSISTENCE AND
ANTIPSYCHOTIC THERAPY: RESULTS
OF A LONGITUDINAL PHARMACY
CLAIMS DATABASE ANALYSIS**

Supported by Pfizer Inc.

Connie Lung, M.B.A., *Marketing Manager, Pfizer Inc., 235 East 42nd Street, New York, NY 10017*; Antony D.

Loebel, M.D., Ilise D. Lombardo, M.D.; Brian Cuffel, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the challenge of treatment persistence as a key issue in the effective treatment of patients diagnosed with schizophrenia.

SUMMARY:

Objective: To evaluate treatment persistence among naturalistically treated patients with schizophrenia and to compare these findings with those from the CATIE schizophrenia trial.

Methods: Verispan's VectorOne™ Indication pharmacy claims data was used to evaluate treatment persistence (time on therapy with no interruption of greater than 1 month) in naturalistically treated patients with schizophrenia or schizoaffective disorder. All patients with antipsychotic prescription activity in September 2004 were tracked for 12 months back and 12 months forward.

Results: Among patients receiving a new prescription, similar levels of persistence were identified for all first-line antipsychotics. Clozapine was associated with greater persistence than other antipsychotics and haloperidol was associated with reduced persistence versus atypical agents. Among patients switched from a previous antipsychotic, all agents demonstrated comparable levels of persistence.

Conclusions: Treatment persistence in this analysis of a large integrated medical and pharmacy claims database was similar to findings regarding discontinuation in phase 1 of the controlled CATIE schizophrenia trial. In contrast to CATIE findings, treatment persistence did not differ among first-line atypical agents and was lower for haloperidol (vs atypicals) among patients who had not received a prescription in the past 12 months.

TARGET AUDIENCE:

Psychiatrists, clinical nurse specialists, pharmacists.

REFERENCES:

1. Lieberman JA, Stroup TS, McEvoy JP, et al, for the CATIE Investigators. Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. *N Engl J Med.* 2005; 353:1209-1223.
2. Antipsychotic Persistency and Length of Therapy Study, Verispan Vector One Indication, December, 2005.

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Friday, October 6
8:30 a.m.-10:00 a.m.

PSYCHIATRIC PATIENTS' REASONS FOR MEDICATION NONADHERENCE

Oleg Lapshin, M.D., *Post-Doctoral Fellow, University of Maryland, 100 N. Greene Street, Room 525, Baltimore, MD 21201*; Joseph Finkelstein, M.D., *Assistant Professor of Epidemiology, University of Maryland, 100 N. Greene Street, Room 513, Baltimore, MD 21201*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the most frequent subjective reasons and objective causes for medication nonadherence in psychiatric patients with severe mental disorders and their distribution in patients with a different degree of nonadherence.

SUMMARY:

Objectives: Medication adherence among psychiatric patients averages only 50%, ranging from 24% to 90% in different populations¹. The most frequently cited reasons for treatment noncompliance are lack of insight, concurrent substance abuse, poor relationships between psychiatrist and patient, and medication side effects². We designed our study to reveal patients' subjective reasons for taking their medications incorrectly.

Methods: We enrolled 22 patients with severe psychiatric disorders. Along with assessing objective causes of noncompliance, we asked patients to select their non-adherence reasons from a list of the 24 most widespread causes identified from a literature review.

Results: Most patients had history of long-term medication non-adherence: 7 (31.8%) patients did not take some of their medications for a week or more during the last 12 months. The most frequent reasons (selected by more than one-third of the patients) why they took their medication incorrectly were: "I forget to take my medication" (42.9%), "I want to feel myself healthy" (38.1%), "I think that I have recovered from my disease" (38.1%).

Conclusions: The identified subjective reasons for nonadherence can be used to direct patient education and other interventions to increase medication adherence.

TARGET AUDIENCE:

Mental health practitioners.

REFERENCES:

1. Cramer JA, Rosenheck R. Compliance with medication regimens for mental and physical disorders. *Psychiatr Serv.* 1998; 49:196-201.
2. Lacro JP, Dunn LB, Dolder CR, Leckband SG, Jeste DV. Prevalence of and risk factors for medication nonadherence in patients with schizophrenia: a com-

prehensive review of recent literature. *J Clin Psychiatry.* 2002; 63:892-909.

Poster 118

Friday, October 6
8:30 a.m.-10:00 a.m.

A SCHOOL-BASED MENTAL HEALTH RECOVERY EFFORT

Leslie E. Lawrence, M.D., *Department of Psychiatry and Neurology, Tulane University Medical Center, 1440 Canal Street, # TB53, New Orleans, LA 70112-2703*; Janet E. Johnson, M.D., *Department of Psychiatry and Neurology, Tulane University Medical Center, 1440 Canal Street, TB-53, New Orleans, LA 70112*; Mark Viron, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to be familiar with the post-Hurricane Katrina mental health recovery program of school-based children; recognize Post-Traumatic Stress Risk Factors and symptoms in Hurricane Katrina victims, grades 6th-8th; be familiar with the use of a psychosocial intervention, *My Personal Story about Hurricane Katrina and Rita: A Guided Activity Workbook for Middle and High School Students* and its implications for reducing post-traumatic stress disorder symptoms in Hurricane Katrina survivors, grades 6-8.

SUMMARY:

Objective: On Monday, August 29th, Hurricane Katrina made landfall in New Orleans, causing extensive destruction and widespread flooding. The objective of this study was to decrease Post Traumatic symptoms in 6th-8th grade children attending New Orleans West (NOW), School based in Houston, TX exclusively for children displaced from New Orleans. The student population is 100% African-American, the majority of whom were from impoverished areas of New Orleans; areas that were widely devastated by Katrina.

Method: The University of California at Los Angeles Child Post-Traumatic Stress Disorder Reaction Index (PTSD-RI) was administered to the children prior to beginning work on the Hurricane Workbook and after approximately two months of working with the workbooks. *My Personal Story about Hurricanes Katrina and Rita: A Guided Activity Workbook for Children* by Gilbert Kliman, *et al.* was given to each child who worked on it for 30 minutes weekly for approximately three months.

Results: For grades 6-8, post-traumatic symptom level scores declined 18.75%, compared with pre-assessment scores (median of 32 to 26). This was statistically significant (p=.0001).

Summary: My Personal Story about Hurricanes Katrina and Rita appears to have contributed to decreasing PTSD symptom factors in 6th-8th graders attending NOW *post*-Hurricane Katrina. Numerous confounders need to be considered.

REFERENCES:

1. http://www.netsnet.org/nctsn_assets/pdfs/intervention;sfmanuals/referraltool.pdf.
2. My Personal Story about Hurricanes Katrina and Rita: A Guided Activity Workbook for Middle and High School Students. Gilbert Kliman, et al.

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Friday, October 6
8:30 a.m.-10:00 a.m.

A NATIONAL SURVEY OF SPIRITUAL BELIEFS

Li-Ching Lee, Ph.D., *Assistant Scientist, Department of Epidemiology, Johns Hopkins University, 615 N. Wolfe Street, Suite E6032, Baltimore, MD 21205*; Kathryn M. Connor, M.D., M.H.S.; Jonathan R.T. Davidson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to assess the associations between traumatic experiences and spiritual beliefs; and recognize predictors of spiritual beliefs.

SUMMARY:

This report describes findings from a national survey of spiritual beliefs that used the East-West Spiritual Beliefs Scale (EWSBS). The objectives of this study were to 1) describe spiritual beliefs in the US population, 2) assess the effect of trauma on beliefs, 3) evaluate predictors of agreement with beliefs, and 4) examine the factor structure of the scale. Data were collected through online survey from community samples representative of the US population before ($n = 769$) and after ($n = 1,200$) September 11, 2001. In addition to the EWSBS, assessments included ratings of health status, resilience, trauma history, posttraumatic stress symptoms, and recent positive and negative affects and interactions. Our findings indicated that a history of trauma was associated with less disagreement with Eastern beliefs and greater agreement with some Western beliefs. The post September 11 cohort reported less disagreement with Eastern beliefs related to the influence of past lives and less agreement with the Western belief in destiny. Predictors of spiritual beliefs in general included being female and non-white, whereas endorsement of Eastern and Western beliefs was associated with different population attributes relating to demographics, health status, trauma history, resilience, and affective tone.

Supported in part by grant K23 AT000583-05 from the National Center for Complementary and Alternative Medicine to Dr. Connor.

REFERENCES:

1. Connor KM, Davidson JRT, Lee L-C. Spirituality, resilience, and anger in survivors of violent trauma: a community survey. *J Trauma Stress* 2003; 16:487-494.
2. Levin J. Spiritual determinants of health and healing: An epidemiologic perspective on salutogenic mechanisms. *Altern Ther Health Med* 2003; 9:48-57.

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Friday, October 6
8:30 a.m.-10:00 a.m.

ASSESSING DEPRESSION AND NUTRITIONAL STATUS IN COMMUNITY-DWELLING ELDER

Ashley Love, D.P.H., *Assistant Professor, Department of Health, University of Texas, 6900 North Loop 1604, West, San Antonio, TX 78249*; Robert J. Love, D.O., *Chief Resident, Department of Psychiatry, University of Texas, 9502 Fallen Willow, San Antonio, TX 78254*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that assessments are not routinely given to community dwelling elders to assess their global well-being; understand the importance of assessing depression and nutritional status of community dwelling elders; and demonstrate that there was no significant depressive symptom differences that were observed between Mexican American and European elders in this pilot study.

SUMMARY:

Objective: To assess depression and nutritional status among elderly in the community-setting to determine if any differences are found between EA and MA elders to improve intervention programs.

Method: A cross-sectional design was used to sample 130 cognitively eligible community dwelling elders attending 9 nutrition centers in the Bexar County, TX. The interviews were completed by 116 elders using standard questionnaires: Centers for Epidemiological Studies on Depression (CES-D) and other demographic/health questions. Anthropometric measures such as height, weight, and body fat were measured.

Result: About 68% of the sample exhibited depressive symptom, however, there were no significant depressive symptom differences between MA and EA elders or between genders. Those who exhibited depressive symptoms ate less % of total fat ($p=0.041$) and less % of

saturated fat ($p=.037$) compared to those who did not show depressive symptoms. There was a trend for higher intakes of carbohydrates ($p=.058$) and lower intakes of fiber ($p=.059$) for those who were depressed.

Conclusions: Depressed elders in the community have different nutritional status than non-depressed elders regardless of race and gender. This study will provide a good stepping stone to create a comprehensive intervention program that can incorporate screening for depression and nutritional status.

TARGET AUDIENCE:

Health professionals working in community-based settings.

REFERENCES:

1. Amarantos, E, Martinez, A, Dwyer, J, Nutrition and quality of life in older adults: *J of Gerontology* 2001; 56A: 54-64.
2. Chen, C. A Framework for Studying the Nutritional Health of Community-Dwelling Elders 2005; 54(2):13-21.

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**Friday, October 6
8:30 a.m.-10:00 a.m.**

AN EVALUATION OF SCREENING FOR MATERNAL DEPRESSION DURING PEDIATRIC WELL-CHILD VISITS

Shari I. Lusskin, M.D., *Director of Reproductive Psychiatry, New York University School of Medicine, 155 E. 29th Street, Suite 26J, New York, NY 10016*; Lori A. Legano, M.D., *Assistant Professor of Pediatrics, New York University School of Medicine, 462 First Avenue, Room GC-65, New York, NY 10016*; Cynthia Cutler, M.D.; Alan Mendelsohn, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe a system for screening for maternal depression in a busy urban pediatric clinic; and compare PHQ-2 to the Edinburgh Postnatal Depression Scale as a screening tool for maternal depression.

SUMMARY:

Objectives: Assess prevalence of positive screens for maternal depression using the PHQ-2 in multiethnic low SES mothers of preschool children presenting for pediatric primary care, identify risk factors for a positive screen and compare the PHQ-2 to the Edinburgh Postnatal Depression Scale (EPDS).

Design/Methods: Convenience sample. Mothers presenting for primary care to urban hospital pediatric clinic. Inclusion criteria: mother >18yrs, child age <6yrs. Mothers

self-administered PHQ-2 and EPDS. Positive screen: PHQ-2 ≥ 3 or EPDS ≥ 10 . Also collected: demographics, previous depression screening by health care provider.

Results: 94 mothers enrolled. Mean (SD) maternal age: 27.4 (5.3); youngest child's age: 1.12 (1.1) yrs; education: 39% <HS. Ethnicity: 66% Latina, 13% Black, 12% Asian, 6% White. 69% immigrants; 77% married, 63/94 (67%) mothers reported no prior screening. 25/94 (27%) were positive on at least one scale. Agreement fair-good between the PHQ-2 and the EPDS ($\kappa=0.49$, $p<0.001$), with 12/94 (13%) positive on PHQ-2 and 23/94 (24.4%) positive on EPDS. With EPDS as the gold standard, sensitivity/specificity of PHQ-2 was 43%/97%. Sensitivity of the PHQ-2 was 25% in mothers with <HS compared to 86% in mothers with >HS. 46.2% mothers reporting no help with child care support screened positive, compared to 19.1% mothers reporting help ($p=0.02$).

Conclusions: Screening for maternal depression is important in the primary care of low SES, multiethnic preschool children because depression is prevalent and screening may not have been done previously. The PHQ-2 may not be useful for screening in this population. Additional study is needed to determine the most effective approach.

This research was supported by the Joseph Dancis research Fund.

TARGET AUDIENCE:

Clinicians.

REFERENCES:

1. Chaudron L, Szilagyi P, Kitzman H. Detection of postpartum depressive symptoms by screening at well-child visits. *Pediatrics*. 2004; 113:551.
2. Olson, A, Dietrich A, Prazar G, Hurley J, Tuddenham A, Hedberg V, Napinsky D. Two approaches to maternal depression screening during well child visits. *Journal of Developmental & Behavioral Pediatrics*. 26(3):169-176, June 2005.

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**Friday, October 6
8:30 a.m.-10:00 a.m.**

THE IMPACT OF URBAN SOCIETY ON PERI-TRAUMATIC PSYCHOSIS

Alfredo A. Massa, M.D., *Medical Resident, Department of Psychiatry, Maimonides Medical Center, 920 48th Street, Brooklyn, NY 11219-2948*; Marian Moca, M.D., *Medical Resident, Department of Psychiatry, Maimonides Medical Center, 920 48th Street, Brooklyn, NY 11219-2909*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to have a better understanding of the relationship between trauma, psychosis and urbanization, to integrate these three terms in one concept and to recognize the role that urban society plays in mental health issues.

SUMMARY:

Introduction: The relationship between trauma and new onset psychosis is not clear. It has been suggested that psychosis is more frequent in urban communities. We explore a possible relationship between urbanicity, trauma and psychosis.

Methods: We reviewed 1114 articles and selected only those (125) focused on urbanicity, trauma and psychosis. Search terms: Psychotic disorders, stress psychological, life change events, urban population.

Results: Psychosis was found to be weakly related to traumatic events. However, one study reports an incidence of 30% of new onset psychosis following trauma. The nature of the relationship between trauma and psychosis remains poorly understood. A traumatic event contributes to psychosis not as a causal but as a precipitating factor in the context of personal vulnerability.

Traumatic experiences increased in urban areas. 77% of school students witnessed a violent event while 47% were direct victims.

Studies showed a strong correlation between degree of urbanization and psychosis. The risk of developing psychosis is 68–77% higher for people in the most populated areas. Little research has been done regarding the relationship between urbanicity, trauma and psychosis.

Conclusion: Life threatening events can precipitate psychosis and the urban environment might serve as a significant additive factor in the onset of psychosis.

TARGET AUDIENCE:

Psychiatrists, psychologists, social workers, medical students, and other health professionals.

REFERENCES:

1. Sandquist K, Frank G. "Urbanization and incidence of psychosis and depression" *British Journal of Psychiatry*, 2004, 184, 293–298.
2. Morrison AP, Frame L, Larkin W "Relationships between trauma and psychosis": A review and integration "British Journal of Clinical Psychology", 2003, 42, 331–353.

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**Friday, October 6
8:30 a.m.-10:00 a.m.**

PATIENT INTRUSIVENESS ON A RECOVERY-ORIENTED, STATE HOSPITAL UNIT

David I. Mayerhoff, M.D., *Staff Psychiatrist, Greystone Park Psychiatric Hospital, and Clinical Associate Pro-*

fessor of Psychiatry, University Medical and Dental of New Jersey, 50 Ellis Drive, Greystone, NJ 07950; Jeffrey R. Nurenberg, M.D., Medical Director, Greystone Park, Main Building Central Avenue, Greystone Park Psychiatric Hospital, NJ 07950; Steven J. Schleifer, M.D.; Russell Smith, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and appreciate the importance of patient intrusiveness/boundary violations in impeding recovery-oriented clinical management of long-term psychiatric inpatients.

SUMMARY:

For the past three years, our multidisciplinary state university affiliation has collaborated to shift the focus of care on a 20-bed state hospital unit from symptom control to recovery-oriented care. Violence and the threat of violence have been barriers to such change, readily undermining therapeutic environments. Our clinical impression was that a related behavioral dimension, patient intrusiveness or perceived violations of personal boundaries, further undermined the milieu even in the absence of threatened violence. We sought to determine if perceived intrusiveness was quantifiable using a single item, Likert-type indicator of the extent to which patients were perceived as being "in-your-face". Staff from multiple disciplines found this Greystone Intrusiveness Measure (GIM) to have face validity and to be readily scorable. GIM showed significant, but modest, associations ($p < 0.02$) with reported aggressive incidents (for perpetrators: $r = 0.25$; for victims: $r = 0.27$). The mean scoring of "in your face" behavior on the unit appeared to be reduced as the unit matured and as indicators of ward atmosphere improved. Clinical sensitivity to intrusiveness, along with other barriers to recovery-oriented care, may support the transformation of chronic care units. Interventions to reduce patient intrusive behavior may enhance post-discharge adaptation in the community.

TARGET AUDIENCE:

Psychiatrists, Rehabilitation staff, and mental health professionals.

REFERENCES:

1. Fagan-Pryor, EC. et al Patients' views of causes of aggression by patients and effective interventions. *Psych Svcs.* 54:549–53, 2003.
2. Nolan KA, et al. Characteristics of assaultive behavior among psychiatric inpatients. *Psych Services.* 54:1012–6, 2003.

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Friday, October 6
8:30 a.m.-10:00 a.m.

TARGET AUDIENCE:

Psychiatrists.

COST-EFFECTIVENESS OF ATYPICAL ANTIPSYCHOTIC AGENTS IN THE TREATMENT OF ACUTE MANIA

Supported by Ortho-McNeil Janssen Scientific Affairs, Inc.

Dennis M. Meletiche, Pharm.D., *Manager, Outcomes Research, Janssen Pharmaceutica and Research Foundation, 1125 Trenton-Harbourton Road, P.O. Box 200, Titusville, NJ 08560-0200*; Kellie Meyer, Pharm.D.; Meg Franklin, Pharm.D.; Sara Poston, Pharm.D.; Amy Grogg, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to compare the cost-effectiveness of atypical antipsychotic agents in the treatment of acute manic or mixed episodes in patients with bipolar I disorder; and discuss the cost-effective role of risperidone in the treatment of acute manic or mixed episodes in patients with bipolar I disorder.

SUMMARY:

Methods: The model estimated the average cost-effectiveness (CE) ratios for each atypical antipsychotic given as monotherapy for acute manic or mixed episodes in patients with bipolar I disorder. CE ratios were defined as the total annual cost per responder (≥50% improvement on YMRS scale) at 3 weeks. The median response rate was used in the base case scenario; 45.5%, 56.7%, 53.3%, 58.0%, and 50.0%, for aripiprazole, olanzapine, quetiapine, risperidone, and ziprasidone, respectively. Total annual costs were calculated based on 1.3 acute manic or mixed episodes/year and included costs of atypical antipsychotics, concomitant psychotropic medications, adverse events, and medical resource utilization. All costs were inflated to 2005 values. Results: Total annual costs per patient were \$7,518, \$7,551, \$7,507, \$7,360, and \$7,373 for aripiprazole, olanzapine, quetiapine, risperidone, and ziprasidone, respectively. CE ratios were \$16,523, \$12,965, \$14,084, \$12,689, and \$14,746, respectively. Conclusion: These findings suggest that treatment with risperidone may be among the most cost-effective choices for acute management of mania in patients with bipolar I disorder. Results are limited to acute treatment of mania, thus no conclusions can be drawn about the cost-effectiveness of atypical antipsychotics as maintenance treatment.

REFERENCES:

1. PharMetrics Patient-Centric Database (medical and pharmaceutical health insurance claims from managed care plans across the United States 2003–2004).
2. IMS Health National Disease and Therapeutic Index™ (NDTI) data, 2nd Quarter 2005.

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Friday, October 6
8:30 a.m.-10:00 a.m.

HEALTH CARE UTILIZATION AND COST OF BIPOLAR I DISORDER WITH AND WITHOUT PSYCHOTIC SYMPTOMS

Supported by Ortho-McNeil Janssen Scientific Affairs, Inc.

Dennis M. Meletiche, Pharm.D., *Manager, Outcomes Research, Janssen Pharmaceutica and Research Foundation, 1125 Trenton-Harbourton Road, P.O. Box 200, Titusville, NJ 08560-0200*; Sara Poston, Pharm.D.; Christopher M. Kozma, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to compare mental-health-related utilization in bipolar I patients with and without psychotic symptoms; and compare the mental-health-related and nonmental-health-related costs for various services in bipolar I patients with and without psychotic symptoms.

SUMMARY:

Methods: We conducted a retrospective independent-group pharmacy and medical claims analysis from a national managed care database. Patients were identified based on their first claim for bipolar diagnosis during 2003 calendar year. Mental-health-related and overall health-care resource utilization and costs were compared in patients with and without diagnosis of psychotic symptoms. Results: Of the 8,221 patients with bipolar mania who met study criteria, 62.1% (5,108) had diagnosis of psychotic symptoms. At least 1 mental-health-related hospitalization was noted in 7.9% of patients with psychotic symptoms and 4.0% of patients without psychotic symptoms (P<0.0001). Mean (±SD) mental-health-related hospital costs per patient were \$625 ± \$3,326 and \$283 ± \$2,223, respectively (P<0.0001). Mean medication costs were \$2,638 ± \$3,765 and \$2,397 ± \$3,482, respectively (P=0.003). Between-group differences in mean costs of outpatient visits (other than physician visits) were not significantly different (P=0.078). Overall mean health-care costs were \$10,263 ± \$19,962 and \$8,649 ± \$15,132, respectively

($P < 0.0001$). Conclusions: Bipolar I patients with psychotic symptoms tended to have higher mental-health-related and overall healthcare utilization and costs compared with patients without psychotic symptoms. Research on interventions targeting bipolar patients with psychotic symptoms may be warranted. Supported by Ortho-McNeil Janssen Scientific Affairs, L.L.C.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. PharMetrics Patient-Centric Database (medical and pharmaceutical health insurance claims from managed care plans across the United States 2003).
2. Elixhauser A, Steiner C, Palmer L. Clinical Classification Software (CCS), 2006. U.S. Agency for Healthcare Research and Quality.

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Friday, October 6
8:30 a.m.-10:00 a.m.

RECOGNIZE, REFLECT, RESPOND: AN APPROACH TO COMPLEX PTSD

Kristina H. Muenzenmaier, M.D., *Department of Psychiatry, Bronx Psychiatric Center, 1500 Waters Place, Bronx, NY 10461*; Madeleine S. Abrams, L.C.S.W., *Director of Family Studies, Albert Einstein College of Medicine, 1500 Waters Place, Bronx, NY 10461*; Joseph Battaglia, M.D.; Elisa L. Chefitz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and assess complex PTSD symptoms; and learn how to treat complex PTSD through an integrative treatment approach, including different treatment modalities such as group and family models.

SUMMARY:

Studies have shown a high prevalence of co-occurring traumatic experiences in the psychiatric population often leading to Complex PTSD. The prevalence rates suggest the need to develop particular screening and treatment approaches for Complex PTSD. An assessment tool for Complex PTSD and an integrative approach treating Complex PTSD utilizing different treatment modalities will be presented. A Syndrome Specific Group Therapy (SSGT) model will describe the cognitive behavioral therapy intervention designed specifically to treat symptoms of Complex PTSD. Results show a reduction in PTSD and dissociative symptoms as well as increased knowledge, use and helpfulness of specific skills. Additionally, we will describe a family therapy model devel-

oped for working with trauma experienced by both individuals with serious mental illness and their families.

TARGET AUDIENCE:

Clinicians, researchers, policy makers and administrators.

REFERENCES:

1. Mueser K, Rosenberg S, Goodman L, Trumbetta S. (2002). Trauma, PTSD, and the Course of Severe Mental Illness; An Interactive Model. *Schizophrenia Research* 53:123-143.
2. Van der Kolk B, Roth S, Pelcovitz D, Sunday S, Spinazzola J, (2005). Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma. *Journal of Traumatic Stress* 18:389-399.

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Friday, October 6
8:30 a.m.-10:00 a.m.

RECOVERY, IDENTITY, AND EMPLOYMENT: AN EXPLORATORY STUDY

Roslyn Shields, M.A., *Community Support, Development, and Research Specialist, Centre for Addiction and Mental Health, 1001 Queen Street, West, Toronto, Ontario, Canada M6J 1H4*; Kate MacDonnell, B.A., *Research Associate, Centre for Addiction and Mental Health, 1001 Queen Street, West, Toronto, Ontario, Canada M6J 1H4*; John Sylvestre, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the dimensions of the seven work-identity profiles, the challenges for each profile group, and suggestions for the support and advocacy for people with different profiles.

SUMMARY:

Objective: Benefits of meaningful work are documented in the research literature, yet many people with mental illness are unemployed. While supported employment programs have demonstrated success in gaining work experiences for people with mental illness, we assert that recovery-focused, identity-centred approaches will address specific challenges that are confronted upon return to work.

Results will be presented from an exploratory study of work identity among people with mental illness who are returning to work. Implications of the findings will be discussed in relation to clinical practice and advocacy. Individuals with Foreclosed and Foreclosed/Diffused identities may be challenging for counselors and will be discussed in more detail.

Method Maximum variation sampling (Patton, 1990) was used to recruit 14 participants from an employment program. All completed the study. Main criteria for inclusion were a DSM IV diagnosis of mental illness and an expressed interest/involvement in work.

Participants were interviewed using a semi-structured interview that was developed with input from people with mental illness. Qualitative data were analyzed according to the tenets of grounded theory technique (Lincoln and Guba, 1985).

Results Seven work identity profiles emerged from the data. Individuals were assigned identities according to their work commitment, approach/avoidance, and anxiety. Factors accounting for assignment to each profile were also identified. Foreclosed and Foreclosed/Diffused individuals were older workers who felt that their only options were to return to their previous work settings.

Conclusion Work identity profiles will enable counselors to use different strategies for supporting people in returning to work. Foreclosed and Foreclosed/Diffused workers may benefit from strategies that help them to recognize the range of options available to them, and assess the challenges of returning to their previous workplace. Advocacy strategies with former employers will also assist in return to work.

REFERENCES:

1. Marcia JE: Identity in Adolescence. In Handbook of Adolescent Psychology, edited by Adelson J, New York, Wiley, 1980, pp 159–181.
2. Tschopp MK, Bishop M, Mulvihill M: Career development of individuals with psychiatric disabilities—an ecological perspective of barriers and interventions. *Journal of Applied Rehabilitation Counseling* 2001; 32:25–30.

Poster 128

**Friday, October 6
8:30 a.m.-10:00 a.m.**

EARLY INTERVENTION IN PSYCHOSIS AND COURT SUPPORT PROGRAMS IN ONTARIO, CANADA: CONTINUITY OF CARE, SATISFACTION, AND PROGRAM BENEFITS FROM CLIENTS’ POINTS OF VIEW

Joan Nandlal, Ph.D., *Manager, Centre for Addiction and Mental Health, 1001 Queen Street, Room 2075, Admin., Toronto, Ontario, Canada M6J 1H4*; Kate MacDonnell, B.A., *Research Associate, Centre for Addiction and Mental Health, 1001 Queen Street, West, Toronto, Ontario, Canada M6J 1H4*; Melanie Ollenber, B.H.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should recognize how Early Intervention in Psychosis and Court Support programs are assessed by service-users in relation to five aspects of continuity of care. System strengths and gaps along with clients’ perceptions of program benefits and elements of satisfaction will also be evident.

SUMMARY:

As part of the Ontario Systems Enhancement Evaluation Initiative, the Matryoshka Project focuses on assessing the impact of Early Intervention in Psychosis (EIP) and Court Support (CS) expansion in relation to aspects of continuity of care (CC): timeliness, intensity, comprehensiveness, coordination, and accessibility. We present preliminary findings based on interviews with 15 EIP or CS service-users. Transcripts were analyzed using a *grounded theory* approach (1, 4, 5) involving a systematic process of constant comparison (3, 6). The analysis revealed that while all five components of CC are important, there are both system strengths and gaps in relation to each. Moreover, users tend to be highly satisfied with their programs and frame their comments about satisfaction with services in relation to “fit” with, and the extent and nature of support received from a specific worker rather than “programs” per se. Perceived benefits include but are not limited to: reducing social isolation, reducing court appearances and processes, and avoiding time in jail. Implications of preliminary findings for further analyses are discussed. Study limitations and directions for future research, such as the importance of various forms of social support: tangible aid, informational, esteem, emotional, and social integration (2) are also considered.

Funding: Ontario Mental Health Foundation and Ontario Ministry of Health and Long-Term Care.

TARGET AUDIENCE:

Researchers, mental health policy developers, EIP/CS program decision-makers.

REFERENCES:

1. Berg BL, (1989). *Qualitative research methods for the social sciences*. Boston: Allyn and Bacon.
2. Cutrona CE, & Russell DW, (1990). Type of social support and specific stress: Toward a theory of optimal matching. In B.R. Sarason, I.G. Sarason & G.R. Pierce (Eds), *Social support: An interactional view*. (pp 319–366). New York: Wiley.

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Friday, October 6
8:30 a.m.-10:00 a.m.

VALIDATING CRITERIA FOR REMISSION IN SCHIZOPHRENIA

Supported by Johnson & Johnson
Pharmaceutical Services

Mark G.A. Opler, Ph.D., *Executive Director, PANSS Institute, 320 West 37th Street, Floor 12-A, Suite 13-B, New York, NY 10018*; Lawrence Yang, Ph.D., *Assistant Professor of Epidemiology, Columbia University College of Physicians and Surgeons, 722 West 168th Street, New York, NY 10032*; Sue Caleo, M.D.; Phillip Alberti, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the remission criteria for schizophrenia and to demonstrate how this construct has been tested and validated using prospectively collected data.

SUMMARY:

Published methods for assessing remission in schizophrenia are variable and none have been definitively validated or standardized. Andreasen et al (2005) suggest systematic operational criteria using eight PANSS items for which patients must score ≤ 3 (mild) for at least six months. Using data from a multi-site clinical trial (n=636), remission criteria were compared to total PANSS scores and other endpoints and demonstrate excellent agreement with overall clinical status. Compared to total PANSS score of 60 points and other criteria, at time points greater than 6 months (8 and 12 months) the specificity of the remission criteria for outpatients enrolled in the trial was 85%, i.e. of the patients who had a total score >60 , 85% were classified as "not in remission". Sensitivity was also very high; 75% of patients with scores of <60 were classified as "in remission." Patients who dropped out of the trial were more likely not to be in remission prior to dropping out. These findings indicate that the remission criteria are both sensitive and specific indicators of clinical status. Additional analyses are required to determine if remission status predicts other outcomes, such as employment, independent living, and prognosis.

REFERENCES:

1. Andreasen NC, Carpenter WT Jr, Kane JM, Lasser RA, Marder SR, Weinberger DR. Remission in schizophrenia: proposed criteria and rationale for consensus. *Am J Psychiatry*. 2005 Mar; 162(3):441-9.
2. Sethuraman G, Taylor CC, Enerson M, Dunayevich E. "A retrospective comparison of cumulative time

spent in remission during treatment with olanzapine or risperidone among patients with schizophrenia." *Schizophr Res*. 2005 Nov 15; 79(2-3):337-40.

Poster 130

Friday, October 6
8:30 a.m.-10:00 a.m.

TWO PATIENTS WHO HAVE SCHIZOPHRENIA WITH POLYDIPSIA HYPONATREMIA COMA

Min-Cheol Park, M.D., *Professor, Department of Psychiatry, Wonkwang University Psychiatric Hospital, 144-23 Dongsan-Dong, Iksan, Cheonbuk 57-060, Korea*; Chong-II Park, M.D.; San-Soo Lee, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to diagnose the symptoms of polydipsia and hyponatremia syndrome and understand therapeutic intervention of polydipsic behavior.

SUMMARY:

Authors suggested prediction of emergency situation and treatment of polydipsic patients by way of two cases report of polydipsic patient with hyponatremia and coma.

<Case 1> 39 years-old male schizophrenic patient for 17 years who medicated haloperidol 20mg showed intermittently polydipsia, polyuria, transient high BP, hyponatremia(110mEq/L) and sudden loss of consciousness with tonic-clonic seizure. Medical treatment for hyponatremia at emergency room was done. After recovery of consciousness and control hyponatremia, psychotherapeutic intervention with behavioral modification was done and changed antipsychotic to clozapine 250mg.

<Case 2> 25 years-old male schizophrenic patients for 8 years who medicated olanzapine 20mg showed intermittently polydipsia, frequency, transient high BP, hyponatremia (118mEq/L) and sudden fallen down with head injury. Medical treatment for hyponatremia and head injury was done. Five days later, who was recovered from coma. After recovery of consciousness therapeutic intervention was done and changed antipsychotic to ability 20mg.

Conclusion: Sudden development of emergency symptoms is very cautious attention for life saving situation due to hyponatremia. And psychotherapeutic intervention with behavioral modification and adequate antipsychotic medication is needed.

REFERENCES:

1. Mercier-Guidez E, Loas G (2000). Polydipsia and water intoxication. *European psychiatry* 15(5):306-311.

2. Vieweg V, Pandursngi A, Levenson J, Silverman J(1991): polydipsia-hyponatremia syndrome in schizophrenia. *Int J Psychiatry Med* 21(4):276–303.

Poster 131

**Friday, October 6
8:30 a.m.-10:00 a.m.**

A NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DEPARTMENT OF THE AGING AND THE MENTAL HEALTH ASSOCIATION OF NEW YORK CITY PARTNERSHIP TO SCREEN AND MANAGE DEPRESSION IN SENIORS

Sands Ramos, *New York City Department of Health and Mental Hygiene, 93 Worth Street, Room 1201, New York, NY 1001*; Jorge R. Petit, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand about depression screening in senior centers; and understand about depression management in senior centers.

SUMMARY:

The Surgeon General’s report states 1 in every 5 persons 55 years and older experience mental disorders not part of normal aging. In NYC, the elderly represent 27% of the population; 37% of elders in primary care settings have symptoms of depression. In elders depressive disorders precipitate chronic disease and suicide. Elder depression remains an unrecognized, under diagnosed and untreated public health problem. Targeted screenings increases early identification, encourages appropriate management and improves overall health outcomes. The depression initiative (DI) addresses the unmet mental health needs of seniors through screening and management. The program identifies seniors with depression and mental disorders, increases and tracks their access to treatment. The DI targets ambulatory seniors at DFTA funded centers and homebound elderly in the South Bronx. The DI educated and trained senior center staff to administer the PHQ-9 to screen for depression. Clients were offered a free screening for depression. Seniors who scored positive for depression (PHQ> 10) were referred to their doctors for further evaluation and treatment. 269 seniors participated in psycho-educational forums and 204 were screened for depression. Close to 1 in 5 (18%) reported between moderate to severe depression and 67% accepted a referral to their PCP.

The depression Initiative pilot was funded by the NYC Department of Mental Health and Mental Hygiene, DFTA and MHA of NYC.

TARGET AUDIENCE:

Physicians, nurses, social workers, case managers and other health professionals working or interested in elder care.

REFERENCES:

1. Sederer, 2004.
2. DFTA, 2000.

Poster 132

**Friday, October 6
8:30 a.m.-10:00 a.m.**

TREATMENT PERSISTENCE WITH ANTIPSYCHOTICS IN PATIENTS WITH SCHIZOPHRENIA

Supported by Eli Lilly and Company

Xinhua Ren, Ph.D., *Research Scientist and Assistant Professor, Health Service Department, VA Medical Center, 200 Springs Road, Building 70, Bedford, MA 01730*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, researchers and clinicians will get a better knowledge about treatment persistence between typical and atypical antipsychotic agents over time.

SUMMARY:

Despite being efficacious in reducing symptoms of schizophrenia, the likelihood of sustaining control of schizophrenia may depend on treatment persistence. However, poor treatment persistence with antipsychotics is a common problem among patients with schizophrenia. In this study, we profiled trends in the levels of treatment persistence between typical and atypical antipsychotics among patients with schizophrenia (identified using >1 inpatient or >2 outpatient ICD-9-CM codes > 7 days apart) in the Veterans Health Administration (VA). Compared to patients who initiated typical antipsychotics, those who initiated atypical antipsychotics tended to have better treatment persistence as reflected in longer stay on the medication within one year between initiation and the first gap of >15 or >30 days (99 vs. 141 days on average; p<0.001). However, between 10/1/1999 and 3/31/2005, treatment persistence with typical antipsychotics remained the same, whereas treatment persistence with atypical antipsychotics decreased from 149 to 135 days. Among individual typical antipsychotics, treatment persistence with chlorpromazine decreased from 110 to 102 days, treatment persistence with haloperidol remained the same, whereas treatment persistence with perphenazine increased from 116 to 128 days. Future research needs to explore factors associated with different levels of treatment persistence across different antipsychotics.

This research was funded by Boston University School of Public Health, Center for Health Quality, Outcomes, and Economic Research, and Eli Lilly and Company.

REFERENCES:

1. Andreason N, et al. Symptoms of Schizophrenia: Methods, Meanings, and Mechanisms. *Arch Gen Psychiatry*, 1995; 52:341–351.
2. Ren XS, et al. Treatment persistence: A comparison among patients with schizophrenia who were initiated on atypical antipsychotic agents. *Journal of Clinical Pharmacy and Therapeutics*, 2006; 31:57–65.

Poster 133

Friday, October 6
8:30 a.m.-10:00 a.m.

NEW HORIZONS: MENTAL HEALTH SERVICES AND CHILDHOOD OBESITY PREVENTION

Margaret R. Rukstalis, M.D., *Clinical Investigator, Geisinger, 100 North Academy Avenue, Danville, PA 17837-7050*; G. Craig Wood, M.S.; Candace L. Ayars, Ph.D.; William Cochran, M.D.; Walter F. Stewart, Ph.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to update clinicians and health services researchers on innovative and practical approaches to improve the identification and prevention of childhood obesity using health information technology.

SUMMARY:

New treatments and mental health services are needed to address the childhood obesity epidemic in the context of practice settings. This study describes the use of health information technology to examine prevalence of overweight (BMI>95th%) and ‘at risk for overweight’ preschool children. (BMI>85th%<95th%) aged 2–5 seen in the Geisinger Clinic the nation’s largest rural integrated healthcare system. Methods: Height, weight, sex, ethnicity, and age were extracted from the electronic health records of 59,369 children examined between 1999–2004. Body mass index (BMI) was calculated and categorized as normal, ‘at risk’ or overweight. Prevalences of ‘at risk’ and overweight were compared to NHANES data (1999–2004) matched for ethnicity (N=704 white). Results: More Geisinger preschool girls were ‘at risk for overweight’ (32.1% vs. 28.4% NHANES, p=0.007, X² test) and more Geisinger boys were overweight (14.4% vs. 10.0% NHANES; p=0.043, X² test). These results support the national call for effective obesity prevention services for preschool children. The funding

source for this project is the Center for Health Research & Rural Advocacy, Geisinger Health System.

TARGET AUDIENCE:

Health services audience including: clinicians, public sector psychiatrists, and those working in systems of care for children.

REFERENCES:

1. Unutzer J, Schoenbaum M, Druss BG, Katon WJ. Transforming Mental Health Care at the Interface with General Medicine: Report for the Presidents Commission. *Psychiatr Serv* 57:37–47, January 2006.
2. Preventing Childhood Obesity: Health in the Balance. Institute of Medicine Committee on Prevention of Obesity in Children and Youth: 2005.

Poster 134

Friday, October 6
8:30 a.m.-10:00 a.m.

ACCEPTANCE OF MAINTENANCE ANTIPSYCHOTIC AMONG PATIENTS WITH FIRST-EPISEDE SCHIZOPHRENIA

Supported by Janssen Pharmaceutica, Inc.

Mamta Sapra, M.D., *Department of Psychiatry, State University of New York, Downstate Medical Center, 7212 Narrows Avenue, Second Floor, Brooklyn, NY 11209-1811*; Abdelouahed Elmouchtari, M.D., *Department of Psychiatry, State University of New York, Downstate Medical Center, 61 Somerset Road, Hopewell Junction, NY 12533*; Peter J. Weiden, M.D.; Stephen M. Goldfinger, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that major obstacle in effective psychoeducation of patients recovering from a first acute episode of schizophrenia is the lack of understanding in the association between medication and relapse prevention.

SUMMARY:

Overview: Patients recovering from a first treatment episode of schizophrenia often respond well to acute antipsychotic treatment but are very reluctant to accept a recommendation for ongoing maintenance antipsychotic treatment. They stop their medication too soon, and then go on relapse. A major obstacle for clinicians working with first-episode patients and their families is that they have yet to learn the connection between maintenance medication and relapse prevention. Therefore, clinicians working with first-episode patients need to become familiar with other educational approaches that are more effective in helping this target population accept a rec-

ommendation of maintenance antipsychotic treatment, and extend the duration of maintenance therapy.

Methods: We are presenting the results of the psychoeducation component of a prospective effectiveness study comparing first-episode schizophrenia patients randomized to a recommendation of maintenance long-acting vs oral atypical antipsychotic. Consenting patients meeting key criteria for maintenance antipsychotic therapy received a 3-session psychoeducation program that included families whenever possible. Sessions utilized life-goal motivational approaches, with the maintenance recommendation tailored to the specific life issues elicited. Other psychoeducation approaches were also modified to the specific beliefs and concerns brought up by first-episode patients and their families.

Results: We will present the primary influences for accepting maintenance antipsychotic for at least 12 weeks with a systematic review of their reasons for medication acceptance.

TARGET AUDIENCE:

Clinicians treating first-episode schizophrenia patients and their families.

REFERENCES:

1. McEvoy JP, Johnson J, Perkins D, et al. Insight in first episode psychosis. *Psychol Med.* Jun 2 2006;1-9.
2. Perkins DO, Johnson JL, Hamer RM, et al. Predictors of antipsychotic medication adherence in patients recovering from a first psychotic episode. *Schizophr Res* Mar 2006; 83(1):53-63.

Poster 135

**Friday, October 6
8:30 a.m.-10:00 a.m.**

**CARING FOR THE VERY SEVERE
MENTALLY ILL WITHOUT A
PSYCHIATRIC HOSPITAL: A CASE
STUDY**

Jean-Francois Trudel, M.D., M.Sc., *Associate Professor of Psychiatry, University of Sherbrooke, 375 Argyll, Sherbrooke, Quebec Canada J1J 3H5*; Alain D. Lesage, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate knowledge of the approximate prevalence of severely ill psychotic patients in need of long-term closely supervised care; acknowledge that it is possible to care for such patients in ways less restrictive than conventional long-term psychiatric facilities; and recognize possible untoward consequences of deinstitutionalisation.

SUMMARY:

Research Objectives: The Eastern Townships, population of 291,359, in Quebec, Canada, has never had a psychiatric hospital and is thus a rather extreme example of deinstitutionalization. The objective was to find out how this system of care deals with its more severely affected long-term patients.

Study design: single case study, combining qualitative (key informant interviews) and quantitative (case finding survey) methods.

Principal findings: we found 36 persistently and severely ill patients (prevalence: 12.4/100,000). This cohort is comparable in size and symptom profile to data found in the literature. The region does not export its worst cases to other areas. A network of small- and medium-sized facilities provides long-term shelter and care. The suicide rate among this client group appears comparable to data found in the literature. However, there is evidence of a slight drift toward incarceration. Dual or triple diagnosis cases have difficulty accessing the care network. Forensic patients posing a serious continuing risk of violence are often rejected by facilities and, in the absence of alternatives, may end up spending months or years in acute care beds (prevalence 1.6/100,000).

Conclusion: it appears feasible to do without a psychiatric hospital if an adequate network of care, shelter and rehabilitation facilities exists and if highly structured facilities, designed for long-term patients who are very ill, are available. These facilities need psychiatric input and rehabilitation interventions in order to provide comprehensive care. The need for such highly structured facilities was assessed at 12/100 000 population in our study, but more urbanised, deprived areas may need up to 40 places/100 000. Locked, forensic facilities are still a necessity (1.6/100 000 in this study). Liaison with correctional facilities should be a part of mental health systems.

TARGET AUDIENCE:

Mental health service planners and administrators; schizophrenia and psychotic disorders clinicians; and social and community psychiatric clinicians and planners

REFERENCES:

1. Trudel JF, Lesage A: Prevalence, Characteristics and Locus of Care of the most Severely and Persistently Mentally Ill in an Area Without a Psychiatric Hospital. *Psychiatric Services*, accepted for publication June 2006.
2. Gudeman J, Shore M: Beyond deinstitutionalization: a new class of facilities for the mentally ill. *New England Journal of Medicine* 311: 832-836, 1984.

Poster 136

Friday, October 6
8:30 a.m.-10:00 a.m.

IMPROVING ADEQUACY OF MEDICAL TREATMENT IN OLDER PERSONS WITH SCHIZOPHRENIA

Supported by the National Institute of General Medical Sciences

Ipsit V. Vahia, M.D., *Resident, Department of Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, P.O. Box 1203, Brooklyn, NY 11203*; Carl I. Cohen, M.D., *Department of Psychiatry, State University of New York, Health Sciences Center, 450 Clarkson Avenue, Brooklyn, NY 11203*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the need for focussed treatment of medical comorbidity in older persons with schizophrenia, and appreciate factors that need closer clinical attention.

SUMMARY:

Introduction: The presence of higher rates of medical comorbidity has been well established in patients with schizophrenia, especially in older persons. We observed a large multi-ethnic inner city population and used Krause's Illness Behavior Model to assess outcome in older persons with schizophrenia and comorbid medical conditions.

Methods: We compared schizophrenia (S) patients age 55+, with a matched community group. Krause's Model of Illness Behavior was used to generate 13 independent variables. We created a dichotomous dependent variable based on receiving treatment for more than half (51%+) of 4 medical conditions - DM, heart disease, HTN, GI ulcers.

Results: There were significant differences between the S and C groups in the proportion receiving treatment for the 4 medical conditions. Greater depression, fewer doctor visits, lower subjective feeling of disability from medical illness, higher positive symptoms and lower negative symptoms were all associated with lower treatment.

Conclusion: We found that focusing on control of depression and positive symptoms may significantly reduce morbidity from medical illness. Our findings suggest that improving treatment adequacy may be a more effective intervention for public policy than accessibility of care, and greater emphasis on both patient and clinician education is necessary.

This study was partially funded by NIGMS Grant SO6GM54650.

TARGET AUDIENCE:

Persons in clinical practice with geriatric populations.

REFERENCES:

1. Dolder CR, Furtek K, Lacro JP, Jeste DV. Antihypertensive medication adherence and blood pressure control in patients with psychotic disorders compared to persons without psychiatric illness. *Psychosomatics*. 2005 Mar-Apr; 46(2):135-41.
2. Lester H, Tritter JQ, England E. Satisfaction with primary care: the perspectives of people with schizophrenia. *Fa Pract*. 2003 Oct; 20(5):508-13.

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Friday, October 6
8:30 a.m.-10:00 a.m.

ANTIPSYCHOTIC POLYPHARMACY COSTS AND COMPLIANCE: A FIVE-STATE MEDICAID STUDY

Supported by Ortho-McNeil Janssen Scientific Affairs, Inc.

Robert J. Valuck, Ph.D., *Associate Professor of Pharmacy, University of Colorado, 4200 E. Ninth Avenue, C-238, Denver, CO 80262*; Elaine H. Morrato, Dr.P.H., *Outcomes Research Fellow, University of Colorado, 4200 E. Ninth Avenue, C-238, Denver, CO 80262*; Sheri L. Dodd, M.S.; Richard R. Allen, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the prevalence and costs of polypharmacy associated with the usage of atypical antipsychotic medications in Medicaid populations.

SUMMARY:

State Medicaid programs are scrutinizing atypical antipsychotic prescribing given relatively high costs and use with other psychotropic medications.

This retrospective cohort study used Medicaid claims data from California, Oregon, Tennessee, Utah, and Wyoming and evaluated 55,576 patients who filled an antipsychotic prescription (1998-2003). Analysis was stratified by antipsychotic regimen: polypharmacy; concomitant psychotropics; polypharmacy + psychotropics; or monotherapy. Multivariate logistic regression determined predictors of polypharmacy adjusting for state and clinical characteristics.

53% of subjects receiving antipsychotics began and stayed on monotherapy; 40% received concomitant psychotropics only; 3% polypharmacy only; and 3% polypharmacy + psychotropics. Polypharmacy rates varied by year (declining 1998-2000; increasing 2000-2002). Patients receiving polypharmacy were more likely to be male, have schizophrenia, and a mental health-related

hospitalization. Adjusted annual health care expenditures were higher for patients receiving polypharmacy and polypharmacy + psychotropics than monotherapy (mean increases: \$4,639 and \$8,090, respectively). Drug costs accounted for approximately 80% of the difference. However, the likelihood that a patient was 80% compliant with antipsychotic therapy was two times higher for polypharmacy vs. monotherapy patients.

Polypharmacy rates were low during the study period, but were higher in patients with more severe mental illness and represented a significant component of an individual's total healthcare expenditures.

TARGET AUDIENCE:

Practicing psychiatrists, medicaid program administrators, and researchers.

REFERENCES:

1. Ganguly R, Kotzan JA, Miller LS, et al. Prevalence, trends, and factors associated with antipsychotic polypharmacy among Medicaid-eligible schizophrenia patients, 1998–2000. *J Clin Psychiatry* 2004; 65:1377–1388.
2. Schumacher JE, Makela EH, Griffin HR. Multiple antipsychotic medication prescribing patterns. *Ann Pharmacother* 2003; 37:951–955.

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**Friday, October 6
8:30 a.m.-10:00 a.m.**

CLOZAPINE IN THE COMMUNITY

Edward A. Volkman, M.D., *Clinical Professor of Psychiatry, Drexel University, 27 E. Mt. Airy Avenue, Philadelphia, PA 19119*; Paul Sachs, *Executive Director, Human Services, Drexel University, 27 E. Mt. Airy Avenue, Philadelphia, PA 19119*; Peter Maggocio, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will be able to specify the relative efficacy of Clozapine (CLZ) in the treatment of schizophrenia; know the difference in rehospitalization rates between CLZ and non-CLZ patients in our community sample; and know the processes for and the impediments to the establishment of a dedicated CLZ program in the community.

SUMMARY:

Clozapine has increasingly come to be recognized as the most effective treatment for schizophrenia, as well as being useful in the treatment of TD, and suicide prevention among the chronically mentally ill.

Most of the studies of its use in the community in the literature have focused on making the drug available to patients in public hospitals, and in patients being discharged from those hospitals. There is a paucity of

work on organizing Clozapine treatment in CMHC's. This study looks at the results of organizing the delivery of Clozapine in a large urban CMHC in terms of hospitalization rates over five years. It mirrors the work of Luchins et al which focused on the economic benefit of providing Clozapine treatment in an organized manner.

In our sample there were a total of 707 patients treated over the five year period. The hospitalization rate in this group was 5.79%, which is even lower than the 50% reduction reported by Luchins. The conclusion is that the benefit of dedicated Clozapine delivery sub-clinics in CMHC's in terms of hospitalization rates, economic costs, and continuity of care make this structure of care delivery very valuable, but underutilized in the community.

REFERENCES:

1. Tamminga C, Practical Treatment Information for Schizophrenia, *Am J Psychiatry*, 163:4, April 2006.
2. Luchins DJ, Hanrahan P, Shinderman M, Lagios L, Fichtner CG. Initiating clozapine treatment in the outpatient clinic: service utilization and cost trends. *Psychiatric Services*. 49(8):1034–8, 1998 Aug.

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**Friday, October 6
8:30 a.m.-10:00 a.m.**

INTEGRATING FORENSIC AND CIVIL INPATIENTS IN A TREATMENT MALL AT A STATE HOSPITAL

Steven L. Webster, M.Div., *Psychosocial Rehabilitation Director, Dorothea Dix Hospital, 3601 MSC Center, Raleigh, NC 27699*; Susan H. Harmon, B.S., O.T., *Assistant Director of Psychosocial Rehabilitation, Dorothea Dix Hospital, 3601 MSC Center, Raleigh, NC 27699*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to discuss the feasibility and potential benefits of integrating forensic and civil inpatients in a centralized hospital psychiatric rehabilitation program.

SUMMARY:

Background: A growing body of literature suggests the potential benefits of reducing the separation between forensic and general psychiatric rehabilitative approaches. This presentation describes results from an inpatient state hospital that integrated the majority of its forensic inpatients with its civil inpatients in a "treatment mall" program. Treatment malls are off-unit centralized programming areas where patients receive treatment, education, skills training and support.

Methods: Patients were referred by treatment teams to mall groups and activities. A six-month sample of

data associated with two adult continued care units and two forensic units (medium and maximum security) was collected from: (1) daily participation ratings assigned to patients at the conclusion of each group, (2) records of restrictive intervention use at the mall, (3) a patient questionnaire.

Results: Forensic patients were significantly better engaged in rehabilitation groups than civil patients (by 17%) and slightly less disruptive (by .006%). There was no use of restrictive interventions. Most patients indicated that the program was helpful in preparing them for discharge (forensic: 60%, civil: 88%).

Conclusion: State psychiatric hospitals should seriously consider designing programs that allow integration of selected forensic inpatients with civil inpatients to promote environmental specificity and cost efficiency.

TARGET AUDIENCE:

Hospital administrators and service planners, inpatient hospital staff, and consumer advocates.

REFERENCES:

1. Mullen PE. (2000) Forensic mental health. *British Journal of Psychiatry*, 176, 307–311.
2. Webster SL, Harmon SH, & Paesler, B. (2005) Building a treatment mall: a first step in moving a state hospital to a culture of rehabilitation and recovery. *The Behavior Therapist*, 28(3):71–77.

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Friday, October 6
8:30 a.m.-10:00 a.m.

ROLE OF SPIRITUALITY IN THE PHARMACOLOGIC TREATMENT OF ACUTE DEPRESSION

Caroline B. Williams, M.D., *Substance Abuse Program, New York University, 126 East 36th Street, Apt. 3, New York, NY 10016*; Eric D. Peselow, M.D., *Medical Director, Freedom From Fear, 32 Bassett Avenue, Brooklyn, NY 11234-6724*; Borboro Orłowski, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to assess whether enhanced spirituality and belief in God has any effect on helping with antidepressant treatment in acute depression.

SUMMARY:

Until recently minimal attention has been paid to the role of spirituality in psychiatric illness. It is the purpose of this report to examine the attitudes of acute depressed patients with regard to spirituality and to see whether these attitudes have any relationship to response to treatment with selective serotonin reuptake inhibitor response

(SSRI) in alleviating depressive symptoms. To date, 84 patients have been treated for acute depression over an 8 week course. The 84 patients were treated with one of three SSRI's including escitalopram (N=34), sertraline (N=28) and paroxetine (N=22) with the choice being made on an open basis on clinical grounds as opposed to random assignment. All patients prior to receiving medications were rated with the Montgomery Asberg Depression Rating Scale (MADRS), the Beck Hopelessness Scale (BHS) and a 7 item religious and spirituality orientation scale as formulated by Goldfarb et. al. 1996 rated on a 5 point scale with 1=strongly agree and 5= strongly disagree with the lower score indicating greater spirituality. In addition the question of whether the patient believed in God or a universal spirit was asked on a Yes/No basis. Overall 68 patients believed in God or a universal spirit and 16 did not. The average improvement in MADRS score was 57% for those who believed in God or a universal spirit and 34% for those who did not ($p<.02$). With respect to Beck Hopelessness Scale there was a non-significant trend in that people who believed in God or a universal spirit had greater improvement vs. those who did not (44% vs. 31%); With respect to the 7 item religious and spirituality orientation scale the average score for the responders (Lower number better) was 16.64 vs 27.63 for the non-responders ($p<.00001$) In conclusion it did appear that greater spiritual belief was associated with a better antidepressant response in acute depression.

TARGET AUDIENCE:

Psychiatrists, psychologists, and clergy.

REFERENCES:

1. Dyce JA. Factor structure of the Beck Hopelessness Scale. *Clin Psychol*. 1996.
2. Goldfarb LM, Galanter G, McDowell D, Lifshutz H, Dermatis H. Medical student and patient attitudes toward religion and spirituality in the recovery process. *Am J Drug Alcohol Abuse*. 1996 Nov; 22(4):549–61.

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Friday, October 6
8:30 a.m.-10:00 a.m.

EFFICACY OF TADALAFIL IN ANORGASMIC WOMEN

Supported by the Minnesota Medical Foundation

Faruk S. Abuzzahab, Sr., M.D., Ph.D., *Department of Psychiatry, University of Minnesota, 701 25th Avenue, South, Suite 303, Minneapolis, MN 55454*; Rachel M. Uppgaard, *Research Assistant, Department of Psychiatry, University of Minnesota, 701 25th Avenue, South,*

Suite 303, Minneapolis, MN 55454; Jon E. Grant, M.D., Ph.D.

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Friday, October 6
8:30 a.m.-10:00 a.m.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and evaluate female anorgasmia induced by SSRI's and menopause; use the Sexual Function Index to assess sexual dysfunction and its improvement; and understand the use and limitations of off-label tadalafil in reversing female anorgasmia.

SUMMARY:

Objectives: The purpose of this preliminary study was to determine the response of women with SSRI or menopause-induced sexual dysfunction treated before sexual activity with tadalafil at varying dosages.

Methods: 10 anorgasmic women, ages 27 to 61, seven using SSRIs or NSRIs and seven menopausal, were entered in this open-label study. The patients received 10mg to 20mg of tadalafil to start, and were given the option to increase this dosage to 40 mg. Efficacy was assessed by giving the patients the Sexual Function Index created by Nurnberg et al. (2000) before they received tadalafil while suffering from sexual dysfunction and after trying tadalafil. The test quantifies the domains of interest, arousal, orgasm, lubrication, and overall sexual satisfaction, while predetermining that the sexual dysfunction was not present prior to SSRI use or menopause.

Results: Of the group, 10 participated in the study and were available for follow up. Mean baseline SFI score before therapy was 5.29 ± 0.93 . The SFI score improved to 3.39 ± 1.95 at 40mg. The mean overall score improved by 35.9%. Only two patients of ten had a significant (over 60%) improvement in the mean SFI score. Side effects included upset stomach, cramping, and lower back pain.

Conclusions: The data suggests that tadalafil is well tolerated in anorgasmic women taking SSRIs or NSRIs or going through menopause. Overall sexual function did not improve significantly through the use of tadalafil, although there were improvements in all of the categories. Supported in part by the Minnesota Medical Foundation and the Psychopharmacology Fund.

TARGET AUDIENCE:

Adult psychiatrists involved in treating depression in women.

REFERENCES:

1. Nurnberg HG, Hensley PL, Gelenberg A, Fava M, Lauriello J, Paine S: Treatment of antidepressant-associated sexual dysfunction with sildenafil. *JAMA* 2003; 289:1:56-63.
2. Balon R: Sexual function and dysfunction during treatment with psychotropic medications. *Clin Psychiatry* 2005; 66:22:1488-1489.

SLEEP LABORATORY ASSESSMENT OF INDIPLON IN PRIMARY INSOMNIA

Supported by Neurocrine Biosciences and Pfizer Inc.

Russell Rosenberg, Ph.D., *Director, Sleep Medicine Institute, Northside Hospital, 5780 Peachtree-Dunwoody Road, Suite 150, Atlanta, GA 30342*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to become familiar with a novel GABA_A receptor modulator for treatment of primary insomnia; and gain knowledge about the data regarding the efficacy and safety of a 15 mg dose of indiplon for primary insomnia.

SUMMARY:

Methods: 100 patients who met DSM-IV criteria for primary insomnia, and who reported >60 minutes of wake time after sleep onset, were randomized to a double-blind, 2-period, 2-night crossover sleep lab comparison of indiplon 15mg and placebo. Polysomnographic assessments included wake time during sleep, wake time after sleep onset, latency to persistent sleep, total sleep time and sleep quality.

Results: Treatment with indiplon was associated with significantly reduced WTDS (60.4 ± 3.5 min vs. 71.5 ± 3.6 min; $p=0.0036$), reduced WASO (73.9 ± 4.0 min vs. 83.0 ± 4.0 min; $p=0.0190$), significantly shorter LPS (12.5 ± 1.1 min vs. 26.1 ± 2.4 min; $p<0.0001$), and significantly longer TST (389.8 ± 4.9 min vs. 362.8 ± 5.0 min; $p<0.0001$) relative to placebo. Sleep quality was rated as significantly improved on indiplon (3.3 ± 0.1) compared to placebo (4.0 ± 0.1 ; $p<0.0001$). The incidence of adverse events was similar on indiplon (8.0%) and placebo (10.4%).

Conclusions: The 15 mg dose of indiplon was safe and effective in inducing and maintaining sleep in patients with primary insomnia. The following information concerns a use that has not been approved by the U.S. Food and Drug Administration. Supported by funding from Neurocrine Biosciences and Pfizer Inc..

REFERENCES:

1. Rosenberg RP. Sleep maintenance insomnia: strengths and weaknesses of current pharmacologic therapies. *Ann Clin Psychiatry*. 2006 Jan-Mar; 18(1):49-56.
2. Neubauer DN. Indiplon: the development of a new hypnotic. *Expert Opin Investig Drugs*. 2005 Oct; 14(10):1269-76.

Poster 143

Friday, October 6
8:30 a.m.-10:00 a.m.

EXAMINING THE PREDICTORS OF SEXUAL ORIENTATION AND HIV-STATUS DISCLOSURE OVER TIME FOR PSYCHIATRIC OUTPATIENTS

W. R. Murray Bennett, M.D., FRCPC, *Department of Psychiatry, University of Washington, 325 Ninth Avenue, 2WC, Seattle, WA 98104*; Eric D. Strachan, Ph.D., *Psychologist, University of Washington School of Medicine, 325 Ninth Avenue, 2WC, Seattle, WA 98104*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to investigate changes in HIV-related psychosocial stressors (i.e., concealment of sexual orientation and HIV-status) over time; and understand the relationship between important demographic variables and disclosure of sexual orientation and HIV status.

SUMMARY:

Purpose: We investigated predictors of sexual orientation (SO) and HIV-status disclosure and the extent to which disclosure changes over time.

Methodology: Data came from an archival database and medical records for psychiatric outpatients at an urban HIV/AIDS clinic. Patients were asked about disclosure of both SO and HIV status at intervals of approximately 3 months using a five-point scale. We used up to four responses for each patient as the DV. As predictors, we included interpersonal functioning, HAART prescription history, age, ethnicity, partner status, employment, education, CD4 cell counts, and physical and mental health functioning. Analyses were performed using MIXOR. Our main hypothesis was that disclosure of HIV status would increase over time but SO disclosure would not. $N=372$.

Results: Contrary to our hypothesis, neither SO nor HIV-status disclosure changed significantly over time. Predictors of greater overall SO disclosure included better interpersonal functioning and white ethnicity. Predictors of greater overall HIV-status disclosure included better interpersonal functioning, a history of HAART prescription, white ethnicity, being unemployed, and years of education.

Conclusions: Although SO and HIV-status disclosure did not vary over time in our sample, there were some differences in the variables that predicted the patterns of disclosure. Specifically, HIV-related treatment, unemployment, and education were associated with greater HIV disclosure but not greater SO disclosure.

TARGET AUDIENCE:

Primary Care Psychiatrists, HIV Psychiatrists and Consultation-Liaison Psychiatrists.

REFERENCES:

1. Annas G. Protecting Patients from discrimination: the Americans with Disabilities Act and HIV Infection. *N Engl J Med.* 1998;339:1255-9.
2. Brown L. Macintyre K., Trujillo L. Interventions to reduce HIV/AIDS Stigma: What have we learned? *AIDS Educ Prev.* 2003;15(1):49-69.

POSTER SESSION 4

Posters 144-191

EFFICACY, SAFETY, AND TOLERABILITY IN THE TREATMENT OF AFFECTIVE DISORDERS, ANXIETY DISORDERS, PERSONALITY DISORDERS, AND ADHD

Poster 144

Friday, October 6
3:00 p.m.-4:30 p.m.

AN EVALUATION OF LAMOTRIGINE TREATMENT FOR MAJOR BIPOLAR I DEPRESSION

Supported by GlaxoSmithKline

Joseph R. Calabrese, M.D., *Director, Mood Disorders Program, Case Western Reserve University, 11100 Euclid Avenue, Suite 200, Cleveland, OH 44106-3986*; Kevin P. Nanry, B.S., *Employee, GlaxoSmithKline, Five Moore Drive, Research Triangle Park, NC 27709*; Russell F. Huffman, Ph.D.; Suzanne E. Edwards, Ph.D.; Robert A. Leadbetter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand patient response and tolerability to lamotrigine treatment.

SUMMARY:

Background: Lamotrigine has proven to be effective for the maintenance treatment of bipolar I disorder.¹ There is also evidence for the effectiveness of lamotrigine in the acute treatment of depression.² This study was designed to confirm lamotrigine efficacy for the treatment of bipolar depression.

Methods: A multicenter, double-blind, placebo-controlled, parallel, 8-week, monotherapy study was conducted with bipolar I patients experiencing a major depressive episode. The primary efficacy measure was mean change from baseline at Week 8 for the Montgomery-Asberg Depression Rating Scale (MADRS), analyzed via analysis of covariance with missing values handled via last observation carried forward. Secondary

efficacy measures included the Hamilton Depression Rating Scale and several subscales, the Mania Rating Scale (MRS) and the Clinical Global Impressions of Severity (CGI-S) and Improvement Scales (CGI-I). Safety was assessed by adverse event reporting.

Results: There was no significant difference between treatments in the mean change from baseline MADRS scores at Week 8 (lamotrigine vs placebo: -12.6 vs. -11.7, $p=0.537$). None of the secondary endpoints showed a significant treatment difference favoring lamotrigine. Adverse events included (placebo vs. lamotrigine): suicide ideation (3% vs. <1%), mania/hypomania/mixed episode (5% vs. 2%), and non-serious rash (2% vs. 6%). There were no reports of serious rash.

Conclusion: This study did not demonstrate lamotrigine's efficacy in the acute treatment of depression in subjects with bipolar I disorder, though was numerically superior to pbo on most measures. Lamotrigine was generally well-tolerated.

REFERENCES:

1. Goodwin GM, Borden CL, Calibrese JR et al. A pooled analysis of 2 placebo-controlled 18-month trials of lamotrigine and lithium maintenance in bipolar I disorder. *J Clin Psychiatry* 2004; 65:432-441.
2. Calabrese JR, Bowden CL, Sachs GS, et al. A double-blind placebo-controlled study of lamotrigine monotherapy in outpatients with Bipolar I depression. *J Clin Psychiatry* 1999; 60-79-88.

Poster 145

**Friday, October 6
3:00 p.m.-4:30 p.m.**

BIPOLAR I DISORDER: LAMOTRIGINE TREATMENT WITH OR WITHOUT QUETIAPINE

Supported by GlaxoSmithKline

Michael N. Zarzar, M.D., *Psychiatrist, 5711 Six Forks Road, Suite 200, Raleigh, NC 27609-3888*; Kevin P. Nanry, B.S., *Employee, GlaxoSmithKline, Five Moore Drive, Research Triangle Park, NC 27709*; James A. Graham, Pharm.D.; Jeremy N. Roberts, M.S.; Robert A. Leadbetter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand patient response and tolerability to lamotrigine treatment.

SUMMARY:

Objective: Lamotrigine is effective and well tolerated in clinical trials of patients with bipolar disorder.¹ The current analysis investigated whether the clinical response and adverse event profiles differs in patients

treated with lamotrigine (alone or with other medications) with or without concomitant quetiapine.

Methods: Secondary analysis was conducted from a prospective, open-label study of lamotrigine² in patients with bipolar I disorder designed to assess the rate of rash in patients with or without specific dermatological precautions. Lamotrigine was administered for 12 weeks, including a 5-week titration period (target dosage 200 mg/day). Clinical Global Impression-Bipolar version (CGI-BP) Severity scores were recorded at baseline, week 5, and week 12 visits. Adverse events were recorded at weeks 5 and 12.

Results: Of the 1175 patients included in this study, 163 (13.9%) were receiving concomitant quetiapine. Statistically significant improvement was observed with lamotrigine with and without quetiapine from baseline in mean \pm SD CGI-BP Severity Overall scores at week 5 (-0.6 ± 1.13 with quetiapine; -0.8 ± 1.07 without quetiapine, $P<0.0001$ for both groups) and at week 12 (-0.9 ± 1.26 with quetiapine; -1.1 ± 1.30 without quetiapine, $P<0.0001$ for both groups). There were no statistically significant differences between patients taking lamotrigine with or without concomitant quetiapine. At least one adverse event was reported by 66% of patients with quetiapine and 58% of those taking lamotrigine only. No serious rash was reported in the study.

Conclusion: These findings suggest that lamotrigine was well tolerated in patients with bipolar I disorder with and without concomitant quetiapine.

REFERENCES:

1. Bowden CL. Lamotrigine in the treatment of bipolar disorder. *Expert Opin Pharmacother.* 2002; 3:1513-1519.
2. Ketter TA et al. The Effect of Dermatologic Precautions on the Incidence of Rash with Addition of Lamotrigine in the Treatment of Bipolar I Disorder. *J Clin Psych.* In Press.

Poster 146

**Friday, October 6
3:00 p.m.-4:30 p.m.**

BIPOLAR I DISORDER: LAMOTRIGINE TREATMENT WITH OR WITHOUT VALPROATE

Supported by GlaxoSmithKline

Elias H. Sarkis, M.D., *Psychiatrist, 529 N.W. 60th Street, #B, Gainesville, FL 32607-2008*; Kevin P. Nanry, B.S., *Employee, GlaxoSmithKline, Five Moore Drive, Research Triangle Park, NC 27709*; James A. Graham, Pharm.D.; Jeremy N. Roberts, M.S.; Robert A. Leadbetter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand patient response and tolerability to lamotrigine treatment.

SUMMARY:

Objective: Lamotrigine was effective and well tolerated in clinical trials of bipolar disorder.¹ The current analysis investigated whether the clinical response and adverse-event profiles differs in patients treated with lamotrigine (alone or with other medications) with or without concomitant valproate.

Methods: A post hoc analysis was conducted from a prospective, open-label study of lamotrigine² in patients with bipolar I disorder designed to assess the rate of rash in patients with or without specific dermatological precautions. Lamotrigine was administered for 12 weeks, including a 5-week titration period (target dosage 200 mg/day). Clinical Global Impression-Bipolar version (CGI-BP) Severity scores were recorded at baseline, week-5, and week-12 visits, and adverse events were recorded at weeks 5 and 12.

Results: Of the 1175 patients included in the study, 260 (22%) were receiving concomitant valproate. Statistically significant improvement was observed with lamotrigine with and without valproate from baseline in mean \pm SD CGI-BP Severity Overall scores at week 5 (-0.6 ± 1.18 with valproate and -0.8 ± 1.04 without valproate, $P < 0.0001$ for both groups) and at week 12 (-0.8 ± 1.40 with valproate and -0.8 ± 1.04 without valproate, $P < 0.0001$ for both groups). Patients without valproate had significantly greater mean CGI-BP Improvement scores at week 12 than those receiving valproate ($P = 0.0025$). At least one adverse event was reported by 63% of patients with valproate and 58% of those without valproate. No serious rash was reported in the study.

Conclusion: These findings suggest that lamotrigine is well tolerated in patients with bipolar I disorder with and without concomitant valproate.

REFERENCES:

1. Bowden CL. Lamotrigine in the treatment of bipolar disorder. *Expert Opin Pharmacother.* 2002; 3:1513–1519.
2. Ketter TA et al. The Effect of Dermatologic Precautions on the Incidence of Rash with Addition of Lamotrigine in the Treatment of Bipolar I Disorder. *J Clin Psych.* In Press.

Poster 147

**Friday, October 6
3:00 p.m.-4:30 p.m.**

MULTIPLE-DOSE PHARMACOKINETICS OF LISDEXAMFETAMINE IN HEALTHY ADULT VOLUNTEERS

Supported by New River Pharmaceuticals and Shire Development, Inc.

Michael Arora, Pharm.D., M.B.A., *Senior Consultant, ADHD Products, Shire Development, Inc., 725 Chesterbrook Boulevard, Wayne, PA 19087; James C. Ermer, M.S.; Suma Krishnan, M.S.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate steady-state pharmacokinetic parameters of LDX in healthy adults after repeated once-daily doses for seven consecutive days.

SUMMARY:

Background: LDX is a pharmacologically inactive prodrug in which *d*-amphetamine is bonded to *l*-lysine. Pharmacologically active *d*-amphetamine is gradually released only after metabolism of the prodrug. LDX was designed to have comparable efficacy and tolerability to available once-daily stimulants, with reduced potential for abuse.

Methods: Open-label, multiple-dose study in which each subject received LDX 70 mg once daily for 7 consecutive days.

Results: Once-daily doses of LDX 70 mg produced steady-state concentrations of *d*-amphetamine by day 5. Elimination of intact LDX was complete at approximately 6 hours postdose. At steady state, the mean PK values for *d*-amphetamine and intact LDX were: AUC_{0-24} 1113 and 60.66 ng·h/mL, AUC_{0-inf} 1453 and 61.06 ng·h/mL, C_{max} 90.1 and 47.9 ng/mL, and T_{max} 3.68 and 1.14 h. Most common AEs were anorexia, insomnia, tachycardia, hyperkinesia, abdominal pain, euphoric mood, headache, and upper respiratory tract infection. After 1 dose of LDX 70 mg, 1 female subject was withdrawn from the study due to tachycardia.

Conclusion: Oral LDX 70 mg produced steady-state concentrations of *d*-amphetamine by Day 5; intact LDX was completely eliminated ~4 hours following the final dose.

REFERENCES:

1. Clausen SB, Read SC, Tulloch SJ. *CNS Spectr.* 2005 Dec; 10(12 Suppl 20):6–15.
2. McGough JJ, Biederman J, Greenhill LL, McCracken JT, Spencer TJ, Posner K, Wigal S, Gornbein J, Tulloch S, Swanson JM. *J Am Acad Child Adolesc Psychiatry.* 2003 Jun; 42(6):684–691.

Poster 148

Friday, October 6
3:00 p.m.-4:30 p.m.**PHARMACOKINETICS OF
LISDEXAMFETAMINE WHEN TAKEN
WITH OR WITHOUT FOOD***Supported by New River Pharmaceuticals and
Shire Development, Inc.*Michael Arora, Pharm.D., M.B.A., *Senior Consultant,
ADHD Products, Shire Development, Inc., 725 Ches-
terbrook Boulevard, Wayne, PA 19087*; James C. Ermer,
M.S.; Suma Krishnan, M.S.**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to demonstrate whether food has an impact on the bioavailability and bioequivalence of *d*-amphetamine from LDX.

SUMMARY:

Background: LDX is a pharmacologically inactive prodrug in which *d*-amphetamine is bonded to *l*-lysine. Pharmacologically active *d*-amphetamine is gradually released only after metabolism of the prodrug. LDX was designed to have comparable efficacy and tolerability to available once-daily, stimulants with reduced potential for abuse.

Methods: Phase 1, open-label, single-dose, crossover study. After a 10-hour overnight fast, each subject received LDX 70 mg in solution or by capsule with or without a high-fat breakfast. Each subject received all 3 treatments randomly, separated by 7-day washouts. Safety was assessed by vital signs, adverse events, and ECG.

Results: A comparative analysis of *d*-amphetamine data showed no significant difference in AUC_{0-inf} for the fasted, fed, and solution groups (1110, 1038, and 1074 ng·h/mL, respectively) or C_{max} (69.3, 65.3, and 68.4 ng/mL, respectively). Bioequivalence analysis showed that fed/fasted and solution/fasted ratios for *d*-amphetamine AUC_{0-inf} and C_{max} all were within 90% CI for bioequivalence. Compared with the fasted group, T_{max} for *d*-amphetamine and intact LDX were delayed by ~1 hour in the fed group. AEs were mild and occurred more frequently in the fasted group than the fed or solution groups. One-hour diastolic blood pressure increased by 4 mmHg in the solution group, while it decreased by 3 mmHg in the fed group.

Conclusions: Food had no effect on the bioequivalence of *d*-amphetamine but delayed T_{max} of *d*-amphetamine and intact LDX by ~1 hour.

REFERENCES:

1. Clausen SB, Read SC, Tulloch SJ. Single- and multiple-dose pharmacokinetics of an oral mixed amphet-

- amine salts extended-release formulation in adults. *CNS Spectr.* 2005 Dec; 10(12 Suppl 20):6–15.
2. Tulloch SJ, Zhang Y, McLean A, Wolf KN. SLI381 (Adderall XR), a two-component, extended-release formulation of mixed amphetamine salts: bioavailability of three test formulations and comparison of fasted, fed, and sprinkled administration. *Pharmacotherapy.* 2002 Nov; 22(11):1405–15.

Poster 149

Friday, October 6
3:00 p.m.-4:30 p.m.**LONG-ACTING, INJECTABLE
RISPERIDONE IN FREQUENTLY
RELAPSING BIPOLAR DISORDER***Supported by Janssen Pharmaceutica and
Research Foundation*Mary J. Kujawa, L.P., *Senior Director, Department of
Medical Affairs, Janssen Pharmaceutica Inc., 1125
Trenton-Harbourton Road, Titusville, NJ 08560–1504*;
Earle E. Bain, M.D., *Associate Director, Medical Affairs
Department, Janssen Pharmaceutica, Inc., Ramy Mah-
moud, M.D.; Ibrahim Turkoz, M.S.; Richard Drucken-
brod, Pharm.D.; Georges M. Gharabawi, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to differentiate the characteristics of patients with frequently relapsing bipolar disorder (FRBD) and recognize the role of a long-acting, atypical antipsychotic in addressing unmet needs in this difficult-to-treat patient population.

SUMMARY:

Objective: To evaluate the efficacy of treatment with adjunctive long-acting risperidone (LAR) on mood symptom control in frequently-relapsing bipolar disorder (FRBD) patients.

Methods: FRBD patients (experiencing ≥ 4 episodes requiring intervention in the past 12 months) received open-label adjunctive LAR (25–50 mg) for 16 weeks. Measures included Montgomery-Åsberg Depression Rating Scale (MADRS), Young Mania Rating Scale (YMRS), and Clinical Global Impressions-Severity (CGI-S). Remitters were eligible to enter a double-blind, relapse-prevention phase.

Results: 275 subjects enrolled in the OL phase. Baseline characteristics include: 87.3% had type I BP; mean age 38.4 ± 11.4 years, 38.9% female; 37.7% had ≥ 3 lifetime hospitalizations; 32.3% had ≥ 1 lifetime suicide attempt; 12.4% had attempted suicide within the past 2 years; and 26.4% had a history of substance abuse.

77.1% of patients completed the OL phase; 48.9% met remission criteria for the relapse-prevention phase

and 25.5% did not meet remission criteria but continued LAR treatment. At 4-month OL endpoint, 19% of patients had CGI-S scores of moderately ill or worse (decreased from 64%). Mean change from baseline in YMRS and MADRS scores were -9.1 ± 12.4 ($P < 0.001$) and -3.6 ± 11.3 ($P < 0.001$), respectively.

Conclusions: OL findings from this ongoing trial suggest that adjunctive treatment with LAR may reduce symptoms in FRBD patients.

TARGET AUDIENCE:

Clinical psychiatrists.

REFERENCES:

1. Schneck CD, Miklowitz DJ, Calabrese JR, et al. Phenomenology of rapid-cycling bipolar disorder: data from the first 500 participants in the Systematic Treatment Enhancement Program. *Am J Psychiatry* 2004; 161:1902–1908.
2. Vieta E, Calabrese JR, Hennen J, et al. Comparison of rapid-cycling and non-rapid-cycling bipolar I manic patients during treatment with olanzapine: analysis of pooled data. *J Clin Psychiatry* 2004; 65:1420–1428.

Poster 150

Friday, October 6
3:00 p.m.-4:30 p.m.

PHARMACOKINETICS OF EXTENDED-RELEASE GUANFACINE IN CHILDREN AND ADOLESCENTS WITH ADHD

Supported by Shire Development, Inc.

Samuel W. Boellner, M.D., *Chief Executive Officer, Department of Neurology, Clinical Study Centers, LLC, Baptist Medical Tower One, 9601 Lile Drive, Little Rock, AR 72205-6370*; Michael Pennick, B.S.C.; Amir Shojaei; Kimberly Fiske; Andrew Lyne, M.S.C.; Joseph Kerkering, M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the pharmacokinetics of single and multiple oral doses of extended-release guanfacine in children and adolescents with ADHD.

SUMMARY:

Background: Guanfacine IR, an α_2A -adrenoceptor agonist, has been used off-label as a nonstimulant therapy for ADHD, but it has a short duration of action.

Methods: Open-label, dose-escalation study in children (aged 6–12 years) and adolescents (aged 13–17 years) with ADHD. Subjects received a single 2-mg dose on day 1. On days 9–15, subjects received 2 mg/qd; on days 16–22, 3 mg/qd; and on days 23–29, 4 mg/qd.

Results: GXR pharmacokinetics were linear in children ($n=14$) and adolescents ($n=14$). AUC and C_{max} were higher in children than in adolescents. $AUC_{0-\infty}$ was 65.2 ± 23.88 h-ng/mL in children and 47.3 ± 13.69 h-ng/mL in adolescents, post-single dose, whereas C_{max} was 2.6 ± 1.03 ng/mL and 1.7 ± 0.43 ng/mL, respectively. No discontinuations occurred due to adverse events. Most frequent AEs were somnolence, insomnia, headache, and blurred vision. Most were mild to moderate in intensity, with the highest incidence associated with the 4 mg doses. Blood pressure, pulse, and ECG readings were all within normal limits.

Conclusions: Plasma concentrations and pharmacokinetic parameters of GXR were higher in children than in adolescents, probably due to the higher weight in adolescents. GXR exposure in both groups was approximately twice as high after repeated daily administration of 4 mg than after 2 mg, consistent with linear pharmacokinetics. GXR was well tolerated.

REFERENCES:

1. Olfson M. New options in the pharmacological management of attention-deficit/hyperactivity disorder. *Am J Manag Care*. 2004 Jul; 10(4 Suppl):S117–24.
2. Waxmonsky JG. Nonstimulant therapies for attention-deficit hyperactivity disorder (ADHD) in children and adults. *Essent Psychopharmacol*. 2005; 6(5):262–76.

Poster 151

Friday, October 6
3:00 p.m.-4:30 p.m.

COMBINATION THERAPY FOR ACUTE MANIA

Supported by Abbott Laboratories

Jeffrey A. Borenstein, M.D., *CEO and Medical Director, Department of Psychiatry, Holliswood Hospital, 8737 Palermo Street, Holliswood, NY 11423-1221*; Aggy J. Vallanat, M.D., *Unit Chief, Department of Psychiatry, Holliswood Hospital, 8737 Palermo Street, Holliswood, NY 11423*; Douglas F. Munsey, M.D.; Boris Khaimov

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: understand the dosage, response and tolerability of combination therapy with divalproex sodium and an atypical antipsychotic for acute mania.

SUMMARY:

In order to analyze the efficacy and tolerability of combination treatment of acute mania, we conducted a retrospective chart review of 50 consecutive patients admitted to a psychiatric hospital with a diagnosis of acute mania and treated with combination therapy of

divalproex sodium and an atypical antipsychotic. The patients (28 females, 22 males) ranged in age from 19 years old to 69 years old; mean age was 42. Of the 50 patients, 29 were psychotic at the time of admission.

The divalproex sodium dosage ranged from 750 mg/day to 2000 mg/day. Fifteen patients received olanzapine, 10 received quetiapine, 9 received ziprasidone, 8 received aripiprazole and 8 received risperidone. The combination treatment of divalproex sodium and atypical antipsychotic was both effective and well tolerated. All 50 patients responded well to treatment becoming euthymic prior to discharge. All 29 patients with psychotic symptoms were no longer psychotic. The length of stay ranged from 5 days to 33 days, with an average length of stay of 12 days.

Only two patients experienced moderate side effects (one with sedation, the other with restlessness); both patients were able to tolerate the combination therapy and respond to treatment.

TARGET AUDIENCE:

Psychiatrists, administrators, nurses, pharmacists, social workers.

REFERENCES:

1. Zarate, Jr., CA, Quiroz JA. Combination treatment in bipolar disorder; a review of controlled trials. *Bipolar Discord* 2003; 5:217–225.
2. Frye MA, Ketter TA, Leverich GS, Huggins T, Lantz C, Denicoff KD, Post RM. The increasing use of polypharmacy for refractory mood disorders: 22 years of study *Journal of Clinical Psychiatry* 2000; 61, [1] 9–15.

Poster 152

Friday, October 6
3:00 p.m.-4:30 p.m.

DURABILITY OF ANTIDEPRESSANT RESPONSE TO VAGUS NERVE STIMULATION

Supported by Cyberonics, Inc.

Stephen K. Brannan, M.D., *Medical Director, Department of Medical Affairs, Cyberonics, Inc., 100 Cyberonics Boulevard, Houston, TX 77058*; Mark T. Bunker, Pharm.D., BCPP, *Department of Medical Affairs, Cyberonics, Inc., 100 Cyberonics Boulevard, Houston, TX 77058*; Harold A. Sackeim, Ph.D.; A. John Rush, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the importance of the need for an enduring benefit for treatments of treatment-resistant depression.

SUMMARY:

Objective: Vagus nerve stimulation (VNS) has shown efficacy in treatment-resistant depression (TRD). This study characterized the durability of improvement in patients who responded early or late while receiving VNS.

Methods: In both a pilot and pivotal study, patients were identified who had at least a 50% reduction in symptom scores 3 months (early responders) or 12 months (late responders) after starting VNS. Probabilities were determined for maintenance of response at 12-month (early responders) and 24-month (early and late responders) time points. Consistency of symptomatic improvement throughout the 24-month study periods was also evaluated, testing for change in serial depression ratings. The potential confound of alternations in antidepressant treatment was examined in the pivotal trial.

Results: In the pilot study, 72.2% and 61.1% of early responders (n=18) were responders at 12 and 24 months, respectively; 78.8% of late responders (n=14) were responders at 24 months. In the pivotal trial, of early responders (n=30), 63.3% and 76.7% maintained response at 12 and 24 months, respectively; of late responders (n=40), 65.0% maintained response at 24 months. Early and late responders had fewer treatment changes than nonresponders across the entire pivotal study period. In both studies, analyses of serial depression ratings showed stable symptomatic improvement in early and late responders.

Conclusion: These patients had exceptional levels of chronicity and treatment resistance. Yet patients who showed substantial clinical benefit early or late after starting VNS maintained the improvement at remarkably high rates. This durability of benefit was not attributable to alterations in other treatments.

TARGET AUDIENCE:

Clinicians treating treatment-resistant depression.

REFERENCES:

1. George MS, Rush AJ, Marangell LB, et al: A one-year comparison of vague nerve stimulation with treatment-as-usual for treatment-resistant depression. *Biol Psychiatry* 2005; 58:364–373.
2. Sackeron HA, Haskett RF, Mulsant BH, et al: Continuation pharmacotherapy following electroconvulsive therapy: a randomized controlled trial. *JAMA* 2001; 285:1299–1307.

Poster 153

**Friday, October 6
3:00 p.m.-4:30 p.m.**

**SURVEY EVALUATION OF ABUSE
POTENTIAL OF SHORT-ACTING VERSUS
LONG-ACTING STIMULANTS IN ADHD**

Supported by Shire Pharmaceuticals, Inc.

George M. Bright, M.D., *Medical Director, Adolescent Health, 13821 Village Mill Drive, Suite B, Midlothian, VA 23114*; Bruce Delphia, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the abuse potential of stimulants used to treat ADHD and recognize the greater likelihood of abuse with short-acting versus long-acting stimulants.

SUMMARY:

Subjects receiving treatment for attention-deficit/hyperactivity disorder (ADHD) were surveyed to assess the abuse potential of commonly used short-acting and long-acting stimulant medications. This is an interim analysis of the ongoing survey intended to be distributed to nearly 1000 respondents enrolled in an ADHD treatment center. Respondents were polled about the type of stimulant medication most frequently misused or abused (short-acting or long-acting) and how the stimulant was prepared and administered (crushed and inhaled; crushed and injected; soaked overnight in water and injected or consumed orally; heated in a microwave to melt down and inject, drink, or snort). A total of 335 surveys have been returned to date. Nearly 90% of the respondents (n=301) had a diagnosis of ADHD; the remaining 10% (n=34) were diagnosed with some form of substance abuse disorder. The majority (81%) of respondents with ADHD also had some form of substance abuse disorder. Seventy-three (22%) of the respondents reported stimulant abuse—59 (81%) with short-acting stimulants and 12 (16%) with long-acting stimulants; 2 (3%) abused both. The most frequently reported method of preparation was crushing and inhalation (n=59; 81%). Short-acting stimulants were involved to a greater extent than long-acting stimulants in misuse/abuse reported by subjects. This suggests a relative benefit of long-acting agents in ensuring appropriate stimulant use and decreased stimulant misuse/diversion.

TARGET AUDIENCE:

Psychiatrists who treat ADHD.

REFERENCES:

1. Foltin RW, Fischman MW. Assessment of abuse liability of stimulant drugs in humans: a methodological survey. *Drug Alcohol Depend.* 1991; 28:3-48.

2. Kollins SH, et al. Comparison of acute behavioral effects of sustained-release and immediate-release methylphenidate. *Exp Clin Psychopharmacol.* 1998; 6:367-374.

Poster 154

**Friday, October 6
3:00 p.m.-4:30 p.m.**

**A PILOT CONTROLLED COMPARISON
TRIAL OF BUPROPION XL VERSUS
ESCITALOPRAM IN GENERALIZED
ANXIETY DISORDER**

Supported by GlaxoSmithKline

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EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to treat generalized anxiety disorder (GAD) with bupropion XL

SUMMARY:

Objective: To compare the efficacy and safety of bupropion XL (150-300 mg/day) with the SSRI escitalopram (10-20 mg/day) in outpatients diagnosed with GAD

Method: A 12-week, double blind, randomized trial was conducted in a private research facility. Participants were between the ages 18 and 64 years with confirmed DSM-IV GAD. The primary efficacy measures include the CGH and HARS. Secondary measures of resilience were obtained by self-reports on the SES. Response to treatment was defined as a reduction of 35% or more on the HARS and symptom remission was defined as a CGI Score of 1 or 2 and a score of ≤ 8 on the HARS.

Results: Bupropion XL demonstrated comparable anxiolytic efficacy to escitalopram in outpatients with GAD. Bupropion XL demonstrated resilience enhancing effects as indicated by significantly improved scores on the SES. Both treatments were well tolerated.

Conclusions: Findings from this pilot project suggest bupropion XL may be useful in treating GAD.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. Ascher JA: Bupropion XL: A review of its mechanism of antidepressant activity. *J Clinical Psychiatry* 1995; 56:395-401.

2. Emmanuel NP, Lydiard RP, Balienger JC: Treatment of social phobia with Bupropion XL. *Journal of Clinical Psychopharmacol* 1991; 11:276-7.

trol versus placebo and were generally well tolerated in school-aged children with ADHD.

Poster 155

**Friday, October 6
3:00 p.m.-4:30 p.m.**

ADHD SYMPTOM IMPROVEMENT IN CHILDREN WITH LISDEXAMFETAMINE AND MAS XR VERSUS PLACEBO

Supported by New River Pharmaceuticals and Shire Development, Inc.

Ann C. Childress, M.D., *Chair, Department of Psychiatry, Center for Psychiatry and Behavioral Medicine, 7351 Prairie Falcon Road, Suite 160, Las Vegas, NV 89128*; Joseph Biederman, M.D.; Samuel W. Boellner, M.D.; Frank A. Lopez, M.D.; Suma Krishnan, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to determine whether LDX improves ADHD symptoms in school-aged children compared with MAS XR and placebo.

SUMMARY:

Background: LDX is a pharmacologically inactive prodrug in which *d*-amphetamine is bonded to *l*-lysine. Pharmacologically active *d*-amphetamine is gradually released only after metabolism of the prodrug. LDX was designed to have comparable efficacy and tolerability to available once-daily stimulants, with reduced potential for abuse.

Methods: Phase 2, multicenter study conducted in an analog classroom environment, comparing LDX (30 mg, 50 mg, or 70 mg) and MAS XR (10 mg, 20 mg, or 30 mg) with placebo, in children (6-12 years) with ADHD who had been treated with a stimulant for 1 month within the past 6 months. Efficacy measures included the SKAMP and PERMP.

Results: LS mean SKAMP-deportment scores significantly improved with LDX (0.8) and MAS XR (0.8) vs placebo (1.7) ($P < .0001$, for both). Significant improvement in LS mean PERMP-attempted (LDX, 133.3; MAS XR, 133.6; placebo, 88.2 [$P < .0001$, for both]) and PERMP-correct scores (LDX, 129.6; MAS XR, 129.4; placebo, 84.1 [$P < .0001$, for both]) was also seen with both active treatments vs placebo. AEs were mild to moderate and comparable between active treatment groups. The most common AEs for LDX were insomnia, decreased appetite, and anorexia; for MAS XR, they were decreased appetite, upper abdominal pain, insomnia, and vomiting.

Conclusions: LDX and MAS XR resulted in comparable, significant improvements in ADHD symptom con-

REFERENCES:

1. Biederman J, Wigal SB, Spencer TJ, McGough JJ, Mays DA. *Clin Ther*. 2006 Feb; 28(2):280-293.
2. Wigal SB, McGough JJ, McCracken JT, Biederman J, Spencer TJ, Posner KL, Wigal TL, Kollins SH, Clark TM, Mays DA, Zhang Y, Tulloch SJ. *J Atten Disord*. 2005 Aug; 9(1):275-289.

Poster 156

**Friday, October 6
3:00 p.m.-4:30 p.m.**

EFFICACY AND SAFETY OF LISDEXAMFETAMINE IN CHILDREN WITH ADHD

Supported by New River Pharmaceuticals and Shire Development, Inc.

Ann C. Childress, M.D., *Chair, Department of Psychiatry, Center for Psychiatry and Behavioral Medicine, 7351 Prairie Falcon Road, Suite 160, Las Vegas, NV 89128*; Joseph Biederman, M.D.; Samuel W. Boellner, M.D.; Frank A. Lopez, M.D.; Suma Krishnan, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the efficacy and safety of LDX compared with placebo in school-aged children (6-12 years of age) with ADHD.

SUMMARY:

Background: LDX is a pharmacologically inactive prodrug in which *d*-amphetamine is bonded to *l*-lysine. Pharmacologically active *d*-amphetamine is gradually released only after metabolism of the prodrug. LDX was designed to have comparable efficacy and tolerability to available once-daily, stimulants with reduced potential for abuse.

Methods: Phase 3, randomized, multicenter, double-blind, forced-titration, parallel-group study of children (6-12 yrs) with ADHD. Subjects underwent a one-week washout and were randomized in a 1:1:1:1 ratio to a single daily dose of LDX (30 mg, 50 mg, or 70 mg) or placebo. The primary efficacy measure was the ADHD-RS. Safety parameters assessed were vital signs, laboratory tests, ECG, and adverse events.

Results: At study end, the ADHD-RS changes from baseline were -6.2, -21.8, -23.4, and -26.7 for placebo, LDX 30 mg, 50 mg, and 70 mg, respectively. Significant improvements in ADHD symptoms were seen with all doses of LDX compared with placebo ($P < 0.0001$). Significant differences for all doses of LDX vs placebo were observed as early as week 1 ($P < 0.0001$ for all

comparisons). Most AEs were mild to moderate and occurred in the first week. The most common AEs were decreased appetite, insomnia, headache, and upper abdominal pain.

Conclusions: In children (6–12 yrs) with ADHD, short-term treatment with LDX significantly improved ADHD symptoms and was generally well tolerated.

REFERENCES:

1. Biederman J, Wigal SB, Spencer TJ, McGough JJ, Mays DA. *Clin Ther.* 2006 Feb; 28(2):280–93.
2. Wigal SB, McGough JJ, McCracken JT, Biederman J, Spencer TJ, Posner KL, Wigal TL, Kollins SH, Clark TM, Mays DA, Zhang Y, Tulloch SJ. *J Atten Disord.* 2005 Aug; 9(1):275–89.

Poster 157

**Friday, October 6
3:00 p.m.-4:30 p.m.**

VALPROATE IN CHILD/ADOLESCENT BIPOLAR DISORDER: COMPREHENSIVE META-ANALYSIS

Supported by Abbott Laboratories

Lee S. Cohen, M.D., *Assistant Clinical Professor of Psychiatry, Columbia University, 623 Warburton Avenue, 2nd Floor, Hastings, NY 10706*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to summarize current results of the psychopharmacology of pediatric bipolar disorder that utilize structured interviews; and review efficacy data and response rates to valproic acid in this population.

SUMMARY:

Objective: To assess valproate efficacy on validated scales in children with bipolar disorder via a review and meta-analysis of the literature. *Method:* PubMed searches conducted in June 2003, September 2005, and May 2006, identified 101 reports of valproate use in patients aged ≤ 18 years with bipolar disorder. Nineteen viable studies were analyzed, based on inclusion criteria of utilizing a structured interview scale and therapeutic valproate level. No reports including patients with comorbid seizure disorder were identified. *Results:* Nineteen published reports included 380 patients ≤ 18 years with bipolar disorder treated with valproate, alone or in combination. The mean serum valproate level across studies was $84.40 \text{ mcg/mL} \pm 10.37$. Overall, 278 (73%) patients achieved $> 30\%$ improvement on evaluation scales (including Young Mania Rating Scale [YMRS], Mania Rating Scale [MRS], Modified Mania Rating Scale [MMRS], Clinical Global Impression [CGI], and Overt Aggression Scale [OAS]). In trials that defined response

as $> 50\%$ improvement on YMRS, MRS, or MMRS or remission (YMRS score ≤ 12), 112 of 174 (64%) patients responded. *Conclusion:* Based on potential benefits of valproate in children and adolescents with bipolar disorder without comorbid epilepsy demonstrated in this meta-analysis, further investigation of valproate in this setting is warranted.

TARGET AUDIENCE:

Psychiatrists and other health care professionals treating children and adolescents with bipolar and mood disorders or mania.

REFERENCES:

1. DelBello MP, Kowatch RA, Adler CM, et al: A double-blind randomized pilot study comparing quetiapine and divalproex for adolescent mania. *J Am Acad Child Adolesc Psychiatry* 45:305–313, 2006.
2. Scheffer RE, Kowatch RA, Carmody T, Rush AJ: Randomized, placebo-controlled trial of mixed amphetamine salts for symptoms of comorbid ADHD in pediatric bipolar after mood stabilization with divalproex sodium. *Am J Psychiatry* 162:58–64, 2005.

Poster 158

**Friday, October 6
3:00 p.m.-4:30 p.m.**

METABOLIC EFFECTS OF DIVALPROEX SODIUM EXTENDED-RELEASE IN ACUTE MANIA

Supported by Abbott Laboratories

Amy C. Kendall, Pharm.D., *Research Scientist, Neuroscience, Abbott Laboratories, 100 Abbott Park Road, Abbott Park, IL 60064*; Michelle A. Collins, Ph.D., *Research Scientist, Neuroscience, Abbott Laboratories, 100 Abbott Park Road, Abbott Park, IL 60064*; Alan C. Swann, M.D.; Charles L. Bowden, M.D.; Joseph R. Calabrese, M.D.; Patricia J. Wozniak, Ph.D.; Mario Saltarelli, M.D., Ph.D.; Walid Abi-Saab, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to examine the metabolic effects of divalproex extended-release (ER) in a three-week trial of bipolar I disorder, manic or mixed type.

SUMMARY:

A 21-day, randomized, placebo-controlled, parallel-group study was conducted in adult patients with bipolar I disorder. Divalproex ER dosing was initiated at 25 mg/kg/day QD, and adjusted to a target serum valproate level of 85–125 mcg/mL. Metabolic assessments (e.g. weight, glucose, and cholesterol) were included as standard safety measures during the study. Post-hoc analyses

examined the metabolic changes associated with divalproex ER in the total study population, and in various sub-populations. Analyses included 377 subjects (192 divalproex ER; 185 placebo). Divalproex ER produced significant reductions in total cholesterol, LDL and HDL cholesterol compared to placebo in the total study population, with no significant change in LDL/HDL ratio. Treatment with divalproex ER was associated with significant weight gain compared to placebo ($p < 0.05$), but was not associated with any significant changes in glucose. Although divalproex ER is associated with weight gain, it is not associated with other negative metabolic changes such as increased glucose and cholesterol.

TARGET AUDIENCE:

Clinicians managing patients with bipolar disorder.

REFERENCES:

1. Nikolaos T, et al. The effect of long-term antiepileptic treatment on serum cholesterol (TC, HDL, LDL) and triglyceride levels in adult epileptic patients on monotherapy. *Med Sci Monit.* 2004; 10(4): MT50–2.
2. Stoner SC, Dubisar BM, Lea JW, Marken PA, Ram-latchman LV, Reynolds JB. Extended-release divalproex sodium for mood stabilization. *Pharmacotherapy.* 2004; 24(9):1147–53.

Poster 159

**Friday, October 6
3:00 p.m.-4:30 p.m.**

DIVALPROEX SODIUM EXTENDED-RELEASE VERSUS PLACEBO IN THE TREATMENT OF ACUTE MANIA

Supported by Abbott Laboratories

Michelle A. Collins, Ph.D., *Research Scientist, Neuroscience, Abbott Laboratories, 100 Abbott Park Road, Abbott Park, IL 60064*; Amy C. Kendall, Pharm.D., *Research Scientist, Neuroscience, Abbott Laboratories, 100 Abbott Park Road, Abbott Park, IL 60064*; Charles L. Bowden, M.D.; Joseph R. Calabrese, M.D.; Alan C. Swann, M.D.; Patricia J. Wozniak, Ph.D.; Walid Abi-Saab, M.D.; Mario Saltarelli, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the safety and efficacy of divalproex extended-release (ER) for the treatment of adult bipolar I disorder, manic or mixed type.

SUMMARY:

A 21-day, randomized, placebo-controlled, parallel-group study was conducted in adult patients hospitalized for acute mania associated with bipolar I disorder. Dival-

proex ER dosing was initiated at 25 mg/kg/day QD, increased by 500 mg on Day 3, and adjusted to a target serum valproate level of 85–125 mcg/mL. Efficacy assessments included the Mania Rating Scale (MRS; primary endpoint), and percentage of patients meeting criteria for response ($\geq 50\%$ improvement on the MRS). Intent-to-treat efficacy analyses included 364 patients (187 divalproex ER; 177 placebo). The mean final dose of divalproex ER was 3097 mg with a mean final serum valproate level of 95.7 mcg/mL. Divalproex ER produced superior improvements vs. placebo on the MRS, and more divalproex ER patients met responder criteria versus placebo (all $p < 0.05$). More adverse events were reported and more premature discontinuations occurred in the divalproex ER group vs. placebo. Adverse events reported by $>15\%$ of patients treated with divalproex ER were: diarrhea, dizziness, dyspepsia, headache, nausea, somnolence, and vomiting. Divalproex ER is a safe and effective treatment for bipolar I disorder, manic or mixed type.

TARGET AUDIENCE:

Clinicians managing patients with bipolar disorder.

REFERENCES:

1. Bowden CL, Brugger AM, Swann AC, Calabrese JR, Janicak PG, Petty F, Dilsaver SC, David JM, Rush AJ, Small JG, Garza-Trevino ES, Risch SC, Goodnick PJ, Morris DD. Efficacy of divalproex vs. lithium and placebo in the treatment of mania. *JAMA* 1994; 271:918–924.
2. Pope HG, McElroy SL, Keck PE. Valproate in the treatment of acute mania: a placebo-controlled study. *Arch. Gen. Psychiatry* 1991; 48:62–68.

Poster 160

**Friday, October 6
3:00 p.m.-4:30 p.m.**

PHARMACOKINETICS OF LISDEXAMFETAMINE AFTER SINGLE INTRANASAL, INTRAVENOUS, OR ORAL DOSES IN RATS

Supported by New River Pharmaceuticals and Shire Development, Inc.

Stacey Curtiss, Pharm.D., *Medical Science Liaison, Shire Development, Inc., 725 Chesterbrook Boulevard, Wayne, PA 19087*; Lee Boyle, Ph.D.; Scott Moncrief, Ph.D.; Suma Krishnan, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to assess pharmacokinetics and bioavailability of equimolar amounts of *d*-amphetamine from LDX versus *d*-amphetamine sulfate following adminis-

tration of single intranasal, intravenous, or oral doses in rats.

SUMMARY:

Background: LDX is a pharmacologically inactive prodrug in which *d*-amphetamine is bonded to *l*-lysine. Pharmacologically active *d*-amphetamine is gradually released only after metabolism of the prodrug. LDX was designed to have comparable efficacy and tolerability to available once-daily, stimulants with reduced potential for abuse.

Methods: Single intranasal (IN), intravenous (IV), and oral (PO) LDX or *d*-amphetamine sulfate doses were administered to groups of 4 male Sprague-Dawley rats. Plasma samples were collected at predefined times postdose.

Results: AUC_{last} for *d*-amphetamine was 95% less, C_{max} 96% less, and T_{max} ~12 times longer with IN doses of LDX compared with *d*-amphetamine sulfate. With IV LDX compared with *d*-amphetamine sulfate, *d*-amphetamine AUC_{inf} was ~50% less, C_{max} 75% less, and T_{max}, ~6 times longer. When LDX and *d*-amphetamine sulfate are given PO, differences between *d*-amphetamine PK were modest near therapeutic doses but substantial at higher doses. For LDX (compared with *d*-amphetamine sulfate), AUC_{inf} was 40%–76% less at higher doses, C_{max} was ~50% less at therapeutic doses but 73%–84% less at higher doses, and T_{max} was 0–12 times longer at therapeutic doses but 5–20 times longer at higher doses. Bioavailability of *d*-amphetamine from LDX or *d*-amphetamine sulfate was similar with PO doses within the HED range, however, bioavailability for *d*-amphetamine from LDX decreased relative to *d*-amphetamine sulfate as doses increased.

Conclusions: IN or IV LDX (vs IN or IV *d*-amphetamine sulfate) substantially decreased and delayed bioavailability of *d*-amphetamine. At therapeutic HEDs, PO-administered LDX and *d*-amphetamine sulfate led to almost equal bioavailability of *d*-amphetamine, but at higher doses bioavailability of *d*-amphetamine decreased for LDX relative to *d*-amphetamine sulfate. These results suggest that LDX may be an effective, long-lasting stimulant with reduced abuse potential.

REFERENCES:

1. Clausen SB, Read SC, Tulloch SJ. Single- and multiple-dose pharmacokinetics of an oral mixed amphetamine salts extended-release formulation in adults. *CNS Spectr*. 2005 Dec; 10(12 Suppl 20):6–15.
2. Melega WP, Williams AE, Schmitz DA, DiStefano EW, Cho AK. Pharmacokinetic and pharmacodynamic analysis of the actions of *D*-amphetamine and *D*-methamphetamine on the dopamine terminal. *J Pharmacol Exp Ther*. 1995 Jul; 274(1):90–6.

Poster 161

Friday, October 6
3:00 p.m.-4:30 p.m.

SERTRALINE'S SIDE EFFECT BURDEN IS SIGNIFICANTLY LOWER THAN OTHER SSRI/SSNRI'S

Daniel A. Deutschman, M.D., *Medical Director, Southwest General Health Center; and Assistant Clinical Professor of Psychiatry, Case Western Reserve University, 18051 Jefferson Park Drive, Suite 106, Middleburg Heights, OH 44130; Douglas H. Deutschman, Ph.D., Associate Professor of Biology, San Diego State University, 5626 Baja Drive, San Diego, CA 92115*

EDUCATIONAL OBJECTIVES:

At the end of the poster presentation, the participant should be able to demonstrate an understanding of the impact of SSRI/SSNRI side effect burden, SEB, on patient adherence; evaluate the impact of non adherence on the long-term course of affective and anxiety spectrum disorders; recognize the three side effects that have the greatest impact on patient adherence, sexual side effects, weight gain, and sedation; understand the rank order of SSRI/SSNRI agents in regards to these effects; and demonstrate the concept of choosing an SSRI/SSNRI on the basis of its side effect profile to facilitate patient adherence, and enhance patient clinical outcomes.

SUMMARY:

Background: Side effect burden, SEB, dramatically effects patient adherence. Non adherence can adversely effect the course of affective and anxiety spectrum disorders. Significant SEB differences could guide physicians in choosing an antidepressant thereby improving patient outcomes.

Hypothesis: Can important differences in SEB be demonstrated between SSRI/SSNRI antidepressants?

Method: Electronic medical records (Behavior2006) of all patients (14,365) seen in a private inpatient/outpatient practice between 1998 and 2005 were screened for treatment with an SSRI/SSNRI, 7,807 had been on an SSRI/SSNRI; 3,646 of these had two or more visits. Demographics, dose, duration and SEB of the latter were assessed.

Results: Patient cohorts ranged from 624 for escitalopram to 1,226 for sertraline; ages from 3 to 100 years; 98% were Caucasian; 61% female; doses ranged from a fraction of the usual starting dose to as much as 100% of the FDA recommended upper level dose for a minority of patients; 52% on the agent for >1 year. SEB (in order from most to least).

Sexual function - citalopram, paroxetine, venlafaxine, escitalopram, fluoxetine, and sertraline; weight gain - paroxetine, citalopram, venlafaxine, escitalopram, flu-

oxetine and sertraline; sedation - citalopram, escitalopram, paroxetine, venlafaxine, fluoxetine and sertraline.

Discussion: This was an open label, naturalistic, retrospective chart review. These data suggest that meaningful differences do exist in the SEB among SSRI/SSNRI. These data are predicted by Richelson's elucidation of the unique receptor profiles of each SSRI/SSNRI. These data could help guide physician decision making and contribute to patient long-term outcomes.

Conclusion: There are demonstrable differences among the SSRI/SSNRI's in regards to their SEB. Sertraline was least burdensome (followed by fluoxetine) while citalopram and paroxetine were most burdensome. These data are preliminary. Further work on this subject is needed.

TARGET AUDIENCE:

Practicing cLinicians.

REFERENCES:

1. Richelson E, 2003. Interactions of Antidepressants with Neurotransmitter Transporters and Receptors and their Clinical Significance. *J. Clinical Psychiatry* 66 [Suppl 13] 5-12.
2. Deutschman DA, 2005. Are there Differences in Side Effect Burden Among the SSRI/SSNRI's. *USPysch Congress November 9, 2005 Las Vegas, NV. Poster Presentation.*

Poster 162

**Friday, October 6
3:00 p.m.-4:30 p.m.**

GEODON FOR MAJOR DEPRESSION, PSYCHOTIC/NON-PSYCHOTIC: SAFE AND EFFECTIVE AS AUGMENTATION OR MONOTHERAPY

Douglas H. Deutschman, Ph.D., *Associate Professor of Biology, San Diego State University, 5626 Baja Drive, San Diego, CA 92115*; Daniel A. Deutschman, M.D., *Medical Director, Southwest General Health Center; and Assistant Clinical Professor of Psychiatry, Case Western Reserve University, 18051 Jefferson Park Drive, Suite 106, Middleburg Heights, OH 44130*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to determine whether or not Geodon should be used to treat psychotic and non-psychotic major depression.

SUMMARY:

Introduction: Staht's receptor data on atypical anti-psychotics shows serotonin, norepinephrine and dopamine reuptake blockade for Geodon. We analyzed our

data on Geodon in Major Depression with and without psychosis, with (augmentation) and without (monotherapy) an accompanying antidepressant for signs of antidepressant efficacy.

Method: Major Depression psychotic (68) and non psychotic (75) patients from 2001 to 2005 were reviewed with an electronic medical record (Behavior2005). In each group those on an ant depressant "augmentation", 65 and 62 respectively and those on no antidepressant "monotherapy", 3 and 13 respectively were identified.

Results: Demographics were similar in all groups: ages 8 to 84 years, 93% Caucasian, 57% female. Average length of follow-up was 140 days psychotic, 85 days non psychotic; average daily doses were 154 mg/d psychotic, 114 mg/d non psychotic. In the monotherapy groups two adverse events were seen in the psychotic group of 3 patients (sedation 1, akathisia 1); no adverse events were seen in the non psychotic group (n = 13). All groups, including the monotherapy (no antidepressant) groups improved significantly with p values in the 0.005 to 0.001 range.

Discussion: Stahl's receptor data on Geodon may have clinical significance. Clinical improvement was impressive with the augmentation groups as well as the small monotherapy groups, 3 and 13. Geodon acting as an "antidepressant" (without weight gain or sexual side effects) would be a welcome addition to our pharmacologic armamentarium.

Conclusion: Geodon appears to offer antidepressant efficacy and safety for both psychotic and non psychotic major depression; however, more study is needed.

REFERENCES:

1. Stahl SM and Shayegan DK. 2003. The psychopharmacology of ziprasidone: Receptor-binding properties and real-world psychiatric practice. *J Clin Psych* 64: 6-12 Suppl. 19, 2003.
2. Deutschman DH. 2005. Geodon (Ziprasidone) for Major Depression (psychotic/nonpsychotic): Safe and Effective as Augmentation or Monotherapy. *US-Psych Cong., Nov. 9, 2005. Poster.*

Poster 163

**Friday, October 6
3:00 p.m.-4:30 p.m.**

CHILDHOOD SEXUAL ABUSE DISCLOSURE BY WOMEN IN THE POSTPARTUM PERIOD

Shailla Misri, M.D., *Clinical Professor of Psychiatry, University of British Columbia, 1081 Burrard Street, Room 28-185, Vancouver, British Columbia, Canada V6Z 1Y6*; Lianne Tomfohr, B.A.; Kristin Kendrick, B.A.; Jules Smith, M.A.; Lisa Milis, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will have a raised awareness of the childhood sexual abuse (CSA) disclosure rates in a postpartum population; and understand how CSA impacts the treatment of postpartum depression.

SUMMARY:

Objective: To raise awareness about reporting of the childhood sexual abuse (CSA) by women with diagnosis of Major Depressive Disorder, Postpartum Onset (PPD); implications for treating physicians is discussed.

Methods: The occurrence of PPD with/without comorbid anxiety disorders was assessed in patients referred to the Reproductive Mental Health Program. Information was gathered about the frequency of CSA disclosure during the diagnostic interview by conducting a retrospective chart review.

Results: Of 354 patients referred, 50 patients (14%) reported a history of CSA during their initial assessment. Further breakdown of "postpartum diagnosis" among these 50 women revealed that 32% had a single Axis I diagnosis of PPD, 44% had PPD, plus additional Axis I diagnosis of Panic Disorder and/or Obsessive Compulsive Disorder, and 24% had PPD plus Posttraumatic Stress Disorder.

Conclusions: The number of women in our sample who reported sexual abuse was found to be below the estimated prevalence rate (20–25%) in the community and significantly lower than the rates found in other psychiatric populations (46–70%). Reluctance to expose the distressing issue of CSA has significant diagnostic, prognostic and treatment implications which will be explored.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. Benedict MI, Paine, LL. Paine LA, Brandt D, Stallings R. The association of childhood sexual abuse with depressive symptoms during pregnancy, and selected pregnancy outcomes. *Child Abuse Negl* 1999; 23(7):659–70.
2. Buist A, Janson H. Childhood sexual abuse, parenting and postpartum depression: a 3-year follow-up study. *Child Abuse Negl* 2001; 25(7):909–21.

Poster 164

**Friday, October 6
3:00 p.m.-4:30 p.m.**

ESCITALOPRAM SIGNIFICANTLY IMPROVES CORE SYMPTOMS OF DEPRESSION

Supported by Forest Laboratories, Inc.

Chetan Gandhi, Ph.D., *Senior Scientist, Medical Affairs, Forest Laboratories, Inc., Harborside Financial Center,*

Jersey City, NJ 07311; William J. Burke, M.D., Professor and Vice Chair, Department of Psychiatry, University of Nebraska, P.O. Box 985580, Omaha, NE 68198-0001; Anjana Bose, Ph.D.; Saikali Khalil, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand escitalopram's effect on the core symptoms of depression.

SUMMARY:

Introduction: Depressed mood and melancholic features are recognized as core symptoms of depression. Escitalopram is the most selective serotonin reuptake inhibitor (SSRI) indicated for major depressive disorder or generalized anxiety disorder.

Methods: Four 8-week, randomized, double-blind, placebo-controlled trials of escitalopram 10-20 mg/day in adults have prospectively assessed the HAMD, HAMD depressed mood item, and the 6-item HAMD melancholia subscale (depressed mood, guilt, work and activities, retardation, psychic anxiety, and general somatic symptoms) as protocol-defined secondary endpoints. Male or female outpatients had moderate-to-severe DSM-IV-defined major depressive disorder (baseline MADRS \geq 22 for three trials, baseline 24-item HAMD \geq 25 for the fourth trial).

Results: Three of the four trials demonstrated separation of escitalopram from placebo at week 8 in the primary efficacy measure of MADRS total score; in the fourth trial, both escitalopram and the active control failed to separate from placebo. In all 4 trials, escitalopram was significantly superior to placebo in change from baseline at week 8 for both HAMD depressed mood and HAMD melancholia subscale (OC; for LOCF, this occurred in three of the trials). When all 4 trials were pooled, each component item of the HAMD melancholia subscale was significantly improved by escitalopram versus placebo ($p < 0.05$), and the LSMD [95%CI] at week 8 (LOCF) for the HAMD melancholia subscale for escitalopram (N=639) versus placebo (N=527) was -1.37 [-1.84, -0.89].

Conclusion: Escitalopram has a consistent effect on the core symptoms of depression.

TARGET AUDIENCE:

Psychiatrists, and clinicians.

REFERENCES:

1. Bech P, Allerup P, Gram LF, et al. The Hamilton depression scale: evaluation of objectivity using logistic models. *Acta Psychiatr Scand*. 1981; 63:290–299.
2. Nelson JC, Charney DS. The symptoms of major depressive illness. *Am J Psychiatry*. 1981; 138:1–13.

Poster 165

Friday, October 6
3:00 p.m.-4:30 p.m.

RISPERIDONE TREATMENT OF RESISTANT DEPRESSION: A DOUBLE-BLIND, RANDOMIZED TRIAL

Supported by Janssen Pharmaceutica, Inc.

Georges M. Gharabawi, M.D., *Group Director, Central Nervous System Outcomes Research, Medical Affairs Department, Janssen Pharmaceutica Products, L.P., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Carla M. Canuso, M.D., *Associate Director, Central Nervous System Clinical Development, Janssen Pharmaceutica Products, L.P., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Gahan J. Pandina, Ph.D.; Cynthia A. Bossie, Ph.D.; Mary J. Kujawa, M.D., Ph.D.; Colette Kosik-Gonzalez, M.A.; Ibrahim Turkoz, M.S.; Ramy Mahmoud, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the efficacy of risperidone added to standard antidepressants in patients with resistant major depressive disorder.

SUMMARY:

Background: Many patients with major depressive disorder (MDD) are suboptimally responsive to antidepressants. Few treatments are effective for such patients.

Methods: Patients with persistent symptoms of MDD after 8 weeks' adequate treatment with antidepressants were randomized to the addition of risperidone or placebo for 6 weeks. The primary efficacy endpoint was change in HAM-D-17 at week-4 endpoint.

Results: 463 patients met criteria for nonresponse to antidepressants; 141 were randomized to adjunctive risperidone and 133 to adjunctive placebo. Mean modal dose of risperidone was 0.89±0.2 mg/day at week-4 endpoint (1.12±0.46 mg/day at week-6 endpoint). HAM-D-17 scores were reduced from 24.2±4.7 with risperidone and 24.6±5.4 with placebo to 15.6±7.0 and 17.5±7.0, respectively, at week-4 endpoint (p<0.03); and to 14.1±7.4 and 16.7±7.5 at week-6 endpoint (p<0.01). Significantly greater improvements at week-6 endpoint were noted with risperidone on the patient-rated Sheehan Disability Scale (p<0.001) and Patient Global Improvement Scale (p<0.05). Adverse events reported in 15% of risperidone or placebo patients were dry mouth (5% and 1%), headache (9% and 15%), and somnolence (5% and 2%). No extrapyramidal adverse events were reported.

Conclusions: Risperidone was effective in reducing symptoms for patients with MDD who are suboptimally responsive to standard antidepressants.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. Keller MB. Issues in treatment-resistant depression. *J Clin Psychiatry* 2005; 66 Suppl 8:5-12.
2. Kennedy SH, Lam RW. Enhancing outcomes in the management of treatment resistant depression: a focus on atypical antipsychotics. *Bipolar Disord.* 2003; 5 Suppl 2:36-47.

Poster 166

Friday, October 6
3:00 p.m.-4:30 p.m.

SAFETY AND EFFICACY OF LAMOTRIGINE FOR ADULT BIPOLAR DISORDER PATIENTS GREATER THAN 55 YEARS OLD

Supported by GlaxoSmithKline

Lawrence D. Ginsberg, M.D., *President and Chief Executive Officer, Red Oak Psychiatry Associates, 17115 Red Oak Drive, Suite 109, Houston, TX 77090-2607*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand patient response and tolerability to lamotrigine treatment.

SUMMARY:

Objective: Lamotrigine is effective in the maintenance treatment of bipolar disorder in adults.¹ This study assessed the effectiveness and safety of lamotrigine in adults greater than 55 years of age.

Method: A chart review of 49 outpatients older than 55 years of age with DSM-IV bipolar disorder and treated with lamotrigine was conducted (77% female; 55% bipolar I, 31% bipolar II, and 14% bipolar NOS). Charts of subjects who received lamotrigine in a private practice setting between October, 1998 and May, 2004 were reviewed. The final mean lamotrigine dose was 109.2 ± 90.1 mg/d. Treatment response was assessed with the Clinical Global Impression-Improvement (CGI-I) scale (1 = very much improved; 2 = much improved; 3 = minimally improved). Relapse was defined as a mood change that occurs 4 weeks after initiation of medication or the return of symptoms from the original episode.²

Results: Thirty-two subjects (65%) taking lamotrigine were very much improved, much improved, and minimally improved (CGI-I score: 1, 14%; 2, 35%; 3, 16%), which reflects slightly lower efficacy than in the overall adult population.² Nineteen subjects (39%) relapsed and rates were relatively similar among bipolar disorder subtypes. Rates of the most frequently reported side effects,

which were non-serious-rash (20%) and insomnia (6%), were higher than those observed in the overall adult patient population²

Conclusion: Lamotrigine appears effective in the treatment of bipolar disorder in adult patients older than 55 years of age, though this subpopulation did not respond as well as the overall adult population.² Those older than 55 years of age tolerated lamotrigine relatively well. These data are encouraging for the use of lamotrigine in patients with bipolar disorder who are older than 55 years of age, thus larger scale studies should be undertaken to further investigate these results.

TARGET AUDIENCE:

Psychiatrists treating elderly bipolar disorder patients.

REFERENCES:

1. Calabrese JR, Bowden CL, Sachs GS, Ascher JA, Monaghan E, Rudd GD. A double-blind placebo-controlled study of lamotrigine monotherapy in outpatients with bipolar I depression. Lamictal 602 Study Group. *J Clin Psychiatry*. 1999; 60:79–88.
2. Ginsberg LD, Safety and efficacy of lamotrigine for adult bipolar disorder patients. APA Poster Presentation, 2005.

Poster 167

Friday, October 6
3:00 p.m.-4:30 p.m.

EFFECTIVENESS OF QUETIAPINE IN A CLINICAL SETTING

Supported by AstraZeneca Pharmaceuticals

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EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that quetiapine appears effective in bipolar disorder patients in a clinical setting, with a moderate discontinuation rate and commonly not requiring subsequent additional pharmacotherapy.

SUMMARY:

Objective: Assess quetiapine effectiveness in bipolar disorder (BD).

Method: Quetiapine was administered to outpatients assessed with the STEP-BD Affective Disorders Evalu-

tion, and followed with the STEP-BD Clinical Monitoring Form.

Results: 96 BD (36 type I, 50 type II, 9 NOS, 1 Schizoaffective Bipolar Type) patients (age 42.3 ± 13.8 , 67% female) had 99 quetiapine trials. Patients were taking 2.6 ± 1.6 other psychotropic and 0.9 ± 1.4 non-psychotropic medications and received quetiapine 374 ± 357 days (final dose 197 ± 274 mg/day). 39% trials had quetiapine discontinued; 19% for CNS adverse effects (primarily sedation), 9% for inefficacy, 6% for nonadherence, 1% for nausea/vomiting, and 4% for other reasons. 36% trials required subsequent additional pharmacotherapy (at 106 ± 122 days); 23% for depression; 7% for mood elevation, 5% for anxiety/insomnia, and 1% for weight control. Thus, in 38% trials quetiapine was continued (duration 313 ± 335 days) with no subsequent psychotropic added, in 22% trials quetiapine was continued (duration 613 ± 403 days) but had subsequent psychotropic added (at 113 ± 143 days), and in 39% trials, quetiapine was discontinued (at 299 ± 295 days).

Conclusion: Quetiapine had a moderate (39%) discontinuation rate and patients commonly did not require subsequent additional pharmacotherapy, suggesting effectiveness in a clinical setting. This research was conducted with support from the Investigator-Sponsored Study Program of AstraZeneca.

TARGET AUDIENCE:

Clinicians treating patients with bipolar disorder.

REFERENCES:

1. Bowden CL, et al.: A randomized, double-blind, placebo-controlled efficacy and safety study of quetiapine or lithium as monotherapy for mania in bipolar disorder. *J Clin Psychiatry* 2005; 66(1):111–121.
2. Calabrese JR, et al.: A randomized, double-blind, placebo-controlled trial of quetiapine in the treatment of bipolar I or II depression. *Am J Psychiatry* 2005; 162(7):1351–60.

Poster 168

Friday, October 6
3:00 p.m.-4:30 p.m.

DIFFERENTIAL WEIGHT GAIN ON DIVALPROEX DELAYED-RELEASE AND DIVALPROEX EXTENDED-RELEASE

Supported by Abbott Laboratories

Robert L. Horne, M.D., *Clinical Associate Professor, Department of Psychiatry, University of Nevada School of Medicine, Lake Mead Hospital, 2915 West Charleston Boulevard, Suite 4, Las Vegas, NV 89102*; Cedric Cunan, B.S.; Deborah A. Martz, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the differential effects of Divalproex DR and Divalproex ER on weight changes during long-term treatment.

SUMMARY:

Introduction: Of 55 consecutive psychiatric patients who gave informed consent to switch from Divalproex DR to an equal dose of Divalproex ER, 37 had been on Divalproex DR for at least one month. A previous paper reported on the change in blood levels, adverse events, and psychiatric symptoms as a result of the switch. Placebo control trials of Divalproex DR and Divalproex ER had shown a lower prevalence of weight gain with Divalproex ER, but these were not head to head trials.

Method: In this study 37 patients were followed after the switch for as long as they had been on Divalproex DR prior to the switch, to compare weight change in the same patients on both medications. Results: The 37 patients had been on Divalproex DR for an average of 377 days prior to the switch (median = 328). Their mean weight at baseline was 183.4 lbs, BMI = 28.1. At the switch the mean weight was 190.1, (BMI = 29.2), up 6.7 lbs. At follow-up, an average of 383 days after the switch (median = 344), their weight was 188.1 lbs. a change of -2.0 lbs. The difference between Divalproex DR and ER is significant. (paired $t = .0056$) 34 patients were on 1-3 concomitant medications. Only 10 of these patients had a change of concomitant medications during the study period. When these ten patients are excluded, there was no significant change in the results. (paired $t = .0053$)

Conclusion: Divalproex ER is preferable to Divalproex DR with regard to weight change over a one year period.

TARGET AUDIENCE:

Interdisciplinary psychiatric clinicians.

REFERENCES:

1. Horns RL, Cunanan C. Safety and Efficacy of Switching Psychiatric Patients from a Delayed-Release to an Extended-Release Formulation of Divalproex Sodium. *J Clin Psychopharmacol.* 2003; 23(2):176-81.
2. Smith MC, Centorrino F, Welge JA, Collins MA. Clinical Comparison of Extended-Release Divalproex versus Delayed-Release Divalproex: Pooled Data Analyses from Nine Trials. *Epilepsy & Behavior.* 2004; 5:746-51.

Poster 169

Friday, October 6
3:00 p.m.-4:30 p.m.

ABUSE LIABILITY OF INTRAVENOUS LISDEXAMFETAMINE DIMESYLATE

Supported by New River Pharmaceuticals and Shire Development, Inc.

Donald R. Jasinski, M.D., *Professor of Medicine, and Chief, Center for Chemical Dependence, Johns Hopkins Bayview Medical Center, Mason F. Lord Building, 4940 Eastern Avenue, Baltimore, MD 21224;* Suma Krishnan, M.S.; George Kehner, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the safety, tolerability, and abuse liability of IV LDX compared with IV IR *d*-amphetamine, by subjective and behavioral assessments, in stimulant abusers.

SUMMARY:

Background: LDX is a pharmacologically inactive prodrug in which *d*-amphetamine is bonded to *l*-lysine. Pharmacologically active *d*-amphetamine is gradually released only after metabolism of the prodrug. LDX was designed to have comparable efficacy and tolerability to available once-daily, stimulants with reduced potential for abuse.

Methods: LDX 50 mg, *d*-amphetamine sulfate 20 mg, and placebo IV were given to 9 stimulant abusers in this double-blind crossover study.

Results: When compared to placebo, *d*-amphetamine sulfate 20 mg given IV produced expected and significant "Liking scores", with peak response in 15 minutes, indicating a significant euphoric response ($P=.01$). Compared with placebo, LDX 50 mg did not produce significant "Liking scores", with mean peak responses at 1 to 3 hours, but significant "Disliking scores" were reported, indicating a lack of euphoric response ($P=.29$). Changes in blood pressure following LDX were significant. When asked if they would take it again, 6 subjects chose *d*-amphetamine sulfate 20 mg, 2 subjects chose none of the treatments, and 1 subject chose LDX 50 mg.

Conclusions: LDX 50 mg did not produce euphoria or amphetamine-like subjective effects, although there were late occurring increases in blood pressure. LDX may have significantly less abuse potential than equal amounts of IR *d*-amphetamine when given IV.

REFERENCES:

1. Wilens TE, Faraone SV, Biederman J, Gunawardene S. Does stimulant therapy of attention-deficit/hyperactivity disorder beget later substance abuse? A meta-analytic review of the literature. *Pediatrics.* 2003 Jan; 111(1):179-85.

2. Connor DF, Steingard RJ. New formulations of stimulants for attention-deficit hyperactivity disorder: therapeutic potential. *CNS Drugs*. 2004; 18(14):1011–30.

Poster 170

**Friday, October 6
3:00 p.m.-4:30 p.m.**

**PHARMACOKINETICS OF
LISDEXAMFETAMINE VERSUS D-
AMPHETAMINE IN ADULTS WITH A
HISTORY OF STIMULANT ABUSE**

*Supported by New River Pharmaceuticals and
Shire Development, Inc.*

Donald R. Jasinski, M.D., *Professor of Medicine, and
Chief, Center for Chemical Dependence, Johns Hopkins
Bayview Medical Center, Mason F. Lord Building, 4940
Eastern Avenue, Baltimore, MD 21224*; Suma Krish-
nan, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the PK profile and abuse potential of LDX (30 mg to 150 mg) in adults with a history of stimulant abuse.

SUMMARY:

Background: LDX is a pharmacologically inactive prodrug in which *d*-amphetamine is bonded to *l*-lysine. Pharmacologically active *d*-amphetamine is gradually released only after metabolism of the prodrug. LDX was designed to have comparable efficacy and tolerability to available once-daily, stimulants with reduced potential for abuse.

Methods: Subjects were divided into 3 cohorts of 4. All received single escalating doses of LDX at 48-hour intervals, with *d*-amphetamine 40 mg and placebo randomly interspersed.

Results: *d*-amphetamine AUC_{last} over the first 4 hours was substantially lower with 100 mg LDX (165.3–213.1 ng/mL) vs 40 mg *d*-amphetamine sulfate (245.5–316.8 ng/mL). C_{max} and AUC_{last} increased with doses of 30 mg to 130 mg LDX. Attenuation of maximum concentration between 130 mg and 150 mg LDX suggests higher doses of LDX may not lead to further increases in C_{max} and AUC_{last} . T_{max} (h) of *d*-amphetamine was longer for LDX (3.78–4.25) vs *d*-amphetamine sulfate (1.88–2.74). Half-life of LDX (0.44–0.76 h) indicated rapid clearance of the prodrug. Adverse effects were mild in severity. LDX had a slower release of *d*-amphetamine compared with *d*-amphetamine sulfate.

Conclusion: These results indicate there is a gradual conversion of LDX that may lead to less abuse and improved safety.

REFERENCES:

1. Wilens TE, Faraone SV, Biederman J, Gunawardene S. Does stimulant therapy of attention-deficit/hyperactivity disorder beget later substance abuse? A meta-analytic review of the literature. *Pediatrics*. 2003 Jan; 111(1):179–85.
2. Connor DF, Steingard RJ. New formulations of stimulants for attention-deficit hyperactivity disorder: therapeutic potential. *CNS Drugs*. 2004; 18(14):1011–30.

Poster 171

**Friday, October 6
3:00 p.m.-4:30 p.m.**

**EVALUATING THE EFFECTS OF
BUPROPION XL, SERTALINE, AND S-
CITALOPRAM ON CORE MAJOR
DEPRESSIVE DISORDER SYMPTOMS**

Supported by GlaxoSmithKline

Louis E. Kopolow, M.D., *Associate Psychiatry Center,
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1308*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify differential effects of bupropion XL, *s*-citalopram, and sertraline on specific core symptoms of depression: pleasure, interest, energy and concentration; and review a novel patient assessment and monitoring tool used to evaluate patients with MDD.

SUMMARY:

Many patients with major depression present with low energy, diminished pleasure, and an inability to concentrate. As these symptoms typically respond well to antidepressants with noradrenergic and/or dopaminergic effects, bupropion would appear to be an effective treatment choice for patients with these symptoms.

This retrospective chart review of patients with MDD treated with bupropion XL, sertraline or *s*-citalopram evaluated changes in responses to the PROS-D patient assessment and monitoring questionnaire. The mean change for bupropion was –1.21, –0.93, –1.43 and –1.29, for sertraline the changes were –1.44, –1.11, –0.56, and for *s*-citalopram the changes were –0.85, –0.92, –0.46 and –0.46 for items #1, 2, 4 and 5 of the PROS-D Scale.

Based on these data, the average change in energy and concentration favored bupropion when compared to both *s*-citalopram and sertraline. The average change in pleasure and interest was also greater with bupropion when compared to *s*-citalopram; although numerically lower than sertraline. As limited by a relatively small sample size and retrospective nature, a larger controlled

analysis is needed to duplicate and confirm these findings.

TARGET AUDIENCE:

Practicing psychiatrists.

REFERENCES:

1. Preskorn SH: Bupropion: What Mechanism of Action? *Journal of Psychiatric Practice* 2000; 6:39–44.
2. Stahl SM et al: A review of the neuropharmacology of bupropion, a NE and DA reuptake inhibitor. *J Clin Psych* 2004; 6:159–66.

Poster 172

Friday, October 6
3:00 p.m.-4:30 p.m.

FEATURES OF ADULTS WITH SUICIDAL BEHAVIOR IN CLINICAL TRIALS OF PAROXETINE

Supported by GlaxoSmithKline

John E. Kraus, M.D., Ph.D., *Director, Clinical Development, GlaxoSmithKline, 109 Hawkscrest Court, Research Triangle Park, NC 27709*; Joseph P. Horrigan, M.D.; David J. Carpenter, Pharm.D.; Regan Fong, Ph.D.; Pam S. Barrett, Pharm.D.; John T. Davies, M.S.C.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize clinical characteristics of adult patients with suicidal behavior in randomized, double-blind, placebo-controlled clinical trials of paroxetine.

SUMMARY:

GlaxoSmithKline (GSK) conducted a meta-analysis of suicidality in placebo-controlled trials of paroxetine in adult patients. A summary of the clinical characteristics of patients with definitive suicidal behavior (DSB) is presented; other suicidality events (e.g., suicidal ideation) are not presented. Methods: Potential cases of DSB were identified via adverse event (AE) text string searches, review of serious AE narratives, and review of comment fields in Case Report Forms. Cases were then reviewed by external suicide experts and classified into different suicidality categories. Cases of DSB were examined for emerging patterns of clinical characteristics. Results: Major Depression: DSB (all suicide attempts) occurred in 11/3455 (0.32%) paroxetine- and 1/1978 (0.05%) placebo-treated patients. Of these paroxetine-treated patients, 8/11 were aged 18–30 years. 9/11 had a precipitating social stressor and 8/11 overdosed. Interestingly, 10/11 showed signs of clinical improvement with 0/11 having active suicidal ideation per rating scale measures at the study visit prior to the event. Non-

Depression: DSB occurred in 7/5238 (0.13%) paroxetine- and 4/3693 (0.11%) placebo-treated patients. These patients had a more heterogeneous clinical picture, with evidence of clinical worsening in some prior to the event. Conclusion: Understanding DSB is an important component of assessing suicidality in psychiatric patients. All patients, particularly young adults, with or without apparent clinical improvement, should receive careful monitoring for suicidality during paroxetine therapy.

TARGET AUDIENCE:

Practicing adult psychiatrists and clinicians who treat depression and anxiety disorders.

REFERENCES:

1. Hammad TA, Laughren TP, Racoosin JA. Suicide rates in short-term randomized controlled trials of newer antidepressants. *J Clin Psychopharmacol*. 2006 Apr; 26(2):203–7.
2. Apter A, Lipschitz A, Fong R, Carpenter DJ, Krulwicz S, Davies JT, Wilkinson C, Perera P, Metz A. Evaluation of suicidal thoughts and behaviors in children and adolescents taking paroxetine. *J Child Adolesc Psychopharmacol*. 2006 Feb-Apr; 16(1–2):77–90.

Poster 173

Friday, October 6
3:00 p.m.-4:30 p.m.

ASSESSING SUICIDALITY IN PATIENTS WITH BIPOLAR DISORDER ON LONG-ACTING RISPERIDONE

Supported by Janssen Pharmaceutica, L.P.

Mary J. Kujawa, M.D., Ph.D., *Senior Director, Medical Affairs Department, Janssen Pharmaceutica Inc., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Earle Baine, M.D., *Associate Director, Medical Affairs Department, Janssen Pharmaceutica Inc., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Ramy Mahmoud, M.D.; Ibrahim Turkoz, M.S.; Jacquelyn D. McLemore, M.D.; Georges M. Gharabawi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be familiar with the measurement of suicidal thinking and its response to treatment with a long-acting, atypical antipsychotic in patients with frequently relapsing bipolar disorder (FRBD).

SUMMARY:

Objective: To evaluate the effects of long-acting risperidone (LAR) on suicidal thinking in patients with frequently relapsing bipolar disorder (FRBD).

Methods: Patients meeting DSM-IV diagnostic criteria for bipolar disorder, with ≥ 4 episodes requiring clinical intervention within 12 months, received open-label augmentation of treatment-as-usual with LAR (25–50 mg/2 weeks) for 16 weeks in the initial phase of an ongoing trial. Measures of suicidal thinking included the InterSePT Scale for Suicidal Thinking-Revised (ISST-R, range 0–24) and Montgomery-Åsberg Depression Rating Scale Item 10 (MADRS-10; range 0–6) at baseline and endpoint. Changes in suicidal thinking were assessed with non-parametric and parametric tests.

Results: Of 275 subjects, 230 provided ISST-R scores at baseline and post-baseline. Of 53 with baseline suicidality, 70% had no suicidality at endpoint, while 91% of the 177 subjects without baseline suicidality remained nonsuicidal at endpoint (McNemar Test for reduction in proportion of subjects with suicidal thinking, $P < 0.01$). Mean change in MADRS-10 at LOCF endpoint was -0.2 ± 1.0 ($P = 0.001$). Tremor, muscle rigidity, and insomnia were the most frequently reported adverse events.

Conclusions: Results from the open-label phase of this ongoing trial suggest that adjunctive treatment with LAR may reduce suicidal thinking in patients with FRBD.

TARGET AUDIENCE:

Clinical psychiatrists.

REFERENCES:

1. Leverich GS, Altshuler LL, Frye MA, et al. Factors associated with suicide attempts in 648 patients with bipolar disorder in the Stanley Foundation Bipolar Network. *J Clin Psychiatry* 2003; 64:506–515.
2. Baldessarini RJ, Tondo L. Suicide risk and treatments for patients with bipolar disorder. *JAMA* 2003; 290:1517–1519. Erratum in: *JAMA* 2004; 291:186.

Poster 174

Friday, October 6
3:00 p.m.-4:30 p.m.

ESCITALOPRAM AND CITALOPRAM IN THE TREATMENT OF MAJOR DEPRESSIVE DISORDER EFFECT OF BASELINE SEVERITY

Supported by H Lundbeck A/S and Forest Laboratories, Inc.

Raymond W. Lam, M.D., *Professor and Chair, Department of Psychiatry, University of British Columbia, 2255 Westbrook Mall, Vancouver, British Columbia, Canada V6T 2A1*; Henning F. Andersen, M.S.C., *Employee, H. Lundbeck A/S, Ottilivaj 9, Copenhagen, Denmark*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the efficacy of escitalopram compared to citalopram.

SUMMARY:

Objective: Pooled analyses from pivotal trials have consistently indicated advantages of escitalopram versus citalopram, especially in patients with more severe depression at baseline. The objective of this study was to critically examine the effect of baseline severity on the efficacy of escitalopram versus citalopram.

Methods: All studies of patients with MDD that included comparisons of escitalopram, citalopram and placebo were selected and the results pooled for analysis. Treatment outcome was assessed by scores from the Montgomery-Åsberg Depression Rating Scale (MADRS) at 8 weeks of treatment. The interaction of baseline severity as assessed by MADRS score and the treatment effects of escitalopram and citalopram were tested in an ANCOVA model adjusting for baseline severity, center and treatment.

Results: Two flexible dose and 1 fixed dose placebo-controlled studies involving patients with moderate to severe MDD were included in the pooled analysis. The fixed dose study examined escitalopram 10 mg and 20 mg versus citalopram 40 mg, so the 10 mg arm was excluded to ensure that similar doses of escitalopram and citalopram were compared (exclusion of this arm did not affect statistical significance of the analyses). Results of the pooled analysis showed that the differences between escitalopram and placebo ($p = 0.001$ for no trend) and between escitalopram and citalopram ($p = 0.0012$ for no trend) increased with increasing baseline severity of MDD; in contrast, the difference between citalopram and placebo was rather constant relative to baseline severity. In addition, there was a superior effect of escitalopram on response to treatment (defined as $\geq 50\%$ decrease in MADRS total score) at week 8 compared to placebo regardless of baseline severity, and compared to citalopram at higher levels of baseline severity.

Conclusion: These results indicate that in the treatment of MDD, escitalopram is superior to citalopram in patients with more severe depression.

TARGET AUDIENCE:

Psychiatrists, and clinicians.

REFERENCES:

1. Gorman J, Korotzer A, Su G. Comparison of escitalopram and citalopram in the treatment of major depressive disorder: Pooled analysis of placebo-controlled trials. *CNS Spectr* 2002; 7(4 Suppl):40–44.
2. Lepolu U, Wilde A, Andersen HF. Do equivalent doses of escitalopram and citalopram leave similar

efficacy? A pooled analysis of two positive placebo-controlled studies in major depressive disorder. *Int Clin Psychopharmacol* 2004; 19:149–155.

2. Thase ME, et al. Poster presented at: The APA's 159th Annual Meeting; May 20–25, Toronto, Ontario.

Poster 175

**Friday, October 6
3:00 p.m.-4:30 p.m.**

**SUICIDALITY IN BIPOLAR DEPRESSION
TREATED WITH QUETIAPINE
MONOTHERAPY**

Supported by AstraZeneca Pharmaceuticals

Wayne MacFadden, M.D., *Clinical Research Physician, AstraZeneca Pharmaceuticals, 1800 Concord Pike, Wilmington, DE 19850*; E. Spong; Margaret C. Minkwitz, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will be able to evaluate the efficacy of quetiapine in improving suicide-related symptoms in depressive episodes of bipolar disorder.

SUMMARY:

Objective: To investigate effects of quetiapine monotherapy on measures of suicidality in depressive episodes in patients with bipolar disorder.

Methods: Post-hoc analysis of suicidality in 1045 patients experiencing depressive episodes associated with bipolar I or II disorder (DSM-IV) randomized to 8 weeks of quetiapine (300 or 600 mg/d) or placebo in 2 studies (BOLDER I and BOLDER II). Suicidality was measured using MADRS item 10 (suicidal thoughts) and HAM-D item 3 (suicide) scores. Treatment-emergent suicidal ideation and behavior were also evaluated using Columbia suicidality criteria.

Results: There were no cases of completed suicide during the 2 studies. The mean MADRS item 10 score decreased significantly more with both quetiapine doses than with placebo at Week 8. The decrease in mean HAM-D item 3 score at Week 8 was also significantly greater with both quetiapine doses than with placebo. Incidences of suicidal ideation and possible suicide attempts identified using the Columbia criteria were low and similar in all 3 treatment groups during the 2 studies.

Conclusion: These findings suggest that quetiapine monotherapy, when compared with placebo, does not increase, and may decrease, suicidal tendencies during depressive episodes of bipolar I or II disorder.

TARGET AUDIENCE:

General adult psychiatrists.

REFERENCES:

1. Calabrese JR, Keck PE Jr, Macfadden W, et al., *Am J Psychiatry*, 2005; 162:1351–1360.

Poster 176

**Friday, October 6
3:00 p.m.-4:30 p.m.**

**QUETIAPINE MONOTHERAPY IMPROVES
ANXIETY SYMPTOMS IN BIPOLAR
DEPRESSION**

Supported by AstraZeneca Pharmaceuticals

Wayne MacFadden, M.D., *Clinical Research Physician, AstraZeneca Pharmaceuticals, 1800 Concord Pike, Wilmington, DE 19850*; Robert B. Lydiard, M.D., M.P.H.; L.A. Culppepper, M.D.; S. Raines

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the role of quetiapine monotherapy in the treatment of anxiety symptoms in bipolar depression.

SUMMARY:

Objective: To evaluate the efficacy and tolerability of quetiapine monotherapy for anxiety symptoms in patients with bipolar disorder experiencing depressive episodes.

Methods: A post-hoc analysis of anxiety symptoms in 1045 depressed patients with bipolar I or II disorder (DSM-IV) from 2 double-blind, randomized, placebo-controlled 8-week studies of quetiapine (300 or 600 mg once-daily) was conducted.^{1,2} Anxiety symptoms were assessed using HAM-A total scores, and HAM-A psychic (items 1–6, 14) and somatic anxiety (items 7–13) factor scores (evaluated using MMRM analysis).

Results: There was a significantly greater improvement from baseline in mean HAM-A total scores at the first assessment (Week 1) in both quetiapine groups compared with placebo. These improvements were sustained through to Week 8 with both quetiapine doses. The effect sizes for quetiapine 300 and 600 mg/d were 0.56 and 0.62, respectively. There was also significant improvement from baseline in HAM-A psychic and somatic anxiety factor scores with quetiapine (both doses) compared with placebo. Common adverse events included dry mouth, sedation, somnolence, and dizziness.

Conclusion: Quetiapine monotherapy is significantly more effective than placebo and generally well tolerated for the treatment of anxiety symptoms associated with bipolar depression.

TARGET AUDIENCE:

General adult psychiatrists.

REFERENCES:

1. Calabrese JR, Keck PE Jr, Macfadden W, et al. *Am J Psychiatry* 2005; 162:1351–1360.
2. Thase ME, McCoy R, Chang W, et al. Presented at CPNP Annual Meeting, Baltimore, MA, USA, April 23–26, 2006.

Poster 177

Friday, October 6
3:00 p.m.-4:30 p.m.

**QUETIAPINE AUGMENTATION OF
SSRI'S/SNRI'S IN MAJOR DEPRESSION
WITH ANXIETY**

Supported by AstraZeneca Pharmaceuticals

Alexander W. McIntyre, M.D., *Department of Psychiatry, Penticton Regional Hospital, 550 Carmi Avenue, Penticton, British Columbia, Canada V2A 3G6*; Alain Gendron, Ph.D.; Amanda McIntyre, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the benefits of using quetiapine to augment SSRI/SNRI therapy in patients with depression and anxiety.

SUMMARY:

Objective: Atypical antipsychotics may be effective in treating major depression.^{1,2} This double-blind, randomized study evaluated quetiapine augmentation of SSRIs/SNRIs for major depression with residual depressive and prominent anxiety symptoms.

Methods: Fifty-eight patients with residual symptoms following 6 weeks' SSRI/SNRI treatment (HAM-D³ 18; HAM-A³ 14) received quetiapine (50–600 mg/day) or placebo for 8 weeks. Primary efficacy endpoint: mean change (baseline to Week 8 [LOCF]) in HAM-D and HAM-A. Secondary endpoints: CGI-Severity; GAS; incidence of AEs.

Results: Eighteen of 29 quetiapine-treated (mean dose: 202±93 mg/day) and 16/29 placebo-treated patients completed the study. Significant improvements (quetiapine vs placebo) were seen at Weeks 1 ($P\leq 0.01$) and 8 ($P\leq 0.01$) for HAM-D (–6.5, –11.2 vs –2.9, –5.5); HAM-A (–7.4, –12.5 vs –3.4, –5.9); CGI-Severity (–0.45, –1.5 vs –0.07, –0.6); GAS (+5.7, +17.5 vs +1.7, +6.6). Overall, 7/17 HAM-D and 6/14 HAM-A items improved with quetiapine ($P<0.05$ vs placebo at Week 8). Main reasons for discontinuation: AEs for quetiapine (n=8); inefficacy for placebo (n=9). Most common AEs (quetiapine vs placebo): sedation/somnolence/lethargy

(n=25 vs n=14); dry mouth (n=13 vs n=4); weight gain (n=12 vs n=5).

Conclusions: Quetiapine combined with SSRIs/SNRIs improved residual depressive and anxiety symptoms in major depression.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. Kennedy SH, Lam RW. *Bipolar Disord.* 2003; 5(Suppl 2):36–47.
2. Yargic LI, Corapcioglu A, Kocabasoglu N, Erdogan A, Koroglu G, Yilmaz D. *Int J Psychiatry Clin Pract.* 2004; 8:205.

Poster 178

Friday, October 6
3:00 p.m.-4:30 p.m.

**ZIPRASIDONE AS COMBINATION OR
MONOTHERAPY IN JUVENILE BIPOLAR
DISORDER**

Supported by Pfizer Inc.

Arnold W. Mech, M.D., *Psychiatrist, Department of Research, The Mech Center, 7500 San Jacinto, Plano, TX 75024*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the potential utility of pursuing a regimen with ziprasidone in the treatment of child and adolescent patients with bipolar disorder.

SUMMARY:

Objective: To explore the benefits of ziprasidone in children and adolescents with bipolar disorder

Method: Case studies of four patients successfully treated with ziprasidone in the wake of failed trials of mood-stabilizing therapy are examined with a focus of dosing strategies, tolerability and safety and use of optimal dosing not limited to 160 mgs/day.

Results: Four patients previously treated with multiple agents subsequently achieved remission of all mood symptoms where previous therapy failed. Mixed bipolar symptoms, bipolar depression and acute mania all responded to rapid titration of ziprasidone to remission levels on the YMRS and BDI or Reynolds Childhood Depression Scale. Improvement was not associated with manic switching with stabilization occurring both “from above” as well as “from below”. The suggestion of a dose-response was seen in the response of patient’s pathology suggesting that more aggressive dosing may allow more patients to receive greater benefit from mo-

notherapy than with combination therapy with other second generation atypicals and anticonvulsants.

Conclusion: Ziprasidone may indeed be effective as an alternative to other mood-stabilizing approaches in some pediatric bipolar patients. Further studies at higher doses are needed to investigate the question of ziprasidone as an effective combination or monotherapy in controlled trials in this population.

TARGET AUDIENCE:

Psychiatrists and other physicians.

REFERENCES:

1. Keck Jr PE, Versiani M, Ptokin S, West S, Giller E, Ice K: Ziprasidone in a treatment of acute bipolar mania: A three week, placebo controlled, double-blind, randomized trial. *Am J Psychiatry* 2003; 160:741-748.
2. Potkin SG, Keck PE, Giller E, et al. Ziprasidone in Bipolar Mania: Efficacy across subgroups. Program and abstracts of the 21004 Annual Meeting of American Psychiatric Association, New York, NY, Abstract NR777.

Poster 179

**Friday, October 6
3:00 p.m.-4:30 p.m.**

BENEFITS OF ARIPIPRAZOLE IN DEPRESSED AND BIPOLAR CHILDREN AND ADOLESCENTS

Supported by Pfizer Inc.

Arnold W. Mech, M.D., *Psychiatrist, Department of Research, The Mech Center, 7500 San Jacinto, Plano, TX 75024*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the benefit of aripiprazole in the treatment of depressed and bipolar children and adolescents.

SUMMARY:

The primary objective was to prove that the benefits of treatment with aripiprazole are not restricted to adult schizophrenic patients. Using a retrospective chart review, data was collected on 15 patients between the ages of 7 to 17 with a DSM-IV primary diagnosis of Major Depressive Disorder or Bipolar I Mixed in an outpatient practice. Patients were on aripiprazole 10 to 30 mg for at least six weeks unless treatment was ended due to side effects. No changes were made to concomitant medications. Charts were reviewed for side effects, weight changes, and inventory scores specifically the Beck Depression Inventory Youth (BDI-Y) and Reyn-

olds Child Depression Screen (RCDS) for depression; Young Mania Rating Scale (YMRS) for mania; and Barkley Inventory for ADHD symptoms.

Six children and nine adolescent charts were reviewed with 2 Bipolar D/O and 13 Major Depression. Secondary diagnosis of ADD was shown in 6 patients. The most common AE reported was increased appetite (n=3). Other AEs reported were nausea (n=1), twitching (n=1), and mood swings (n=1). In those patients with a primary dx of depression (n=5) showed improvement in mood, (n=6) showed improvement in attention and/or hyperactivity and (n=2) showed no improvement. Of those patients diagnosed with bipolar disorder, one showed improvement in mood and hyperactivity and one showed no change. Few patients (n=4) showed a weight gain of >20 lbs in length of treatment, but each of these patients was treated with concomitant medications that have demonstrated weight gain. Correlation of weight gain to aripiprazole use is inconclusive, 73% of patients (n=11) showed normal weight gain by growth standards.

These results suggest that aripiprazole had benefit in the treatment of depressed and bipolar children and adolescents. Overall, the medication was well-tolerated with few side effects, while having the patient experience a reduction in depression or bipolar symptoms.

TARGET AUDIENCE(S):

Psychiatrists and other physicians.

REFERENCES:

1. Mech A. The Use of Ziprasidone as Monotherapy in Bipolar Adults. Society of Biological Psychiatry, Annual meeting, May 19-21, 2005, Atlanta, GA, USA.
2. Mech A. The Use of Zonisamide in Depressed and Bipolar Adult Patients. American Psychiatric Association Annual Meeting, May, 2004; New York, USA.

Poster 180

**Friday, October 6
3:00 p.m.-4:30 p.m.**

A COMPARISON OF DOSING SCHEDULES WITH ORAL ZIPRASIDONE

Supported by Pfizer Inc.

Arnold W. Mech, M.D., *Psychiatrist, Department of Research, The Mech Center, 7500 San Jacinto, Plano, TX 75024*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the effectiveness of once-daily dosing of ziprasidone.

SUMMARY:

The purpose of this study was to investigate ziprasidone as monotherapy for bipolar disorder and the effect of dosing schedules: once daily versus twice daily on efficacy, safety, compliance, and patient reported tolerability of ziprasidone in the treatment of adult patients in an outpatient setting. After meeting inclusion criteria and stable on ziprasidone for 4 weeks, patients were randomly assigned to either once daily dosing group (n=15) or continued in the twice daily dosing group (n=15). Screening included standard assessments and diagnostic criteria to confirm eligibility. Baseline visit and weekly visits included vital signs, weights, administration of YMRS, PANSS, HAM-D, and patient satisfaction survey. An ECG and safety labs were obtained at baseline and final visit. Dosing was less than or equal to 320 mg per day. If there is no differential effect of dosing on efficacy, safety, or tolerability, ziprasidone could be safely administered once daily with improved compliance and simplicity of administration. Overall, the results suggest that ziprasidone once daily dosing has benefit in the treatment of Bipolar I disorder in adults, and the medication is well-tolerated with few adverse events. Overall, patients showed greater compliance with once daily dosing. There was no compromise to effectiveness with once daily dosing. Only 3 of the 15 patients randomized to once daily dosing switched back.

TARGET AUDIENCE:

Psychiatrists and other physicians.

REFERENCES:

1. Keck Jr PE, Versiani M, Potkin S, West S, Giller E, Ice K: Ziprasidone in a treatment of acute bipolar mania: A three week, placebo-controlled, double-blind, randomized trial. *Am J Psychiatry* 2003; 160:741-748.
2. Potkin SG, Keck PE, Giller E, et al. Ziprasidone in Bipolar Mania: Efficacy across patient subgroups. Program and abstracts of the 2004 Annual Meeting of American Psychiatric Association. New York, NY. Abstract NR777.

Poster 181

**Friday, October 6
3:00 p.m.-4:30 p.m.**

**AN EVALUATION OF LAMOTRIGINE
TREATMENT FOR MAJOR BIPOLAR II
DEPRESSION**

Supported by GlaxoSmithKline

Charles H. Merideth, M.D., *Employee, Affiliated Research, 8989 Rio San Diego Drive, Suite 350, San Diego, CA 92108*; Russell F. Huffman, Ph.D., *Employee, GlaxoSmithKline, Five Moore Drive, Research Triangle*

Park, NC 27709; Suzanne E. Edwards, Ph.D.; Robert A. Leadbetter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand patient response and tolerability to lamotrigine treatment.

SUMMARY:

Background: Lamotrigine has been shown to be an effective mood stabilizer in the treatment of Bipolar I patients and there is preliminary evidence of efficacy for the prevention of mood episodes in rapid cycling Bipolar II patients.¹⁻²

Methods: A multicenter, double-blind, placebo-controlled, parallel, 8-week, monotherapy study was conducted with outpatient, bipolar II patients experiencing a major depressive episode. The primary efficacy measure was mean change from baseline at Week 8 for the Montgomery-Asberg Depression Rating Scale (MADRS). Safety was assessed by adverse event reporting.

Results: There was no significant difference between treatments in the mean change from baseline MADRS scores at Week 8 (lamotrigine vs placebo: -13.4 vs -12.0, p=0.328). A high placebo response was observed (46% of patients with a \geq 50% improvement on MADRS). Significant improvement (p<0.05) associated with lamotrigine treatment was noted on some secondary measures (Bech Melancholia Scale and CGI-I response). Serious adverse events (n=6) occurred among placebo patients only. There were no suicides or other deaths, and no serious rashes in this study. The rate of non-serious rash was 6% for both treatment groups.

Conclusion: This study did not demonstrate lamotrigine's efficacy in the acute treatment of depression in subjects with bipolar II disorder, based on the MADRS. Lamotrigine was well-tolerated in patients with bipolar II disorder.

REFERENCES:

1. Goodwin GM, Borden CL, Calábrese JR et al. A pooled analysis of 2 placebo-controlled 18-month trials of lamotrigine and lithium maintenance in bipolar I disorder. *J Clin Psychiatry* 2004; 65:432-441.
2. Calabrese JR, Suppes T, Bowden CL, et al. (2000) A double-blind, placebo-controlled, prophylaxis study of lamotrigine in rapid cycling bipolar disorder. *J Clin Psychiatry* 61:841-850.

Poster 182

**Friday, October 6
3:00 p.m.-4:30 p.m.**

**QUETIAPINE AUGMENTATION OF
ANTIDEPRESSANTS IN LACTATION**

Shailla Misri, M.D., *Clinical Professor of Psychiatry, University of British Columbia, 1081 Burrard Street,*

Room 28-185, Vancouver, British Columbia V6Z 1Y6; Maria R. Corral, M.D.; Andrea A. Wardrop, B.A.; Kristin Kendrick, B.A.

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Friday, October 6
3:00 p.m.-4:30 p.m.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to treat women with comorbid psychiatric disorders during lactation; understand quetiapine augmentation of antidepressants in lactation; and be familiar with the effects of combination therapy on infant development.

SUMMARY:

Objective: To further knowledge regarding the effects of quetiapine as an augmenting agent of antidepressants during lactation.

Method: Participants were six women diagnosed with Major Depressive Disorder in conjunction with another Axis I disorder, and treated with quetiapine and either an SSRI or SNRI postnatally. Levels of psychotropic medications in breastmilk were obtained and infant exposure was estimated. Developmental assessments were performed with the Bayley Scales of Infant Development, Second Edition (BSID-II).

Results: In half of the cases, no medication was detected in the breastmilk, and in all but one case, estimated levels of infant medication exposure were less than 0.01 mg/kg/day for each medication. Four babies scored within normal limits on the BSID-II, while two showed mild developmental delays. In comparison to the four cases of typical development, the two showing mild delays did not have higher estimated levels of psychotropic medication exposure through breastmilk.

Conclusions: In our limited sample there appears to be no association between developmental functioning of babies up to 18 months of age and estimated levels of exposure. When pharmacotherapy is utilized to ensure stability of maternal mood during lactation, monitoring women and developmental milestones of their infants is recommended.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. Lee A, Giesbrecht E, Dunn E, Ito S: Excretion of quetiapine in breast milk. *Am J Psychiatry* 2004; 161(9):1715-1716.
2. Misri S, Milis L: Obsessive-compulsive disorder in the postpartum: open-label trial of quetiapine augmentation. *Journal of Clinical Psychopharmacology* 2004; 24(6):624-627.

ARE ALL THE ANTICONVULSANTS EQUALLY USEFUL FOR BORDERLINE PERSONALITY DISORDER PATIENTS? FOCUS ON GABAPENTIN

Lola Peris, M.D., *Psychiatrist, Barcelona, Spain, Joseph M. De Segarra, 47, Granollers, Barcelona, Spain 08400;* Nestor Szerman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the use of anticonvulsants for BPD patients in order to find if it is possible to adequate their profiles to the clinical manifestations of the disorder in each patient.

SUMMARY:

Introduction: Anticonvulsants have been suggested to be helpful to regulate Borderline Personality Disorder (BPD) affective instability and lack of impulse control. Although they are widely used in clinical settings few studies have been published, showing improvements on different BPD symptoms. Their beneficial effects and the observed efficacy of Gabapentin in anxiety and drug abuse disorders were the basis for our trial.

Method: Open-label multicenter prospective 6 months follow-up study with Gabapentin for BPD patients resistant to previous therapies, following DSM-IV-TR and DIB-R criteria assessed by Hamilton-A (Anxiety), Young (Mania), Beck (Depression), Barratt (Impulsivity) and CGI (Severity and Improvement) Scales. Gabapentin dosage varied between 1200 and 3600 mg/day.

Results: N=48 (ANOVA and LOCF). Basal final scores were (p<0.0001) Beck from baseline 25.09±10.93 to 6th month 13.11±8.08, Young from 11.02±7.76 to 5.11±4.39, HAM-A from 22.88±9.76 to 11.32±6.95, Barratt from 64.85±5.56 to 62.35±6.94, CGI-Severity from 4.76±0.71 to 3.28±1.08 and CGI-Improvement from 3.3±1.8 to 2.1±0.9. No adverse events were reported.

Conclusions: Gabapentin showed to be effective and safe in BPD treatment, especially in alleviating anxious and depressive symptoms, which could also facilitate a better psychotherapeutic outcome. Although double-blind controlled studies are needed to confirm these results, recent trials showing the efficacy of topiramate, divalproex or lamotrigine on aggression and/or impulsivity, guide a reflection on their role in different BPD patients.

REFERENCES:

1. Hollander E, Swann AC, Coccaro EF et al. Impact of trait impulsivity and state aggression on divalproex

versus placebo response in borderline personality disorder. *Am J Psychiatry* 2005, 162, 621–4.

- Nickel MK, Nickel C, Mitterlehner MO et al. Topiramate treatment of aggression in female borderline personality disorder patients. A double-blind, placebo controlled study. *J Clin Psychiatry* 2004, 65, 1515–1519.

Poster 184

Friday, October 6
3:00 p.m.-4:30 p.m.

OLANZAPINE-FLUOXETINE COMBINATION VERSUS LAMOTRIGINE FOR BIPOLAR I DEPRESSION: QUALITY OF LIFE OUTCOME ANALYSIS

Supported by Eli Lilly and Company

Kevin Piezer, R.Ph., BCPP, *Medical Liaison Consultant, Department of Neuroscience, Eli Lilly and Company, Lilly Corporate Center, DC4133, Indianapolis, IN 46285*; Eileen Brown, Ph.D.; John P. Houston, M.D., Ph.D.; Michael D. Stensland, Ph.D.; Paul Orth, Pharm.D.; Jonna Ahl, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss health-outcome effects on patients treated with olanzapine-fluoxetine combination or lamotrigine for bipolar I depression.

SUMMARY:

Objective: To determine the difference in quality-of-life between olanzapine/fluoxetine-treated and lamotrigine-treated patients with bipolar I depression.

Method: A 25-week randomized, double-blind study compared olanzapine-fluoxetine combination (OFC; 6/25, 6/50, 12/25, or 12/50 mg/day, N=205) with lamotrigine (titrated to 200 mg/day, N=205) in depressed bipolar I patients. Quality-of-life measures included the Sheehan Disability Scale (SDS) and the SF-36. An additional questionnaire collected information regarding physical and suicidal threats. Analytical techniques included analysis of variance on change from baseline to endpoint (last-observation-carried forward) and Fisher's exact test for categorical variables.

Results: There were no differences between treatment groups on any of three SDS dimensions (family life, social life, work). On the SF-36, patients treated with OFC experienced greater improvement in bodily pain ($p=.005$), general health ($p=.020$), mental health ($p=.046$), and social functioning ($p=.019$). No significant differences were detected for the other 4 dimensions (physical functioning, role limitations due to emotional or physical problems and vitality). Fewer OFC-treated

patients threatened to strike or injure others ($p=.007$), and fewer made suicidal threats ($p=.027$).

Conclusion: OFC-treated patients with bipolar I depression experienced greater improvements in some measures of quality of life and had lower rates of threatening injury or suicide than lamotrigine-treated patients.

TARGET AUDIENCE:

Psychiatrists and other mental health professionals who treat bipolar patients.

REFERENCES:

- Yatham LN, Lecrubier Y, Flevy RR et al. Quality of life in patients with bipolar I depression: data from 920 patients. *Bipolar Disorder* 2004; 6(5):379–85.
- Shi L, Namjoshi MA, Swindle R et al. Effects of olanzapine alone and olanzapine/fluoxetine combination on health-related quality of life in patients with bipolar depression: secondary analysis of a double-blind, placebo-controlled, randomized clinical trial. *Clinical Therapeutics* 2004; 26(1):125–34.

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Friday, October 6
3:00 p.m.-4:30 p.m.

ATOMOXETINE TREATMENT FOR ADHD: YOUNG ADULTS COMPARED WITH OLDER ADULTS

Supported by Eli Lilly and Company

Calvin Sumner, M.D., *Clinical Research Physician, Neuroscience Medical Studies, Eli Lilly and Company, Lilly Corporate Center, DC4133, Indianapolis, IN 46285*; Todd Durell, M.D.; Lenard A. Adler, M.D.; Timothy E. Wilens, M.D.; Martin Paczkowski, M.P.H.; Kory Schuh, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to compare the effects of atomoxetine for treating ADHD in young adults, aged 18 to 25 years, with adults older than 25.

SUMMARY:

Objective: Atomoxetine is a nonstimulant medication for treating child, adolescent, and adult ADHD.^{1,2} This meta-analysis compared the effects in young and older adults.

Methods: Patients in two identical studies received twice-daily atomoxetine or placebo for about 10 weeks. Data from patients aged 18–25 years (atomoxetine, n=26; placebo, n=29) were compared with patients older than 25 (atomoxetine, n=244; placebo, n=237). Efficacy measures included the Conners' Adult ADHD Rating

Scale (CAARS) and the Clinical Global Impressions-Severity (CGI-S).

Results: In younger adults, atomoxetine produced significantly greater benefits relative to placebo as measured by mean changes from baseline on the CAARS Total ADHD Symptom Score (-11.77 versus -8.38 for atomoxetine and placebo, respectively; $p=.041$; effect size=.797) and the CGI-S (-0.88 vs -0.52; $p=.006$; effect size=1.121). In older adults, atomoxetine also produced significant benefits (CAARS Total score changes of -12.22 and -8.36; $p<.001$; effect size=.326; CGI-S changes of -0.95 vs -0.55; $p<.001$; effect size=.346). Larger effect sizes for the young adults reflect smaller variability for this group. Tolerability was generally similar between age groups although older adults reported more sexual side effects.

Conclusion: These data indicate that atomoxetine is efficacious for treating ADHD in young adults, although this analysis has limitations due to a small sample size.

TARGET AUDIENCE:

Clinicians and physicians who treat patients with ADHD.

REFERENCES:

1. Michelson D, Allen AJ, Busner J, Casat C, Dunn D, Kratochvil C, Newcorn J, Sallee FR, Sangal RB, Saylor K, West S, Kelsey D, Wernicke J, Trapp NJ, Harder D: Once-daily atomoxetine treatment for children and adolescents with attention-deficit/hyperactivity disorder: A randomized, placebo-controlled study. *Am J Psychiatry* 2002; 159:1896-1901.
2. Kelsey DK, Sumner CR, Casat CD, Coury DL, Quintana H, Saylor KE, Sutton VK, Gonzales J, Malcolm SK, Schuh KJ, and Allen AJ: Once-daily atomoxetine treatment for children with attention-deficit/hyperactivity disorder, including an assessment of evening and morning behavior: A double-blind, placebo-controlled trial. *Pediatrics* 2004; 114(1):e1.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to summarize the effects of atomoxetine compared to placebo on symptoms and functional outcomes in children with ADHD and comorbid anxiety disorder.

SUMMARY:

Objective: Research suggests that 25-50% of children with attention-deficit/hyperactivity disorder (ADHD) also suffer from anxiety disorders¹. Stimulant treatment of this comorbid subgroup is complicated by potential adverse effects². Atomoxetine, a nonstimulant medication approved for treatment of pediatric and adult ADHD, was compared with placebo for treatment of children with ADHD and comorbid anxiety disorders.

Methods: In this double-blind, acute phase of a multicenter study, children meeting DSM-IV criteria for ADHD and either generalized anxiety disorder, separation anxiety disorder, or social phobia were randomized to 12 weeks of atomoxetine treatment (n=87) or placebo (n=89). Changes in efficacy and functional outcome scores (from baseline to last observation carried forward endpoint) were compared across treatment groups using analysis of covariance.

Results: Sixty-six patients in each treatment group completed the study ($p=ns$ for any reason for discontinuation). Mean scores improved significantly for atomoxetine versus placebo, respectively, on the Multidimensional Anxiety Scale for Children (-4.6 versus 2.1; $p=.009$), Life Participation Scale for ADHD-Revised (9.6 versus 2.5; $p=.001$), and Child Health Questionnaire-Parent-Completed Full Length (6.9 versus 3.3; $p=.019$).

Conclusion: Results suggest atomoxetine is efficacious and improves functioning in children and adolescents with ADHD and comorbid anxiety disorder.

TARGET AUDIENCE:

Clinicians and physicians who treat patients with ADHD.

REFERENCES:

1. Biederman J, Newcorn J, Sprich S: Comorbidity of attention-deficit/hyperactivity disorder with conduct, depressive, anxiety and other disorders. *Am J Psych* 1991; 148:564-577.
2. Urman R, Ickowicz A, Fulford P, Tannock R: An exaggerated cardiovascular response to methylphenidate in ADHD children with anxiety. *J Child Adolesc Psychopharmacol* 1995; 5:29-37.

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Friday, October 6
3:00 p.m.-4:30 p.m.

ATOMOXETINE TREATMENT FOR PEDIATRIC PATIENTS WITH ADHD AND COMORBID ANXIETY DISORDER

Supported by Eli Lilly and Company

Calvin Sumner, M.D., *Clinical Research Physician, Neuroscience Medical Studies, Eli Lilly and Company, Lilly Corporate Center, DC4133, Indianapolis, IN 46285*; Daniel Geller, M.B., B.S.; Craig Donnelly, M.D.; Frank A. Lopez, M.D.; Richard Rubin, M.D.; Rosalie Bakken, Ph.D.; Martin Paczkowski, M.P.H.; Douglas K. Kelsey, M.D., Ph.D.

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Friday, October 6
3:00 p.m.-4:30 p.m.

DETERMINANTS OF ANTIDEPRESSANT TREATMENT SELECTION FOLLOWING THE INTRODUCTION OF DULOXETINE

Supported by Eli Lilly and Company

Andrine Swensen, Ph.D., *Outcomes Liaison, Eli Lilly and Company, 100 Grant Street, Centerport, NY 11721*; Rebecca L. Robinson, M.S.; Michael Pollack, M.S.; Stephen Able, Ph.D.; Ralph Swindle, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize variations between duloxetine initiators and other select medications in terms of demographics, prior medical comorbidities, and treatment history in the first four months after duloxetine was introduced to the U.S. marketplace.

SUMMARY:

Objective: To compare factors associated with treatment selection for patients initiating on duloxetine versus "other" antidepressants (venlafaxine XR, bupropion, SSRIs, escitalopram).

Methods: Diagnostic and treatment histories were obtained through retrospective claims for adults initiating on antidepressants between 8/31/04 to 12/31/04.

Results: Of the 230,738 eligible patients, 29.7% had depression diagnoses, 77.9% initiated on SSRIs, the mean age was 44.6 years, and 71.4% were women. Using logistic regression, depressed duloxetine initiators versus "other" initiators had more prior pain diagnoses, depression-related diagnoses, recurrent depression episodes, psychotherapy, pain medications, and antidepressants. Duloxetine patients also initiated therapy later in the study, were older, and received prescriptions from mental health or other specialists. Findings were consistent in a non-depression subgroup. Non-depressed duloxetine initiators also were more likely to be men. Depressed and non-depressed duloxetine initiators consistently had more prior pain medications, antidepressants, mental health specialty prescribers, depression-related diagnoses, and late study initiation when compared with each drug separately.

Conclusions: Physicians discriminate among the types of patients they deem appropriate for select antidepressants. Patients with pain and worse depression treatment histories tend to initiate on duloxetine. Case mix adjustments should be made when comparing drugs. Trends over time are necessary to determine the robustness of results.

TARGET AUDIENCE:

Clinicians and payers.

REFERENCES:

1. Detke MJ, Lu Y, Goldstein DJ, McNamara RK, Demitrack MA. Duloxetine 60mg once daily dosing versus placebo in the acute treatment of major depression. *Journal of Psychiatric Research* 2002; 36:383-390.
2. Simon GE, VonKorff M, Wagner EH, Barlow W. Patterns of antidepressant use in community practice. *Gen Hosp Psychiatry* 1993; 15:399-408.

Poster 188

Friday, October 6
3:00 p.m.-4:30 p.m.

ANTIPSYCHOTICS FOR BIPOLAR DISORDER: MCLEAN HOSPITAL INPATIENTS, 2004

Supported by Bristol-Myers Squibb Company, Abbott Laboratories, GlaxoSmithKline, and Pfizer Inc.

Alessandra Talamo, M.D., *Research Fellow, Department of Research, McLean Hospital, 115 Mill Street, NB311, Belmont, MA 02478*; Franca Centorrino, M.D.; Stephanie L. Cincotta, B.A.; Kate V. Fogarty, B.A.; Mark G. Saadeh, M.D.; Paola Salvatore, M.D.; Francesca Guzzetta, M.D.; Ross J. Baldessarini, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to better understand current trends in the use of antipsychotic agents and concomitant psychotropics for inpatient treatment of bipolar disorder.

SUMMARY:

Background: Since modern antipsychotics (APDs) had been recently FDA-approved for bipolar disorder (BPD), we examined their use for such patients. *Method:* We analyzed medical records of 80 McLean Hospital DSM-IV BPD Inpatients given APDs in mid-2004 for dosing and use of other psychotropics, and compared findings to similar 1998 [N=83] and 2002 [N=93] samples. *Results:* Hospitalization of 80 BPD patients (aged 41.8 ± 13.5 ; 60% women) was for: depression (46%) > mania (29%) & mixed-states (25%), lasted 10.7 days (vs. 13.6 in 2002, 22.4 in 1998), and was longest for mania. Usage ranked: risperidone > quetiapine > olanzapine & aripiprazole > all others. Discharge doses averaged 312 ± 296 chlorpromazine-equivalent mg/day (higher with mania than depression). Depressed patients received more antidepressants and more total psychotropics. Concomitant mood stabilizers ranked: valproate > lithium > oxcarbazepine > lamotrigine > all others. In 2004, but

not earlier, discharge prescriptions for APDs/patient (1.2) outnumbered lithium-plus-anticonvulsants (0.8). More BPD patients were discharged with ≥ 3 psychotropics in 2004 than 2002, and use of APDs as primary treatments doubled from 1998 to 2004. Use of olanzapine declined 1.9-fold from 1998 to 2004, and clozapine use decreased by 88% from its 2002 peak. Conclusions: For hospitalized BPD patients, modern antipsychotics were used more than lithium, anticonvulsants, or older neuroleptics. Funding provided by Bristol-Myers Squibb, Abbott, GlaxoSmithKline, and Pfizer (to FC), a grant for the Bruce J. Anderson Foundation, and the McLean Private Donors Neuropsychopharmacology Research Fund (to RJB).

TARGET AUDIENCE:

Psychiatric professionals interested in pharmacological therapies for bipolar disorder.

REFERENCES:

1. Centorrino F, Fogarty KV, Sani G, Salvatore P, Cimbolli P, Baldessarini RJ: Antipsychotic drug use: McLean Hospital, 2002. *Hum Psychopharmacol* 2005; 20:355–358.
2. Centorrino F, Fogarty KV, Salvatore P, Sani G, Cincotta SL, Hennen J, Guzzetta F, Talamo A, Saadeh MG, Baldessarini RJ: Use of combinations of antipsychotics: McLean Hospital inpatients, 2002. *Hum Psychopharmacol* 2005; 20:485–492.

Poster 189

Friday, October 6
3:00 p.m.-4:30 p.m.

QUETIAPINE MONOTHERAPY IN BIPOLAR DEPRESSION: THE BOLDER II STUDY

Supported by AstraZeneca Pharmaceuticals

Michael E. Thase, M.D., *Professor of Psychiatry, University of Pittsburgh Medical Center, 3811 O'Hara Street, Pittsburgh, PA 15213*; Wayne MacFadden, M.D.; Robin McCoy, R.N.; W. Chang; Joseph R. Calabrese, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the recent data on efficacy and tolerability of quetiapine for bipolar depression, and use this information in the management of patients with bipolar disorder.

SUMMARY:

Objective: Evaluate the efficacy and tolerability of quetiapine monotherapy for bipolar disorder depressive episodes as a confirmatory study to BOLDER I.

Methods: Patients with bipolar I or II disorder (DSM-IV) exhibiting moderate to severe depression were randomized to 8 weeks of double-blind treatment with quetiapine (300 or 600 mg/d; once-daily, evening dosing) or placebo. The primary endpoint was change in MADRS total score from baseline at Week 8 (ANCOVA/LOCF analysis).

Results: Improvements from baseline in mean MADRS scores were significantly greater from the first evaluation (Week 1) through Week 8 with both quetiapine doses than with placebo. Effect sizes at Week 8: 0.61 and 0.54 for quetiapine 300 and 600 mg/d, respectively. Improvements in mean HAM-D scores were also significantly greater with both quetiapine doses than with placebo at every assessment. There were no significant differences between the quetiapine doses on any of the primary or secondary outcome measures. Common adverse events included dry mouth, sedation, somnolence, dizziness, and constipation, which were generally mild to moderate in intensity.

Conclusions: Quetiapine monotherapy is effective and generally well tolerated for depressive episodes of bipolar disorder. These results are similar to those of the BOLDER I study.

TARGET AUDIENCE:

General adult psychiatrists.

REFERENCES:

1. Calabrese JR, Keck PE, Jr, Macfadden W, et al. *Am J Psychiatry*. 2005; 162:1351–1360.
2. Bowden CL, Davis J, Morris D, et al. *Depress Anxiety* 1997; 6:26–30.

Poster 190

Friday, October 6
3:00 p.m.-4:30 p.m.

ATOMOXETINE AUGMENTATION FOR REFRACTORY ANXIETY DISORDERS

Supported by Massachusetts General Hospital

John J. Worthington, M.D., *Staff Psychiatrist, Massachusetts General Hospital, 15 Parkman Street, WAC-815, Boston, MA 02114-2215*; Elana Golan, *Graduate Student, Department of Social Work, Columbia University, 1255 Amsterdam Avenue, New York, NY 10027*; Hammah Reese, B.A.; Gustavo D. Kinrys, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that Atomoxetine is an option for refractory anxiety disorder patients; and appreciate the prevalence of attentional problems in anxiety disorder patients.

SUMMARY:

Objective: Although many patients achieve some response with the current pharmacotherapies for the anxiety disorders, most remain somewhat symptomatic and others have virtually no response to initial therapy. We examined the effect of atomoxetine augmentation of anxiolytic pharmacotherapy in patients with anxiety disorders remaining symptomatic despite initial therapy.

Methods: Retrospective chart review of 13 cases of augmentation with atomoxetine in adult outpatients with anxiety disorders who were not full responders to a variety of anxiolytic medications. Primary outcome measures were the Clinical Global Impression of Improvement and Severity Scales (CGI-I, CGI-S). Patients were evaluated in regard to their anxiety disorder symptomatology.

Results: The mean dose of atomoxetine used at end point evaluation was 77 ± 36 mg/d, and the mean duration of treatment assessed was 8 ± 5 weeks. Seven of 13 subjects (54 percent) were much or very much improved (CGI-I of 1 or 2), with the mean CGI-I = 2.5 ± 1.0 . The mean CGI-S at baseline was 5.8 ± 0.6 , which fell to 4.2 ± 1.1 at endpoint ($p < .001$, $t = 5.2$, $df = 12$, $p < .001$).

Conclusion: Results from this open, retrospective case series suggest that atomoxetine may effectively augment response to anxiolytic medications in patients with treatment resistant anxiety disorders.

Supported by funding from the Mood and Anxiety Disorders Institute of Massachusetts General Hospital.

The above information concerns a use that is not approved by the U.S. Food and Drug Administration.

TARGET AUDIENCE:

Psychiatrists, physicians, and all other mental health workers.

REFERENCES:

1. Gadow KD, Nolan EE, Sverd J, Sprafkin J, Schwartz J: Anxiety and Depression Symptoms and Response to Methylphenidate in Children with Attention; -Deficit Hyperactivity Disorder and Tic Disorder. *J Clin Psychopharmacol* 2002; 22:267-74.
2. Michelson D, Adler L, Spencer T, Reimherr FW, West SA, Allen AJ, Kelsey D, Wernicke J, Dietrich A, Milton D: Atomoxetine in Adults with ADHD: Two Randomized, Placebo-Controlled Studies. *Biol Psychiatry* 2003; 53: 112-120.

Poster 191

**Friday, October 6
3:00 p.m.-4:30 p.m.**

OROS METHYLPHENIDATE TREATMENT EFFECTS BETWEEN GIRLS AND BOYS WITH ADHD

Supported by Ortho-McNeil Pharmaceuticals, Inc.

Huabin F. Zhang, M.D., M.P.H., *Associate Director, Outcomes, McNeil Pediatrics, 7050 Camp Hill Road, Fort Washington, PA 19034*; Jason E. Kemner, M.P.H.; H. Lynn Starr, M.D.; Kimberly M. Cooper, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the absence of gender effects on ADHD symptom improvement in girls and boys treated with OROS methylphenidate.

SUMMARY:

Objective: To evaluate symptom improvement in OROS[®] methylphenidate (MPH)-treated girls and boys with attention-deficit/hyperactivity disorder (ADHD).

Method: In this analysis, all 850 once-daily OROS MPH-treated children (219 girls and 631 boys 6 to 12 years of age with ADHD) were identified from a prospective, open-label, 3-week, randomized (2:1 OROS MPH or atomoxetine) trial. Initiation and titration of medication was based on each investigator's clinical judgment. Investigators assessed ADHD symptoms and clinical improvement using the ADHD Rating Scale (ADHD-RS), Clinical Global Impression-Severity of Illness (CGI-S) and Clinical Global Impression-Improvement of Illness (CGI-I). Gender differences were measured by ANOVA and Chi-square tests.

Results: Baseline ADHD symptoms were similar between OROS MPH-treated girls and boys (ADHD-RS: 39.1 vs. 40.3; CGI-S: 4.52 vs. 4.75). At the end of study, ADHD symptom improvement was comparable between girls and boys: change from baseline on ADHD-RS was 20.2 vs. 20.5 and CGI-I was 2.26 vs. 2.21. Analyses comparing the percentage of subjects achieving response (defined as $\leq 30\%$, $\leq 40\%$, or $\leq 50\%$ reduction from baseline ADHD-RS as well as scoring ≤ 2 on the CGI-I scale) were comparable by gender.

Conclusions: OROS MPH is equally effective in the management of ADHD symptoms in both girls and boys with ADHD.

REFERENCES:

1. Biederman J, Kwon A, Aleardi M, et al: Absence of gender effects on attention deficit hyperactivity disorder: findings in nonreferred subjects. *Am J Psychiatry* 2005; 162:1083-1089.

- Biederman J, Mick E, Faraone SV, et al: Influence of gender on attention deficit hyperactivity disorder in children referred to a psychiatric clinic. *Am J Psychiatry* 2002; 159:36-42.

Poster 193

Saturday, October 7
8:30 a.m.-10:00 a.m.

POSTER SESSION 5

Posters 192-238

**CLINICAL CORRELATES,
EVALUATION, AND INNOVATIVE
TREATMENT APPROACHES TO UNIQUE
POPULATIONS**

**IMMIGRANT POPULATION AND
DEMAND FOR CARE IN A MENTAL
HEALTH CENTER IN THE
FUENLABRADA DISTRICT OF MADRID,
SPAIN**

Eduardo Balbo, M.D., *Psychiatrist, Department of Mental Health, Comunidad De Madrid 10, Fuenlabrada, Spain*; Carlos Gonzalez-Juarez, M.D., *Psychiatrist, Department of Mental Health, Institute Psig J. Germain, LA Luna 1, Leganes, Spain 28911*; Ruth Candela, Ph.D.; Miguel Morales, Ph.D.

Poster 192

Saturday, October 7
8:30 a.m.-10:00 a.m.

**THE TRAUMA OF THE TRAUMATIZED
CHILDREN IN IRAQ**

Sadiq H. Al-Samarrai, M.D., *Department of Psychiatry, Olean General Hospital, 515 Main Street, Olean, NY 14760-1700*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the characteristics and type of care demanded by the immigrant population in a mental health care; understand the differences between sexes and their respective demands for care and the specific conditions experienced by the patients; and recognize the social, legal, and financial situation and its influence on pathological conditions and care demand in these patients.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to better understand the adverse effects that the Iraqi war has had on the children of Iraq.

SUMMARY:

Objective: To pinpoint the characteristics, and the nature of demand for health care, of an immigrant population at the Mental Health Center of Fuenlabrada (Madrid, Spain), and with this, how it compares with the native, Spanish population.

SUMMARY:

Iraqi children have been exposed to the traumatizing situations since 1980. They are suffering a variety of mental illnesses related to sustained violence and wars that need to be explained thoroughly.

Method: All medical records of immigrant patients seeking mental health care from October 2004 to March 2005 were analyzed and collated with simultaneously collected information on their socio-demographic characteristics, their situation in Spain, and their demand for services.

This poster will present the types of mental disorders of the Iraqi children through literature review and field studies.

Results: Of a total of 1845 new visits, 129 corresponded to immigrants (7%). Of these, 101 were women and 28 were men. Most of these immigrant patients were between 25 and 30 years old. The countries most represented were Morocco (17), Rumania (16), Ecuador (15), and Equatorial Guinea (12). The rest of the immigrant patients were from 26 other countries. Visits of second-generation immigrants (50.4%) were more frequent than visits of first-generation immigrants (40.3%). 17.8% were illegal aliens and 29.5% were unemployed. The level of Spanish-language-use was high in 73.6% (South Americans). 54.3% of the visits involved assessment of mental condition for elective abortion. Over half of the patients were diagnosed with some adaptional disorder (66.7%) and the most common treatment of choice, along with benzodiazepines, were SSRIs.

TARGET AUDIENCE:

Psychiatrists, psychologists, social workers, students and researchers in the field of trauma and mental illnesses.

REFERENCES:

- The Harvard study team. The effect of the Gulf crisis on the children of Iraq *N. Engl. J. Med.*, 315:977-980, 1990.
- Association of psychologists of Iraq. Study released Feb. 6 2006.

Conclusions: Women, as in the non-immigrant population, account for more medical visits than men, and cases of adaptional disorder outnumber actual psychotic conditions, which are more frequent in men, particularly those coming from the north or south of Africa. Women, cut off from their families, are the group most susceptible to mental disorders. Demand for care generally does not occur at the start of immigration, but after 3 to 5 years.

TARGET AUDIENCE:

Psychiatrists and social workers.

REFERENCES:

1. Tseng WS. Handbook of Cultural Psychiatry. San Diego: Academic Press, 2001.
2. Hilton C. For debate: collecting ethnic group data for inpatients: is it useful? *BMJ*. 1996; 313:923–925.

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**Saturday, October 7
8:30 a.m.-10:00 a.m.**

DEPRESSION AND MENTAL HEALTH TREATMENT SEEKING AMONG ASIAN AMERICANS

Supported by the University of Michigan

Ashley R. Bowerman, *Student, Department of Psychiatry, University of Michigan, 4419 Ford Road, Ann Arbor, MI 48105*; Heather A. Flynn, Ph.D.; Sheila M. Marcus, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize differences in prevalence rates in perinatal depression, based on EPDS results and rates of treatment use between Caucasian Americans and Asian Americans.

SUMMARY:

The prevalence of depression and rates of mental health treatment use may be vastly different cross-culturally. This sub-analysis of a larger study aims to show differences in depression and mental health treatment between Caucasians and Asian Americans. This has implications for strategies for tailoring depression identification and treatment linkage. In total 1,785 pregnant women completed the Edinburgh Postnatal Depression Scale (EPDS) while waiting for their prenatal care visits. 11% identified their racial group as Asian American (75% Caucasian). Using a cut-off score of EPDS>10, 10% of all Asian American women showed depression risk (compared to 15% of Caucasians, ns). All consenting women scoring>10 on EPDS completed interviews (n=96) to assess depression treatment use among women at risk. Asian American women were significantly less

likely to agree to participate in the research as compared to Caucasian women. Only 10% of Asian American women with EPDS>10 sought any mental health treatment; significantly less than Caucasian women (27%). These results suggest that Asian American women may be at risk for depression at rates comparable to white women, but may be less likely to participate in clinical research and seek mental health treatment.

TARGET AUDIENCE:

Mental health practitioners.

REFERENCES:

1. Kirmayer L, (1989). Cultural Variations in the Response to Psychiatric Disorders and Emotional Distress. *Social Science Medicine*, 29(3), 327–339.
2. Lin K, & Cheung F, (1999). Mental Health Issues for Asian Americans. *Psychiatric Services*, 50, 774–780.

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**Saturday, October 7
8:30 a.m.-10:00 a.m.**

NEUROANATOMICAL CORRELATES OF APATHY VERSUS DEPRESSION IN ALZHEIMER'S DISEASE

Supported by the Korean Science Engineering Foundation

You-Ra Lee, M.D., *Department of Psychiatry, Seoul National University Hospital, 28 Youngon-Ding Chongno-GU, Seoul, South Korea*; Hong-Jin Jeon, M.D., *Department of Psychiatry, Seoul National University Hospital, 28 Yongon-Dong Chong No-Gu, Seoul, South Korea*; Lee Jun-Young, M.D.; Kim Jin-Yeong, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the psychological symptom of Alzheimer's Disease and its correlates with the brain.

SUMMARY:

Apathy means a state of indifference where an individual is unresponsive to aspects of emotional, social, or physical life. Apathy is a common problem in Alzheimer's disease (AD) but may be confused with depression. We compared apathy and depression in AD with the voxel-based morphometry (VBM) of MRI, eliminating the investigator bias. We used VBM to 42 AD patients with apathy (n = 16) and depression (n = 18). Apathy was significantly associated with the right medial frontal gyrus (Z = 2.31) and the right posterior cingulate gyrus (Z = 2.12). Depression was also associated the cingulate gyrus (Z = 2.32) but was not significantly associated with the right frontal cortex. In conclusion,

apathy is associated with the volume reduction of the gray matter of the right medial frontal gyrus.

This study was supported by Korea Science Engineering Foundation, Grant No. R01-2004-000-10178-0.

REFERENCES:

1. Dement Griat Cong Disord 2006; 215–220 Structural changes of the corpus collosum in MC II and Alzheimer’s disease.
2. Neural 2001:57 (p) 1636–1647 TI-weighted horizontal slice of the MRI of one of the volunteers displays the subcortical areas in the left hemispheres.

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**Saturday, October 7
8:30 a.m.-10:00 a.m.**

PARTIAL PTSD VERSUS FULL PTSD IN THE KOREAN COMMUNITY

Supported by the Korean Ministry of Health and Welfare

Sung-Man Chang, M.D., *Department of Psychiatry, Seoul National University Hospital, 28 Yongon-Dong Chongno-Gu, Seoul, South Korea*; Hong-Jin Jeon, M.D., *Department of Psychiatry, Seoul National University Hospital, 28 Yongon-Dong Chong No-Gu, Seoul, South Korea*; Lee Eu-Ra, M.D.; Kim Shin-Kyum, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to diagnose PTSD, and understand the symptoms of PTSD.

SUMMARY:

Partial PTSD is a concept that has been recently extended to community dwelling victims of trauma, but has not been fully investigated. A representative sample of 6,258 has not been fully investigated. A representative sample of 6,258 version of the Composite International Diagnosis Interview including lifetime traumas. Partial PTSD was defined as 1 symptom in each of three symptom groups (criteria B, C and D) and duration of > 1 month. Estimated lifetime prevalence of partial PTSD was 2.7% (S.E. - 0.2) and that of PTSD was 1.7% (S.E.= 0.2). The mean durations of partial PTSD were 6.7 years in men and 6.3 years in women, which were not significantly different from those of PTSD. Traumas associated with the development of partial PTSD rather than full PTSD, were ‘military combat’ in men and ‘learning about traumas to others’ in women, whereas threatened by others’ was more associated with development of full PTSD. In conclusion, partial PTSD did not differ significantly from PTSD in terms of duration, comorbidity and dysfunctions, but they differed markedly in terms of the types of traumas that they were associated with.

This study was supported by the Korean Ministry of Health and Welfare, and partly by BK21 project for medicine, dentistry and pharmacy.

REFERENCES:

1. Breslau, N.: Partial PTSD versus full PTSD; An empirical examination of associated impairment. *Psychol Med.* 2004.
2. Mylle, J. et. al.; Partial posttraumatic stress disorder revisited. *J. Affect Disord.* 2004.

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**Saturday, October 7
8:30 a.m.-10:00 a.m.**

PSYCHIATRIC DIFFERENCES AMONG ADOLESCENTS IN THE HOSPITAL VERSUS TRAINING SCHOOL

Joyce T. Chen, B.A., *Medical Student, Brown Medical School, 214 Olney Street, Apt. 8, Providence, RI 02906-1656*; Jeffrey Hunt, M.D.; Joseph V. Penn, M.D.; Anthony Spirito, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to gain insight into whether specific psychiatric characteristics differ between adolescents in correctional schools and in psychiatric hospitals.

SUMMARY:

Background: While proper mental health care during formative years is critical, most juvenile systems lack resources to adequately treat psychiatric disorders. It is unclear whether adolescents at correctional facilities have different psychiatric characteristics and thus, treatment needs, as their counterparts at psychiatric hospitals.

Method: Data from two preexisting data sets were used to compare 1) suicidal ideation, 2) anger (STAXI T-scores), and 3) psychotropic medication use. We compared 80 adolescents from a children’s psychiatric hospital (Bradley Hospital [BH]) to 55 juveniles from a state correctional facility (Rhode Island Training School [RITS]). Chi-square and T-test were used to determine significance.

Results: Psychotropic medication use at the time of admission was significantly greater (p=0.008) at BH than RITS for all classes of drugs, except sleep medications. Suicidal ideation was also greater at the hospital at the time of admission (p<0.001). Based on STAXI, youths at RITS had greater control of their anger (p=0.010) and were better able to hold it in (p=0.004).

Conclusion: Psychiatric differences exist between juveniles and their counterparts, suggesting that treatment strategies between the two groups are not comparable. Tailoring treatment regimens in correctional settings

based upon understanding such differences could improve outcome in later life.

TARGET AUDIENCE:

Psychiatrists, psychologists, and social workers.

REFERENCES:

1. Penn J, Esposito C, Schaeffer L, et al. 2003. Suicide attempts and self-mutilate behavior in a juvenile correctional facility. *Journal of American Academic Child and Adolescence Psychiatry*. 42(7):762-769.
2. Teplin A, Abram K, McClelland G et al. 2002. Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry*. 59:1133-1143.

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**Saturday, October 7
8:00 a.m.-10:00 a.m.**

WEST NILE VIRUS AND CONVERSION DISORDER: CASE REPORT

Catherine Chung, B.A., *Medical Student, Department of Psychiatry, State University of New York, Upstate Medical University, 750 East Adams Street, Room 1702-UH, Syracuse, NY 13210*; Adekola O. Alao, M.D., *Assistant Professor, Department of Psychiatry, State University of New York, Upstate Medical University, 750 East Adams Street, Syracuse, NY 13210*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to raise awareness that West Nile Virus (WNV) can present with neurological deficits, thereby mimicking conversion disorder, and it should be considered in the differential diagnosis when a patient is evaluated for possible conversion disorder.

SUMMARY:

West Nile Virus (WNV) has spread across the country since its introduction to the United States in 1999. In severe cases, WNV can be complicated by a number of neurological deficits, thus possibly mimicking conversion disorder. Here we report a 19-year-old pregnant female referred to psychiatry as a possible case of conversion disorder who later tested positive for West Nile Virus.

Ms. A, a single, 19-year-old African American woman, was admitted to the obstetrics and gynecology unit of a teaching hospital in her eighth month of pregnancy after presenting with unilateral paralysis of her right leg and foot. A routine examination including a complete blood count, electrolytes, urea, liver and thyroid function tests, urinalysis, and a non-contrast CT scan of the head yielded normal results.

A psychiatric consult was called to rule out conversion disorder. On evaluation, Ms. A had no presenting symp-

toms and denied any previous psychiatric history. There was no evidence of psychosis such as delusions or hallucinations and no evidence of mania or any other anxiety disorders. Ms. A denied any history of sexual or physical trauma, as well as any current stressors. A mental status examination revealed Ms. A to be calm and cooperative. Her speech was spontaneous and normal in rate, tone, and volume, and her affect was full-ranged.

The fact that Ms. A did not have any current or previous stressors and the fact that she was psychiatrically asymptomatic argued against a diagnosis of conversion disorder. We therefore recommended to the primary treatment team to investigate Ms. A more aggressively. Following further testing, Ms. A was positively confirmed for West Nile Virus infection.

TARGET AUDIENCE:

Consultation-liaison psychiatrists, and primary care physicians.

REFERENCES:

1. Saad M, Youssef S, Kirschke D, Shubair M, Haddadin D, Myers J, Moorman J. Acute flaccid paralysis: the spectrum of a newly recognized complication of West Nile Virus infection. *Journal of Infection* 2005; 51:120-7.
2. Campbell GL, Marfin AA, Lanciotti RS, Gubler DJ. West Nile virus. *The Lancet Infectious Diseases* 2002; 2:519-29.

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**Saturday, October 7
8:30 a.m.-10:00 a.m.**

NICOTINE DEPENDENCE IN CO-OCCURRING SUBSTANCE USE AND PSYCHIATRIC DISORDERS IN AN AMERICAN INDIAN VETERANS SAMPLE *Supported by the Minneapolis Veterans Administration*

Daniel L. Dickerson, D.O., *Resident, Department of Addiction Psychiatry, Yale University, 1730 State Street, Hamden, CT 06517*; Stephanie S. O'Malley, Ph.D.; James W. Thompson, M.D., M.P.H.; Paul Thuras, Ph.D.; Jose Canive, M.D.; Joseph J. Westermeyer, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the association of nicotine dependence and psychiatric disorders in American Indian Veterans; and understand the lack of association between nicotine dependence and other substance use disorders in this select patient population.

SUMMARY:

Background: No information on the co-occurrence of DSM-IV nicotine dependence and Axis I psychiatric and substance use disorders is available in the American Indian and Alaskan Native population.

Objectives: To present data on the co-occurrence of DSM-IV nicotine dependence and other axis I psychiatric and substance use disorders in an American Indian patient sample, and provide useful screening and treatment recommendations based on these findings.

Methods: 558 community-based American Indian Veterans from the Minneapolis VA Hospital completed a demographic questionnaire, and the Quick-Diagnostic Interview Schedule (Q-DIS) which provided DSM-IV Axis I and II diagnosis. Odds ratios from logistic regression analysis were used to study associations between nicotine dependence and Axis I and II disorders.

Results: Nicotine dependence is significantly correlated with comorbid anxiety disorders, affective disorders, PTSD, and gambling disorders in this sample of American Indian Veterans. Nicotine dependence and substance use disorders were not significantly correlated.

Conclusions: Culturally-competent nicotine cessation treatments can be improved by recognizing the association of psychiatric disorders and nicotine dependence in American Indian smokers. Future analyses will examine how participation in traditional practices may moderate the association between nicotine dependence and psychiatric illnesses. The Minneapolis Veterans Administration Hospital HSR provided financial support for this study.

TARGET AUDIENCE:

Addiction psychiatrists and cultural psychiatrists.

REFERENCES:

1. Grant B, (2004). Nicotine Dependence and Psychiatric Disorders in the United States. *Arch Gen Psychiatry*, 61, 1107–1115.
2. Kallman D, Morissette SB, George TP, (2005). Co-Morbidity of Smoking in Patients with Psychiatric and Substance Use Disorders. *AM J Addictions*, 14:2, 106–123.

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**Saturday, October 7
8:30 a.m.-10:00 a.m.**

DIMINISHING DEPRESSION IN OLDER ADULTS WITH SCHIZOPHRENIA

Supported by the National Institute of General Medical Sciences

Shilpa P. Diwan, M.D., *Clinical Assistant Instructor, Department of Psychiatry, State University of New York, Downstate Medical Center, 415 100th Street, Brooklyn,*

NY 11209-8308; Carl I. Cohen, M.D.; Paul M. Ramirez, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the prevalence of depression and the factors associated with depression in elderly persons with schizophrenia.

SUMMARY:

Rationale: Although depression is thought to increase as persons with schizophrenia grow old, it has not been well-studied. We examine those factors that impact on depression in a multi-racial urban sample of older people with schizophrenia.

Methods: The schizophrenia (S) group consisted of 198 persons aged 55+ living in the community who developed schizophrenia before age 45 and a community comparison (C) group of 113 was selected. The questionnaire consisted of 23 scales that assessed psychiatric and physical health and functioning, cognition, service use, treatment, and psychosocial indices. We adapted George's Social Antecedent Model of Depression that consists of 6 categories comprising 16 independent variables. We used a dichotomous dependent variable based on a CES-D cut-off score of ℓ 16.

Results: The S group had significantly more persons with clinical depression than the C group. In the S group, in bivariate analysis, 8 of the 16 variables in the model were significantly related to clinical depression. In logistic regression, 6 variables retained significance: physical illness, presence of positive symptoms, proportion of confidants, cope by using medications, cope with conflicts by keeping calm and quality of life index.

Conclusion: Consistent with earlier studies of older schizophrenic populations, we found physical health and several non-clinical variables to be associated with depression. We found an association of depression with positive symptoms. Potential points for intervention include strengthening social supports, improving physical well-being, more aggressive treatment of positive symptoms, and increasing the recognition and treatment of depression.

Funded by the National Institute of General Medical Sciences, Grant no. SO6GM54650.

REFERENCES:

1. Cohen CI, Talavera N, Hartung R: Depression among aging persons with schizophrenia who live in the community; *Psychiatric Services* 1996 Jun; 47(6):601–7.
2. Jin H, Zisook S, Palmer BW, Patterson TL, Heaton RK, Jeste DV: Association of depressive symptoms with worse functioning in schizophrenia: a study in older outpatients; *J Clin Psychiatry*. 2001 Oct; 62(10):797–803.

Poster 201

Saturday, October 7
8:30 a.m.-10:00 a.m.**GROUP THERAPY EFFECTIVENESS IN A COMBAT ZONE**Roger H. Duda, M.D., *Division Psychiatrist, U.S. Army, 507 Monroe Road, Merion Station, PA 19066***EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should understand the psychiatric diagnosis of soldiers receiving mental health services, and the effectiveness of group therapy for treating 'at risk' soldiers.

SUMMARY:

Group therapy is a treatment whose utility extends into a combat zone in dealing with 'at-risk' soldiers. In Camp in Taji, Iraq, combat stress group therapy was implemented.

Over the course of a six month period, 408 individual soldiers were seen with referrals from self, command, and chaplain. Soldiers suffered from adjustment disorders with depressed mood, mood disorders, combat stress, anxiety, and occupational problems. Approximately 10% (42) were considered to be 'at-risk' to harm themselves or others. Out of those, eight were evacuated out of theater prior to treatment because of psychosis, mania, or unsuccessful suicide attempt. The rest, 34, attended the combat stress program. None of the soldiers who attended the group therapy committed suicide and all returned to duty. One was evacuated worsening pre-existing PTSD. Five were administratively discharged with personality disorders (cluster b).

Group therapy, in an 'at risk' population, demonstrates to be an effective treatment modality in a combat zone. The combat stress group included more soldiers than 'at-risk' and improved statistical reporting of treatment cases is needed. More research is needed as well on the long term benefits of group therapy in combat. Author has received no funding source.

TARGET AUDIENCE:

Group therapists with 'at-risk' populations.

REFERENCES:

1. Reyes VA, Hicklin, TA: Anger in the combat zone. *Military Medicine*. 2005 Jun; 170(6):483-7.
2. Wessely, S: Risk, Psychiatry, and the Military. *British Journal of Psychiatry* (2005) 186:459-466.

Poster 202

Saturday, October 7
8:30 a.m.-10:00 a.m.**ATTENTIONAL AND SENSORY GATING ABNORMALITIES IN SCHIZOPHRENIA: IMPLICATIONS FOR UNDERSTANDING SCHIZOPHRENIA**Zeinab Elbaz, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, 2088 Ellen Drive, South Merrick, NY 11566-5404***EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to understand the role sensory gating and attentional abnormalities play in the pathophysiology of schizophrenia and their potential utility as genetic markers and as a novel and useful screening tool of new candidate antipsychotic drugs.

SUMMARY:

Deficits in sensory gating are consistent neuropsychological findings in schizophrenia. Affected individuals appear to have deficits in the ability to gate or internally screen, sensory stimuli, such that only the relevant stimuli are attended to. Theoretically when sensory gating mechanisms fail, the individual is vulnerable to sensory overload, cognitive fragmentation and thought disorder. These observations were initially framed in descriptive and phenomenological context related to Bleuler's fundamental domains of schizophrenia, now characterized as core neurocognitive deficits and disorganization. Sensory gating abnormalities are trait linked marker of vulnerability to schizophrenia disorders seen across the spectrum, and are amenable to linkage analysis. They also have state related contributions associated with level of psychosis or neurocognitive deficits. The Thalamus plays a gating and modulatory role in relaying sensory information. The Thalamus determines whether sensory information reaches our conscious awareness in the neocortex. Systemic pharmacologic manipulations, such as administration of dopamine agonist apomorphine, can induce loss of gating, which can be blocked by neuroleptics. Gating phenomenon at the level of the hippocampus and temporal lobes, may rely on cholinergic mechanisms which can be normalized by the administration of nicotine. P50 gating has been linked to the alpha 7 region of the nicotinic receptor of chr.15, a finding that has now been replicated.

REFERENCES:

1. Freedman R, Coon H, Myles-Worsley M, et al: Linkage of a neurophysiological deficits in schizophrenia to a chromosome 15 locus. *proc Nat/Acad Sci USA* 94:587-592, 1997.

2. Braff DL, and Geyyer, MA. (1990) sensorimotor gating and schizophrenia, human and animal model studies. *Arch. Gen. Psych* 47:181–188.

Poster 203

**Saturday, October 7
8:30 a.m.-10:00 a.m.**

GENDER, COMORBIDITIES, AND SERVICE CHARACTERISTICS OF PTSD IN PSYCHIATRIC OUTPATIENTS

Mohamed El-Defrawi, M.D., *Department of Psychiatry, Southern Illinois University, 407 West Calhoun Avenue, Apt. 30, Springfield, IL 62702*; Jill Toepfer, M.A., *Department of Psychiatry, Southern Illinois University, 901 West Jefferson, Springfield, IL 62794*; Steven Markwell, M.A.; Andrea K. Stonecipher, M.D.; Sandra Vicari, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the significance of gender characteristics, comorbidities and services received in psychiatric outpatients diagnosed with PTSD.

SUMMARY:

Objective: to study gender characteristics, comorbidities and services received in patients with PTSD.

Methods: Data were obtained from a retrospective chart review of PTSD psychiatric outpatients during a 5-year period.

Results: Females (N=112) were significantly more likely than males (N=47) to report physical or sexual assault (75.9% vs 38.3%; $p=0.0001$). Males were significantly more likely than females to reported war or combat trauma (14.9% vs 0%; $p=0.0001$) and a history of suicide attempt (76.3% vs 52.8%; $p=0.022$). Comorbidities included depression (59.1%, anxiety (42.1%), substance (42.1%) and alcohol abuse (33.9%), dysthymia (20.8%), bipolar disorder (15.1%), schizophrenia (11.3%), and P.D. cluster B (52.9%). A primary diagnosis of PTSD (45.9%) was significantly more likely to be associated with a history of psychiatric hospitalization (54.1% vs 32%; $p=0.0154$) in comparison with secondary PTSD (54.1%) which was significantly more likely associated with depression (54.1% vs 32%; $p=0.0006$).

Males were significantly more likely than females to have a single service (45.7% vs 27.3%), medication or therapy, ($p=0.039$), while females were significantly more likely than males to have receive SSRI (83.9% vs 66.1%; $p=0.042$).

Conclusion: Data suggest that gender characteristics, comorbidities and services delivered could have a potential implications for clinical management of PTSD in outpatients.

TARGET AUDIENCE:

Psychiatrists, non-psychiatric physicians, nurses, psychologists, social workers, and other mental health professionals.

REFERENCES:

1. Zlotnick C, Franklin CL, Zimmerman M. Is comorbidity of posttraumatic stress disorder and borderline personality disorder related to greater pathology and impairment? *Am J Psychiatry* 2002; 159:1940–1943.
2. Tagay S, Hepertz S, Langkafel M, Senf W. Posttraumatic stress disorder in a psychosomatic outpatient clinic. Gender effects, psychosocial functioning, sense of coherence, and service utilization. *J Psychosom Res* 2005; 58(5):439–446.

Poster 204

**Saturday, October 7
8:30 a.m.-10:00 a.m.**

PTSD, BODY MASS INDEX, AND PRIORITY GROUPS IN U.S. MILITARY VETERANS: THE RICHMOND EXPERIENCE

Antony Fernandez, M.D., *Director, PTSD Program, McGuire VA Medical Center, 1201 Broad Rock Boulevard, Box 116A, Richmond, VA 23249-0001*; Demetrios A. Julius, M.D., *Chief, Mental Health Services, McGuire VA Medical Center, 1201 Broad Rock Boulevard, Box 116A, Richmond, VA 23249-0001*; Lynn Satterwhite, A.N.P.; Stan Feuer, L.C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize comorbid obesity in military veterans with Post-Traumatic Stress Disorder and relate it to socioeconomic status as defined by Priority Groups.

SUMMARY:

Post-Traumatic Stress Disorder (PTSD) is associated with co morbid obesity. Body Mass Index (BMI) is a useful parameter to estimate the prevalence of overweight and obesity. In 1996 the US Congress defined eligibility criteria for medical case within the Veterans Administration and defined medical benefits package and Priority Groups based on multiple variables, including low income. The PTSD program database was reviewed. Variables assessed included (1) age, (2) decade of life, (3) height, (4) weight, (5) sex, (6) race, (7) priority groups. We calculated BMI. Of the 252 veterans 167 (66.27%) were in the age range of 50 to 59 years. The mean BMI of all veterans was $30.2 \pm 5.6 \text{ kg/m}^2$. Far exceeding current U.S. population findings, 84.1% of our study population was either overweight or obese. Analysis of variance (ANOVA) revealed decade of life

did not predict BMI ($df = 6$, $F = 1.372$, $p = 0.226$). Combining Priority Groups 1 & 2 into a single group and Groups 3–6 into a single group revealed that preferred priority grouping was associated with higher BMI. Study suggested that low Socioeconomic status is most likely explanation for greater BMI's in lower priority groups than in higher priority groups. Clearly, more definitive studies are needed with much larger study populations.

TARGET AUDIENCE:

Psychiatrists, physicians, nurse practitioners, social workers.

REFERENCES:

1. Flegal KM, Carroll MD, Ogden CL, Johnson CL. Prevalence and trends in obesity among US adults, 1999–2000. *JAMA* 2002; 288:1723–7.
2. Magruder KM, Frueh BC, Knapp RG, et al: PTSD symptoms, demographic characteristics, and functional status among veterans treated in VA primary care clinics. *J Traum Stress* 2004; 17:293–301.

Poster 205

Saturday, October 7
8:30 a.m.-10:00 a.m.

CORRELATION OF PTSD SEVERITY AND DISRUPTIVE NOCTURNAL BEHAVIORS IN MALE MILITARY VETERANS WITH PTSD

Antony Fernandez, M.D., *Director, PTSD Program, McGuire VA Medical Center, 1201 Broad Rock Boulevard, Box 116A, Richmond, VA 23249-0001*; Lynn Satterwhite, A.N.P., *Adult Nurse Practitioner, McGuire VA Medical Center, 1201 Broad Rock Boulevard, Box 116A, Richmond, VA 23249*; John Lynch, Ph.D.; John P. Benesek, Psy.D.; Demetrios A. Julius, M.D.; Victor Viweg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that assessment of sleep disturbances in PTSD patients may facilitate the identification of those who may benefit from adjunctive sleep focused interventions.

SUMMARY:

Severe insomnia and Disruptive nocturnal behaviors in PTSD may represent PTSD specific sleep disturbances. The Pittsburg Sleep Quality Index Addendum for PTSD (PSQI-A) is a valid instrument for PTSD applicable in clinical as well as research settings. Disruptive nocturnal behaviors (DNB) such as trauma related nightmares, nocturnal intrusive memories, distressing dreams not related to the trauma, sleep terrors, nocturnal

panic attacks, dream enactment behaviors, and other complex motor behaviors may represent more specific sleep disturbances in PTSD. A global score of 5 or greater indicates clinically significant sleep disturbances. The goal of this study was to examine and characterize DNB in a group of military veterans with PTSD and correlate findings with severity of PTSD as measured by PCL_M

The 41 patients enrolled in our PTSD program completed the (PSQI-A), a self-report instrument designed to assess the frequency of seven DNB. We calculated PSQI-A total score. Study variables included (1) age, (2) Global PSQI-A score (3) PCL_M score, (4) race. The mean age was 58.33 ± 8.35 years. 78% of our sample was African American. The mean Global PSQI-A score was 11.82 ± 5.05 suggesting severe DNB. Statistical analysis was carried out using Pearson's correlation coefficient. There was statistically significant correlation between severity of PTSD (as measured by the PCL_M) and PSQI-A ($p < 0.001$). More definitive studies are needed with much larger populations with a broader range of traumatic events.

TARGET AUDIENCE:

Psychiatrists, psychologists, social workers, nurse practitioners.

REFERENCES:

1. Germain A, Hall M, Krakow B, Katherine Shear M, Buysse DJ. A brief sleep scale for Posttraumatic Stress Disorder: Pittsburgh Sleep Quality Index Addendum for PTSD. *J Anxiety Disord.* 2005; 19(2):233–44.
2. Blanchard, EB, Jones-Alexander, J, Buckley, TC, Forneris, CA, (1996). Psychometric properties of the PTSD Checklist (PCL). *Behaviour Research and Therapy*, 34, 669–673.

Poster 206

Saturday, October 7
8:30 a.m.-10:00 a.m.

PERSONAL AND SOCIAL PERFORMANCE SCALE: PATIENTS WITH STABLE SCHIZOPHRENIA

*Supported by Johnson & Johnson
Pharmaceutical Services*

Dennis D. Gagnon, M.A., MABF, *Director of Health Economics and Pricing, Johnson & Johnson Pharmaceutical Services, L.L.C., P.O. Box 670, 700 U.S. Highway 202, South, Raritan, NJ 08869*; Ines Adriaenssen, M.S.C., *Manager, Health, Economics, and Pricing, Johnson & Johnson Pharmaceutical Services, L.L.C., Turnhout 30, Beerse, Belgium B2340*; Henry A. Nasralah, M.D.; Pier L. Morosini, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand that the Personal and Social Performance scale is a reliable and valid measure of personal and social function in patients with stable schizophrenia with good construct validity and sensitivity to clinical change.

SUMMARY:

The Personal and Social Performance scale (PSP) addresses 4 domains of personal and social functioning and has shown good reliability and validity in patients with stabilized schizophrenia¹. This study assesses the reliability, validity, responsiveness and minimally important difference (MID) of the PSP in an outpatient population with stabilized schizophrenia.

Data from two clinical antipsychotic studies (n=411; mean baseline PANSS=66.4 and CGI-S=3.5) were analyzed. Outcome measures included PANSS, CGI-S, Strauss-Carpenter Level of Function (LOF) and PSP. Test-retest reliability for the PSP were assessed and intraclass correlation coefficients (ICC) derived. Convergent and discriminant validity was assessed. Sensitivity of the PSP to clinical change and the MID were evaluated.

The test-retest ICC exceeded 0.70, indicating good reliability. PSP was more highly correlated with LOF (p=0.61) than with the PANSS (p=-0.45). The PSP discriminated between different levels of CGI severity (p<0.0001). Regression analyses showed that PSP is sensitive to change in PANSS total score (p<0.0001). Based on a 1 category improvement in CGI-S, the observed between-group MID for PSP in stable patients was 6-7 points.

These data support the PSP as a reliable clinician-reported measure of personal and social function in outpatients with stabilized schizophrenia with good construct validity and sensitivity to clinical change.

TARGET AUDIENCE:

Psychiatrists and mental health professionals.

REFERENCES:

1. Morosini PL, et al: Acta Psychiatr Scand 2000; 101(4):323-329.
2. Bellack A, Muesser K, Gingerich S, Agresta J. Social Skills Training for Schizophrenia: A Step-By-Step Guide 2004. Cortland, New York: Therapeutic Resources, Inc.

Poster 207

Saturday, October 7
8:30 a.m.-10:00 a.m.

MANAGEMENT OF THE VIOLENT PATIENT IN THE COMMUNITY MENTAL HEALTH CENTER

Gerard Gallucci, M.D., *Medical Director, Community Psychiatry, Johns Hopkins Bayview Medical Center,*

4940 Eastern Avenue, D2 East, Baltimore, MD 21224-2735; Sheila Seltzer, *Manager, Adult Outpatient Programs, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, D2 East, Baltimore, MD 21224;* Pritika Chatterjee

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize some of the risk factors associated with violence in the health care setting and understand some of the policies and procedural issues developed to manage the violent patient in the Community Mental Health Center.

SUMMARY:

Violence in health care settings is increasing and most episodes of violent behavior community-based clinics are committed by patients. A number of risk factors for violence have been identified and include poor socioeconomic status, a reduction in available mental health and substance treatment services, and more severely ill patients with mental disorders living in the community.

Public psychiatry clinics are most vulnerable to these problems due to the demographic characteristics of the population served, the severity of symptoms experienced by patients and the reduction of resources available for treatment.

The Johns Hopkins Bayview Community Psychiatry Program has reviewed the literature regarding violence in the workplace and has examined situations involving patients' threats of violence in our Community Mental Health Center. Moral, legal and treatment-related issues associated with managing the violent patient in the CMHC will be discussed.

TARGET AUDIENCE:

Physicians, nurses, social work and other mental health therapists.

REFERENCES:

1. Speedy, S. Workplace violence: the dark side of organizational life. *Contemp Nurse.* 2006 May; 21(2):239-50.
2. Heitt MC, Tamburo MB. The development and evaluation of an internal workplace violence risk assessment protocol: one organization's experience. *Int J Emerg Ment Health.* 2005 Summer; 7(3):219-26.

Poster 208

Saturday, October 7
8:30 a.m.-10:00 a.m.

THE INPATIENT DILEMMA: PATIENTS WITH MENTAL RETARDATION AND CO-OCCURRING MENTAL ILLNESS

Joseph M. Garbely, D.O., *Assistant Professor, Department of Psychiatry, Temple University, 100 East Lehigh*

Avenue, Suite 305 MAB, Philadelphia, PA 19125; Javed A. Joy, M.D., Assistant Professor, Department of Psychiatry, Temple University, 100 East Lehigh Avenue, Suite 305 MAB, Philadelphia, PA 19125

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the unique challenges the psychiatrist's encounters when treating patients with mental retardation and co-occurring mental illness; create a more appropriate treatment milieu on an inpatient unit; construct a more efficient treatment team approach.

SUMMARY:

Introduction: 27%–71% of patients with Mental Retardation (MR) have co-occurring mental illness. There is limited research on successful treatment programs, sparse outcome data and a lack of validated psychometric tests for this group of patients. These patients often have an insufficient length of stay (LOS) necessary to address their complex problems, receive inappropriate medications to treat behavior leading to misdiagnosis in an effort to support medication choice. The disconnect between behavior, diagnosis, and treatment led to the necessity of establishing a specialized inpatient unit with the partnership of Philadelphia Mental Retardation Services.

Methods: Phase I included training new staff; II included developing specialized programming, improving communication with outpatient providers, and optimizing coordination of care; III introduced a battery of psychometric tests designed to improve accuracy of diagnosis and assess degree of functioning; Phase IV was a chart review of the 100 patients admitted beginning in 2003 with the diagnosis of MR and mental illness.

Results: Pilot data comparing this specialized unit with matched controls in the non-specialized units showed a significantly longer LOS (19 days vs 11 days, $p < 0.05$), more definitive diagnoses (e.g. fewer NOS diagnoses 0.0% vs. 7.3%), an overall trend towards reduction in the number of medications.

Discussion: Improved diagnostic accuracy, achieved through intensive evaluation permitted by longer LOS, led to appropriate treatment choices, reduction of unnecessary medications and side effects, with decreased recidivism. Ongoing prospective data collected to measure congruence between behavior, diagnosis, treatment, medication side effects, recidivism and impact of psychometrics on diagnostic accuracy. This research has the potential to redefine diagnostic approaches, treatment strategies, and quality of care in this challenging yet ever-rewarding patient population.

TARGET AUDIENCE:

Developmental Psychiatrists/Inpatient Psychiatrists.

REFERENCES:

1. Cowley A, Newton J, Sturmey P, Boras N: Psychiatric Inpatient Admissions of Adults with Intellectual

Disabilities: Predictive Factors AJMR 2005; 110, 3215–225.

2. Moss S, Emerson E, et al: Psychiatric Symptoms in Adults with learning Disability and Challenging behavior. The British Journal of Psychiatry 2000; 177: APA 452–456.

Poster 209

Saturday, October 7

8:30 a.m.-10:00 a.m.

PREVALENCE OF COMORBID ADULT ADD IN AN OUTPATIENT SETTING

John A. Gergen, M.D., *Psychiatrist, 250 Pantops Mountain Road, Apt. 5107, Charlottesville, VA 22911-8701*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to be aware of a significant prevalence of comorbid adult attention deficit disorder (AADD) in psychiatric outpatient settings; identify situations where this is most likely to be present; recognize possibilities of AADD being an intervening variable in other studies.

SUMMARY:

Recent observations have begun to allow better identification of adults with comorbid attention deficit difficulties (AADD). ADHD in children and adolescents is frequently accompanied by comorbid difficulties. However, genetic underpinnings of ADHD are better considered as leading to a series of personality traits rather than a disorder. Adult traits consistent with the genetic roots of ADHD free of comorbid overlap have been designated as altered attention traits (AAT). When present with symptoms of ADHD there is a high specificity for comorbid presence. The present study attempts to identify the prevalence of comorbidity in one psychiatric outpatient setting. A retrospective chart review was pursued for 126 adults seen consecutively (average age 44; 83 female), recognizing that inconsistent data was likely to be present and that estimates of probabilities of comorbidity would be necessary. 22 patients were discarded as data was insufficient for any estimate; 29 were unlikely (0–10% probability); 14 as limited possibility (10–30%); 21 as possible (30–60%); 22 as highly suggestive (60–90%) and 18 as confirmed (90–100%). Primary diagnoses for highly suggestive and confirmed were bipolar spectrum, anxiety with panic, OCD or PTSD and substance abuse. Likelihood of onset of these difficulties was rare beyond age 21.

REFERENCES:

1. Dubovsky JL: How to reduce mania risk when prescribing stimulants. Evidence-based hierarchy helps when bipolar and ADHD symptoms overlap. Current Psychiatry Online 2005; Vol 4, No 10/October.

2. Gergen JA: ADD Comorbidity in Adults. New Research Abstracts; American Psychiatric Association Annual Meeting 2006; NR54/pgs22-23.

Poster 210

**Saturday, October 7
8:30 a.m.-10:00 a.m.**

**INSIGHT IN SCHIZOPHRENIA AND ITS
RELATIONSHIP TO FUNCTIONING**

Supported by Janssen, L.P.

Georges M. Gharabawi, M.D., *Therapeutica Area Leader, CNS, Medical Affairs Department, Janssen Pharmaceutica, Inc., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Cynthia A. Bossie, Ph.D., *Central Nervous System Clinical Development, Janssen Pharmaceutica Products, L.P., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Ibrahim Turkoz, M.S.; P. Bouhours, M.D.; Richard Druckenbrod, Pharm.D.; Mary J. Kujawa, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the relationship between insight and variables reflecting clinical status, social functioning, and cognition. Further, the participant should be able to identify the impact of insight, negative symptoms, and treatment duration on social functioning.

SUMMARY:

Objective: To assess the relationship between insight, demographics, and clinical variables with functioning.

Methods: Stable patients with schizophrenia or schizoaffective disorder received long-acting, injectable risperidone every 2 weeks in a 1-year trial. Insight was measured by the Positive and Negative Syndrome Scale (PANSS) G12 item. Other measures included PANSS factors, Clinical Global Impressions-Severity (CGI-S), Strauss-Carpenter Levels of Functioning (LOF), Personal and Social Performance Scale (PSP), and a cognitive battery. Correlation and regression analyses examined associations between insight, treatment duration, demographics, and clinical/functional measures.

Results: Baseline insight scores correlated significantly with baseline CGI-S, ($r=0.30, P<0.001$), PANSS factors (range, $r=0.57-0.24, P<0.001$), functioning scores (LOF item 7, $r=-0.19, P<0.001$); PSP total ($r=-0.22, P<0.001$), and cognitive domain Z scores ($P<0.05$). Significant correlations were observed for changes in many of these domain scores at endpoint. Regression models identified three significant ($P<0.01$) factors of PSP variance: insight (-1.7 PSP point/+1 insight point), negative symptom change (-0.7 PSP point/+1 negative symptom point), and treatment duration (0.8 PSP point/month).

Conclusions: Insight correlated significantly with measures of symptom/illness severity, cognition, and functioning. A significant association was noted between level of insight, negative symptoms and duration in study (compliance proxy) in patients with schizophrenia/schizoaffective disorder.

Source of Funding: Janssen, L.P.

TARGET AUDIENCE:

Clinical Psychiatrists.

REFERENCES

1. Amador XF, Strauss DH, Yale SA, et al: Awareness of illness in schizophrenia. *Schizophr Bull.* 1991; 17(1):113-32.
2. Mintz AR, Dobson KS, Romney DM. Insight in schizophrenia: a meta-analysis. *Schizophr Res.* 2003; 61(1):75-88.

Poster 211

**Saturday, October 7
8:30 a.m.-10:00 a.m.**

**IMPROVING ATTITUDES AND BEHAVIOR
IN HIGH-RISK, INNER-CITY YOUTH**

*North Carolina Psychiatric Association's
Cultural Diversity Committee*

Roger C. Gibson, D.M., *Research Fellow, Department of Psychiatry, West Indies University, University Hospital, Mona, Jamaica KGN7*; Frederick W. Hickling, D.M.; Kai A. Morgan, Psy.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate an understanding of the role of the arts in community mental health programs, especially as they relate to inner-city youth; demonstrate an understanding of the role of large discussion groups in a similar context.

SUMMARY:

Inner-city communities are characterized by poverty, violence and unequal opportunities for advancement. Many inner-city youth are unmotivated to strive for excellence because they perceive their future as a depressing foregone conclusion. They are also at high risk for mood and anxiety disorders, stress-related health problems and anti-social behavior. Several intervention models have attempted to ameliorate these risks. A unique school-based model was established in an inner-city community in Kingston, Jamaica from 2001 to 2004. It targeted a single remedial inner-city school which had requested help from a university psychiatry department because of feelings of frustration with their own attempts to deal with the severe conduct and academic problems

which the students exhibited. The intervention utilized the performing and visual arts as well as large discussion groups of up to 70 adolescent participants as therapeutic strategies. The students and their teachers discussed the impact of the program in tape-recorded group interviews. They identified positive changes in students' attitudes and behavior and increases in their self-acceptance and self-worth as direct outcomes. They also thought that more involvement from community and family members would strengthen the model.

Funding was received from the Environmental Foundation of Jamaica and the Planning Institute of Jamaica.

REFERENCES:

1. Hickling, FW (1989) Sociodrama in the rehabilitation of chronic mental illness. *Hospital and Community Psychiatry*, 40:402–6.
2. Samms-Vaughan, M. (2000) Cognition, educational attainment and behaviour in a cohort of Jamaican children. Kingston: Planning Institute of Jamaica.

Poster 212

Saturday, October 7
8:30 a.m.-10:00 a.m.

URINE NEURAL THREAD PROTEIN IN ALZHEIMER'S DISEASE

Supported by Nymox Corporation

Ira Goodman, M.D., *Orlando Regional Healthcare, 818 Main Lane, Orlando, FL 32801*; Greg Golden, M.D.; Stephen Flitman, M.D.; Kevin Xie, M.D.; Alireza Minaagar, M.D.; Earl Zimmerman, M.D.; Ralph Richter; Paul Averback

EDUCATIONAL OBJECTIVES:

At the end of this session, the participants should recognize that Urine Neural Thread Protein (UNTP) is valuable in the routine evaluation of cases of suspected Alzheimer's disease.

SUMMARY:

A prospective study was carried out to demonstrate the utility of UNTP measurement in the diagnosis of Alzheimer's disease. NTP is a 41 kD protein present in neurons which is selectively upregulated in Alzheimer's disease (AD) brain and which is associated with the pathology of the disease. Over-expression of NTP in transfected neuronal cells promotes neuritic sprouting, apoptosis and cell death. Using a new competitive ELISA UNTP assay kit, levels have been measured in samples from cases of AD as well as age matched normal controls and a variety of neurological disease controls (N=168). Levels of greater than 22 µg/mL are found consistently in cases of probable AD and in less than 10% of controls. UNTP measurement provides an im-

provement of 23% in positive predictive value, and an improvement of 78% in negative predictive value, compared to prior probability based on prevalence. This prospective study confirms earlier retrospective studies of UNTP and demonstrates its usefulness in the routine evaluation of cases of suspected AD.

Supported in part by funding from Nymox Corporation

TARGET AUDIENCE:

Geriatric psychiatrists.

REFERENCES:

1. de la Monte SM, et al: Characterization of the AD7C-NTP cDNA expression in Alzheimer's disease and measurement of a 41-kD protein in cerebrospinal fluid. *J. Clin. Invest.* 1997; 100:3093–3104.
2. Kahle PJ, Jakowec M, Teipel SJ, et al: Combined assessment of tau and neuronal thread protein in Alzheimer's disease CSF. *Neurology*, 2000; 54:1498–1504.

Poster 213

Saturday, October 7
8:30 a.m.-10:00 a.m.

A RESIDENT FORUM ON THE USE OF SECOND GENERATION ANTIPSYCHOTICS IN BIPOLAR DISORDER: DOES CLINICAL PRACTICE REFLECT CLINICAL RESEARCH?

Amanda B. Gowans, M.D., *Department of Psychiatry, Medical College of Georgia, 1515 Pope Avenue, Augusta, GA 30912*; R. Gregg Dwyer, M.D., Ed.D., *Department of Psychiatry, University of South Carolina School of Medicine, 31 Hamptonwood Way, Columbia, SC 29209-1390*; C. Simon Sebastian, M.D.; Meera Narasimhan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that selection of atypical antipsychotics for treating acute mania lags behind current research trends.

SUMMARY:

Objective: This study evaluated resident opinions and practice habits for utilizing atypical antipsychotics in acute mania. *Method:* Resident focus groups using case scenarios at two southeastern psychiatry residency programs discussed their opinions and prescribing practices for treating acute mania with atypical antipsychotics. *Results:* Although most of the twenty-five participating residents considered atypical antipsychotics as first-line treatment for acute mania, few prescribed antipsychotics

as monotherapy. A majority reported antipsychotics as equal or superior in efficacy to lithium for treating acute mania. Conclusions: Selection of atypical antipsychotics for treating acute mania in a clinical setting (residency training) lags behind current research trends.

There are no funding sources to disclose.

TARGET AUDIENCE:

psychiatry residents, psychiatry resident educators.

REFERENCES:

1. Stahl SM. *J Clin Psychiatry* 2004; 65(10):1298–1299.
2. Suppes T, et al: *J Clin Psychiatry* 2005; 66(7):870–886.

Poster 214

**Saturday, October 7
8:30 a.m.-10:00 a.m.**

ARIPIPRAZOLE: EFFECTS ON METABOLIC RISK FACTORS AND SEXUAL SATISFACTION

Supported by Bristol-Myers Squibb Company

Lisa H. Guzik, B.A., *Department of Psychiatry, Greater Los Angeles VA Medical Center, 11301 Wilshire Boulevard, Building 210, Los Angeles, CA 90073*; Shirly Mahgerefteh, B.A., *Researcher, Greater Los Angeles VA Medical Center, 11301 Wilshire Boulevard, Building 210, Los Angeles, CA 90073*; William C. Wirshing, M.D.; Shirley J. Mena, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should understand the impact of changing to aripiprazole on cardiovascular parameters and subjective sexual satisfaction.

SUMMARY:

Objective: To determine the impact of changing to aripiprazole on metabolic parameters and reported sexual satisfaction.

Method: A 6-month, open-label, predominantly naturalistic, prospective, changeover design was employed with the metabolic and sexual satisfaction data harvested through out the protocol.

Results: Seven, male subjects were enrolled, one completed, but 4 of 7 continued to take aripiprazole months after termination. Three of 7 had a worsening of their manic symptoms that ranged from mild (protocol continued) to severe (immediately dropped and several weeks required to restabilize). The protocol mandated discontinuation for doses other than 15–30mg of aripiprazole or required adjunctive psychotropics. Thus, two patients were dropped for needing only 7.5mg and another two receiving 40mg. Only the severe manic decompensation

patient and another subject who had a mild deepening of his baseline depressive symptoms showed any symptomatic worsening. Impressively, all seven patients preferred the aripiprazole to their previous treatment. The metabolic changes were variable, unpredicted, and on average, without trend, though the variances on weight and circulating triglycerides were high. No patient, though, demonstrated the temporal pattern of weight gain that we have typically seen the other newer antipsychotics. There was little change on the sexual functioning survey.

Conclusions: The change to aripiprazole was associated with symptomatic manic worsening and enhanced subjective tolerability unrelated to improvements in sexual functioning or metabolic parameters.

Bristol-Myers Squibb.

REFERENCES:

1. Burke MA, McEvoy JP, Ritchie JC: A pilot study of a structured interview addressing sexual function in men with schizophrenia. *Biol Psychiatry* 1994; 35:32–35.
2. Meltzer HY, Davidson M, Glassman AH, Vieweg WV: Assessing cardiovascular risks versus clinical benefits of atypical antipsychotic drug treatment. *J. Clin Psychiatry* 2002; 63 Suppl 9:25–9.

Poster 215

**Saturday, October 7
8:30 a.m.-10:00 a.m.**

ASSESSMENT OF WEIGHT LOSS CLASSES FOR PATIENTS WITH SEVERE MENTAL ILLNESS

Supported by Bristol-Myers Squibb Company

Lisa H. Guzik, B.A., *Department of Psychiatry, Greater Los Angeles VA Medical Center, 11301 Wilshire Boulevard, Building 210, Los Angeles, CA 90073*; Zach Erickson, B.A., *Department of Psychiatry, Greater Los Angeles VA Medical Center, 11301 Wilshire Boulevard, Building 210, Los Angeles, CA 90073*; Donna A. Wirshing, M.D.; Shirly Mahgerefteh, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to understand that patients who suffer from severe mental illness have the ability benefit from behavioral intervention classes.

SUMMARY:

Since their introduction in the early 1990s, second generation antipsychotic medications (SGA's) have become first line treatments in the United States for schizophrenia. Though the SGAs have little extrapyramidal toxicity, weight gain is the new Tardive Dyskenisia of

these drugs. Weight gain is an emotionally distressing side effect that contributes to non-adherence. Additionally, it has been found that patients treated with antipsychotic medications who gain weight have a reduced quality of life, poorer self-reported general health, and decreased vitality.

There is much skepticism and stigma about whether patients with severe mental illness (SMI) can participate, understand, and benefit from a behavioral approach to weight loss. The goal of this study was to develop a set of sixteen classes, adapted from the Diabetes Prevention Program, that were understandable and enjoyable for overweight patients with SMI. The efficacy of these classes was assessed in small pilot groups at an outpatient schizophrenia clinic.

Optional weekly surveys reflected that the classes were understandable, informative, and enjoyable, as well as outstanding attendance. By the end of the program most patients had initiated a modest exercise program, and reported some weight loss. Secondarily, classes had a pro-social effect for patients with profound negative symptoms.

Educational Objective: Patients who suffer from SMI have the ability to attend, benefit from, and enjoy behavioral intervention classes given on a regular basis. Patients were able and motivated to alter their nutritional and exercise regimen in attempts to counteract the metabolic side effects of SGAs.

REFERENCES:

1. Rotatori, Weight loss with psychiatric residents in a behavioral self control program. *Psychol Rep*, 1980.46: p. 483–486.
2. Diabetes Prevention Program, The Diabetes Prevention Program (DPP): description of lifestyle intervention. *Diabetes Care*, 2002. 25(12): p.2165–71.

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**Saturday, October 7
8:30 a.m.-10:00 a.m.**

SUBSTANCE ABUSE PREDICTS HOSPITALIZATION IN 2,963 VETERANS WITH BIPOLAR DISORDER

Jennifer C. Hoblyn, M.D., M.P.H., *Department of Psychiatry, Stanford VA Hospital, 3801 Miranda Avenue, Unit 2B1, Palo Alto, CA 94304-1207*; John O. Brooks, M.D., Ph.D., *Assistant Professor, Department of Psychiatry, Stanford VA Hospital, 3801 Miranda Avenue, Unit 2B1, Palo Alto, CA 94304-1207*; Steven L. Bait, M.D., M.S.C.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to identify those patient with bipolar disorder who are at high risk for admission to psychiatry.

SUMMARY:

Objective: To develop profiles of risk factors for psychiatric hospitalization so healthcare needs may be planned.

Method: This retrospective study used the database maintained by the Veteran's Affairs Health Care System, Palo Alto, (2003–2004) to extract data for veterans diagnosed with bipolar disorder (Types I, II, and NOS).

Predictors included age, gender, ethnicity, and presence of comorbid substance use disorders. A Receiver Operator Characteristic (ROC) was used to determine the association of the predictors with hospitalization.

Results: Veterans with bipolar disorder had a risk of psychiatric hospitalization of 20%. Patients with comorbid alcohol use disorder had a 43% risk of hospitalization; comorbid polysubstance dependence (PSD) increased the risk to 57% and those separated had a risk of 100%. Patients without an alcohol use disorder, but who were separated from their spouses the risk of hospitalization was 76%. Age did not appear to predict inpatient hospitalization.

Conclusions: High rates of alcohol and substance use are reported in bipolar patients (Cassidy, 2001) and annual societal costs approach \$45 billion (Sajatovic, 2005). Comorbid alcohol use, polysubstance dependence, and marital separation increased the risk of psychiatric hospitalization in this population.

REFERENCES:

1. Cassidy F, Ahern EP, Carroll BJ. Substance abuse in bipolar disorder. *Bipolar Disorders* 2001; 3: 181–188.
2. Sajatovic M. Bipolar Disorder: Disease Burden. *Am J Manag Care* 2005; 11:3 Suppl. 80–84.

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**Saturday, October 7
8:30 a.m.-10:00 a.m.**

WEIGHT LOSS PROGRAM FOR PATIENTS WITH SCHIZOPHRENIA TAKING ANTIPSYCHOTIC MEDICATION

Supported by Eli Lilly and Company and the Weltner Foundation

Michel Jean-Baptiste, M.D., *Assistant Professor of Psychiatry, Yale University, 34 Park Street, New Haven, CT 06511-2820*; Umesh R. Chakunta, M.S., *Research Assistant, Department of Psychiatry, Yale University, 34 Park Street, New Haven, CT 06519*; Akm Q. Hassan, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to determine whether obese patients with schizophrenia or schizoaffective disorder, taking antipsychotic medications, will show significant and durable

weight reduction and improved metabolic profile by participating in the LEARN Program for weight management in conjunction with a behavioral and nutritional intervention program.

SUMMARY:

Objective: We hypothesize that obese patients with schizophrenia or schizoaffective disorder taking antipsychotic medications will show significant and durable weight reduction and improved metabolic profile by participating in the LEARN Program for weight management in conjunction with a food provision program.

Methods: Randomized, controlled, prospective study of 18 obese (BMI \geq 30kg/m²) outpatients at the Connecticut Mental Health Center, with schizophrenia or schizoaffective disorder, taking typical or atypical antipsychotic medications, comparing body weight, blood pressure, fasting glucose, triglycerides and cholesterol at the beginning and end of a 16 week behavioral intervention (LEARN program plus food provision) or treatment as usual, and then crossed over to the other condition for an additional 16 weeks. All measurements repeated 6 months after completion of intervention.

Comparison of the results by t tests between week one and week 16 and week 1 and 6 months, along with comparing the results using repeated ANOVA.

Results: For all subjects who completed 6 months (n=12) a significant mean effect due to time was observed. There was a decline in the mean weight across time with mean =224.0 at week 1, mean =217.4 at week 16, and mean = 213.0 at 6 months. With F(2,20) = 4.78, p<0.02, and a significant linear trend (p<0.02) indicating that change happened steadily over time. Pair wise comparisons showed a significant weight loss (p<0.05) between week 1 and week 16 (mean = 6.60 lbs) and between week 1 and 6 months (mean = 10.99 lbs). Paired T tests between week 1 and week 16 for those participants who lost weight showed a significant decline in fasting blood glucose t(6) = 5.27, p<0.002, two-tailed.

Conclusion: Health risks of antipsychotic medications can be reduced by a behavioral weight program in conjunction with food provision. The results need to be confirmed in a larger study.

TARGET AUDIENCE:

Health care professionals including physicians, psychiatrists, residents, and students).

REFERENCES:

1. Brownell KD. (2000). The LEARN Program for weight management 2000. Dallas TX: American Health Publishing.
2. Keck PE, McElroy SL. Bipolar disorder, obesity, and pharmacotherapy-associated weight gain. J Clin Psychiatry. 2003 Dec; 64(12):1426–35.

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Saturday, October 7
8:30 a.m.-10:00 a.m.

EMERGENCY MANAGEMENT OF AGITATION IN PREGNANCY

April S. Ladavac, M.D., *Resident Physician, Department of Psychiatry, Temple University Hospital, 100 East Lehigh Avenue, Suite 305, Philadelphia, PA 19125;* William R. Dubin, M.D.; Autumn Ning, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the impact of antipsychotic medication and benzodiazepines on pregnant women and the fetus; and evaluate management strategies for pregnant women who are treated in a psychiatric emergency service.

SUMMARY:

Objective: To better understand how agitated pregnant women are pharmacologically managed in a psychiatric emergency service (PES). *Method:* A retrospective chart review was conducted on 80 women admitted to a PES with HCG-positive urine, from January 1, 2004 to June 30, 2005. Demographics chief complaint, medical status, drug use, medical management in the PES, pregnancy awareness, prenatal care, and trimester of pregnancy were analyzed. Where possible, pregnancy outcomes were obtained from Temple University Hospital Systems (TUHS) records. Demographic profiling and characterization of other variables were completed using simple frequency calculations and cross tabulations with SPSS.

Results: Thirty-one (39%) patients received psychotropic medication. A total of 34 doses were administered to these patients; only three of which were a second dose. Haloperidol, alone or in combination with a benzodiazepine, was the most frequently administered psychotropic medication. Of the delivery records were available, all eleven babies has normal birth weights and APGAR scores. *Conclusion:* Acute agitation can successfully be managed with antipsychotic medication and/or benzodiazepines. Haloperidol, given as a single agent, is the authors' preferred drug. However, the minimal amount of medication necessary should be used and any intervention should also include interpersonal management techniques to attenuate the agitation.

TARGET AUDIENCE:

Emergency psychiatrists, and hospital-based psychiatrists.

REFERENCES:

1. Allen MH, Currier GW, Hughes DH: Medication strategies for a pregnant woman who is agitated, psychotic, and unresponsive to direction. The Expert

- Consensus Guideline Series. In: Treatment of Behavioral Emergencies. Postgraduate Medicine 2001:48.
2. Altshuler LL, Cohen L, Szuba MP, Burt VK, Gitlin M, Mintz J: Pharmacologic management of psychiatric illness during pregnancy: dilemmas and guidelines. Am J Psychiatry 1996; 153; 592–606.

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**Saturday, October 7
8:30 a.m.-10:00 a.m.**

CHILDHOOD TRAUMA AND BORDERLINE PERSONALITY DISORDER

Nahla A. Mahgoub, M.D., *Resident, Department of Psychiatry, Bergen Regional Medical Center, 501 Eastbrook Road, Ridgewood, NJ 07450*; Saima Shafiq, M.D., *Resident, Department of Psychiatry, Bergen Regional Medical Center, 230 East Ridgewood Avenue, Building 14, Ridgewood, NJ 07652*; Bharati A. Palkhiwala, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to determine the association between early childhood trauma and borderline personality.

SUMMARY:

Objective: To determine the association between a diagnosis of borderline personality disorder and history of childhood abuse.

Background: Personality disorders affect 10–15% of the adult US population and prevalence of borderline personality disorder in general population is 2%. Most theories about the etiology of BPD include the biological predisposition and psychosocial factors.

Biological factors, such as abnormal monoaminergic functioning (especially in serotonergic function) has been implicated but has not been well established by research. Psychosocial formulations highlight the high prevalence of abuse (sexual, physical, and emotional) during childhood in these patients.

Method: Patients with DSM IV criteria of borderline personality disorder were compared to a healthy control group with regard to childhood abuse.

A retrospective chart review of 82 patients with diagnosis of borderline personality disorder and 82 patients without diagnosis of personality disorder in Outpatient Clinic at Bergen Regional Medical Center. History of childhood abuse was obtained. Other data collected included age, race and gender.

Results: Of the 82 patients with diagnosis of borderline personality disorder, 61 (74 %) patients reported history of childhood abuse.

Of the 61 borderline patients with history of childhood abuse, 24 (39.3 %) patients had history of sexual abuse, 5 (8.1 %) patients suffered from physical abuse and 1 (1.6 %) patient reported history of verbal abuse while

31 (51 %) patients described multiple forms of abuse. 52 (85 %) patients were females and 50 (81%) patients were Caucasian.

Of the 82 patients without diagnosis of personality disorder, 39 (47.5 %) patients reported history of childhood abuse in different forms.

Conclusion: Our study indicated a higher incidence of childhood abuse among patients with diagnosis of borderline personality disorder. The results indicated that different forms of childhood abuse are broadly represented among patients with borderline personality disorders and majority of these patients reported sexual abuse during childhood.

TARGET AUDIENCE:

Psychiatrists, residents, and fellows.

REFERENCES:

1. Bierer LM, et al. Abuse and neglect in childhood: relationship to personality. CNS Spectr. 2003.
2. Herman JL, et al. Childhood trauma in borderline personality disorder. Am J Psychiatry 1989 April.

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**Saturday, October 7
8:30 a.m.-10:00 a.m.**

IS HYPERCHOLESTEROLEMIA A RISK FACTOR FOR THE DEVELOPMENT OF ALZHEIMER'S DISEASE?

Nahla A. Mahgoub, M.D., *Resident, Department of Psychiatry, Bergen Regional Medical Center, 501 Eastbrook Road, Ridgewood, NJ 07450*; Amel A. Badr, M.D., *Department of Psychiatry, Bergen Regional Medical Center, 230 East Ridgewood Avenue, Paramus, NJ 07652*; Asghar Hossain, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to consider high cholesterol level as a risk factor for development of Alzheimer's Disease.

SUMMARY:

Objective: To determine the effect of increased serum total cholesterol on the development of Alzheimer's disease.

Background: Alzheimer's disease is the most common cause of dementia in the United States. Clinical studies showed that advanced age, family history, low education, head trauma and Down's Syndrome are risk factors for developing Alzheimer's disease.

Cholesterol has become an important countenance of studies in cognitive deficits and some studies suggested that cholesterol is a potent risk factor for the development of Alzheimer's disease. Researchers believed that im-

paired neuronal cholesterol homeostasis may account for neuropathological findings of Alzheimer's disease such as amyloid formation and tau hyperphosphorylation causing neurites degeneration and loss of synaptic plasticity.

Method: A retrospective chart review of 100 patients who were admitted in the geriatric psychiatric unit at Bergen Regional Medical Center between January 2003 and December 2005.

50 patients have diagnosis of dementia of Alzheimer type and 50 patients within the same age and gender frame, who have psychiatric diagnosis other than dementia of Alzheimer type, were labeled as controls.

The data collected included age, gender, ethnicity, age of onset of Alzheimer's disease, Axis I diagnosis, and fasting serum total cholesterol for the study and control patients.

Data Analysis and Results: Of the 50 patients who have diagnosis of dementia of Alzheimer type, 25 (50%) showed increased fasting serum total cholesterol. Of these patients, 10 (40%) were males and 15 (60%) were females, 22 (88%) were Caucasians and 3 (12%) were African-Americans with ages between 65 and 88 years and age of onset of Alzheimer's disease between 65 and 73 years. Of the 50 patients who have psychiatric diagnosis other than dementia of Alzheimer type, 11 (22%) showed increased fasting serum total cholesterol.

Conclusion: Our study indicated that 50% of patients with diagnosis of Alzheimer's disease have elevated total cholesterol. Of these patients, 88% were Caucasians and 60% were females with ages between 65 and 88 years and age of onset of Alzheimer's disease between 65 and 73 years. The findings suggest that elevated total cholesterol may play a role in the development of Alzheimer's disease.

TARGET AUDIENCE:

Psychiatrists, and primary care physicians.

REFERENCES:

1. Sjogren M, Blennow K. The link between cholesterol and Alzheimer's disease world Biol Psychiatry. 2005; 6(2):85-97.
2. Alexei R, Natalia V. Brain cholesterol Pathology is the cause of Alzheimer's disease. Clinical Medicine and Health Research 2001.

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**Saturday, October 7
8:30 a.m.-10:00 a.m.**

SEASONAL VARIATIONS IN HOSPITAL ADMISSIONS IN THE GERIATRIC PSYCHIATRIC UNIT

Nahla A. Mahgoub, M.D., *Resident, Department of Psychiatry, Bergen Regional Medical Center, 501 East-*

brook Road, Ridgewood, NJ 07450; Amel A. Badr, M.D., Department of Psychiatry, Bergen Regional Medical Center, 230 East Ridgewood Avenue, Paramus, NJ 07652; Shafiq Saima, M.D.; Asghar Hossain, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the effect of the season on the rate of admissions with different psychiatric diagnoses in different seasons.

SUMMARY:

Background: Influence of seasonal changes on mood and behavior is called seasonality. DSM IV recognized the cyclic pattern of mood disorder symptoms in adults in absence of psychosocial stresses. Several studies showed effects of climate and sunlight on the rate of admissions of adult patients. However, little is known about effect of seasonal fluctuations on geriatric population.

Method: A retrospective chart review of 144 patients who were admitted in the geriatric psychiatric unit at Bergen Regional Medical Center between January 2004 and December 2004 with diagnosis of depression, bipolar disorder, schizophrenia, schizoaffective disorder, and dementia. The data collected included age, gender, race, date of admission, date of discharge, and psychiatric diagnosis.

Results: The data showed recognizable seasonal variation in admissions with different psychiatric disorders. 47% of patients with diagnosis of depression were admitted in winter, 40% of patients with diagnosis of bipolar disorder-manic were admitted in fall, 40% of patients with diagnosis of schizoaffective disorder were admitted in fall, 32% of patients with diagnosis of schizophrenia were admitted in winter, and 36% of patients with diagnosis of dementia with behavioral disturbances were admitted in spring. Higher incidence of seasonal fluctuations was found in Caucasian females.

Conclusion: Our study indicated that most of psychiatric admissions of elderly population occurred during fall and winter except for dementia with behavioral disturbances that was more prevalent during spring. The findings may suggest a seasonal pattern of hospital admissions of the elderly psychiatric patients. Further research is needed to ascertain this findings.

TARGET AUDIENCE:

Psychiatrists, residents, and fellows.

REFERENCES:

1. Daniels BA et al. Seasonal variation in Hospital admissions. Acta Psychiatr. Scand., 2000 July.
2. Madden PA et al. Seasonal changes in mood and behavior. Arch Gen Psychiatry, 1996 Jan.

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Saturday, October 7
8:30 a.m.-10:00 a.m.**EFFECT OF CHRONIC COCAINE USE ON THYROID STIMULATING HORMONE LEVELS**

Nahla A. Mahgoub, M.D., *Resident, Department of Psychiatry, Bergen Regional Medical Center, 501 Eastbrook Road, Ridgewood, NJ 07450*; Aijaz A. Nanjiani, M.D., *Resident, Department of Psychiatry, Bergen Regional Medical Center, 230 East Ridgewood Avenue, Paramus, NJ 07652*; Saima Shafiq, M.D.; Asghar Hosain, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to assess the effect of chronic cocaine use on thyroid stimulating hormone (TSH) levels.

SUMMARY:

Background: Theoretically TSH (thyroid stimulating hormone) level in the anterior Pituitary is under control of TRH (thyroid releasing hormone) in the hypothalamus. If T3 and T4 levels are low, TRH is triggered from the hypothalamus and stimulates TSH release from the anterior Pituitary. TSH stimulates thyroid gland to release T3 and T4. Cocaine can induce endocrine and neurochemical changes that affect certain hormonal levels. The clinical manifestations of cocaine use mimic signs and symptoms of hyperthyroidism and some studies suggested that cocaine may affect the thyroid.

Method: A retrospective chart review of 200 patients who were admitted at Bergen Regional Medical Center. 100 patients have more than 1 year history of cocaine use and 100 patients within the same age and gender frame who don't have history of cocaine use and labeled as controls. T4d TSH levels for the 200 patients were documented.

Results: Of the 100 patients who have diagnosis of cocaine dependence, 10 % showed TSH levels below normal. Of patients who showed low TSH levels, 80 % had normal T4 levels, 50 % were males and 50% were females. Of the 100 patients who don't have history of cocaine use, 2 % showed low TSH levels with normal T4 levels.

Conclusion: Our study indicated that 10% of patients with diagnosis of cocaine dependence showed low TSH levels and of these patients 80% showed normal T4 levels. Our hypothesis that low TSH levels in cocaine dependent patients are not thyroidal phenomenon and it further has no effect on T4 levels. There is very little literature on this topic. Further studies can be done to investigate this phenomenon.

TARGET AUDIENCE:

Psychiatrists, residents, and fellows.

REFERENCES:

1. Byton KR et al. Hyperthyroidism in a cocaine dependent patient. *J clin Psychiatry*. Aug 1989.
2. Di Paolo T et al. Endocrine and neurochemical actions of cocaine. *Can J Physiol Pharmacol*. Sept 1989.

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Saturday, October 7
8:30 a.m.-10:00 a.m.**INNOVATIVE PROGRAM TARGETS "SKID ROW" PSYCHIATRIC PATIENTS: TWO-YEAR OUTCOMES**

Kathleen McGarvey, M.D., *Clinical Assistant Professor of Psychiatry, University of British Columbia, 2601 Lougheed Highway, Coquitam, British Columbia, Canada V3C 4JZ*; Glenn Haley, Ph.D., *Psychologist, Department of Psychiatry, Riverview Hospital, 2601 Lougheed Highway, Coquitam, British Columbia, Canada V3C 4J2*; Maragaret E. Moreau, Ph.D.; Gerry Bradley, M.S.W.; Ralph L. Buckley, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the two major components of the innovative inpatient program; describe how this patient population presents a unique challenge for mental health workers in urban centres; demonstrate the assessment methodology and describe its limitations; and assess whether patients improved at follow-up.

SUMMARY:

Objectives: To determine whether an integrated inpatient-outpatient program could increase and sustain treatment adherence and improvement in a group of impoverished and disenfranchised psychiatric patients in Vancouver's downtown eastside. *Methods:* We designed a new inpatient-outpatient program to increase therapeutic alliance with patients who have limited successful mental-health contact. Community caregivers provided continuous contact throughout hospital admission; ward programming was developed to improve treatment adherence. Community case managers retrospectively rated the first 50 new admissions at baseline, 6 months prior to admission and at 3, 6, 12, 18, and 24 month intervals post-discharge. Ratings on a 7-point scale included: therapeutic alliance, medication adherence, case manager contact, psychiatric symptoms, abstinence, stable housing, health/safety risks, social activities, and CGI. *Results:* All patients were rated; none were lost to follow-up after 2 years. At baseline, we found a high frequency of homelessness (60% SRO, 15% NFA), stim-

ulant abuse (55%), HIV 20% Hep C 30% and chronic non-compliance 80%. At follow-up, all showed significant sustained improvements on all ratings compared to baseline; 68% of patients avoided readmission to any hospital for one year. *Discussion:* These results suggest that sustained improvement is possible with coordinated community and hospital care.

TARGET AUDIENCE:

Administrators and staff that treat marginalized mental health clients.

REFERENCES:

1. Hunt GE, Bergen J, Bashir M. Medication compliance and comorbid substance abuse in schizophrenia: impact on community survival 4 years after a relapse. *Schizophrenia Research* 54:253–264, 2002.
2. Olfson M, Mechanic D, Boyer CA, Hansell S. Linking Inpatients With Schizophrenia to Outpatient Care. *Psychiatr Serv* 49:911–917, 1998.

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Poster 225 **Saturday, October 7
8:30 a.m.-10:00 a.m.**

BARRIERS TO EFFECTIVE ASSESSMENT AND TREATMENT OF TRAUMA

Kristina H. Muenzenmaier, M.D., *Department of Psychiatry, Bronx Psychiatric Center, 1500 Waters Place, Bronx, NY 10461*; Madeleine S. Abrams, L.C.S.W., *Director of Family Studies, Albert Einstein College of Medicine, 1500 Waters Place, Bronx, NY 10461*; Anthony J. Carino, M.D.; Raymond Suarez, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify and discuss individual, clinical and system barriers hindering the implementation of assessment and Best Practices trauma treatment; and make recommendations in how one might remedy these problems.

SUMMARY:

Studies have shown high prevalence rates of traumatic experiences (45–98%) and PTSD in people diagnosed with Serious Mental Illness (SMI). However, despite those high prevalence rates (29–43%) PTSD is rarely assessed either alone or as a comorbid condition in people with SMI. We will present a model outlining the complexities of the overlap of individual, clinical and systemic barriers and elaborate how those barriers hinder the implementation of specific assessments and Best

Practices treatment approaches for PTSD in this particular patient population. Drawn from the model we will propose specific recommendations and outline how to remedy those gaps.

TARGET AUDIENCE:

Clinicians, researchers, policy makers, and administrators.

REFERENCES:

1. Muenzenmaier K., Castille D., Shelley AM, et. al. (2005). Comorbid Posttraumatic Stress Disorder and Schizophrenia. *Psychiatric Annals* 35: 51–56.
2. Salyers M., Evans L., Bond G., et. al. (2004). Barriers to Assessment and Treatment of Posttraumatic Stress Disorder and Other Trauma-Related Problems in People with Severe Mental Illness. *Community Mental Health Journal* 40:17–31.

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**Saturday, October 7
8:30 a.m.-10:00 a.m.**

VIDEOPHONES IN PSYCHIATRY, ACCESS, SATISFACTION, AND COST SAVINGS

Jose E. Nieves, M.D., *Department of Psychiatry, Veterans Hospital, 100 Emancipation Drive, Hampton, VA 23667*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to recognize the applications of telemedicine in psychiatry outpatient case management.

SUMMARY:

Videophone deployment in our outpatient case management program, an effort to overcome distance, traffic and improve case management time utilization, has increased medical access and patient satisfaction. In a patient population of 57 seriously mentally ill patients, 64.9% with 2 or more medical comorbidities, some refused to travel due to illness, 90% are highly satisfied or satisfied with videophone access to their psychiatrist. Psychiatrist access while making home visits has decreased emergency room utilization and missed appointments. In addition patients feel they are being treated with an innovative treatment alternative and their family members and care takers are also pleased with this treatment adjunct to face to face visits.

Case managers are also satisfied or highly satisfied with the ability to reach medical support and it has improved substantially their time utilization.

In addition to further decrease emergency room visits and bed days of care, videophones have also decreased

beneficiary transportation expenses. This has generated savings as case managers become more comfortable with videophone use and venture further into our catchment area. This has saved \$680.00 dollars in the months of August/September 2005 alone. To date we have not experienced any technical failures, and continue to employ this resource effectively.

TARGET AUDIENCES:

Psychiatrists, other physicians, social workers, registered nurses, advanced practice psychiatric nurses, and other mental health professionals.

REFERENCES:

1. McLaren P. "Telemedicine and Telecare: What can it Offer Mental Health Services?". *Advances in Psychiatric Treatment* (2003). Vol. 9, 54-61.
2. Cukor P, Baer L, Willis B, et al: "Use of Videophones and Low-Cost Standard Telephone Lines to Provide Social Presence in Psychiatry". *Telemedicine Journal* 1998; 4(4):313-321.

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**Saturday, October 7
8:30 a.m.-10:00 a.m.**

OUTCOMES OF ADOLESCENTS WHO RECEIVED ELECTROCONVULSIVE THERAPY

Victoria A. Osborne, M.S.W., *Doctoral Student in Social Work, Washington University of St. Louis, 1 Brookings Drive, Box 1196, St. Louis, MO 63130*; Debra Munro-Kienstra, M.S.W., *Research Assistant, Department of Psychiatry, Washington University of St. Louis, 1 Brookings Drive, Box 1196, St. Louis, MO 63130*; Keith E. Isenberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the impact of adolescent mental illness in adulthood; and understand differences in adult psychosocial outcomes of those treated with ECT and those not treated with Electroconvulsive therapy (ECT) as adolescents.

SUMMARY:

The long-term impact of electroconvulsive therapy (ECT) administration to adolescents is largely unknown. We identified adults who were hospitalized while adolescents in a retrospective fashion, matching patients who received ECT with those pharmacologically treated, and conducted follow-up interviews. Subjects were asked about past care experience, quality of life, current psychiatric diagnoses and care. Those who had received ECT as an adolescent were asked about their experience

with and feelings about ECT, including any long-lasting effects.

Mean age of patients when they received treatment was 17.2 years. More than half (53%) of the 72 patients studied were diagnosed with major depressive disorder. Most had a family history of psychiatric illness (69%). Mean number of treatments for those who received ECT was 8.8. At follow-up, those patients who received ECT reported that ECT helped them a lot (67%); however, they also noted that a person should be seriously ill before having to receive ECT as a treatment. When asked how ECT compared to going to the dentist, all subjects reported it was "not as bad".

This study suggests giving ECT to adolescents does not appear to have devastating, long-term psychosocial or physical effects.

REFERENCES:

1. Taieb O, Flament MF, Chevret S, Jeammet P, Allilaire JF, Mazet P, Cohen D, (2002). Clinical relevance of electroconvulsive therapy (ECT) in adolescents with severe mood disorder: evidence from a follow-up study. *European Psychiatry*, 17:206-12.
2. Ghaziuddin N, Kutcher SP, Knapp P, Bernet W, Arnold V, Beitchman J, Benson RS, Bukstein O, Kinlan J, McClellan J, Rue D, Shaw JA, Stock S, Kroeger Ptakowski K. (2004). Practice parameter for use of electroconvulsive therapy with adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(12):1521-39.

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**Saturday, October 7
8:30 a.m.-10:00 a.m.**

EXPLORING CHALLENGES TO ALCOHOL MISUSE DETECTION IN WOMEN IN PRIMARY CARE

Victoria A. Osborne, M.S.W., *Doctoral Student in Social Work, Washington University of St. Louis, 1 Brookings Drive, Box 1196, St. Louis, MO 63130*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify major barriers to detection of alcohol misuse in women in primary care; recognize how primary care physicians detect alcohol misuse in female patients; and understand reasons why alcohol misuse in women may go undetected in primary care.

SUMMARY:

Although alcohol misuse in women is a major public health concern, research finds that misuse frequently is neither detected nor assessed in primary care settings.

The limited existing research in this area concentrates on barriers to assessment and detection in primary care, without focusing on how these barriers interfere with detection. Moreover, this research tends to have a gender-neutral lens. Little is known about the process of assessment and detection, and how it leads to under-detection in female primary care patients.

A convenience sample of primary care physicians participated in an hour-long focus group. Participants were asked to reflect on their personal process around detection of alcohol misuse in their female patients. Focus group data was digitally audiorecorded and transcribed. Themes were identified, and responses coded into each theme.

Physicians report facing structural barriers to assessment and detection, including having limited time available to spend with each patient and decreased continuity of care. Emphasis was placed on the importance of establishing trust and some form of relationship between physician and patient. Increasing patient awareness of alcohol misuse, communication between doctor and patient, and continual assessment at follow-up were suggested as the most important ways to facilitate increased detection.

Future research should focus on interventions that incorporate the issues of establishing trust and communication in the physician-patient relationship, and should explore ways to increase effectiveness and efficiency of assessment practices that work well within given constraints of the modern health care practice environment.

REFERENCES:

1. Saitz R, Horton NJ, Sullivan LM, Moskowitz MA, Samet JH (2003). Addressing alcohol problems in primary care: a cluster randomized, controlled trial of a systems intervention. *Annals of Internal Medicine*, 138: 372-82.
2. Wilson L, Kahan M, Liu E, Brewster JM, Sobell MB, Sobell LC (2002). Physician behavior towards male and female problem drinkers: a controlled study using simulated patients. *Journal of Addictive Diseases*, 21(3), 87-99.

Poster 229

Saturday, October 7
8:30 a.m.-10:00 a.m.

DEMOGRAPHIC DIFFERENCES IN DIAGNOSIS OF PSYCHOSIS IN PSYCHIATRIC INPATIENTS

Kristen S. Ossa, M.D., M.P.H., *Resident, Department of Psychiatry, Medical University of South Carolina, 67 President Street, 5 South, Charleston, SC 29425-0861*; Richard L. Holt, M.D., *Resident, Department of Psychia-*

try, Medical University of South Carolina, 67 President Street, 5 South, Charleston, SC 29403-4649

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to summarize the literature on demographic differences in diagnosis of psychosis in the United States; recognize potential causes of such differences; and use this information to examine local care of patients with schizophrenia and similar disorders.

SUMMARY:

Epidemiologic studies in the United States have found significant demographic differences in the diagnosis of schizophrenia. For example, several studies report that African Americans are significantly more likely to be diagnosed with a primary psychotic disorder compared to Caucasians. Such discrepancies may reflect actual differences in prevalence, various forms of bias, or some combination. This poster broadly attempts to assess state and local differences in diagnosis of psychosis by age, race and socioeconomic status in South Carolina. In particular, the authors use public data on psychiatric inpatient discharge diagnoses to develop odds ratios for diagnosis of psychosis in African American patients compared to all other patients. These data suggest no significant difference in discharge diagnosis of psychosis by race statewide. When stratified by age, however, African Americans are significantly less likely to be diagnosed with psychosis at younger ages but more likely at older ages. In addition, African Americans are significantly more likely to be diagnosed with psychosis in the poorest areas of the state. The authors discuss possible explanations for these findings. Understanding regional differences in the diagnosis of psychotic disorders is important to informing and improving care of these patients.

TARGET AUDIENCE:

Mental health clinicians involved in care of patients with schizophrenia and similar disorders, and epidemiologists and other researchers interested in demographic differences in the diagnosis of psychotic disorders.

REFERENCES:

1. Blow FC, Zeber JE, McCarthy JF, Valenstein M, Gillon L, Bingham CR. Ethnicity and diagnostic patterns in veterans with psychoses. *Soc Psychiatry Psychiatr Epidemiol*. 2004 Oct; 39 (10):841-51.
2. Minsky S, Vega W, Miskimen T, Gara M, Escobar J. Diagnostic patterns in Latino, African American, and European American psychiatric patients. *Arch Gen Psychiatry*, 2003 Jun; 60(6):637-44.

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Saturday, October 7
8:30 a.m.-10:00 a.m.**ADAPTIVE FUNCTIONING IN OLDER PERSONS WITH SCHIZOPHRENIA***Supported by the National Institute of General Medical Sciences*Nikhil J. Palekar, M.D., *Clinical Assistant Instructor, Department of Psychiatry, State University of New York, Downstate Medical Center, 450 Lenox Road, Brooklyn, NY 11203*; Henry Cohen, M.D.**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to recognize and target clinical, psychosocial, and environmental risk factors to enhance functioning in older persons with schizophrenia.

SUMMARY:

Adaptive functioning entails the ability to handle instrumental activities of daily living (IADL) and to establish socially meaningful relationships. We examine factors associated with IADL and confidants in older schizophrenic persons. Methods: The Schizophrenia group (S) consisted of 198 persons age 55+. We used an adaptation of Berkman-Gurland's model of social functioning that consisted of two dependent variables: IADL and number of confidants, and 14 independent variables. Results: In logistic regression, 4 of 14 variables attained significance for being in the high IADL group: non-white, fewer negative symptoms, fewer physical disorders, and non-group living. Three of 14 variables attained significance for being in the high confidant group: younger age, higher income, greater use of "finding meaning" as a coping strategy. Conclusion: The IADL and confidant groups were not associated with each other in logistic regression analysis. They seem to be separate measures of functioning. Our findings suggest service strategies to enhance functioning must concomitantly target clinical, psychosocial, and environmental risk factors.

Funded by National Institute of General Medical Sciences, SO6GM54650.

TARGET AUDIENCE:

General psychiatrists, geriatric psychiatrists, clinical social workers, and hospital administrators.

REFERENCES:

1. Functional Impairment in Older Schizophrenic Persons. *Am J Geriatr Psychiatry* 8:237-244, August 2000.
2. Psychosocial functioning on the Independent Living Skills Survey in older outpatients with schizophrenia. *Schizophr Res.* 2004 Aug 1; 69(2-3):307-16.

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Saturday, October 7
8:30 a.m.-10:00 a.m.**DISCONTINUATION AFTER FIVE YEARS OF ANTIDEPRESSANT PROPHYLAXIS**Tara Pundiak, M.D., *Department of Psychiatry, New York University Medical Center, 20 Sherman Street, Fairfield, CT 06824*; Eric D. Peselow, M.D., *Medical Director, Freedom From Fear, 32 Bassett Avenue, Brooklyn, NY 11234-6724*; Borboro Orłowski, Ph.D.**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to evaluate whether five year stability on antidepressants is an adequate time period after which one may consider a discontinuation of medication.

SUMMARY:

Naturalistic studies regarding the efficacy of antidepressants have been pretty scarce. The long-term efficacy of selective serotonin reuptake inhibitors (SSRI's) in preventing recurrent episodes of depression after successful treatment of the acute episode has not been shown for > 2 years in controlled trials or naturalistic studies.

To evaluate the prophylactic efficacy of four SSRI's: fluoxetine, citalopram, sertraline and paroxetine in a naturalistic clinical setting to responders to these medicines during acute depression who continued on the medications for at least five years.

71 patients who were treated for depression with one of the three SSRI's were evaluated. After 5 years of clinical stability 22 chose to be tapered and discontinued from their SSRI's over a 2-5 month period and 49 which to continue SSRI prophylaxis. In following these patients for an additional 3 years, it was noted that 14/22 patients discontinued from medication had a known relapse over a subsequent 3 year period vs 17/49 who continued on SSRI's ($p < .001$)

In conclusion: in this naturalistic setting, despite five years prior stability, discontinuation led to more frequent relapse than continuation over a five year period.

TARGET AUDIENCE:

Clinical psychiatrists, and residents.

REFERENCES:

1. Kupfer DJ, Frank E, Perel JM. Five year outcome for maintenance therapies in recurrent depression. *Archives of General Psychiatry*, 1992; 49:769-773.
2. Greenberg PE, Birnbaum HG. The economic burden of depression in the US: societal and patient perspectives. [Review] *Expert Opinion on Pharmacotherapy*. 2005 Mar; 6(3):369-76.

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Saturday, October 7
8:30 a.m.-10:00 a.m.

DEPRESSION, PSYCHOSES, AND FUNCTIONING IN OLDER ADULTS WITH SCHIZOPHRENIA

Supported by the National Institute of General Medical Sciences

Pia N. Reyes, M.D., *Resident, Department of Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, P.O. Box 1203, Brooklyn, NY 11203*; Carl I. Cohen, M.D., *Department of Psychiatry, State University of New York, Health Sciences Center, 450 Clarkson Avenue, Brooklyn, NY 11203*; Paul M. Ramirez, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate interaction between comorbid depression and symptoms of psychosis in older persons with schizophrenia; and illustrate clinical significance of comorbid psychopathology, as well as its impact on functioning.

SUMMARY:

Background: Older adults with schizophrenia can be categorized based on the presence or absence of psychoses and depression: no depression/no psychosis, no depression/psychosis, depression/no psychosis, depression/psychosis. We examined the association between these categories and various measures of functioning.

Methods: The sample consisted of older schizophrenic persons (S) and a matched comparison group from the community (C). The independent variable consisted of 4 aforementioned categories based on the PANSS and CESD. The dependent variables consisted of the 5 subscales and the total score on the Dementia Rating Scale (DRS), the Instrumental Activities of Daily Living (IADL) scale, and the number of confidants.

Results: The S subgroups scored significantly worse than the C group on all dependant variables. For the 4 subcategories of the S group, there were significant group differences on conceptualization subscale of DRS, overall DRS score, number of confidants, but not the IADL scale. The groups with no psychoses generally scored higher than the groups with psychoses.

Conclusions: Although all S groups were more impaired than the C group, those persons with psychoses had the greatest impairment, and being depressed without psychoses was not associated with additional functional impairment. The implications for treatment and research will be discussed.

This study was partially funded by NIGMS, Grant SO6GM54650.

REFERENCES:

1. Karow A., et al. PANSS syndromes and quality of life in schizophrenia. *Psychopathology*. 2005 Nov-Dec; 38(6):320-6. Epub 2005 Oct 12.
2. Rocca P., et al. Depressive and negative symptoms in schizophrenia: different effects on clinical features. *Compr Psychiatry*. 2005 Jul-Aug; 46 (4):304-10.

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Saturday, October 7
8:30 a.m.-10:00 a.m.

SOMATIZATION AND ACCULTURATION AMONG RUSSIAN AND HISPANIC IMMIGRANTS WITH CHRONIC MENTAL ILLNESS

Paulo R. Shiroma, M.D., *Chief Resident, Department of Psychiatry, Maimonides Medical Center, 914 48th Street, Brooklyn, NY 11219-2918*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the multiple factors that may alter the frequency of somatic complaints.

SUMMARY:

Objective: To investigate 1) the frequency of somatic symptoms among Russian and Hispanic immigrants who were chronically mentally ill and in a partial hospitalization program, 2) the relationship between acculturation and somatization; and 3) whether demographic factors may alter the presentation of somatic complaints in these patients.

Method: 60 Russian origin patients and 60 Hispanic origin patients in a psychiatric day program were assessed for somatization and acculturation. The patients were chronically ill and had suffered from mood disorders and/or psychosis but were in remission. We defined somatoform symptoms by the score on the somatization subscale of the Symptom Check List Revised 90. Acculturation level was measured by a short acculturation scale. Demographic data was collected, including age, gender, marital status, occupation, length of time in the U.S. and educational level. Chi-square was used to categorical variables. Student's t test was used for comparison of continuous variables and a Pearson product moment correlation between continuous variables.

Results: a) Somatization was significantly higher among Russian (mean=1.50+/-0.70) than Hispanics (mean=1.12+/-0.86); b) Acculturation was significantly higher among Hispanics (mean=1.83+/-0.6) than Russians (mean=1.58+/-0.67); c) There was a significant correlation between somatization and acculturation overall (r=-0.22, p<.05) and in Russians (r=-0.28, P<.05) but not in Hispanics; d) The length of stay in

the US correlated with the acculturation level overall ($r=0.3$, $p<0.001$) and in Russian ($r=0.48$, $p<0.01$) and Hispanic ($r=0.27$, $p<0.05$); e) Hispanics have lived a longer time in the US than Russians. Russians were significantly more educated than Hispanics; f) Somatization correlates with gender overall ($r=0.27$, $p<0.01$) and in Hispanics ($r=0.35$, $p<0.01$) and Russians ($r=0.26$, $p<0.05$).

Conclusions: Somatization negatively correlates with the acculturation process overall and in Russians only. Apparently this relationship is affected by the length of time in the new country as the Russians with lower acculturation scores and higher somatization scores have been in the US a shorter period of time compared with the Hispanics in whom the relationship is not significant. Females were more prone than males to somatize as previous studies showed. Length of time in the U.S. and gender are the primary factors effecting somatization not cultural differences or education.

TARGET AUDIENCE:

Physicians, nurses, medical students, and psychologists.

REFERENCES:

1. Escobar JI: Somatization in the community. *Arch Gen Psychiatry* 1987; 44:713-718.
2. Angel R, Guarnaccia PJ: Mind, Body and Culture: Somatization among Hispanics. *Soc Sci Med* 1989; 28:1229-1238.

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**Saturday, October 7
8:30 a.m.-10:00 a.m.**

TRANSFORMING PSYCHIATRY: REDUCING REDUCTIONISM

Wesley E. Sowers, M.D., *President, American Association of Community Psychiatrists; Member, APA/IPS Scientific Program Committee; and Medical Director, Human Services, Allegheny County, 304 Wood Street, Room 505, Pittsburgh, PA 15222*; Kenneth S. Thompson, M.D., *Associate Professor of Psychiatry, University of Pittsburgh, and Former APA/Bristol-Myers Squibb Fellow, 3811 O'Hara Street, Pittsburgh, PA 15213*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify forces constricting the scope of practice in psychiatry, and be familiar with the major areas of change recommended within organized psychiatry.

SUMMARY:

Despite the expansion we have seen in our understanding of the mechanics of the human brain, the scope of

psychiatry has actually been growing smaller in recent years. We have watched as our systems have evolved in ways that constricts the range of our practice and the growth of our skills. Our programs for training psychiatrists have too often acquiesced to this system, and young psychiatrists are increasingly ill prepared to assume the clinical leadership roles.

High caseloads and limited time to engage in empathic communication has created circumstances that no one can be happy with. Consumers, families and communities want more personal contact and more choices in the services they receive. Psychiatrists lament that all they have time for is writing prescriptions and completing required documentation.

It is time that psychiatrists in public service and those they work with, begin to think differently. It is time to begin transforming both the profession and mental health care. To do this, psychiatrists must develop a thorough understanding of recovery as a goal and a process and embrace the added value of effective partnerships with consumers, families, and other disciplines and stakeholders. At the same time, systems of care must creatively develop methods to support psychiatrists in this effort.

TARGET AUDIENCE:

Mental health professionals.

REFERENCES:

1. Reducing Reductionism: Reclaiming Psych, Sowers Psych Svcs, June 2005.
2. Transforming Psychiatry - Discussion Group Summary, www.communitypsychiatry.org (AACP).

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**Saturday, October 7
8:30 a.m.-10:00 a.m.**

DO PATIENTS WITH DRUG ABUSE BEHAVIOR HAVE MORE VIOLENT ACUTE EPISODES?

Andrea Tortelli, M.D., *Department of Psychiatry, Maison-Blanche Hospital, Boulevard Saint Michel, NR-55, Paris, France 75005*; Sara B. Bahadori, M.D., *Department of Psychiatry, Maison-Blanche Hospital, Boulevard Saint Michel, NR-55, Paris, France 75005*; Norbert Skurnik, M.D.; Alix Meillant, M.D.; Lahlou Ailam, M.D.; Mohamed Rhidi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and evaluate the risk of violence among inpatient drug abusers.

SUMMARY:

The purpose of this work is to determine if there is a link between violence within acute psychiatric episodes and use of common drugs such as marijuana, alcohol, cocaine, opiate drugs and amphetamines among people suffering from psychiatric disorders.

The research center is The “Maison Blanche Avron Hospital Center” dedicated to the inhabitants of 20th district of Paris, rather no wealthy population confronted with both delinquency and mental health problems.

For four months, screening drug detection was done for every new hospitalized patient. Violence was also evaluated with the Borset Violent Scale.

Afterwards results were confronted to diagnosis and hospitalisation modality.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. A National study of violent behavior in persons with schizophrenia. Arch Gen Psychiatry May 2006.
2. Psychotic-like experiences and interpersonal violence in the general population Soc. Psychiatry Epidemiol March 2006.

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Saturday, October 7
8:30 a.m.-10:00 a.m.

COPING AND SCHIZOPHRENIA: A NEW FRAMEWORK

Abraham Rudnick, M.D., Ph.D., Associate Professor, Department of Psychiatry, University of Western Ontario, RMHC, 850 Highbury Avenue, London, Ontario, Canada N6A 4H1; Jennifer Martins

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that cognitive behavior therapy (CBT) can be used as a first step in reducing trauma related systems in chronically ill hospitalized psychiatric patients.

SUMMARY:

Rationale: Chronically ill hospitalized psychiatric patients have a high prevalence of trauma and abuse.

Kingsboro Psychiatric Center, an affiliate hospital of SUNY Downstate routinely screens patients at intake for a history of physical abuse or neglect, domestic violence, sexual abuse, or other traumas such as having been a witness or victim of a violent crime. The inpatient setting provides an opportunity to evaluate the effect of group CBT on such patients.

Methods: The cohort consisted of twenty four patients with a Major Axis 1 Diagnosis and co-morbid PTSD. Four psychologists underwent twelve week seminar training in Trauma Healing using a group model proposed by the NYS Office of Mental Health.

Patients underwent 12 weeks of supportive psychotherapy followed by 12 weeks of CBT in Trauma Healing. Treatment outcome was compared using the Modified Impact of Events, and Brief Psychiatric Rating Scales (BPRS) prior to commencing and at the completion of each treatment modality.

Results: Following the completion of Supportive therapy and CBT, patients continued to have elevation of intrusive and avoidance symptoms but only CBT patients showed reduction of anxiety, hostility tension, and suspiciousness on the BPRS.

Conclusions: Since chronically ill hospitalized patients are not candidates for traditional CBT or exposure therapy, and the focus of early treatment is on issues of trust, safety, and arousal-management strategies, these findings are an encouraging first step in reducing trauma related symptoms in this population.

REFERENCES:

1. Herman JL, 1999 Complex PTSD. A Syndrome in Survivors of Prolonged and Repeated Trauma. In Essential Papers on PTSD edited by M.J. Horowitz. New York University Press.
2. Rosenbloom D, and Williams MB, 1999 Life After Trauma: A Workbook for Healing. New York: Guilford Press.

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Saturday, October 7
8:30 a.m.-10:00 a.m.

USING FILMS IN INTENSIVE OUTPATIENT TREATMENT PROGRAMS

Fuat Ulus, M.D., Intensive Outpatient Treatment Program, Behavioral Health Services, St. Vincent Hospital, 5976 Southland Drive, Erie, PA 16509

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to learn therapeutic qualities of the movies applied in a group setting

SUMMARY:

St. Vincent Hospital and Health Services, Erie, PA, has started Behavioral Health, Intensive Outpatient Treatment Program and been consolidating Group Movie Therapy Sessions since September 2005.

These gatherings based on Three E’s Principle: Entertainment, Education and Empowerment (Healing) have been provided in 90 minute sessions on Mondays and Thursdays.

Its format consists of watching film clips related to the theme of the sessions including but not limited to problem solving, ego strength, positive thinking, changing beliefs, emotions, anger & stress management, forgiveness and healthy communications. Once they are shown, the participants move to discussion about what has been going on in a given scene(s). The last part of review is drawing parallels to the attendants' own difficulties and tools with which they resolve them. Dr. Ulus has been licensed by the Motion Picture Licensing Corporation, Inc. in conforming to copyright laws.

TARGET AUDIENCE:

Psychiatrists, psychologists, clinical social workers and educators.

REFERENCES:

1. Reality Therapy in Action, William Glasser, M.D., 2001.
2. The Healing Movie Book, Michael Kalm, M.D., 2003.

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Saturday, October 7
8:30 a.m.-10:00 a.m.

USE OF METHYLPHENIDATE IN TREATMENT RESISTANT DEPRESSION

Supported by Ortho-McNeil Pharmaceuticals, Inc.

Joel L. Young, M.D., *Medical Director, Department of Psychiatry, Rochester Medical Center, 441 S. Livernois Road, Suite 205, Rochester Hills, MI 48323-1811*; Birgit H. Amann, M.D.; Karen L. Azar, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to better understand the relationship be-

tween depression and ADHD; and recognize the importance of screening depressed patients for ADHD.

SUMMARY:

Because depression and ADHD frequently co-occur, the authors hypothesized that treatment resistant depression (TRD) would respond to the addition of a psychostimulant to standard SSRI treatment. The study was a single-site, double-blind, placebo-controlled clinical trial of the psychostimulant Concerta (18 to 54 mg/day) added to fluoxetine (20 to 40 mg/day) (CAF) compared to placebo added to fluoxetine (PAF) for seven weeks. The TRD group consisted of 40 adults. A convenience sample of 40 adults without known mental illness was used to compare ADHD scores and prevalence. There was no significant difference in the change in the Hamilton Depression Inventory score for the CAF versus PAF (-8.6 vs. -7.1, $p=0.63$) groups. Secondary outcome measures showed greater improvement in the CAF than PAF groups, including the ASRS Scale B ($p=0.065$), the Quality of Life Enjoyment and Satisfaction Questionnaire ($p=0.005$), the Sheehan Disability Scale ($p=0.051$), and the Clinical Global Impression of severity of depression ($p=0.0086$) and ADHD ($p=0.039$). The addition of the psychostimulant Concerta to fluoxetine was associated with greater improvement in some measures of depression, ADHD, quality of life and disability. Support for this study was provided by McNeil Consumer and Specialty Pharmaceuticals, Fort Washington, PA.

TARGET AUDIENCE:

Practitioners treating patients with mood disorders.

REFERENCES:

1. Shelton C, et. al: A novel augmentation strategy for treating resistant major depression. *Am J. Psychiatry* 2001; Jan 158:131-134.
2. Gotto, J & Rapaport, MH: Treatment options in treatment-resistant depression. *Primary Psychiatry* 2005; 12(2):42-50.

THE CONTEXT FOR PSYCHIATRIC INTERVENTION: NARRATIVES OF WOMEN SURVIVORS OF CHILDHOOD MALTREATMENT

Joanne M. Hall, Ph.D., *Professor, Department of Nursing, University of Tennessee, 1200 Volunteer Boulevard, Knoxville, TN 37996*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize and support diverse paths to healing in life narratives of female survivors of childhood maltreatment.

SUMMARY:

This research was an interdisciplinary NIH funded narrative study regarding women thriving abuse survivors. This study focused on how these women became successful despite their traumatic experiences of childhood abuse. Samples consisted of 27 community dwelling women who responded to a newspaper article describing the study as unique in its non-pathologizing stance. Study aims focused on exploring aftereffects, strengths, interactions, and social contexts relevant to success. Narratives were obtained in three, open-ended interviews spaced over 7–12 months. “Successful struggling” rather than “thriving” was determined by the research team to more accurately describe the process of success for these women. The core conceptualization of the process of success for these women is two-fold: becoming and being resolute. The processes are described in terms of trajectories, turning points, family and social interactions, and health care experiences. The panel will discuss issues related to health care experiences, trajectories, relationships, and memory. Potential outcomes include reducing human and monetary costs and interrupting intergenerational and culturally-tolerated childhood abuse.

**No. 1A
LIFE TRAJECTORIES OF WOMEN SURVIVORS OF CHILD MALTREATMENT: REDEMPTIVE AND CONTAMINATING SEQUENCES**

Sandra P. Thomas, Ph.D., *Professor and Co-Investigator, Department of Nursing, University of Tennessee, 1200 Volunteer Boulevard, Knoxville, TN 37996*

SUMMARY:

We used narratives to reconstruct chronologies of women abuse survivors’ paths through life to define turning points, and sequences of events following transitional, pivotal events in life after abuse. Using McAdams’ method for examining life stories we identify intentionally positive actions by survivors, and the sequences that followed. The two types of sequences McAdams defines are (a) redemptive (relating positive outcomes, such as better relationships, gaining safety, achievements, etc.), and (b) contaminating. Contaminating sequences are negative outcomes that follow attempts to help or change one’s constricted, traumatizing circumstances. The diversity of trajectories in this group of women survivors is well articulated in verbatim quotes, and brief case summaries as exemplars of each type of sequence. The account of one participant may contain several narrations of a key life event, told at different interview points. This informed the trajectory analysis as well, providing ways that abuse and healing are narrated for different purposes, or from different self-perspectives of the participant. Often the “severity” of abuse as traditionally gauged is not correspondent to the personal perception of damage, and similarly, of the magnitude of evil faced. Attributions about, and aftereffects of abuse, influence decision points and transitions confronted in recovery, in addition to traumatic events as actually experienced. Participants demonstrated great diversity in patterns of facing, interpreting, describing and overcoming adversities as manifested in private worlds of abuse and neglect. This paper will also discuss typology and characteristic life patterns with clinical implications.

**No. 1B
RELATIONSHIPS AND INTERACTIONS IN THE AFTERMATH OF CHILD ABUSE: CONSTANCY, DIFFERENTIATION, AND CHALLENGE**

Marian Roman, Ph.D., R.N., *Assistant Professor, Department of Nursing, University of Tennessee, 1200 Volunteer Boulevard, Knoxville, TN 37996*; Kimberly Bolton, M.S.N.

SUMMARY:

In analyzing the narratives of the women abuse survivors in this study, the role of relationships emerged as a key and complex component. This paper will present description and analysis of the nature of key relationships that the respondents perceive to have been central to seeing abuse for what it was/is, and becoming adept at moving beyond it. Interactions of import could be brief encounters with strangers to enduring relationships. The most frequently reported positive interpersonal relation-

ships in childhood were with teachers and coaches, these exceeded grandparents, siblings and other relatives combined. In adulthood, husbands, bosses and coworkers, therapists and one's own children were the most reported. Participants described helpful relationships in great detail, in both emotional and substantive language. Through iterative close readings and analysis, it became evident that across stories, stages of life and casts of characters, many positive interpersonal relationships bore similar characteristics and could be categorized as one of two distinct motifs, we referred to as the "No matter what" or "Saw something in me," a typology derived from the participants' own words. A third motif emerged from within negative contexts, a "Who I am not" relationship that provided definition by converse and challenge. The perceived meanings and contributions of these relationships to the journeys of successfully struggling survivors will be discussed within the context of extant and emerging theories from attachment to lifelong neuroplasticity with possible implications for practitioners, as well as for careful, caring adults in any setting.

No. 1C
MEMORY AGAINST EVIL: A TYPOLOGY OF NARRATIVE REMEMBERING OF ABUSE

Jill Powell, Ph.D., *Department of Psychiatry, Veterans Administration, 8717 Millertown Pike, Knoxville, TN 37924*

SUMMARY:

The volume of in-depth textual, verbal data generated in this study facilitated examination of abuse memories not divisive of cognition, levels of consciousness, and fragmentation of identity. Instead the framework included close reading for prominence of context, and language patterns used in survivors' telling the past stories of abuse and its aftermath. Here close reading refers to Barthesian discourse analysis, in which subjective meaning is the method's focus. The memory patterns seen in this study are distinctive, but needn't be seen as damaged or distorted. Traumatic memory has in the past been pathologized in the concept of dissociation as immature and dysfunctional. We considered that clinical pathologizing can be a secondary trauma visited upon abuse survivors in that health care providers lose the narrative thread in algorithmic, one-way communication involved in diagnosis. Memory and remembering, viewed from a narrative perspective is a set of non-linear dynamics and that occur and recur. Memories surface, and resurface (or are resurfaced) at pivotal times. We entertain that their triggering needs not be reinjury, but may aid in recovery. Some remembering is "frac-

tionary," lacking rich detail and placement in temporal and geographic context. Some memories emerge as only a sense of dread, or a visual flash. A single participant maintained chronological, continuous, contextualized recall of abuse events throughout her life. Five types of remembering narratively are described, differentiated on the basis of contextual elements available in the told story of that memory. This analysis challenges some extant conceptualizations about trauma and memory, including that memories of abuse need to be "exorcized" through retelling, re-experiencing and/or desensitization. Implications for diagnosis, prognosis and psychotherapy are discussed.

No. 1D
HEALTH CARE EXPERIENCES IN THE NARRATIVES OF WOMEN SURVIVORS OF CHILDHOOD MALTREATMENT

Jill Powell, Ph.D., *Department of Psychiatry, Veterans Administration, 8717 Millertown Pike, Knoxville, TN 37924; Clifton R. Tennison, M.D.*

SUMMARY:

In the narratives of childhood, adolescence, and adulthood accounts of women survivors of child maltreatment various paths to healing were revealed. Almost all participants had some form of clinical intervention with identifiable patterns of diverse outcomes and evaluations. Helpful therapies/therapists allowed women to relate their stories under their conditions, and in their own time. Some women described long-term, in-depth and often intense therapy, with disclosures of abuse incidents in detail, and resolutions of problematic family of origin dynamics. Other participants sought brief periods of therapy during critical developmental or situational crises, or situations in their current lives. Contrary to the researchers' expectations, many women based assessment of their overall life success, and in not wanting or needing to retell the detailed story of their childhood maltreatment in detail. Some of these women located therapists who did not press for disclosure. Harmful therapies/therapists involved "pushing" the client to reveal her traumatic experiences, to disclose before she was ready; encouraging the women to forgive abuser(s); and re-experience the emotional impact of specific painful incidents without regard to current situational needs and personal prerogative in therapy disclosures. Women reported satisfaction and benefits from therapy involving reading, journaling, artwork, and "working with their hands." We will discuss the potential benefits of medication, in view of high incidence of depression and anxiety in this population. Few women spoke of using medication as an aid to healing, and many who had medication

prescribed were apparently not given adequate education about the drug and its mode of action.

REFERENCES:

1. Bourdieu, P. (1980). *The Logic of Practice*. Stanford, CA: Stanford University Press.
2. McAdams, D. P., Josselson, R., & Lieblich, A. (2001). *Turns in the Road: narrative studies of Lives in Transition*. Washington, DC: American Psychological Association.
3. Edelman, H. (1994). *Motherless Daughters: The Legacy of Loss*. New York, NY: Bantam Doubleday Dell Publishing Group.
4. van der Kolk, B. A., McFarlane, A. C., & Weisaeth, L. (1996). *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*. London: The Guilford Press.
5. Gold, S. (2000). *Not Trauma Alone: Therapy for Child Abuse Survivors in Family and Social Context*. Philadelphia, PA: Brunner/Routledge.

Symposium 2

Thursday, October 5
8:30 a.m.-11:30 a.m.

MOTIVATION-BASED APPROACHES TO COGNITIVE REHABILITATION OF SCHIZOPHRENIA

Steven M. Silverstein, Ph.D., *Associate Professor of Psychiatry, University of Illinois at Chicago, 912 South Wood Street, Chicago, IL 60612-7327*; Robert Heinszen, Ph.D., ABPP

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the role that motivational deficits play in cognitive functioning in schizophrenia; discuss recently developed strategies for improving cognitive functioning in schizophrenia that are based on motivation-enhancing techniques; and recognize which of these techniques, or combination thereof, is appropriate for his/her clinical setting and patient population.

SUMMARY:

Cognitive difficulties are common in schizophrenia and are significant barriers to effective functioning in social, vocational, and educational (including psychoeducational) settings. Because antipsychotic medications have not demonstrated clinically meaningful improvements in cognition and functioning, cognitive rehabilitation interventions have been developed. These have produced mixed results, however. Those that rely primarily on repeated practice show limited effectiveness. In contrast, recently developed techniques that address both cognitive functioning and motivation to engage in train-

ing tasks have reported positive outcomes. In this symposium, four different motivation-based techniques will be highlighted. These techniques use varying formats (i.e., individual vs. group; computerized vs. non-computerized), and varied approaches (e.g., extrinsic vs. intrinsic reinforcement). At the conclusion of the four papers, the Discussant will compare and contrast the techniques, and integrate the findings into a conceptual model that can be used to guide the choice of technique to match patient needs.

No. 2A

ATTENTION SHAPING AS SUPPORTED COGNITION FOR SCHIZOPHRENIA

Steven M. Silverstein, Ph.D., *Associate Professor of Psychiatry, University of Illinois at Chicago, 912 South Wood Street, Chicago, IL 60612-7327*; Sandra M. Wilk-niss, Ph.D.

SUMMARY:

Reduced attention span is a problem for many people with schizophrenia, and it interferes with the ability to learn new information in evidence-based psychosocial interventions. The behavioral technique of *attention shaping* has been used to successfully lengthen attention span, and increase learning, during skills training groups among patients who had previously been considered unable to benefit from these treatments. In this presentation, we report recent data on attention shaping as a method of supported cognition within the psychosocial treatment environment. We also present a model of the manner in which the initial use of extrinsic reinforcers to promote task success can lead to increases in self-efficacy, an improved working alliance with group leaders, and greater satisfaction with treatment. These can then act as intrinsic reinforcers to increase behavioral momentum, and ultimately sustain new attentive and participatory behaviors in the absence of tangible rewards. Implications of this model for the continued development of cognitive rehabilitation of schizophrenia will be discussed.

No. 2B

APPLICATIONS OF ERRORLESS LEARNING FOR REHABILITATION OF PERSONS WITH SCHIZOPHRENIA

Robert S. Kern, Ph.D., *Associate Research Psychologist, Department of Psychiatry and Biobehavioral Services, UCLA, 11301 Wilshire Boulevard, Room 116, Building 210, Los Angeles, CA 90073*; Michael F. Green, Ph.D.; Sharon S. Mitchell, Ph.D.; Robert Paul Liberman, M.D.

SUMMARY:

It is widely held that neurocognitive deficits are a core feature of schizophrenia and are related to community functioning. From a rehabilitation perspective, there is a clear need to develop psychosocial interventions that consider the influence of neurocognitive deficits on learning new skills necessary for successful independent living. Our lab has been involved in a program of research aimed at: (a) gaining a stronger understanding of the severity and scope of neurocognitive deficits associated with schizophrenia; (b) understanding the relationship between neurocognitive functioning and functional outcome (e.g., work and social functioning); and (c) developing innovative rehabilitation interventions borne out of the knowledge of neurocognitive deficits as rate-limiting factors to rehabilitation success. One compensatory intervention we have studied is called *errorless learning*. It is based on empirical findings that learning is stronger and more durable if it occurs without errors. Initial studies were laboratory-based and targeted performance deficits on neurocognitive tests. Subsequent efforts have included more clinically relevant targets, such as teaching entry level job tasks and social problem-solving abilities. We are currently extending our research to community mental health settings to teach employment specialists how to implement errorless learning principles in teaching work skills to their clients with severe mental illness.

No. 2C**THE ROLE OF INTRINSIC MOTIVATION IN COGNITIVE SKILLS TRAINING**

Alice Medalia, Ph.D., *Professor, Department of Psychiatry, Montefiore Hospital, Albert Einstein College of Medicine, Klau-2, 111 East 210th Street, Bronx, NY 10467*

SUMMARY:

Cognitive skills training sets out to improve neuropsychological skills by providing exercises to either directly enhance the deficit area, or provide compensatory strategies to bypass the weak skills. Typical cognitive targets of intervention are attention, memory and problem solving, all areas of cognition associated with functional outcome in schizophrenia. In as much as the cognitive exercises involve learning a set of skills, the role of motivation in achieving these learning goals must be appreciated. Intrinsic motivation refers to the motivation to reach a goal which is viewed as inherently of interest. People who are intrinsically motivated to learn have been found to have a high level of learning, persistence of activity, increased satisfaction and engagement with learning. Educational psychology has promoted the adaptation of learning experiences to enhance intrinsic

motivation, and there is now a methodology that can be applied to skills training with schizophrenia. NEAR is a model of cognitive remediation that incorporates educational and neuropsychological principles in a program designed to increase intrinsic motivation and enhance learning of cognitive skills. This presentation will review the role of intrinsic motivation in learning, present the NEAR model, and discuss research on the impact of intrinsic motivation on learning in schizophrenia.

No. 2D**PRELIMINARY RESULTS FROM RANDOMIZED TRIALS OF MARYLAND COMPUTER ASSISTED COGNITIVE REMEDIATION FOR SCHIZOPHRENIA**

Dwight Dickinson, Ph.D., *Assistant Professor of Psychiatry, Maryland Psychiatric Research Center, 10 North Greene Street, Suite 6A, Baltimore, MD 21201*

SUMMARY:

The Maryland Computer Assisted Cognitive Remediation program (MCACR) is designed to address a range of cognitive deficits in schizophrenia, from more basic processing speed and attention through integrative executive and cognitive control functions. Problems with motivation and mental effort are common among our patients and a central challenge for cognitive remediation. The core components of MCACR are: (1) training and shaping of organized, strategy-based problem solving; (2) guided practice on a curriculum of computer exercises; and (3) a supportive, one-on-one training model. The program enhances participant engagement by building from accessible, intuitive problem solving strategies (e.g., verbalization to enhance encoding and guide problem solving), using carefully selected but appealing computer exercises, and employing a warm and encouraging training style. We are currently testing the program in two randomized pilot trials with stable, mainly outpatient, schizophrenia participants. The control condition matches for computer activity and therapist contact. Outcome measures include training exercise metrics, neuropsychological test performance, and role-play-based proxy measures of community functioning. We will present preliminary analyses of the effect of MCACR on these outcomes. We will also present data relating to the moderating influence of motivation.

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Symposium 3

**Thursday, October 5
2:00 p.m.-5:00 p.m.**

FOSTER CARE FOR FAMILIES IN DISTRESS: HELP OR HURT FOR TRAUMATIZED CHILDREN?

Charles W. Huffine, Jr., M.D., *Chair, APA/IPS Scientific Program Committee; Private Practice, Adolescent Psychiatry; and Medical Director, Children and Adolescents Programs, King County Mental Health Services, 3123 Fairview Avenue, East, Seattle, WA 98102*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the complexity of the task of keeping children safe, treating their trauma and respecting their complex needs when they have suffered abuse or neglect and are in distress; and recognize the complex needs of distressed mothers about losing their children.

SUMMARY:

This panel of experts, practitioners on the line, and families and youth involved in foster care will explore the history, phenomenology, medical and psychiatric interface with, and special problems of foster youth in 2006. This panel is formed at the specific request of the Scientific Program Committee of IPS as a means of extending the theme of Violence and Trauma into the issues of children and families. This diverse panel has each had a significant, but very different encounter with the phenomenon of foster care and will present from each of their unique perspectives. We hope to tap the child serving community in New York for a foster mother and a foster youth to comment on the primary presentations from their perspectives in foster care.

No. 3A

HISTORY, CURRENT STATUS, AND SPECIAL CHALLENGES IN FOSTER CARE AS OF 2006

David M. Osher, Ph.D., *Managing Research Scientist, American Institutes for Research, 1000 Thomas Jefferson Street, N.W., Washington, DC 20007-3835*

SUMMARY:

The history of modern foster care will be traced from the First White House Conference on Dependent Children in 1909 through the two world wars and the shift in emphasis to protection of abuse and neglected children after the Steele and Kempe article on the Battered Child Syndrome in 1962. The growing numbers of children entering foster care, difficulties in establishing a safe and permanent home for foster children, and the phenomenon of foster care drift will be addressed. Federal attempts to respond to this problem through the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) and the Adoption and Safe Family Act of 1994 (ASFA: P.L. 105-89) will be explained. Alternatives to out of home placement will be reviewed as well, particularly the innovations in systemic integration and community-based care pioneered by the initiation of the Child and Adolescent Service System Program in the mid '80's through the evolution of a System of Care approach to community-based care and the rise of Therapeutic Foster Care as a best practice.

No. 3B

COMPREHENSIVE PSYCHIATRIC CARE FOR CHILDREN AND ADOLESCENTS IN FOSTER CARE: WHERE DO WE STAND?

Lisa M. Cullins, M.D., *Assistant Training Director, Department of Psychiatry, Children's National Medical Center, 111 Michigan Avenue N.W., Washington, DC 20009.*

SUMMARY:

Children in foster care have suffered unthinkable traumas, repeated losses and separations. In addition to these insults, they continue to be marginalized with poor quality and access to medical and mental health care. Effective mental health service delivery programs are desperately needed to treat this population. This presentation will review literature on the psychiatric needs of youth in foster care and services to foster care children with an emphasis on problems in access, quality, continuity and cultural competence. This presentation will also review the DC KIDS Program, which is an innovative program that provides comprehensive medical and mental health care services to the foster children in Washington, DC, through a partnership between Children's National Medical Center, Child and Family Services Agency, and the Department of Mental Health. Details of the structure of the program will be provided. Utilization of services descriptive data will be summarized. Current challenges and strategies for improvement will be explored.

No. 3C
SERVING DISTRESSED WOMEN AND
THEIR CHILDREN AT RISK FOR FOSTER
CARE

Laila F.M. Contractor, M.D., *Resident, Department of Psychiatry, Western Psychiatric Institute and Clinic, 5600 Munhall Road, Pittsburgh, PA 15217*

SUMMARY:

Women with substance use disorders are most often separated from their children when they seek treatment. Likewise, children are separated from their mothers when they too receive treatment, much of which is affected by maternal substance use. Both are often plagued with underlying emotional difficulties, domestic violence, and insufficient support, making treatment challenging. This presentation will give a resident's experiences of delivering "fragmented" mental health services in various settings (inpatient, outpatient, and in the emergency room) to distressed birth mothers and their children at risk of being separated. The experiential material will be supplemented by research into the effective interventions for both women and their offspring designed to support both and prevent the need for out of home placement.

No. 3D
PERMANENCY, PLANNING, AND OTHER
DILEMMAS FOR YOUTH IN FOSTER
CARE

Charles W. Huffine, Jr., M.D., *Chair, APA/IPS Scientific Program Committee; Private Practice, Adolescent Psychiatry; and Medical Director, Children and Adolescents Programs, King County Mental Health Services, 3123 Fairview Avenue, East, Seattle, WA 98102*

SUMMARY:

This presentation will describe an Adolescent Work Group process in Washington State's social service system, driven by stakeholder in-put, to examine the special needs of adolescence for a different set of rules for their placement in foster homes. Those with knowledge of adolescent development raised questions about rules that stifle the participation in normative teenage activities such as traveling across state lines with foster families, learning to drive, and having unsupervised time with peers and peer's families. The dilemma of permanency with adolescents, when many have primary relationships with birth families and will be forced to leave foster care on their 18th birthday, was a primary focus of this work group. Solutions and resistance to implementation will be discussed. The resistance of adolescents to staying in foster care, preferring to live on the streets, will

also be discussed, as well as efforts in the state of Washington to empower youth, including former foster children, to speak out in policy settings about the dilemmas of youth in foster care.

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Symposium 4

Thursday, October 5
2:00 p.m.-5:00 p.m.

WOMEN IN THE COMMUNITY:
CLINICAL ISSUES ACROSS THE
REPRODUCTIVE LIFE CYCLE

Shari I. Lusskin, M.D., *Director of Reproductive Psychiatry, New York University School of Medicine, 155 E. 29th Street, Suite 26J, New York, NY 10016*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to diagnose and treat psychiatric disorders in pregnant and postpartum women, including those with a history of physical or emotional trauma; coordinate care with other providers in the community to reduce morbidity and mortality; evaluate and treat premenstrual mood disorders; and diagnose and treat depression during the menopausal transition.

SUMMARY:

Psychiatric disorders that present in relation to a woman's reproductive life cycle are underdiagnosed and undertreated. This symposium is designed to facilitate rational clinical decision making in the treatment of mood disorders across the life cycle.

The most up-to-date information on the pathophysiology and treatment of Premenstrual Dysphoric Disorder (PMDD), Perinatal Mood/Anxiety Disorders, and depression during the menopausal transition will be presented. Participants will learn about new methods for studying ovarian steroids, the serotonin system and the GABA system in the development of premenstrual mood changes. The diagnosis of mood/anxiety disorders in perinatal women, the impact of trauma, and the effects on the mother-infant dyad will be discussed in depth. Emerging controversies regarding the use of pharmacotherapy in pregnancy and lactation will be addressed, helping participants design individualized treatment plans for their patients. Depression associated with the menopausal transition, including epidemiologic risk factors, concerns regarding the use of hormonal therapy in the post-Women's Health Initiative Study era, and treatment options will be discussed in detail.

No. 4A
PERINATAL MOOD AND ANXIETY DISORDERS: IDENTIFYING A VULNERABLE POPULATION

Shaila Misri, M.D., *Clinical Professor, Department of Psychiatry, University of British Columbia, Room 28-185, 1081 Burrard Street, Vancouver, British Columbia, Canada V6Z 1Y6*

SUMMARY:

An estimated 12% of women suffer from depression in pregnancy while the prevalence rate of postpartum mood disorder is estimated to be 13%. Thus the perinatal period is clearly a time of increased vulnerability to developing mood and co-morbid anxiety disorders in predisposed women. The purpose of this presentation is to identify women who are at risk for developing: Major Depression including Bipolar Depression, Panic Disorder, Generalized Anxiety Disorder, Obsessive Compulsive Disorder, Post-traumatic Stress Disorder (PTSD) and Eating Disorders during pregnancy and the postpartum period. Women with a history of sexual abuse who present with symptoms of PTSD in the perinatal period are often misdiagnosed. This issue will be addressed in terms of early identification and intervention. The effects of maternal mental illness on bonding and attachment will be described as it relates to the mother infant dyad. Finally, the increased risk of suicide, neonaticide, and

infanticide in a mentally ill perinatal population will be addressed.

No. 4B
PERINATAL PHARMACOTHERAPY IN THE PUBLIC EYE: EMERGING CONTROVERSIES

Shari I. Lusskin, M.D., *Director of Reproductive Psychiatry, New York University School of Medicine, 155 E. 29th Street, Suite 26J, New York, NY 10016*

SUMMARY:

The use of psychotropic medications in pregnant and lactating women is increasing, but both clinicians and consumers question frequently whether their use is safe. For patients with mild-moderate disease, the risk-benefit decision may be more challenging than for those who are severely and persistently mentally ill. The largest amount of safety data regarding teratogenicity and long-term neurobehavioral development exists for antidepressants. However, in 2004, the FDA issued a public advisory that exposure to serotonergic antidepressants in the third trimester may be associated with transient neonatal complications, and in 2005, a preliminary study was released by the manufacturer which suggested an increased risk of cardiovascular malformations following first trimester exposure to paroxetine relative to other SSRIs.

This presentation is designed to facilitate rational clinical decision making in the treatment of perinatal depression and anxiety. The FDA advisory process will be reviewed, and the limitations of the available studies on pharmacotherapy and on child development in treated and untreated maternal depression and anxiety will be discussed. The fetal programming hypothesis will also be presented.

No. 4C
MENSTRUAL CYCLICITY AND MOOD: WHAT DO HORMONES HAVE TO DO WITH IT?

C. Neill Epperson, M.D., *Director, Behavioral Gynecology Program, Yale University School of Medicine, 300 George Street, 9th Floor, New Haven, CT 06511*

SUMMARY:

While the early Greek physicians theorized that intermittent behavioral disturbances and seizures observed in some women were secondary to the cycles of the moon, they were eventually linked to the monthly menstrual flow experienced by reproductive aged-women. Despite our modern conceptualization of the menstrual

cycle, ovarian hormone fluctuations and their considerable impact on central nervous system function, our understanding of the mechanism by which ovarian hormones contribute to the pathogenesis of premenstrual dysphoric disorder (PMDD) and premenstrual exacerbation of ongoing neuropsychiatric disorders is still in its infancy. Fortunately, this is a burgeoning field of investigation as novel research techniques have become available over the past decade and are being applied to the study of women's reproductive behavioral health. Thus, the goals of this presentation are three-fold: 1) to bring the clinician up to date with the latest diagnostic tools used to assess menstrual cycle-related changes in mood/behavior; 2) to provide an overview of research implicating serotonin and gamma-amino butyric acid neurotransmitter systems in the pathogenesis and treatment of PMDD; and 3) to discuss potential strategies for treating women with ongoing psychiatric disorders who destabilize during the premenstruum.

No. 4D DEPRESSION DURING THE MENOPAUSAL TRANSITION: WHO IS AT RISK AND HOW TO TREAT IT?

Claudio N. Soares, M.D., Ph.D., *Director, Women's Health Concerns Clinic, McMaster University, 301 St. James Street, South, FB# 638, Hamilton, Ontario, Canada L8P 3B6*

SUMMARY:

More than 1.7 million American women are expected to reach menopause each year. Recent statistics show that a 50-year old woman can now expect to live until her mid-80s, which implies living at least one-third of her life after menopause. The menopausal transition is typically marked by intense hormonal fluctuations accompanied by vasomotor symptoms (e.g., hot flashes, night sweats), sleep disturbance, and changes in sexual function. Recent studies have also demonstrated a significant association between menopausal transition and a higher risk for developing depression. In the post-Women's Health Initiative era, physicians and patients are questioning the safety and efficacy of long-term hormone therapy to improve well being and to prevent/alleviate somatic and psychological symptoms during the menopausal years and beyond.

This presentation will review the existing evidence on the benefits and risks of hormonal and non-hormonal therapies for the treatment of menopause-related mood and sleep disturbances, including estrogens, antidepressants, benzodiazepine-receptor agonists, and natural supplements. Epidemiologic data on risk factors for depression associated with the menopausal transition will be discussed.

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Symposium 5

**Thursday, October 5
2:00 p.m.-5:00 p.m.**

MONITORING DEPRESSION SEVERITY: CLINICAL APPLICATIONS IN PSYCHIATRY

Health Services Research Track

Darrel A. Regier, M.D., M.P.H., *Director, Office of Research, and Executive Director, American Psychiatric Institute of Research and Education, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209; Farifteh F. Duffy, Ph.D., M.H.S., Research Scientist and Director, National Depression Leadership Management Initiative, American Psychiatric Institute for Research and Education, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209; Madhukar H. Trivedi, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to update clinicians and researchers on the use of the nine-item Patient Health Questionnaire (PHQ-9) for the management of depression in psychiatry; and become familiar with innovative and practical approaches for improving care for patients with depression.

SUMMARY:

Depression is a common medical condition, responsible for an estimated economic cost of over \$40 billion annually, a large impact on quality of life and productivity, and indirect effects on other health states including cardiovascular disease (1–3). Prior research highlights the importance of a systematic approach to ensure adequate diagnosis and management of depression in clinical practices. Routine follow-up and monitoring are considered essential components for the management of depression. However, the majority of clinicians do not employ a systematic approach in monitoring patient outcomes when treating depression. Much like blood pressure monitoring for hypertension, a simple quantitative instrument such as PHQ-9 holds significant promise in improving treatment for depression by equipping physicians with a standardized tool for monitoring depression severity.

This session will introduce an innovative, collaborative venture of the APA, the American Academy of Family Physicians, and the American College of Physicians designed to improve depression care in primary care and psychiatry. The session will: 1) familiarize the audience with the APA National Depression Management Leadership Initiative; 2) present data on clinical utility of the PHQ-9 for the treatment of depression in diverse psychiatric practices and current dissemination efforts; and 3) describe the process involved in integrating evidence-based depression management strategies into existing clinical practice, and successes and barriers in implementing change in diverse systems of care.

No. 5A
NATIONAL DEPRESSION MANAGEMENT LEADERSHIP INITIATIVE: IMPROVING DEPRESSION CARE

David J. Katzelnick, M.D., *Director, Healthcare Technology Systems, 7617 Mineral Point Road, #300, Madison, WI 53717*; Henry Chung, M.D.

SUMMARY:

Presently, primary care and psychiatric physicians do not routinely use an outcome measure to monitor severity of a patient's depressive disorder. Collection of a standardized outcome measure in Diabetes Mellitus treat-

ment (HgbA1c) has catalyzed the use of programs designed to improve diabetes outcomes. The Patient Health Questionnaire (PHQ-9) has emerged as a practical self-rated depression screening and severity measure for depression. Can the PHQ-9 become for depression what the HgbA1c is for diabetes?

The American Psychiatric Practice Research Network (PRN) of the APA, the American Academy of Family Physicians, and the American College of Physicians teamed up to engage 19 psychiatric and 18 primary care practices in a collaborative to develop practice-driven strategies to improve management of depression in routine clinical practice. This twelve month collaborative is based on the learning model created by the Institute of Healthcare Improvement and included three, in-person learning sessions in 2005. The symposium will focus on the psychiatric experience with the collaborative.

Data will be presented on treatment outcomes achieved by the practices and the utility of using PHQ-9 in clinical practice.

No. 5B
DEPRESSION MANAGEMENT IN PRIVATE PRACTICE: PRIMARY CARE AND PSYCHIATRY

Rodrigo A. Munoz, M.D., *Former Consultant, APA/IPS Scientific Program Committee; and Past President, American Psychiatric Association, 3130 5th Avenue, San Diego, CA 92103-5839*; Alicia Munoz, M.A.

SUMMARY:

In this session, approaches toward integrating evidence-based depression management into routine clinical care will be described. Our efforts at creating a close interaction with Primary Care Physicians (PCPs) in San Diego have so far resulted in two very different situations.

At a community clinic staffed by PCPs and psychiatrists, the interaction has been smooth and mutually rewarding. The Clinical Director, a PCP, has become the champion in the effort at obtaining universal screening using the PHQ-9, enhancing treatment strategies, inducing patients to increase their participation, and establishing common outcome goals.

Similar efforts creating an interaction in private practice between PCPs and psychiatrists working in the same community and attending the same hospitals, but using different offices have advanced very slowly, so that only a minority of the PCPs we have approached are using the PHQ-9, they are using it with selected patients, and are reluctant to use it to evaluate outcomes.

Barriers in private practice will be discussed including: PCPs perceptions about stigma; their reluctance to address issues related to suicide; and their feeling that

third party payers will not reimburse them for depression treatment.

No. 5C
IMPROVING MANAGEMENT OF
DEPRESSION IN A CLINIC SETTING

Paul H. Wick, M.D., *Medical Director, Trinity Clinic, 3300 S. Broadway Avenue, #102, Tyler, TX 75701*; Cathy Reynolds, M.S.

SUMMARY:

Experiences in improving the management of depression in a moderately sized multispecialty group practice setting are described. The process has involved attitudinal shifts among physicians and office staff with the use of performance indicators and chronic disease management systems. The patient is quickly involved in assuming some responsibility and goals in his treatment by initially completing a standardized self-rating depression tool and then being introduced to various self-care management strategies. These may vary from simple suggestions to cognitive-behavioral goals. The self-rating scales plus clinical judgment guide the physician in treatment decisions as to whether to stay the course or alter treatment. Office staff initiates the assessment tool on every visit, logs results, distributes educational information and offers telephonic reminders and support. Progress and barriers in spreading these methods to better manage depression to primary care physicians are discussed. An overview of data collected from this practice will be presented.

No. 5D
IMPROVING DEPRESSION
MANAGEMENT IN A CULTURALLY
DIVERSE HOSPITAL SETTING

Daniel C. Chen, M.D., *Department of Psychiatry and Addiction Services, Flushing Hospital Medical Center, Medisys Health System; and Department of Psychiatry, North Shore University Hospital, New York University School of Medicine, 146-01 45th Avenue, Suite 310, Flushing Meadow, NY 11355*; Ana Muller, L.C.S.W.

SUMMARY:

Major Depressive Disorder has been found to be one of the most common psychiatric disorders, with a lifetime prevalence of approximately 15% (Sadock & Sadock, 2003). Therefore, there is a need for a short and simple diagnostic and assessment tool, much like a blood pressure test. Currently, doctors in New York City have begun to use such a simple questionnaire (Santora & Carey, 2005), known as the Patient Health Question-

naire-9 (PHQ-9), which might be served as an entry point for patients with depression and their clinicians to communicate about disease control and to adjust their therapy accordingly (Kroenke & Spitzer, 2002).

By joining the American Psychiatric Association's collaborative effort to develop strategies to enhance the clinical management of depression, the investigators at Flushing Hospital Medical Center have found that the PHQ-9 is helpful in successful depression management, including among Asian Americans. In addition, the investigators believe that other elements are important during the treatment process, such as: ongoing patient and family education; active family involvement; other community resources utilization; patient's self-health management; and vigorous follow-ups and case management. In conclusion, due to its usefulness, the PHQ-9 has been expanded to the entire mental health clinic and other parts of the hospital.

No. 5E
SYSTEMATIC APPROACH TO
DEPRESSION MANAGEMENT IN A
LARGE HEALTH CARE SYSTEM

Gabrielle J. Melin, M.D., *Department of Psychiatry, Mayo Clinic, 200 1st Street, S.W., Rochester, MN 55905*; Mark William, M.D.; Kristen Vickers-Douglas, Ph.D.; Pamela Van Steinburg, B.S.N.

SUMMARY:

As part of the National Depression Management Leadership Initiative, four clinicians from the Mayo Clinic Department of Psychiatry and Psychology initiated a program involving small steps toward system change. In this session, presenters will describe the process involved in integrating evidence-based depression management strategies into their existing clinical practice. In particular, strategies used to consistently assess depression (PHQ-9) at each patient visit, to record and track the PHQ-9 data, and to use PHQ-9 data summaries for clinician feedback will be described as the foundation for system redesign. Successes and barriers in initiating and spreading change to other clinicians will be highlighted, with some barriers relating to the challenges specific to change in a large system (e.g., time-consuming, complex process necessary to introduce a new data tracking mechanism into the electronic medical record), as well as other barriers relating to system change in any size system (e.g., clinician resistance to change in practice). Plans for implementing the successful depression management innovations throughout the entire clinical department and greater institution will be discussed.

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Symposium 6

Friday, October 6
8:30 a.m.-11:30 a.m.

HIV CARE FOR THE MENTAL HEALTH CLINICIAN: PART 1

Francine Cournos, M.D., *Professor of Clinical Psychiatry, Columbia University College of Physicians and Surgeons, and Deputy Director, New York State Psychiatric Institute, 5355 Henry Hudson Parkway, West, Apt. 9-F, Bronx, NY 10471-2868*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the spectrum of HIV-related neuropsychiatric, psychiatric, and somatic disorders; learn to recognize common complaints, assess mental status, and provide follow-up care; understand his/her role on the treatment team; and participate in a case discussion.

SUMMARY:

The devastating toll of HIV disease is evident in almost every country in the world. Populations most affected by this pandemic include newborns, sexually active youth, men who have sex with men (MSM), injecting drug users, and women of color. As the life expectancy of people living with HIV infection has increased, mental health providers are more likely to encounter neuropsychiatric manifestations of the disease. Studies estimate that 75 percent of all AIDS patients will show symptomatic CNS consequences. Subsequently, as quality of life becomes a more central consideration in the management of this disease, better awareness of these neuropsychiatric manifestations is paramount.

The purpose of this three-part, multidisciplinary symposium is to create a dialog for understanding, diagnosing, and treating the psychiatric dimensions of HIV and AIDS. Attendees of this session will discuss the role of the mental health treatment team in ensuring the best possible care for persons living with HIV and AIDS, and gain knowledge about associated neuropsychiatric and psychiatric complications, assessment and patient care. Question and answer periods staggered throughout the program will provide the audience with an opportunity to discuss individual clinical cases and explore questions and concerns.

No. 6A THE NEUROPSYCHIATRIC ASPECTS OF HIV INFECTION

Marshall Forstein, M.D., *Director of Psychiatric Residency Training, Department of Psychiatry, Cambridge Hospital, Harvard School of Medicine, 24 Olmstead Street, Jamaica Plain, MA 02130-2910*

SUMMARY:

There are significant direct consequences to the invasion of HIV into the nervous system that may present as neurological, neuropsychiatric, and/or psychiatric syndromes and disorders. These may arise acutely and require rapid evaluation and intervention or they may be chronic, subtle, and present accompanied by physical complaints. Dramatic changes in cognition, motor capacity, mood or behavior have obvious consequences for the individual. However, subtle neurocognitive impairments may affect coping mechanisms and the ability to work, adherence to HAART and medical care, and adherence to protective sexual practices. Appropriate training is needed to assess, diagnose, and treat the neuropsychiatric sequelae of HIV disease.

This presentation will focus on the treatment of psychiatric disorders in people with HIV and AIDS, with a focus on neuropsychiatric manifestations, psychiatric syndromes, and somatic complaints. Presenters will share their clinical experiences, focusing on the prevalence, clinical features, patient complaints, clinical course, differential diagnosis and treatment of these disorders.

**No. 6B
CLINICAL ASSESSMENT AND
INTERVENTION**

Milton L. Wainberg, M.D., *Associate Clinical Professor, Department of Psychiatry, Columbia University, 404 Riverside Drive, #5-B, New York, NY 10025-1861*

SUMMARY:

Early involvement of mental health clinicians, in the assessment and treatment of neuropsychiatric complaints are essential to both the overall well-being of the patient and to the efficacy of other treatments. In addition to the enormous psychological burden of progressive illness and loss of physical function, even subtle and sub-clinical changes in brain function may significantly affect both quality of life and the ability for a person to participate in his or her own medical care.

This presentation will teach participants to recognize changes in affect, behavior, or cognition that may indicate CNS involvement, psychiatric impairment, or medication side effects or toxicities; understand how to assess mental health status; and provide appropriate interventions. This presentation will follow a lecture format and include a question and answer period to provide participants with an opportunity to discuss clinical problems.

**No. 6C
CASE DISCUSSION**

Milton L. Wainberg, M.D., *Associate Clinical Professor, Department of Psychiatry, Columbia University, 404 Riverside Drive, #5-B, New York, NY 10025-1861*

SUMMARY:

As with any process that imposes high levels of stress on the body over a long period of time, the spectrum of consequences of HIV infection frequently includes psychiatric manifestations. Recognizing and treating these conditions is only the beginning. The patient and doctor also must consider the potential for drug interactions between psychiatric medications and drugs used to manage HIV disease, and must adjust dosages as needed.

The Case Discussion presentation will provide an opportunity for mental health providers to become active participants in the symposium. This session will take participants through a case from the initial presentation of symptoms, to differential diagnosis, diagnosis, treatment and follow-up.

REFERENCES:

1. Forstein, M: A Clinical Guide to Supportive & Palliative Care for HIV/AIDS: Psychiatric Problems, Health Resources and Services Administration, 2003 Edition.
2. Bocellaria AA, Shore M, Strood M. Neuropsychologic assessment in HIV-related disorders. In Cohen PT, Sande MA, Volberding PA (eds). The AIDS Knowledge Base. Boston: Little Brown & Company. 5-32, 1994.
3. McArthur JC, Brew BJ, Nath A, Neurological complications of HIV infection. The Lancet 4, 543-555, September 2005.

Symposium 7

**Friday, October 6
8:30 a.m.-11:30 a.m.**

**TRAUMA, VIOLENCE, AND
PSYCHOEDUCATION: THE IMPORTANCE
OF KNOWING**

Therapeutic Education Association

Garry M. Vickar, M.D., *Chair, Department of Psychiatry, Christian Hospital, 11125 Dunn Road, Suite 213, St. Louis, MO 63136*; Karen A. Landwehr, M.C., *Clinician and Educator, Comprehensive Mental Health Community Education Partnership, 514 South 13th Street, Tacoma, WA 98402*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe psychoeducation approaches to decreasing violence among consumers and family members and for decreasing symptoms of PTSD; and cite information about the effects of violence on police officers, who are the first responders in crisis situations.

SUMMARY:

This symposium will focus on how psychoeducation can help people cope more effectively with trauma and violence. "Technology for Teaching Normal Social Interaction for Displacing Aggression in the Seriously Mentally Ill" will present data from 30 years of work with aggressive patients. Evidence-based techniques with brief vignettes, will make the presentation graphic and credible to clinicians.

"Consumer Psychoeducation about Trauma and PTSD to Promote Hope and Healing" will offer an overview of ways to provide information and concrete examples of ways to promote consumer, family, and provider recognition of a recovery from trauma resulting in PTSD and complex PTSD.

"Family Education Based on Dialectical Behavior Therapy for Complex PTSD" will describe a family workshop approach to treating complex PTSD and Borderline Personality Disorder, using DBT to improve family members' knowledge, attitudes and skills in promoting a recovery environment.

When aggression spins out of control, police officers are often those called upon first. "Psychiatric Effects of Trauma and Violence on Police Officers" will provide a description of the St. Louis Police Department's program to train officers to deal with crisis incidents and the emotional effects such critical training evokes in respondents

No. 7A
TECHNOLOGY OF TEACHING NORMAL SOCIAL COMPETENCE TO THE AGGRESSIVE MENTALLY ILL

Robert Paul Liberman, M.D., *Distinguished Professor of Psychiatry, Department of Psychiatry and Biobehavioral Services, UCLA School of Medicine, 760 Westwood Plaza, Los Angeles, CA 91361*

SUMMARY:

While there appears to be genetic, neurodevelopmental and neurotransmitter anomalies that predispose mentally ill individuals to aggressive behavior toward self and others, angry, abusive, violent and destructive behavior are under the control of their immediate antecedents and consequences. A wide variety of events can elicit aggression in psychiatric patients, which is then inadvertently reinforced by the attention, anger, struggling, fighting, catharsis and interventions. The most common reinforcing consequence to aggressive behavior are verbal, debriefing encounters with well-meaning clinicians who attempt to defuse and deter future aggression by "talking it through" or "understanding the causes," both proximal and historical. Thus, it can be construed that aggressive behavior is learned through one's experi-

ences in life and strengthened or maintained by reinforcing consequences in therapeutic and natural, social environments.

Since aggression is largely a learned behavior, it is possible to use educational programs to teach patients normative social behavior that can supplant maladaptive, disturbing and fearsome violence that is intolerable in the community. There is a spectrum of evidence-based interventions that can serve as corrective, emotional, "re-learning" experiences. These include positive programming, social skills training, the teaching interaction, differential reinforcement of non-aggressive behavior, over-correction, required relaxation and time-out from reinforcement. Collectively, these treatments comprise a technology for teaching appropriate social behavior. Research data and case examples will illustrate the control of violent behavior by means of the technology of teaching.

No. 7B
CONSUMER PSYCHOEDUCATION ABOUT TRAUMA AND PTSD TO PROMOTE HOPE AND HEALING

Veronica O. Bowlan, M.S.W., L.S.W., *Faculty, Behavioral Health Education, Drexel University College of Medicine, P.O. Box 45357, Philadelphia, PA 19124*

SUMMARY:

As behavioral health systems are being transformed to use recovery models in treating mental illness, principles of recovery such as hope, personal responsibility, education and self-advocacy are being disseminated through a variety of programs such as the Wellness Recovery Action Plan by Mary Ellen Copeland. However, for people in recovery from trauma, including the traumas associated with having a long-term mental illness and dealing with inadequate treatment systems, more specialized information for understanding and coping with PTSD and complex PTSD are critical in becoming educated self-advocates. This presentation will provide an overview of user-friendly ways to package and disseminate critical information, based on evidence-based models for understanding trauma and treating PTSD and complex PTSD. It will include concrete examples for how to translate this complex and emotionally-charged material to consumers, family members and providers to promote recognition of and recovery from trauma, PTSD and complex PTSD.

No. 7C
FAMILY EDUCATION BASED ON DIALECTICAL BEHAVIOR THERAPY FOR COMPLEX PTSD

Edith J. Mannion, M.F.T., *Co-Founder and Manager, Training and Education Center, Mental Health Associa-*

tion of Southeastern Pennsylvania, 1211 Chestnut Street, 11th Floor, Philadelphia, PA 19107

SUMMARY:

Dialectical Behavior Therapy (DBT) has emerged as an evidence-based practice for treating Borderline Personality Disorder (BPD), which often co-occurs with PTSD and has been conceptualized by some experts as a complex form of PTSD. Stage 1 DBT involves psychoeducational skills groups for helping people self-regulate in preparation for stage 2, which is exposure therapy to treat PTSD if it is present. However, family psychoeducation was not initially a part of DBT. This presentation will showcase an 8-week educational workshop just for family members of people with BPD/complex PTSD that can be an adjunct to DBT. This family workshop approach can also help the many family members whose relatives avoid treatment or do not have access to DBT. The goal is to improve family members' knowledge, attitudes and skills in promoting a recovery environment, rather than leaving them vulnerable to inadvertently exacerbating the disorder and developing their own PTSD symptoms. This intervention is delivered by a DBT clinician and a trained family "peer consultant" who has "been there" and can help participants learn and trust the material. Although there is no controlled research, pre-post measures indicate promising results.

No. 7D

THE PSYCHIATRIC EFFECTS OF TRAUMA AND VIOLENCE ON POLICE OFFICERS

Colonel Joseph Mokwa, *Chief of Police, St. Louis Police Department, 1200 Clark Avenue, St. Louis, MO 63103*

SUMMARY:

This presentation will provide insight into the experiences of St. Louis, Missouri, police officers in their role as first responders in crisis situations. Information about the training officers receive to help de-escalate crisis situations will be presented, along with a description of the training provided to help officers develop positive mechanisms for conflicts/traumatic events will be provided and the physical and emotional impact such events have on the responding officers and their family members will be described. Other factors affecting the mental health of police officers will be discussed, as well as the procedures in place to provide support for officers following traumatic experiences. The collaborative relationship between the St. Louis Police Department and local mental health professionals will be discussed, along with ways to improve communication between the two systems.

REFERENCES:

1. Wong SE, Slama K, Liberman RP: Behavioral analysis and therapy for aggressive Psychiatric and developmentally disabled patients. In Roth L (Ed) *Clinical Treatment of the Violent Person*. New York: Guilford Press, 1986, pp 20–53.
2. Liberman RP: *From Disability to Recovery: Manual of Psychiatric Rehabilitation* Arlington VA: American Psychiatric Press, 2006.
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5. Carlier, I.V.E., Lamberts, R.D., & Gersons, B.P.R. Risk Factors for Posttraumatic Stress Symptomatology in Police Officers: A Prospective Analysis. *J of Nervous & Mental Disease*. 185(8):498–506, Aug 1997.

Symposium 8

**Friday, October 6
8:30 a.m.-11:30 a.m.**

DSM-IV-TR CULTURAL FORMULATIONS: DIAGNOSIS AND THERAPY

Russell F. Lim, M.D., *Assistant Clinical Professor, Behavioral Health Clinic, Department of Psychiatry and Behavioral Sciences, University of California School of Medicine at Davis; and Medical Director, Northgate Point, Regional Support Team, 2230 Stockton Boulevard, Sacramento, CA 95817*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand and describe the five parts of the *DSM-IV-TR* outline for cultural formulation; apply the *DSM-IV-TR* Cultural Formulation to the assessment and treatment of two or three of the following four groups: African American, Asian, Hispanic, and American Indian patients; and understand how ethnicity affects psychopharmacology and psychotherapy.

SUMMARY:

The increasing cultural diversity of the United States, as shown by U.S. Census data, requires that clinicians understand how cultural differences affect diagnosis and treatment. Between 1980 and 2000, the number of Asian Americans increased by 230%, American Indians by 139%, Hispanic Americans by 142%, and African Americans by 32%. In contrast, the Caucasian population increased by 11%. In 2001, the Surgeon General of the United States released a supplement to his report on Mental Health entitled "Culture, Race, and Ethnicity," which stated that "culture counts" in the diag-

nosis and treatment of the above four ethnic groups. Finally, in 2003, the Institute of Medicine published their report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, which is a groundbreaking study of the deleterious effect of race and ethnicity on decisions made in medical treatment.

Culturally diverse individuals have special needs and clinicians require special skills and knowledge to treat them both appropriately and effectively. The symposium will present clinicians with a framework for the assessment of culturally diverse patients, as well as guidelines for psychopharmacology with these populations. Participants will be presented with four cases that will highlight salient issues in the assessment and treatment of African, Asian, Hispanic, or American Indian patients.

No. 8A
THE DSM-IV-TR CULTURAL FORMULATION: AN ASIAN AMERICAN MAN WITH PSYCHOSIS

Russell F. Lim, M.D., *Assistant Clinical Professor, Behavioral Health Clinic, Department of Psychiatry and Behavioral Sciences, University of California School of Medicine at Davis; and Medical Director, Northgate Point, Regional Support Team, 2230 Stockton Boulevard, Sacramento, CA 95817*

SUMMARY:

The case of Mr. A is presented, a Chinese American man with psychosis, to illustrate the use of the DSM-IV-TR Outline for Cultural Formulation (OCF). His case is first presented in the traditional Western psychiatric formulation. The OCF is then applied to the case, revealing details previously unexplored. Key concepts that will be described are the cultural identity of the individual, the individual's cultural health beliefs, the individual's socio-cultural environment and level of functioning, the cultural elements of the relationship between the individual and clinician, and the overall cultural formulation for diagnosis and treatment. Other key concepts include cultural norms, the proper use of an interpreter and a cultural consultant, and the influence of the clinician's racial identity on transference and countertransference.

No. 8B
ETHNOPSYCHOPHARMACOLOGY: AN UPDATE

David C. Henderson, M.D., *Associate Director, Psychotic Disorders Program, and Assistant Professor of Psychiatry, Harvard Medical School, 25 Staniford Street, Boston, MA 02114*

SUMMARY:

Understanding basic psychopharmacology principles and the impact of race, sex, and culture on metabolism, response, adverse events, medication interactions and medication compliance, ethnopsychopharmacology examines biological and non-biological differences across race, ethnicity, sex and culture and is critical for safe prescribing practices. A growing body of published evidence is documenting important inter- and intra-group differences in how patients from diverse racial and ethnic backgrounds experience health and illness, and is affected by pharmacologic treatment. Recommendations will be provided to improve compliance, reduce adverse events and medication interactions, and to improve clinical outcomes. An expanded understanding of the interactions between psychopharmacological treatment and gender, ethnic and cultural diversity informs conceptualizations of psychopharmacological treatments of various populations. This presentation will review principles of ethnopsychopharmacology and highlight issues influenced by race, gender, and culture in the pharmacologic treatment of various psychiatric disorders.

No. 8C
EFFECTIVE INTERVENTION FOR AMERICAN INDIANS AND ALASKA NATIVES

Candace M. Fleming, Ph.D., *Associate Professor, Department of Psychiatry, University of Colorado Health Sciences Center; and Associate Director of Training, National Center for American Indian and Alaskan Native Mental Health Research, P.O. Box 6508, Aurora, CO 80045*

SUMMARY:

According to the U.S. Census 2000, there are 2,475,956 American Indians and Alaska Natives (AI/ANs) living in the United States, less than 1% of the total U.S. population. Further, only 21% living on reservations, while the other 79% live in rural and urban areas not set aside as part of treaty negotiations. Like other ethnic minorities, AI/AN persons and families have experienced historical and institutional discrimination resulting in hundreds of years of cultural oppression and intergenerational trauma (Duran & Duran, 1995). Indian Health Service (1999) data report that the suicide rate for AI/ANs is 19.3 per 100,000 compared to 11/2 for non-Indians. Other alarming rates where great disparities are seen are the alcohol death rate, diabetes death rate, and poverty level. This paper will describe major behavioral health needs and resiliencies experienced by AI/ANs and will summarize strategies viewed to be effective in diagnosis and treatment.

No. 8D
THE CULTURAL FORMULATION
MODEL: A HISPANIC CASE
ILLUSTRATION

Roberto Lewis-Fernandez, M.D., *Assistant Professor of Clinical Psychiatry, College of Physicians and Surgeons, Columbia University, 1051 Riverside Drive, Unit 69, New York, NY 10032*; Peter Guarnaccia, Ph.D.

SUMMARY:

The growing cultural pluralism of U.S. society requires clinicians to examine the impact of cultural factors on psychiatric illness, including on symptom presentation and help-seeking behavior. In order to render an accurate diagnosis across cultural boundaries and formulate treatment plans acceptable to the patient, clinicians need a systematic method for eliciting and evaluating cultural information in the clinical encounter. This talk illustrates one such method, the Cultural Formulation model, by describing a case scenario of a Puerto Rican woman suffering from *ataque de nervios* (attack of nerves). *Ataque* is a cultural syndrome characterized by intense emotional paroxysms that is prominent among Caribbean Latinos and is included in the *DSM-IV-TR* Glossary of Culture-Bound Syndromes. Empirical data on *ataque de nervios* will be presented, including on phenomenology, epidemiology, and relationship to psychiatric disorders, such as panic, MDD, PTSD, and the dissociative disorders. Using case material, each of the components of the Cultural Formulation model will be illustrated, and the substantial effect on illness course and treatment outcome of implementing the model in clinical practice will be discussed.

No. 8E
MULTIPLE LOSSES: AN AFRICAN
AMERICAN CASE STUDY

J. Charles Ndlela, M.D., M.P.H., *Assistant Clinical Professor of Psychiatry, University of California at San Francisco School of Medicine, 1001 Potrero Avenue, San Francisco, CA 94110*

SUMMARY:

Mr. X, a 40 year old African American male presented in the psychiatric emergency service with suicidal ideation and a plan to shoot himself with a gun. The main trigger was that the next day would be the anniversary of his wedding to his wife who had recently been killed together with his two children by a drunken driver.

The hospitalization course was marked by profound depression with strong suicidality. He exhibited signs and symptoms of post-traumatic stress disorder. He had significant support from the Black staff. He was able to

participate in the cultural events celebrated by the Unit such as Juneteenth. Spirituality was an important component of the treatment offered by the Black Focus Unit at San Francisco General Hospital.

The application of the *DSM-IV* Outline for Cultural Formulation helped us to understand the various facets of this man's cultural identity, which impacted on management. His treatment in the Black Focus Unit had a positive outcome.

REFERENCE:

1. Comas-Diaz L, Jacobsen FM: Ethnocultural transference and countertransference in the therapeutic dyad. *Am J Orthopsychiatry* 61:392-402, 1991.
2. Lu FG, Lim RF, Mezzich JE: Issues in the assessment and diagnosis of culturally diverse individuals, in *American Psychiatric Press Annual Review of Psychiatry*, Volume 14. Edited by Oldham J, Riba M. American Psychiatric Press, Washington, DC, 1995 pp. 477-510.
3. Comas-Diaz L, Jacobsen FM: Ethnocultural transference and countertransference in the therapeutic dyad. *Am J Orthopsychiatry* 61:392-402, 1991.
4. Lu FG, Lim RF, Mezzich JE: Issues in the assessment and diagnosis of culturally diverse individuals, in *American Psychiatric Press Annual Review of Psychiatry*, Volume 14. Edited by Oldham J, Riba M. American Psychiatric Press, Washington, DC, 1995 pp. 477-510.
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7. Choney, S.K. et al. (1995). The acculturation of American Indians: Developing frameworks for research and practices. In J.G. Ponterorto, J.M. Cosas, L.A. Suzuki, C.M. Alexander (Eds), *Handbook of Multicultural Counseling* (pp 73-92) California Sage.
8. Lewis-Fernández R and Díaz N. "The Cultural Formulation: A method for assessing cultural factors affecting the clinical encounter". *Psychiatric Quarterly*, 2002, 73:271-295.
9. Guarnaccia PJ, Canino G, Rubio-Stipec M, Bravo M. "The prevalence of ataques de nervios in the Puerto Rico Disaster Study". *J Nerv Mental Disease*, 1993, 181: 157-165.
10. Group for the Advancement of Psychiatry. (2002). *Cultural Assessment in Clinical Psychiatry*. Washington, D.C., American Psychiatric Press, Inc.

Symposium 9

Friday, October 6
2:00 p.m.-5:00 p.m.

HIV CARE FOR THE MENTAL HEALTH CLINICIAN: PART II

Marshall Forstein, M.D., *Director of Psychiatric Residency Training, Department of Psychiatry, Cambridge Hospital, Harvard School of Medicine, 24 Olmstead Street, Jamaica Plain, MA 02130-2910*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the prevalence of HIV infection and other clinical issues relevant to patients with HIV and mental health; identify emerging issues regarding risk patterns and challenges to prevention and risk reduction concerning patients with mental illness; and demonstrate practical counseling exercises to encourage persons living with HIV/AIDS to reduce participation in high-risk behaviors.

SUMMARY:

People with depression and other mental illness comprise a growing proportion of individuals living with HIV in the United States at the same time, the prevalence of HIV among mentally ill individuals is at least seven times higher than in the general population. Such individuals, who report high rates of sex and/or drug risk behaviors, include HIV infected drug users, patients presenting at HIV primary care clinics for medical treatment, and HIV infected men who have sex with men (MSM). Apparently, knowledge of HIV and its transmission is insufficient to deter these individuals from engaging in HIV risk behaviors, suggesting that certain personality characteristics may increase the likelihood of engaging in high-risk behavior.

Attendees will be introduced to effective prevention and treatment programs for HIV infected persons that consider specific personality factors for reducing the practice of high-risk sexual behaviors. Question and answer periods staggered throughout the program will provide the audience with an opportunity to discuss individual clinical cases and explore questions and concerns.

No. 9A

HIV INFECTION AND PEOPLE WITH SEVERE MENTAL ILLNESS

Francine Cournos, M.D., *Professor of Clinical Psychiatry, Columbia University College of Physicians and Surgeons, and Deputy Director, New York State Psychiatric Institute, 5355 Henry Hudson Parkway, West, Apt. 9-F, Bronx, NY 10471-2868.*

SUMMARY:

Living with HIV/AIDS is even more difficult when coupled with the challenge of living with mental illness. Studies of various segments of the mental illness population have found HIV prevalence rates ranging from 4% to 18%, compared to an estimated prevalence of 1% in the general population. Factors associated with increased susceptibility to HIV infection among this population include higher rates of drug and alcohol use associated with high-risk behavior, a lack of safer sex education designed for people with mental illnesses, and the increased vulnerability of people with mental illnesses to sexual assault and abuse, including institutional settings. In spite of this, mentally ill people are often not screened for HIV, nor are they targeted for prevention education. This session will provide participants with an overview of the prevalence of HIV among people with severe mental illness, barriers to care, and special medical concerns in this population.

No. 9B

HIV RISK BEHAVIORS IN PEOPLE WITH MENTAL ILLNESS

Meg Kaplan, Ph.D., *Director, Sexual Behavior Clinic, Columbia University, 513 West 166th Street, Third Floor, New York, NY 10023*

SUMMARY:

Psychiatrists and other mental health professionals must play an active role in educating their patients about HIV risk behaviors and strategies for adopting and maintaining behaviors that prevent or reduce risk. This session will help clinicians increase their own comfort level in discussing sensitive issues specific to high-risk behaviors regarding HIV acquisition and transmission.

No. 9C

RISK REDUCTION STRATEGIES FOR PEOPLE WITH MENTAL ILLNESS

Meg Kaplan, Ph.D., *Director, Sexual Behavior Clinic, Columbia University, 513 West 166th Street, Third Floor, New York, NY 10023; Richard Herman, M.A.*

SUMMARY:

Psychiatrists and other mental health professionals play a key role in educating their patients about effective ways to protect themselves from infection. This session will help clinicians increase their comfort level in providing information about harm reduction strategies and safer sex practices, and also equip patients with the necessary skills to implement risk reduction strategies in the "real world."

REFERENCES:

1. Weiser, Sheri D: The HIV epidemic among individuals with mental illness in the United States. *BioMed Central* 2005;1:186–192.
2. Hutton, Heidi E. and Treisman, Glenn: Understanding the role of personality in HIV risk behaviors: Implications for prevention and treatment. *The Hopkins HIV Report*. 2001.
3. Brunnette M, Rosenberg S, Goodman L, et al: HIV risk factors among people with severe mental illness in rural and suburban areas. *Psychiatric Services*.
4. Robin L, Dittus P, Whitaker D, et al: Behavioral interventions to reduce incidence of HIV, STD, and pregnancy among adolescents: a decade in review. *Journal of Adolescent Health* 2004; 34:3–26.
5. McKinnon K, et al, HIV among people with chronic mental illness, *Psychiatr Q.* 2002 Spring;73(1):17–31.
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Symposium 10

**Friday, October 6
2:00 p.m.-5:00 p.m.**

**INNOVATIONS IN LEVEL OF CARE
ASSESSMENT FOR PSYCHIATRIC AND
SUBSTANCE DISORDERS**

Kenneth M. Minkoff, M.D., *Clinical Assistant Professor of Psychiatry, and Senior System Consultant, Harvard Medical School, 100 Powdermill Road, #319, Acton, MA 01720*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe the concept of independent de-linked dimensions of service intensity, and identify four such dimensions; discuss the concept of multidimensional service intensity assessment, and identify six assessment dimensions commonly utilized for addiction and/or psychiatric patients; and evaluate the current utility and validity of the ASAM PPC 2R and LOCUS 2.0 in application to real clinical situations for individuals with co-occurring disorders.

SUMMARY:

Despite the fact that there has been extensive controversy regarding managed care, there has been surprisingly little available objective data on the clinical process of utilization management and level of care determina-

tion. Fortunately, in recent years, this has begun to change, as there has been increasing development and investigation of more sophisticated instruments for assessment of level of care or service intensity requirements for individuals with mental health and/or substance use disorders.

This symposium attempts to bring together in a single forum a presentation of the most up to date level of care assessment tools available in the public domain. The symposium begins with a presentation of general principles of utilization management, including the description of independent dimensions of service intensity and the concept of multidimensional service intensity assessment.

The symposium continues with presentations by the major developers of the most well-known service intensity assessment tools for individuals with mental health and substance disorders: The ASAM Patient Placement Criteria, Second Edition Revised (2001), and the American Association of Community Psychiatrists Level of Care Utilization System (LOCUS 2.0) (2001). Each instrument will be described by its major author, along with information on validity and reliability studies, and instructions on use.

The final section of the symposium will emphasize audience participation in the level of care assessment process. A sample case illustrating a complex patient with co-occurring disorders in crisis will be distributed, along with copies of the tools, and the audience will participate in using each tool to evaluate level of care. The strengths and limitations of each instrument will then be discussed.

In total, the symposium will present the participant with an accurate portrayal of the current field of level of care assessment, and the directions for future research. This material will be valuable for anyone—clinician or manager—involved in the development of managed care evaluation systems, or in the delivery of clinical services that require such utilization management or assessment.

**No. 10A
PRINCIPLE OF UTILIZATION
MANAGEMENT AND LEVEL OF CARE
ASSESSMENT**

Kenneth M. Minkoff, M.D., *Clinical Assistant Professor of Psychiatry, and Senior System Consultant, Harvard Medical School, 100 Powdermill Road, #319, Acton, MA 01720*

SUMMARY:

The presentation begins with an outline of basic principles of utilization management. This will include the concept of independent dimensions of service intensity, including biomedical, residential, treatment, and case

management intensity, which lead in turn to the reconceptualization of “levels of care” as “matrices of service intensity”. In this model, the independent dimensions are “de-linked” so that program models can vary flexibly across dimensional categories.

The second key concept is that of multidimensional service intensity assessment. Level of care instruments are based on identifying these dimensions, and connecting ratings on each dimension, separately and together, to the identification of patient service intensity requirements. Later talks in this symposium will illustrate how this is currently being done for individuals with substance and/or psychiatric disorders (ASAM PPC 2R, LOCUS 2.0).

The goal of the presentation will be to provide a general framework for attendees to consider utilization management as a CLINICAL decision making process, and to be able to objectively evaluate current methodology for objective service intensity assessment and decision making.

No. 10B
UNDERSTANDING AND USING THE
PATIENT PLACEMENT CRITERIA OF
THE AMERICAN SOCIETY OF
ADDICTION MEDICINE

David Mee-Lee, M.D., *Chair, Coalition for National Clinical Criteria, 4228 Boxelder Place, Davis, CA 95616*

SUMMARY:

Clinicians involved in planning and managing care often lack a common language and systematic assessment and treatment approach that allows for effective, individualized treatment plans and level of care placement. The Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine (ASAM) first published in 1991, provided common language to help the field develop a broader continuum of care. The Revised Second Edition (ASAM PPC-2R) published in April 2001, added criteria for co-occurring mental and substance-related disorders, which made the ASAM PPC-2R even more applicable to behavioral health systems.

No. 10C
THE LEVEL OF CARE UTILIZATION
SYSTEM: A SIMPLE METHOD FOR
LEVEL OF CARE DECISIONS

Wesley E. Sowers, M.D., *Member, APA/IPS Scientific Program Committee; President, American Association of Community Psychiatrists; and Medical Director, Of-*

fice of Behavioral Health, Allegheny County, 206 Burry Road, Bradford Woods, PA 15015

SUMMARY:

The Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) was developed by the American Association of Community Psychiatrists in 1995, and updated to the current version (LOCUS 2.0) in 2001. The instrument attempts to assist in making level of care determinations for individuals with mental health and/or substance use disorders to balance clinical quality with the need for efficient management of utilization of care. It is designed to be easily understood and used by clinicians. A number of principles were identified to guide the development of LOCUS: 1) Integration of mental health and addiction variables; 2) dimensional and quantifiable assessment parameters; 3) levels of care defined flexibly in terms of resource intensity rather than rigidly defined program requirements; and 4) adaptable to the variety of circumstances encountered in behavioral health environments. LOCUS has been field tested over the past several years, and has been updated to accommodate suggestions from that process. Preliminary testing has demonstrated reliability, and consistency with expert determinations for placement decisions. This workshop will provide an overview of how to use the LOCUS, discuss practical applications, and illustrate utility in relation to a specific case example.

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1. Minkoff and Regner: Innovations in Dual Diagnosis Treatment in Managed Care: The Choate Dual Diagnosis Case Rate Program: *J. Psychoactive Drugs*, 1999.
2. Minkoff: Level of Care Determination for Individuals with Co-Occurring Disorders: *Psychiatric Rehabilitation Skills*: 2001.
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Symposium 11

Friday, October 6
2:00 p.m.-5:00 p.m.

WHERE TRAUMA OFTEN LEADS: ADJUSTMENT DISORDERS

Roger Peele, M.D., *Chief Psychiatrist, U.S. Department of Health and Human Services, P.O. Box 1040, Rockville, MD 20849*; Maryam A. Razavi, M.D., *Department of Psychiatry, George Washington University, 1600 North Oak Street, Apartment 1805, Arlington, VA 22209*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to explicate the importance and treatment of Adjustment Disorders.

SUMMARY:

Traumas can result in Adjustment Disorders, and in many settings, this is the most common after-trauma diagnostic grouping. The importance and seriousness of Adjustment Disorders is highlighted by studies of suicides that find a significant percentage had an Adjustment Disorder. Additionally, it is common that an Adjustment Disorder leads to another psychiatric disorder and further educational, social, and occupational dysfunctions.

While *DSM-III* and *DSM-III-R*, defined Adjustment Disorder as self-limited, the *DSM-IV* recognition of the Chronic Type opens Adjustment Disorders to the vast number of people living with chronic intra-family trauma. Moreover, people living in highly stressful communities may suffer the Chronic Type of Adjustment Disorders. Thus, Adjustment Disorders reflect the presence of social and community traumas.

Despite the importance of Adjustment Disorders as to occurrence, the number who suicide, its potential to lead to another disorder, and its important reflection of family and community pathology, there is lack of promulgations as to its treatment. In this symposium, the importance and treatment of Adjustment Disorders is reviewed.

No. 11A OVERVIEW OF ADJUSTMENT DISORDERS

Maryam A. Razavi, M.D., *Department of Psychiatry, George Washington University, 1600 North Oak Street, Apartment 1805, Arlington, VA 22209*

SUMMARY:

Adjustment Disorders have as a core feature a close temporal relationship to a stressful event or multiple events. According to the *DSM-IV-TR*, criteria for diagnosis with an Adjustment Disorder consists of symptoms that must appear within three months of a stressor's onset. The stressor is generally a short-term, maladaptive reaction to psychosocial stressors, and is expected to have remission after the stressor ceases or when a new level of adaptation is achieved. There is some overlap with other disorders, such as Depressive Disorder NOS, Bipolar Disorder NOS, and Anxiety Disorder NOS, although Adjustment Disorders have a clear stressor as a precipitating event. According to the *DSM-IV-TR* the prevalence of this disorder in the general population is estimated to be from 2–8%, with as many as 50% of those with specific medical problems or stressors having been diagnosed with adjustment disorders. There is sparse literature on treatment guidelines for these patients, with the limited data pointing to greatest benefit from various forms of psychotherapy. Considering Adjustment Disorder is one of the most common disorders in the primary care setting and that there is a link between Adjustment Disorder and suicidal behavior, it is imperative to develop scientifically sound algorithms for diagnosis and further explore treatment options and ways of managing stress.

No. 11B ADJUSTMENT DISORDERS WITH DEPRESSION

Vincenzo Holder-Perkins, M.D., *Department of Psychiatry, George Washington University, 3302 Gallows Road, Falls Church, VA 22047*

SUMMARY:

Adjustment disorder with depressed mood is caused by specific sources of stress, such as severe personal crisis (the murder of a loved one, recent physical or sexual abuse) or major unexpected negative events (9–11). In some cases, ongoing problems, such as living in a crime ridden neighborhood can reach a breaking point that may lead to the development and maintenance of depressive symptoms. Traumatic experience(s) can be damaging to one's self-esteem. Self-loathing, shame, and guilt all fuel depression and can be triggers. Other depressive symptoms that are common reactions to trauma or violence are sleep disturbance, learned helplessness and loss. Interpersonal relationships become strained leading to a withdrawal phenomenon from social and occupational settings. Traumatic events and violent activities are ubiquitous in most American communities. Individual psychotherapy and psychopharmacology are usually the primary forms of treatment for trauma-related

psychiatric disorders such as adjustment disorder with depressed mood.

No. 11C
ADJUSTMENT DISORDERS WITH ANXIETY

Roger Peele, M.D., *Chief Psychiatrist, U.S. Department of Health and Human Services, P.O. Box 1040, Rockville, MD 20849*

SUMMARY:

Adjustment Disorder with anxiety manifests itself in nervousness, worry, agitation, insomnia, undue perfectionism, panic attacks, or unwarranted preoccupation with somatic signs after trauma, such as an automobile accident, diagnosis of cancer, or divorce. It is very important that this disorder, quite common in primary care settings, be effectively addressed to prevent progression into substance-related disorders, other anxiety disorders, disabilities, or even suicide. Successful treatment often includes crisis management tied to case management, group therapy of patients in similar circumstances [e.g., breast cancer patients], cognitive behavior, or supportive psychotherapy focused on realistic reassurance, coping skills and exploring environmental changes that can remove or reduce the trauma. Medications, usually SSRIs or lesser-addicting benzodiazepines, are used minimally and briefly.

No. 11D
ADJUSTMENT DISORDERS WITH DISTURBANCE OF CONDUCT

Mozhdeh Roozegar, M.D., *Department of Psychiatry, St. Elizabeth's Hospital, Washington, DC 20032*

SUMMARY:

Adjustment Disorder with Disordered Conduct [ADDC] is often overlooked in clinical practice. It is not adequately stressed in the literature due to the short-term and subthreshold nature. The severity of the traumas does not foresee the severity of the ensuing conduct disorder; emphasizing the precipitating role of ordinary life stressors indicating the constitutional vulnerability of the affected population. The latter makes children and particularly adolescents prone to ADDC. In this age group the common stressors include academic problems, family conflict, or sexuality issues. Of importance is the tendency toward conduct subtype among adolescents marked by externalization of the maladjustment to the trauma. Similarly ADDC can complicate the course of medical illnesses and is often an additional diagnosis to other major Axis I or Axis II disorders. Unremitting

environmental stressors precipitate the chronic subtype. In addition, transformation to more typical mental illnesses, the potential for suicide, and the potential for violence indicate the need to raise awareness toward ADDC in mental, forensic and primary care setting. ADDC requires minimal pharmacotherapy. Psychotherapy helps adapting to the stressor and serves as a preventive intervention when the stressor is remitting.

REFERENCES:

1. Strain JJ, Newcorn J, Fulop G, Sokolyanskaya BA: Adjustment Disorder. In *The American Psychiatric Press Textbook of Psychiatry*, 3rd Edition, edited by Hales RE, Yudofsky SC, Talbott JA, Washington, DC, American Psychiatric Association Press, 2005, pp 759–771.
2. Casey Patricia. Adult Adjustment Disorder: A Review of It's Current Diagnostic Status, *Journal of Psychiatric Practice*. 7(1):32–40, Jan 2001.
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Symposium 12

Saturday, October 7
8:30 a.m.-11:30 a.m.

PREVENTION OF AGGRESSION IN CHILDREN AND YOUNG ADULTS

American Orthopsychiatric Association

Oscar A. Barbarin, Ph.D., *School of Social Work, University of North Carolina, 102 Forest Ridge Drive, Chapel Hill, NC 27514*; Charles W. Huffine, Jr., M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to apply severity indicators to distinguish typical and atypical aggression; conceptualize and use systemic preventive interventions targeted at aggression;

and use social cognitive intervention to reduce aggression.

SUMMARY:

Developmental epidemiology has consistently demonstrated that early detection and intervention in problems of aggression and conduct in young children are among the most effective ways to prevent serious difficulties arising in adolescence and adulthood. This symposium addresses issues of violence as a symptom of serious mental health problems at three stages in the life span: early childhood, middle childhood and young adulthood. This symposium describes relevant empirical research and theory that support preventive approaches to violence in children, adolescents, and young adults. The presentations underscore the role of development and context in understanding the nature, origin and prevention of aggression and victimization. Presentation one describes a preventive system of mental health service delivery in pre-school programs that includes universal screening and multi-level intervention. Presentation two describes the state-of-the-art with respect to programs designed to promote social competence and prevent aggressive behavior in third-grade children. Details are provided for a skills-training program that has been derived from research on social information processing (SIP) and emotion regulation and has been effective in reducing aggression in third-grade students. Using an investigation of young adult sexual assault survivors and person-centered analytic techniques, presentation three describes research that identifies contextual patterns and interpersonal factors that shape vulnerability to sexual violence. It highlights implications for tailored, multidimensional prevention interventions.

No. 12A PREVENTING AGGRESSION IN PRE-SCHOOL CHILDREN

Oscar A. Barbarin, Ph.D., *School of Social Work, University of North Carolina, 102 Forest Ridge Drive, Chapel Hill, NC 27514*

SUMMARY:

Aggression is ubiquitous in early childhood settings, but its presence is not always prodromal to psychopathology. This symposium describes a system of mental health services for pre-school children. The system begins with a program-wide screening that gathers information from parents and pre-school teachers to help distinguish typical from atypical aggression (ABLE, Barbarin, 2004). Following the screening is a set of interventions that integrate services at individual, classroom and program levels. The presentation begins with the conceptual underpinnings of the mental health ser-

vice system. It then discusses the critical decision points in the implementation of the system. The screening of aggression uses seven key severity indicators and this information helps to determine the level of services to be provided to children considered at risk for conduct or other disorders. Interventions at the program level include in-service training, system wide adoption of an approach for dealing with aggression and oppositional behavior. Classroom level consultations focus on risky situations in the classroom related to routines, schedules, and transitions that create an environment in which aggression flourishes. Specific consultation is offered to teachers about how to deal with a specific child and on the establishment of an emotional connection between teacher and child.

No. 12B SOCIAL INFORMATION PROCESSING SKILLS TRAINING

Mark W. Fraser, Ph.D., *Professor, School of Social Work, University of North Carolina, 301 Pittsboro, CB 3550, Chapel Hill, NC 27599*; Mary A. Terzian, M.S.W.; Maeda J. Galinsky, Ph.D.; Paul R. Smokowski, Ph.D.; Shenyang Guo, Ph.D.

SUMMARY:

This paper presents the results of a three-year study of a prevention program intended to promote social competence and prevent aggressive behavior in 548 third-grade children. Based on social information processing (SIP) and emotion regulation theoretical perspectives, a skills-training program was developed and delivered to third-grade students (51% male) in two schools comprised of African American (20%), Latino (41%), non-Latino White (34%), and other (5%) children. Teacher ratings of student behaviors and child assessments of SIP skills were collected in each of the three years during which the study was conducted. Behavioral outcomes measures include: cognitive concentration, social competence, social contact, social aggression, authority acceptance, and overt aggression. SIP-related skill acquisition was assessed using post-test analogue methods. Measures included: encoding, hostile attribution, goal formulation, and response decision-making. No significant differences were observed among groups at pretest. Controlling for covariates and testing for cross-level interactions, children in classrooms receiving the intervention had fewer behavioral problems at post-test when compared to the comparison cohort. In contrast to children in the comparison group, children in the intervention condition demonstrated significantly improved SIP skills. Findings suggest that strengthening children's skills in regulating emotions and processing social information reduces conduct problems in childhood.

No. 12C
PROFILES OF SEXUAL ASSAULT
SURVIVORS: IMPLICATIONS FOR
HOLISTIC PREVENTION
INTERVENTIONS

Rebecca J. Macy, Ph.D., A.C.S.W., *Assistant Professor, School of Social Work, University of North Carolina, 307 Pittsboro Street, CB3550, Chapel Hill, NC 27599*; Paula S. Nurius, Ph.D.; Jeannette Norris, Ph.D.

SUMMARY:

Little guidance exists about how to tailor rape prevention programming to be responsive to varying groups of women, though empowerment trainings need to prepare women to recognize and resist sexual assault within a range of experiences and contexts. Using an investigation of 415 college women who completed a survey about a range of sexual assault experiences by known male assailants, this investigation tested for distinct multivariate profiles of contextual factors among sexually assaulted women in order to discern how these factors may differentially combine to influence women's vulnerability to sexual assault. We applied the person-centered analytic technique of latent profile analysis (LPA) to determine meaningful subgroups of women based on interrelationships among factors that contextualize women's vulnerability to sexual assault, including prior victimization, alcohol consumption, relationship expectancies of the assailant, and assertive precautionary habits. LPA established four significantly distinct multivariate profiles of substantively different groups of women. Different tests aided in group profile interpretations and showed that the four profile groups significantly differed in their assault responses. The results highlight the utility of multivariate analytic tools for understanding the complex factors that shape vulnerability to violent victimization. Implications for tailored and holistic empowerment-based rape prevention trainings for women will be discussed.

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2. Huesmann LR, Maxwell CD, Eron L, et al. (1996). Evaluating a cognitive/ecological program for the prevention of aggression among urban children. *American Journal of Preventive Medicine* 12 (5): 120–128 Suppl. S SEP-OCT.
3. Fraser, Mark W.; Day, Steven H.; Galinsky, Maeda J.; Hodges, Vanessa G.; Smokowski, Paul R. (2004). Conduct Problems and Peer Rejection in Childhood: A Randomized Trial of the Making Choices and

- Strong Families Programs. *Research on Social Work Practice*, Sep2004, Vol. 14 Issue 5, p313–324.
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Symposium 13

Saturday, October 7
8:30 a.m.-11:30 a.m.

NATIONAL INSTITUTE OF MENTAL
HEALTH CLINICAL TRIALS:
IMPLICATIONS FOR PSYCHIATRIC
TREATMENT AND RESEARCH

Health Services Research Track

Philip S. Wang, M.D., *Director, Division of Services and Intervention Research, National Institute of Mental Health, 5600 Fishers Lane, Rockville, MD 20857*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should become familiar with four major clinical research trials, sponsored by the National Institute of Mental Health, and understand how these trials will have implications for psychiatric practice and research.

SUMMARY:

This symposium will highlight the major clinical research trials sponsored by the National Institute of Mental Health (NIMH), reviewing their scope, methodology, and latest findings, with emphasis on the implications for psychiatric practice and research. These studies include the Clinical Antipsychotic Trials of Interventions Effectiveness (CATIE), the Sequential Treatment Alternatives to Relieve Depression (STAR*D), The Treatment of Adolescents with Depression Study (TADS),

and the Systematic Treatment Enhancement for Bipolar Disorder (STEP-BD).

No. 13A
COMPARATIVE EFFECTIVENESS OF
ANTIPSYCHOTIC DRUGS IN PATIENTS
WITH CHRONIC SCHIZOPHRENIA:
FINDINGS FROM THE CATIE
SCHIZOPHRENIA TRIAL

Jeffrey A. Lieberman, M.D., *Chair, Department of Psychiatry, College of Physicians and Surgeons, Columbia University; Director, New York State Psychiatric Institute; and Director, Lieber Center for Schizophrenia Research, 455 Central Park West, Apt. 9-C, New York, NY 10025-3850*

SUMMARY:

The National Institute of Mental Health (NIMH) initiated the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) program to evaluate antipsychotic drugs in clinical situations. The CATIE schizophrenia trial compares relative effectiveness among and between first generation antipsychotic drugs (FGAs), introduced in the 1950's, and second generation antipsychotic drugs (SGAs), used extensively since their introduction in the 1990's.

Approximately 50 U.S. sites enrolled 1,500 persons with schizophrenia. The primary outcome was all-cause treatment discontinuation. Secondary outcomes included symptoms, side effects, neurocognitive functioning, and cost effectiveness. Phase I, double-blind and randomized, compared treatment with SGAs olanzapine, quetiapine, risperidone, and ziprasidone to perphenazine, a midpotency FGA. If the initially assigned medication was not effective, subjects could choose a Phase II trial: (1) randomization to open-label clozapine or a double-blinded SGA that was available, but not assigned in Phase I; or (2) double-blinded, randomization to ziprasidone or another SGA that was available, but not assigned in Phase I. If the Phase II study drug was discontinued, subjects could enter Phase III, an open-label treatment based on the individual's experience in Phase I and Phase II. The initial efficacy and safety results of Phases I and Phase II of the trial have been reported (Lieberman et. al. 2005, Stroup et. al. 2006, McEvoy et. al. 2006).

The CATIE study indicates, not unexpectedly, that medications work, but with substantial limitations. In fact, 74% of patients elected to seek something better, rather than stay on their assigned medication. The biggest surprise was that the older medication, perphenazine, was comparably effective to at least three newer SGA medications, and not much worse than the best SGA, olanzapine. However, olanzapine had the most side effect incidence of weight gain and changes in

glucose and lipid metabolism. Contrary to expectations, the older medication did not cause substantially more neurological side effects than the newer; we believe, because we administered a lower potency APD at moderate doses.

In Phase II for patients who discontinued their Phase I medication due to lack of symptom control and went into the clozapine pathway, clozapine was substantially better than all the other SGA medications.

In Phase II for patients who discontinued their Phase I medication and went into the ziprasidone pathway, it is important to examine the results separately, per the reason for discontinuance. If the reason was inadequate control of psychotic symptoms, those taking olanzapine or risperidone stayed on their medication significantly longer than those taking quetiapine or ziprasidone. If the reason was side effects, no significant difference among the four Phase II medications was revealed. Thus, the success of symptom control and side effects experienced by the patient on the first medication may help predict which medication may be more successful next.

The CATIE Phase II results show that for patients whose symptoms are not wholly responsive to other antipsychotic medications, clozapine is an effective choice for the next step. Olanzapine and risperidone are more effective than ziprasidone and quetiapine. But olanzapine is associated with substantial weight gain and metabolic problems, while ziprasidone is consistently associated with reduction in weight and improvement in metabolic indicators.

No. 13B
SEQUENCE TREATMENT
ALTERNATIVES TO RELIEVE
DEPRESSION: WHAT HAVE WE
LEARNED?

A. John Rush, M.D., *Professor of Psychiatry; Vice Chair, Department of Psychiatry; and Betty Jo Hay Distinguished Chair in Mental Health, University of Texas, Southwestern Medical Center, 5323 Harry Hines Boulevard, Room E5.506, Dallas, TX 75390-7208*

SUMMARY:

This presentation will summarize the overall acute treatment results and selected results from the one-year naturalistic follow-up from the Sequenced Treatment Alternatives to Relieve Depression trial (STAR*D) including the overall study design and rationale; Level 1 (citalopram) acute and longer-term outcomes and analogous results from patients who entered Level 2 switch and Level 2 augmentation treatments; Level 3 switch and augmentation, and Level 4 acute and longer-term results. Discussion will focus on the implications of these

findings for both future clinical trials and for clinical practice.

No. 13C
THE TREATMENT OF ADOLESCENTS
WITH DEPRESSION STUDY:
IMPLICATIONS FOR CURRENT
PRACTICE AND FURTHER RESEARCH

Benedetto Vitiello, M.D., *Chief, Child and Adolescent Treatment and Preventive Intervention Research Branch, Division of Services and Intervention Research, National Institute of Mental Health, 8316 Arlington Boulevard, Suite 600, Fairfax, VA 22031-5204*

SUMMARY:

Objective: Both pharmacological treatment and psychotherapeutic interventions have been found to be efficacious for adolescents with Major Depressive Disorder. TADS is a publicly funded randomized clinical trial to directly compare the relative effectiveness of fluoxetine and cognitive-behavioral therapy (CBT), alone or in combination, for the treatment of adolescents suffering from moderate to severe Major Depressive Disorder. *Methods:* A multisite, randomized, controlled clinical trial with four parallel treatment conditions: medication management with fluoxetine, medication management with placebo, Cognitive-Behavior Therapy (CBT), and a combination of CBT and fluoxetine treatment, each for 12 weeks, was conducted. At the end of the 12 weeks of acute treatment, responders continued in maintenance treatment for an additional six months. Primary outcome measures were the Child Depression Rating Scale-Revised total score (CDRS-R) and the Clinical Global Impression-Improvement score (CGI-I). *Results:* A total of 439 adolescents (12–17 years of age) with *DSM-IV* MDD were randomized. On the CDRS-R, the combined treatment was superior to placebo ($p < 0.001$), fluoxetine alone ($p < 0.02$), and CBT alone ($P < 0.01$); fluoxetine was superior to CBT ($p < 0.01$) at the end of the first 12 weeks of treatment. Response rate was greater on combined treatment (71%) or fluoxetine alone (61%) than on CBT (43%) or placebo (35%). *Discussion:* The combination of fluoxetine and CBT showed the highest effectiveness. The results will be discussed in light of the implications for current practice and further research.

No. 13D
THE SYSTEMATIC TREATMENT
ENHANCEMENT PROGRAM FOR
BIPOLAR DISORDER: RECENT FINDINGS
AND THEIR IMPLICATIONS

Gary S. Sachs, M.D., *Director and Associate Professor, Department of Psychiatry, Harvard Medical School; and*

Director, Bipolar Clinic and Research Program, Massachusetts General Hospital, 50 Stanford Street, Fifth Floor, Boston, MA 02114

SUMMARY:

The Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) was an NIMH-funded collaboration which sought to determine the effectiveness of treatments for Bipolar Disorder. The rational design and methods for STEP-BD were developed with the overall aim of providing clinically meaningful outcomes that could be used to guide treatment of Bipolar Disorder in routine practice.

The collaboration involved accessioning 4,361 bipolar subjects into 26 treatment centers across the United States that had agreed to use a common disease management program. From this cohort of well characterized patients followed longitudinally, subjects were recruited for other specific studies with STEP-BD. STEP-BD has completed several randomized studies and quasi-experimental comparisons which focused on the use of various medications and psychotherapies for bipolar depression. In addition STEP-BD has collected data relevant to relapse prevention, the risk of Polycystic Ovarian Syndrome, psychiatric comorbidity, and suicidality. Data from published STEP-BD studies will be reviewed.

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Symposium 14

Saturday, October 7
2:00 p.m.-5:00 p.m.

HURRICANE RELIEF: LESSONS LEARNED IN THE FIELD

Janis B. Petzel, M.D., *Psychiatrist, Maine General Health, 37 Winthrop Street, Hallowell, ME 04347-1136*;
Kenneth M. Sakauye, M.D., *Director of Geriatric Psychiatry, Louisiana State University Health Science Center, 3 South Lark Street, New Orleans, LA 70124*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should have an understanding about the complex issues surrounding disaster relief including the clinical, eco-

nomic, and logistical factors facing caregivers and disaster planners.

SUMMARY:

The breadth of the destruction and interruption of civic, medical and mental health services in Louisiana and the Gulf Coast after Hurricanes Katrina and Rita was unprecedented in the history of this country. This symposium seeks to tap the wealth of experience of medical caregivers who provided emergency relief aid in the aftermath of the storms (as did all of the speakers). We will present papers on the experiences of a New Orleans psychiatrist who provided on-going care and who is himself experiencing the effects of dislocation. Practical discussion of emergency work will be discussed from various points of view, including primary care in special needs shelters, the role of psychiatry in the emergency response, and working with agencies such as the Red Cross or within the Veterans Administration. Ideas on preparing volunteers for disaster relief work will be presented. Our goal is to synthesize the experience for the audience and to begin the discussion of how to make adequate use of the lessons learned from this natural disaster.

The intended audience is composed of physicians and other medical and psychiatric providers who have an interest in preparing for disaster relief work, either in their own communities or in the wider world.

No. 14A

SUPPORT OF PHYSICIANS IN LOUISIANA AFTER THE HURRICANES

Kenneth M. Sakauye, M.D., *Director of Geriatric Psychiatry, Louisiana State University Health Science Center, 3 South Lark Street, New Orleans, LA 70124*

SUMMARY:

Disaster response involves four distinct phases: evacuation, emergency phase (first response), early post-impact phase, and restoration. Disaster plans usually end with the evacuation and emergency phase, but should include restoration of services and allocation of funds to local providers. Over 6,000 physicians were displaced after Hurricane Katrina in Louisiana and Mississippi. There was no coordinated plan to restore hospitals, retain staff, or provide services after first response. By four months later in New Orleans, only 30% of the population had returned; 10% of businesses had reopened, and only 40% of psychiatrists returned. Only one general hospital and one free-standing psychiatry unit reopened within the city boundaries. FEMA and SAMHSA contracts went to large groups like the Red Cross or contractors specializing in such services in Washington, D.C. No open bidding was allowed for local carriers. Loans, not

grants, were available to small businesses, ignoring the high-risk of business failures and defaults when reopening in a disaster area. By January 2006, FEMA refused paying to rebuild Charity or the University Hospitals. Problems faced by local university and training programs and hospitals in New Orleans without such planning will be emphasized. Solutions involve planning and coordination by a health care administration.

No. 14B
PRIMARY CARE IN A SPECIAL NEEDS SHELTER

Lewis W. Marshall Jr., M.D., J.D., *Chairman, Emergency Medicine, Brookdale University, 1 Brookdale Plaza, Brooklyn, NY 11212*

SUMMARY:

The provision of primary care in a post-disaster situation is problematic and presents many challenges for the primary care provider. The provision of such care is complicated by the myriad situational issues that arise in circumstances in which displaced persons are forced to reside in shelters, interact with various medical providers, social services, and State and Federal workers. In such situations, latent psychological conditions and overt psychological diseases exacerbate the ability of the primary care provider to address the medical needs of the evacuees. In such circumstances it is important to have the expertise of psychiatrists accustomed to dealing with these trying circumstances.

This talk will describe the experience of working under conditions where patients with significant medical problems are in a shelter setting. It will cover the importance of considering the psychological aspects of post-disaster displaced persons in managing their medical conditions, the importance of the consultation-liaison between psychiatric and medical providers, and the benefit to patient care when the two (psychiatric and medical) work together to manage the medical and psychiatric manifestations of disease that are exhibited in the post-disaster shelter situation.

No. 14C
A SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION KAT TEAM AT THE RED CROSS SHELTER

Maryanne Jones Godbout, R.N., *Nurse, Muhlenberg Behavioral Health Care, 2545 Schoenersville Road, Bethlehem, PA 18017*

SUMMARY:

The natural catastrophic events of hurricanes Katrina and Rita displaced many individuals of southeastern Louisiana and the surrounding areas of Lake Charles, Louisiana from their loved ones, homes and places of employment. Many evacuees became extended residents in the Red Cross Shelter in Monroe, Louisiana. The Red Cross Shelter became a community of residents coping with the actual stress of the hurricanes and individuals with previous mental health disorders. Mental health providers delivered services to individuals experiencing acute grief and stress responses to the stabilization of those with persistent and chronic mental illness.

This speaker will present the challenges of meeting the mental health needs of the diverse shelter population during the two-week period of 10/4/05–10/17/05. Case studies will be used to describe the presentation of the mental health disorders in the shelter, the adjustment of evacuees with persistent and chronic mental illness to shelter life, the management of behavioral emergencies in the shelter and networking with local mental health agencies. This presenter will also discuss the responses of the volunteers and experiences working with interdisciplinary mental health professionals from various agencies and geographical regions.

No. 14D
PREPARING VOLUNTEERS FOR A DISASTER RELIEF EXPERIENCE

Margaret Gering, R.N., B.S., *Geriatric Nurse, Kirkland Village, 1 Kirkland Village Circle, Bethlehem, PA 18017*

SUMMARY:

Relief workers ideally should possess medical and physical fitness, psychological stability and maturity. Flexibility is more important than academic credentials during a disaster. Various aspects of relief worker training will be discussed, including field exercises, mentoring, and team building. Disaster relief workers must have realistic expectations of what they can accomplish in the field, and have a clear definition of purpose and scope of practice. They must also understand and be provided a clear definition of policies, procedures and command structure. Deployment briefing and debriefing will be discussed along with the benefits of having a complement of mental health professionals available in the field. These training criteria will be presented from the point of view of a DMAT-trained medical professional with disaster relief experience, along with examples from the deployment to Louisiana following Hurricanes Rita and Katrina.

No. 14E
THE PSYCHIATRIST AND PEDIATRIC
SUB-SPECIALIST IN DISASTER RELIEF

Michael Seyffert, M.D., *Pediatric Neurology, New York Child Study, New York University, 215 Lexington Avenue, 14th Floor, Room 1421, New York, NY 10016*

SUMMARY:

In the aftermath of a disaster situation, the availability of the pediatric expert is especially important. Given the physical disruption of the family unit, the urgent need for re-establishing a safe and comfortable environment in which the child can express their feelings and re-establish a sense of control. First on the list should be an assessment of the child's physical status including nutritional status, exposure to traumatic events, eating and sleep patterns. Second, is the need to get the child's interpretation of what has happened to them, what their current behavioral state is, and what their assumption is about the future. This can include open-ended questions, encouraging them to talk, write and draw. Finally, there is a need to normalize the child's emotional reactions by reminding them of their safety, referring them to the appropriate specialist and by re-integrating them into a daily routine. Cooperating with the psychiatric physicians in a consult-liaison model proved to be an effective method to address the child and adolescent patients' needs, and to focus care where it was most needed.

No. 14F
THE CONSULTATION-LIAISON ROLE OF
THE PSYCHIATRIST IN SHELTERS

Janis B. Petzel, M.D., *Psychiatrist, Maine General Health, 37 Winthrop Street, Hallowell, ME 04347-1136*

SUMMARY:

Direct patient care is only one aspect of psychiatric care that comes to bear in a disaster situation. The consultation-liaison role is particularly important given the systems issues that arise when large numbers of displaced persons with medical and psychiatric disorders are forced into close proximity under conditions of shelter life, and are cared for by large numbers of ever-changing volunteers from different organizations and different parts of the country. Psychiatric training in geriatrics and psychosomatic medicine is particularly valuable.

This talk will describe my experiences as a volunteer psychiatrist in Special Needs Shelters in Louisiana following the hurricanes of 2005. Aligning with the primary care physicians in a consult-liaison model was an effective way to triage patient needs, and to focus the care where it was most needed. This opened the way for

psychiatry to aid in the communication between very different groups of volunteers, to provide rapid in-service training for nursing staff who had little experience with the mentally ill; to interpret group dynamics to facilitate volunteer adjustment to trying circumstances; to make recommendations to shelter administrators about safety and morale; and to assess volunteers who had mental illness exacerbations while working in the shelter.

REFERENCES:

1. Demand and supply of emergency help: An economic analysis of Red Cross services. *Health Policy*. 2005 Oct 18.
2. Eager to help. Healthcare volunteers charge into afflicted areas. *Mod Health*. 2005 Sep 12;35(37):12-4.
3. Hurricane Katrina. Public health response—assessing needs. *N Engl J Med*. 2005 Oct 13; 353(15):1544-6.
4. Hurricane Katrina. Volunteer work—logistics first. *N Engl J Med*. 2005 Oct 13; 353(15):1541-4.
5. Katrina reveals fatal weaknesses in US public health. *Lancet*. 2005 Sep 10-16;366(9489):8.
6. Center for Disease Control and Prevention. Hurricane Katrina response and guidance for health-care providers, relief workers, and shelter operators. *MMWR Morb Mortal Wkly Rep*. 2005 Sep 9;54(35):877.

Symposium 15

Saturday, October 7
2:00 p.m.-5:00 p.m.

CHANGING THE WORLD: NATIONAL
STRATEGIES FOR SYSTEMIC
IMPLEMENTATION OF INTEGRATED
SERVICES: APPLICATIONS IN NEW
YORK CITY

Kenneth M. Minkoff, M.D., *Clinical Assistant Professor of Psychiatry, and Senior System Consultant, Harvard Medical School, 100 Powdermill Road, #319, Acton, MA 01720*; Christie A. Cline, M.D., M.B.A., *President, Zialogic, 166 Bayview Drive, San Rafael, CA 94901-2502*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the eight principles of a comprehensive, continuous integrated system of care and their application to system design within an integrated philosophy; recognize the 12 Steps of implementation for integrated systems and their utilization in real world systems; understand real world applications and use of top down bottom up CQI strategies for building dual diagnosis capability at a system, program, clinical practice, and clinician level; and describe the real challenges of implementation in New York City, with regard to

utilization of quality improvement as a change strategy, and the role of system administrators, program leaders, and clinicians in the process.

SUMMARY:

Individuals with co-occurring mental health and substance use disorders 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 “dual diagnosis is 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 “dual diagnosis programs” meeting minimal standards of dual diagnosis capability, but each program has a different job, to provide matched services to its existing cohort of cod clients, based on a set of consensus best practice principles within an integrated disease and recovery 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 within the New York City Office of Mental Health (OMH). Presentations will review the overarching system wide strategy to utilize quality improvement as a vehicle for implementation of best practices within a complex, scarce resourced system, and then specific strategies by which the OMH has undertaken to address improvement in integrated services for clients with co-occurring disorders through this process.

No. 15A COMPREHENSIVE CONTINUOUS INTEGRATED SYSTEM OF CARE: DESCRIPTION OF THE FRAMEWORK

Kenneth M. Minkoff, M.D., *Clinical Assistant Professor of Psychiatry, and Senior System Consultant, Harvard Medical School, 100 Powdermill Road, #319, Acton, MA 01720*

SUMMARY:

Individuals with co-occurring disorders 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 sys-

tem of care with scarce resources, the CCISC model organizes a framework for system design in which every program is a dual diagnosis program meeting minimum standards of Dual Diagnosis Capability (DDC) (along with some specialized program elements that are Dual Diagnosis Enhanced) 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 co-occurring disorders 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 clinician is a dual diagnosis clinician meeting minimal standards of dual 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.

No. 15B COMPREHENSIVE CONTINUOUS INTEGRATED SYSTEM OF CARE: REAL WORLD APPLICATION AND IMPLEMENTATION STRATEGIES

Christie A. Cline, M.D., M.B.A., *President, Zialogic, 166 Bayview Drive, San Rafael, CA 94901-2502*

SUMMARY:

Based on the author’s experience with implementation projects in 30 states and three Canadian provinces during the past five 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. 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 programmatic improvement and clinician 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 (COFIT), program self-assessment for dual diagnosis capability (COMPASS), and clinician self-assessment of attitudes and skills (CO-DECAT). 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 planning, as grounding features of clinical 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.

No. 15C

THE ROLE OF LOCAL GOVERNMENT IN IMPROVING MENTAL HYGIENE SERVICES

Hunter L. McQuiston, M.D., *Clinical Director, Division of Integrated Services, Department of Psychiatry, St. Luke's-Roosevelt Hospital; and Former APA/Bristol-Myers Squibb Fellow, 93 Worth Street, Room 413, New York, NY 10013*; Cheryl King, M.S.; Robin Kerner, Ph.D.

SUMMARY:

Quality IMPACT (Improving Programs and Communities Together) is a multi-year quality improvement initiative developed by the New York City Department of Health and Mental Hygiene's, Division of Mental Hygiene to promote incremental improvements in the mental hygiene service system. Critical components of Quality IMPACT include:

- Collaboration of government, providers, consumers and families in all facets of planning and implementation;
- Use of a data-driven continuous quality improvement (CQI) process;
- Provider education about CQI methods; and
- Use of local government leverage points to require and support participation.

After introducing the Division of Mental Hygiene's overall quality initiative, of which QI is a cornerstone, this paper will focus on a major priority of Quality IMPACT: the improvement of services for individuals with co-occurring disorders. The development and implementation of three related co-occurring disorders projects involving over 60 programs over two years will be discussed. The presentation will highlight successes and challenges, and review two years of data. A Quality IMPACT team leader from a key provider team will present the provider's experience. Finally, the presenters will discuss developing plans in Quality IMPACT.

REFERENCES:

1. Minkoff and Cline, Changing the World: Design and Implementation of Comprehensive Continuous Integrated Systems of Care. *Psychiatric Clinics of North America*, Dec 2004.

2. Minkoff and Cline, Developing Welcoming Systems of Care for Individuals with Co-occurring Disorders, *Journal of Dual Diagnosis*, 2005.
3. Panel on Co-Occurring Psychiatric and Substance Disorders, Center for Mental Health Services Managed Care Initiative (K. Minkoff, Chair). *Co-Occurring Psychiatric and Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies and Training Curricula*, January 1998.
4. Muezerk, Noordy D, Draku R. and Fox L ed. (2003) *Integrated Treatment for Dual Disorders. A Guide to Effective Practice*, The Guilford Press, NY.

Symposium 16

Sunday, October 8
8:30 a.m.-11:30 a.m.

MENTAL HEALTH WORKFORCE DEVELOPMENT AND CORE COMPETENCIES

Neal H. Adams, M.D., M.P.H., *Director of Special Projects, California State Department of Mental Health, 4129 Cherryvale Avenue, Soquel, CA 95073*; David A. Pollack, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the overall issues related to mental health workplace development and competency-based approaches; describe particular challenges faced by psychiatry; gain opportunities for innovation; and understand the special issues related to trauma and cultural competence.

SUMMARY:

In the spring of 2006, the Annapolis Coalition completed a draft national strategic plan for behavioral health workforce development. The plan reflects a multiyear development process that involved stakeholders throughout the field and addresses issues of both workforce capacity and competency. The plan has specific implications for psychiatry not only in terms of recruitment and retention, but also addresses the need to revamp current training methods and objectives to assure that psychiatrists are prepared for leadership participation in emerging new models of care. Successful innovations in training and practice need to be identified and disseminated-community engaged scholarship is an approach that holds much promise that more effectively links training and service recipients needs/experiences. Two critical areas of focus warrant special attention: 1) the need for clinicians to be more aware of and competent in assessing and responding to the impacts of trauma; and 2) the ongoing challenge of assuring diversity and

cultural competence in the workforce in order to respond to continued ethnic and racial disparities in access to mental health services and general well being in the community.

No. 16A
CORE COMPETENCIES IN PUBLIC MENTAL HEALTH

Neal H. Adams, M.D., M.P.H., *Director of Special Projects, California State Department of Mental Health, 4129 Cherryvale Avenue, Soquel, CA 95073*

SUMMARY:

Increasing attention is being directed to the competency of those who deliver health care in the United States. In behavioral health, there is growing recognition of the need to define, teach, and assess essential competencies. Since attention to this issue in behavioral health is relatively recent, there is much to be gained by learning from the principles, definitions, and conceptual models of competency that have been developed in other fields. This paper will examine some of the forces that drive the current focus on competency with a focus on the mental health workforce. Relevant history, principles, definitions, and models that have evolved through research and application in business and industry are reviewed. The implications of this competency model and its application to community psychiatry training and practice will be discussed.

No. 16B
CAN PATIENTS AND FAMILIES DEFINE CORE COMPETENCIES FOR PSYCHIATRISTS?

Leighton Y. Huey, M.D., *Professor, Chairman, and Training Director, Department of Psychiatry, University of Connecticut, 263 Farmington Avenue, Farmington, CT 06030*; Sue Bergeson; Joyce Burland, Ph.D.; Clarke Ross

SUMMARY:

Influential reports have highlighted problems in health care and in behavioral health care in particular. Some experts believe that reconstituting the manner in which both pre-professional and the existing behavioral health workforce is trained is critical to correcting the problems. How training occurs, how it is financed, and the development of contemporary core competencies associated with each discipline in behavioral health are important considerations. How core competencies are developed, by whom, and how to determine actual competency are also important. For psychiatry, having patients/consum-

ers and families involved with psychiatrists in the development of core competencies would seem to be a natural extension of the effort to transform the system into a new model. This paper will consider these issues.

No. 16C
COMMUNITY ENGAGED SCHOLARSHIP IN PSYCHIATRY

Kenneth S. Thompson, M.D., *Associate Professor of Psychiatry, University of Pittsburgh, and Former APA/Bristol-Myers Squibb Fellow, 6108 Kentucky Avenue, Pittsburgh, PA 15206*

SUMMARY:

The teaching and practice of community psychiatry in academic medical centers has become harder and harder to sustain, threatening the creation of the next generation of psychiatrists dedicated to community service. In particular, under pressure to bill for clinical services or develop extensive research portfolios, community psychiatry faculty are struggling to develop a career path in academic psychiatry that allows them to develop and maintain the relationships and project oriented work needed for engaged community practice. One solution to this dilemma being proposed is the development of a faculty track in "community engaged scholarships", mirroring similar tracks in research and clinical teaching. A recent effort by the Community and University Partnership for Health (CCPH), funded by the Kellogg Foundation, has elaborated the concept in depth and suggested the mechanisms by which a community engaged scholar would be promoted in an academic department of psychiatry. This presentation will outline the concepts behind community engaged scholarship and trace its historical evolution. It will suggest practical ways community psychiatrists might find a secure place in academic departments of psychiatry.

No. 16D
CULTURAL COMPETENCY COMPATIBILITY WITH CORE COMPETENCIES

Mario Cruz, M.D., *Department of Psychiatry, University of Pittsburgh, 5900 Jackson Street, Pittsburgh, PA 15213*

SUMMARY:

Problems in the delivery of mental health care by psychiatrists to patients of different race/ethnicity/culture than their own have been identified over the last three decades. Disparities in diagnosis, engagement, and treatment outcomes for different racial/ethnic/cultural

groups are well documented. These findings have resulted in the National Institutes of Health developing a five-year, strategic plan to reduce health disparities and the Department of Health and Human Services to recommend the implementation of Cultural and Linguistically Appropriate Service Standards (CLAS). In this symposium, the presenter will review present methods to incorporate cultural competency training in psychiatric residency and their effectiveness. Thereafter, the presenter will facilitate a discussion whose product will be a strategy to develop and test the implementation of cultural competency methods in the training of psychiatrists to serve trauma victims.

No. 16E

CREATING A TRAUMA-INFORMED MENTAL HEALTH WORKFORCE: KNOWLEDGE, SKILLS, ATTITUDES, AND TRANSDISCIPLINARY COMPETENCIES

Kevin A. Huckshorn, R.N., M.S.N., *Director, National Technical Assistance Center, National Association of Mental Health Program Directors, 66 Canal Center Plaza, Suite 302, Alexandria, VA 22314*

SUMMARY:

The work of the Surgeon General, the Institute of Medicine and the New Freedom Mental Health Commission have identified the need to significantly transform the way mental health services are provided, starting with recovery oriented goals that include illness self-management and building resiliency. Currently, the mental health field has not defined or standardized this "call for transformation" into workforce core competencies that will assure proficiency to work in a transformed system. Research on recovery has identified trauma-informed care as a core system change construct. This paper will describe the prevalence and impact of trauma in the lives of people being served in mental health settings and the principles that underlie the emerging science of trauma informed care. It will include specific descriptions of how trauma-informed knowledge changes organizational policies and clinical practice and offer examples of transdisciplinary trauma-informed, mental health workforce competencies. The model presented is based on work done by the National Child Traumatic Stress Network, the National Association of State Mental Health Program Administrators, SAMHSA's Centers, and on the emerging core competencies found in the mental health literature and the Annapolis Coalition's Web site.

REFERENCES:

1. Hoge, M.A., et al. (2005), Report of Recommendations: The Annapolis Coalition Conf on Behavioral

Health Workforce Competencies, Admin Policy in MH, 32(516); 651-663.

2. Hoge, MA, Tondora, J, Marrelli, AF. The Fundamentals of Workforce Competencies: Implications For Behavioral Health. Adm. Policy Mental Health 32(516): 509-531, 2005.
3. Hoge, MA, et al. Report of Recommendations: The Annapolis Coalition Conference on Behavioral Health Workforce Competencies. Adm. Policy Mental Health 32(516): 651-663, 2005.
4. Scholarship Reconsidered: Priorities of the Professoriate. Ernest L. Boyer, October 1997. Carnegie Foundation for the Advancement for Teaching.
5. Cooger-Patrick L, Gallo JJ, Gonzalez JJ, et al; Race, Gender, and partnership in the patient-physician relationship. JAMA 282:583-589, 1999.
6. Cusack, KJ, et al (2004) Trauma history screening in a community mental health center, Psych Ser, 55(2); 157-162.

Symposium 17

**Sunday, October 8
8:30 a.m.-11:30 a.m.**

SEX, LIES, AND HEAT: ASSESSMENT AND TREATMENT OF PSYCHOPATHS, PEDOPHILES, AND FIRESETTERS

Jeffrey L. Geller, M.D., M.P.H., *Professor of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue, North, Worcester, MA 01655-0002*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate an understanding of three cohorts of dangerous or malevolent individuals (e.g., psychopaths, pedophiles, and firesetters), and gain knowledge about their phenomenology, assessment, and treatment.

SUMMARY:

Throughout the history of organized psychiatry there has been an ongoing debate about the dangerousness of persons with psychiatric disorders. Much of the focus has been on those with psychotic disorders. Receiving less notice throughout the twentieth century has been attention to psychiatric pathology that may best be described as characterized by malfeasance. While the demarcation between responsibility and lack thereof for dangerous acts by patients with psychotic disorders may be difficult, differentiating between malevolence and psychopathology is proving even more challenging in contemporary society. In this symposium, the presenters focus on three cohorts who have proven to be high risks for society-at-large, a challenge for clinicians, and an ever-increasing percentage of the longer stay institu-

tional populations: psychopaths, pedophiles, and firesetters. Each speaker will focus on one group, discussing the phenomenology, assessments and interventions for that group. A discussion of the general problems of such populations will follow.

No. 17A
PSYCHOPATHIC PERSONALITY
DISORDER: ASSESSMENT AND RISK FOR
VIOLENCE

Gina M. Vincent, Ph.D., *Assistant Professor of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655*

SUMMARY:

Psychopathy has become widely accepted as a personality disorder marked by maladaptive patterns of behavior, affect, and cognition that are stable across situations and social interactions. Interpersonally, psychopathic individuals are arrogant and deceitful; affectively, they are shallow and lacking in empathy; behaviorally, they are impulsive and irresponsible. Given the characteristics of this disorder, individuals with psychopathy are frequently in trouble with the law, especially with respect to violent activity.

The “gold standard” for assessing psychopathic personality disorder is the Psychopathy Checklist-Revised (PCL-R), now in its second edition. This clinical assessment tool measures psychopathy both dichotomously (as a diagnosis that is present or absent) and dimensionally (as a constellation of traits that can be scored from 0 to 40). Meta-analytic studies indicate that the association between PCL-R scores and future violence is around .35, just slightly lower than the association between cardiac bypass surgery and a reduction in angina pain ($r = .38$) and significantly higher than the association between bypass surgery and decreased mortality ($r = .08$).

The goals of this presentation are threefold. First, it will cover the best practices in the psychological assessment of psychopathy. Second, the presenter will discuss the occurrence and nature of violence among psychopaths, and will end with strategies for treatment and risk management.

No. 17B
PEDOPHILIA: DIAGNOSTIC AND
TREATMENT CONSIDERATIONS

Fabian M. Saleh, M.D., *Assistant Professor of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue, North, Worcester, MA 01655*

SUMMARY:

Sex offender treatment remains the subject of media attention and controversy. With the adoption of sex offender commitment statutes in many states, there is a pressing need to properly evaluate and provide evidence-based treatments for sex offenders who are amenable to treatment. This is particularly true for those sex offenders who are afflicted with paraphilic disorders, such as pedophilia. This presentation will review the literature on the phenomenology and etiology of sexual offending behavior, in particular as it relates to pedophilia. Strategies used to diagnose pedophilia will be reviewed. Differential diagnostic considerations will also be addressed. In addition, psychological and biological based treatment modalities used to treat this population will be examined. Finally, recommendations based on this presentation will be discussed.

No. 17C
THE BURNING ISSUE OF
PATHOLOGICAL FIRESETTING

Jeffrey L. Geller, M.D., M.P.H., *Professor of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue, North, Worcester, MA 01655-0002*

SUMMARY:

Fire is a frightening and expensive problem throughout the world. Arson is a leading cause of nonresidential fires, residential fires, and fire fatalities. There is no adequate description of the typical arsonist, for there is not now, nor has there ever been, such a character. Arson is a complex, multidetermined event that has its origins in everything from profit to pathology. Pathological firesetting has been associated with mental disorders (disorders of thought, perception, mood, judgment, impulse control) and medical or neurologic disorders, e.g., epilepsy, AIDS, hypoglycemia. Revenge, the most common motive for firesetting, while not generally considered in the pathological category, may be just that—for why does the revengeful person choose fire? What appears to unite all these forms of firesetting are the social skills deficits of those who set fires. This presentation provides the groundwork for understanding firesetting through a capability model that postulates firesetting, avoids areas of conflict for the socially challenged person, and becomes reinforcing through its successful outcome for persons with low levels of personal accomplishment. The treatment implications of this model are discussed, as are the societal implications.

REFERENCES:

1. Hare, R. D. (2003). *The Hare PCL-R* (2nd Edition). Toronto, Ontario: Multi-Health Systems.

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3. Saleh, F.M., & Berlin, F.S. (2003). Sexual Deviancy: Diagnostic and Neurobiological Considerations. *Journal Child Sexual Abuse (Special Edition)*; Vol. 12, No 3/4, 233–253.
4. Saleh, F.M., & Guidry, L.L. (2003). Psychosocial and Biological Treatment Considerations for the Paraphilic and Nonparaphilic Sex Offender. *The Journal of the American Academy of Psychiatry and the Law*, 31:486–93.
5. Geller JL: Pathological firesetting in adults. *International Journal of Law and Psychiatry* 15:283–302, 1992.

Symposium 18

Sunday, October 8
8:30 a.m.-11:30 a.m.

MOBILE CRISIS SERVICES: MODELS, PRACTICES, AND COMMUNITIES

Hunter L. McQuiston, M.D., *Clinical Director, Division of Integrated Services, Department of Psychiatry, St. Luke's-Roosevelt Hospital; and Former APA/Bristol-Myers Squibb Fellow, 93 Worth Street, Room 413, New York, NY 10013*; David S. Heath, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand, from historical system's perspectives, the functional variety among mental health mobile crisis services and the challenges this intervention confronts as a model, including issues of program mission, management, and composition, as well as the role of government-level leadership.

SUMMARY:

Mobile crisis services are a key component of many community mental health systems. Nevertheless, as a model, mobile crisis is variegated and highly localized, with a range of mission, application, programmatic characteristics, staffing configurations, and role. In addition to exploring the meaning of the term "mobile crisis", this symposium will examine mobile crisis services in detail: who do they serve and what is their mandate; how are they constituted; how are they funded; and how do they fit into the broader service system? In discussing these questions, common threads will be discerned, as well as divergences. To accomplish this, presenters will first provide an overview of mobile crisis through a discussion of the current academic and program-based literature. This will be followed by detailed descriptions of mobile crisis services from two different localities.

Finally, still other models, like "mobile home treatment" will be discussed, as well as an attempt to formulate community-level best practices in mobile crisis that, in turn, inform the creation of measurable performance indicators.

No. 18A

MOBILE CRISIS SERVICES: A REVIEW OF THE LITERATURE

Patrick J. Moynihan, Ph.D., *Assistant Professor, Department of Sociology, Fordham University, 113 West 60th Street, New York, NY 10023*

SUMMARY:

This paper will summarize key thematic issues and trends within the literature regarding mobile crisis services, as well as those areas of research that remain underdeveloped. While there is general agreement that weak research designs dominant existing reports evaluating mobile crisis services, this review will attempt to organize the literature around the most robust empirical findings. Here, heavily descriptive work (in the form of case studies), as well as those more analytic designs (which tend to focus on specific utilization patterns and outcomes) will be highlighted. Of particular note, however, is the absence of information on the inner workings of crisis intervention services, the structure of and relationships within units, and how these services are integrated with other mental health programs in practice. As such, a set of directions for future research concerning mobile crisis services will be offered. By emphasizing that—like all mental health services—the efficacy of mobile crisis services needs to be rigorously evaluated at all levels of operation, the added value of qualitative methodologies (e.g., institutional ethnography) will be discussed.

No. 18B

MOBILE CRISIS IN CLEVELAND

David E. Biegel, Ph.D., *Professor of Social Work, Department of Psychiatry, Case Western Reserve University, 10900 Euclid Avenue, Cleveland, OH 44106*

SUMMARY:

This presentation discusses the implementation and impact of a community-based crisis program serving a large, midwestern community. In reorganizing its crisis services, the local mental health authority instituted a centralized approach to the delivery of psychiatric emergency services that included hotline, mobile outreach for both children and adults, and authorization for state hospitalization under the administration of a single

agency. Prior to the implementation of mobile services, people experiencing crises would go to a hospital-based psychiatric emergency room. The emergency room had authority for approving admission to the state hospital. The change in service delivery was accomplished by shifting funds from the emergency room to the mobile crisis program at no change in cost to the system.

Mobile crisis services are provided by an interdisciplinary team composed of Crisis Intervention Specialists, psychiatrists, and registered nurses. The Crisis Intervention Specialists are licensed mental health professionals who provide diagnostic assessment, pre-hospital screening, and case management services in addition to their crisis intervention duties. Psychiatric and nursing staff provide medical services and conduct diagnostic assessments. Data showed that community-based mobile crisis services resulted in a lower rate of hospitalization of clients than did hospital-based crisis services.

No. 18C
**MOBILE CRISIS IN NEW YORK CITY:
 THE VISITING NURSE SERVICE
 EXPERIENCE**

David C. Lindy, M.D., *Clinical Director and Chief Psychiatrist, Community Mental Health Services, Visiting Nurse Service of New York, and Associate Clinical Professor, Department of Psychiatry, Columbia University College of Physicians and Surgeons, 685 West End Avenue, Suite 1-AF, New York, NY 10025-6819*; Neil Pessin, Ph.D.

SUMMARY:

In 1986, the Visiting Nurse Service of New York's Community Mental Health Services (VNS) was awarded three mobile crisis contracts by the New York City Department of Mental Health (DMH) as part of a city-wide mobile crisis system started at that time. Teams were to prevent psychiatric hospitalization whenever possible, but also to facilitate ER evaluation as necessary, including involuntary removal by the police. Interestingly, this system did not attempt to rigidly define the nature of the service and was intended to allow individual teams to meet DMH goals as they saw best. The VNS service was designed to be home-visiting, free-standing, and community-based, with the capacity to quickly respond to non-911 type psychiatric crises. We serve three different boroughs and interact with multiple providers in each location. Over the years, we have seen the mobile crisis landscape of New York change, e.g., the shift to more hospital-based teams and

DMH's new focus on standardization of care. We will present a brief review of the history of New York City mobile crisis, describe our teams and differences between them (related in part to exigencies of their different locations), and discuss our plans for meeting the challenges of the future.

No. 18D
**DEVELOPING MOBILE CRISIS IN NEW
 YORK CITY**

Hunter L. McQuiston, M.D., *Clinical Director, Division of Integrated Services, Department of Psychiatry, St. Luke's-Roosevelt Hospital; and Former APA/Bristol-Myers Squibb Fellow, 93 Worth Street, Room 413, New York, NY 10013*; Monika Eros-Sarnyai, M.D.

SUMMARY:

New York City's Mobile Crisis network dates back over twenty years. Its 23 mobile crisis teams traditionally have had a dual role of responding to community calls to evaluate, stabilize, and triage people in acute psychiatric distress and to perform mental health disaster response. This presentation will focus on policy-level initiatives by the New York City Department of Health and Mental Hygiene to update this network's mission and function. In so doing, the presenter will describe the network's historical evolution and the complex nature of its funding and administration, thereby discussing challenges in systems reform. A resultant phased process of system improvement then will be described beginning with the presentation of data from an evaluation study that defined service gaps, proceeding to the discussion of a Best Practices framework, with resultant introduction of qualitative and quantitative indicators to measure the network's performance in meeting the needs of its community.

REFERENCES:

1. Guo, S., Biegel, D.F., Johnsen J., & Dyches, H. (2001). Assessing the impact of mobile crisis services on preventing hospitalization: A community-based evaluation. *Psychiatric Services*, 52 (2), 223-228.
2. Geller JL, Fisher WH, McDermeit M: A national survey of mobile crisis services and their evaluation. *Psychiatric Services* 46:893-897, 1995.
3. Fisher et al. 1990. Empirically assessing the impact of mobile crisis capacity on state hospital admission. *Community Mental Health Journal* 26(3):245-253.
4. McQuiston, HL. Eros-Sarnyai, M, Sederer, U. New York City Mobile Crisis Team Survey and Recommendations, NYC Dept. of Health and Mental Hygiene, NYC, 2004.

Workshop 1**Thursday, October 5
8:00 a.m.-9:30 a.m.****TRAUMA AND VIOLENCE IN MUSLIM COMMUNITIES**

Osman M. Ali, M.D., *Department of Psychiatry, Bellevue Hospital, 462 First Avenue, 20 West 1, New York, NY 10016*; Wahiba Abu-Ras, Ph.D.; Ali M. Gheith, M.S.; Abdullah M. Hasan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the nature and extent of traumatic experiences and violence affecting Muslim communities; and demonstrate culturally-sensitive approaches toward evaluation and treatment of this growing minority group.

SUMMARY:

Muslim mental health experts will address the need for Muslim and non-Muslim mental health providers and policy-makers to understand the diversity of American Muslims' unique psychological and spiritual experiences and their impact on presentation for and acceptance of psychiatric services. In the first part of the workshop, discussions will focus on the mental health impact of natural and man-made disasters on Muslim communities in the U.S. We will address the immigrant and refugee Muslim experience in New York City. We will also describe the psychosocial consequences of 9/11 and its aftermath on this community. In the second half of the workshop, we address the problem of domestic and intimate partner violence. Through audience participation, we will develop and encourage culturally-informed strategies for intervention, such as collaboration with clergy and engagement with the extended family.

TARGET AUDIENCE(S):

Outreach and mental health professionals, clergy, and administrators.

REFERENCES:

1. Ali OM, Milstein G, Marzuk PM. The Imam's role in meeting the counseling needs of Muslim communities in the United States. *Psychiatr Serv.* 2005 Feb; 56(2):202-5.
2. Lukens, EP, O'Neill, P, Thorning, H, Waterman-Cecutti, J, Gubiseh-Ayala, D, Abu-Ras, W, Batista, M, Chen, T. Building Resiliency and Cultural Collaboration Post September 11th: A Group Model of Brief Integrative Psychoeducation for Diverse Communities. *Traumatology.* June 2004; 10(2):107-129.

Workshop 2**Thursday, October 5
8:00 a.m.-9:30 a.m.****TRAUMA AND VIOLENCE IN AN ASSERTIVE COMMUNITY TREATMENT PROGRAM: MANAGING THE EFFECTS OF VICARIOUS TRAUMATIZATION OF MENTAL HEALTH WORKERS**

Ann L. Hackman, M.D., *Assistant Professor, Department of Psychiatry, University of Maryland Medical School, 630 West Fayette Street, Baltimore, MD 21201*; Curtis N. Adams, Jr., M.D.; Theodora G. Balis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify trauma and related disorders and understand efforts of trauma in patients with serious mental illness (SMI); identify and understand how care givers on an ACT team can be vicariously traumatized through treatment of patients; and identify and develop strategies for helping interdisciplinary teams cope with the psychological effects of treating seriously mentally ill patients with multiple traumas.

SUMMARY:

This workshop considers the impact of patient related trauma and violence on staff in an interdisciplinary, urban Assertive Community Treatment (ACT) team and ways to help the team cope with these issues. Literature indicates that people with severe mental illness (SMI) are frequently victim of violent crime and also occasionally the perpetrators of such crimes. Further, there is literature addressing the vicarious traumatization of health care workers. However there is little specifically addressing the effects of trauma and violence on staff in an ACT program or ways to ameliorate these effects.

The Baltimore ACT team treats 150 people with SMI, providing intensive outreach services in the community since 1990. In our patient population 85% are dually diagnosed; more than 50% have histories of homelessness. Instances of trauma and violence have included the following: seven patients deaths from homicide, three deaths from suicide, innumerable instances of assault, victimization and untimely patient death, three assaults on staff and several threats to staff. Strategies for helping the team cope include education, daily team meetings, providing the team with opportunities to support each other, holding memorial services when there is a patient death.

We will briefly consider the literature, describe our experiences with patients and trauma, and our approach to helping staff to cope with these issues. The audience will be invited to share their experiences; together we will explore ways to assist teams dealing with these difficult issues.

TARGET AUDIENCE(S):

Psychiatrists, social workers, ACT staff, and other interdisciplinary team staff.

REFERENCES:

1. Collins S, Long A (2003) Working with the psychological effects of trauma: consequences for mental health workers—a literature review. *Journal of Psychiatry and Mental Health Nursing*, 10, 417–424.
2. Walsh E, Moran P, Scott C et al (2003) Prevalence of violent victimization in severe mental illness. *The British Journal of Psychiatry*, 183, 233–238.

Workshop 3

**Thursday, October 5
8:00 a.m.-9:30 a.m.**

**THE EXPERIENCE OF PSYCHOSIS AS A
PRECIPITANT FOR PTSD: RETHINKING
SYMPTOMS, DIAGNOSIS, AND
TREATMENT**

Gopal R. Vyas, D.O., *Resident, Department of Psychiatry, University of Maryland, 16 Stretham Court, Owings Mills, MD 211117*; Dyanne Simpson, D.O., *Resident, Department of Psychiatry, University of Maryland, 706 Gittings Avenue, Baltimore, MD 21212*; Meredith A. Johnston, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify PTSD symptomatology associated with psychotic illnesses and understand that these symptoms can present after recovery from an acute psychotic episode; recognize and discuss psychotic symptoms most likely to result in the development of PTSD symptoms; and identify and develop strategies for the treatment of PTSD symptoms resulting from the experience of psychotic symptoms.

SUMMARY:

This resident presented workshop will examine the potential of understanding psychosis as trauma. Psychotic patients frequently perceive themselves to be at risk of harm or death, and this perceived threat may be experienced by these patients as traumatic.

As psychiatry residents rotating on acute inpatient services, we noticed that clinicians seemed to have little understanding of the subjective experience of psychosis. Literature indicates that the experience of psychotic symptoms such as paranoia, persecutory delusions, hallucinations and disorganized thoughts, can lead to traumatic reactions. Little is known about the impact of these experiences on patients. A better understanding of the traumatic components of psychosis and its treatment could have significant impact on approaches to helping

patients cope with this experience, and perhaps their illness.

Discussion will begin with brief presentations from the fresh perspective of psychiatric trainees on whether psychotic patients are traumatized by their experiences. Additionally, we will consider whether criteria for PTSD should be applied or considered, particularly after first break episodes, and whether the application of a trauma model in the treatment of these patients may be useful in their management.

TARGET AUDIENCE(S):

Psychiatrists, social workers, psychologists, and other interdisciplinary team staff.

REFERENCES:

1. Williams-Keeler L, Milliken H, Jones B (1994) Psychosis as precipitating trauma for PTSD: a treatment strategy. *American Journal of Orthopsychiatry*, 64, 493–498.
2. Lundy MS (1992) Psychosis-induced posttraumatic stress disorder. *American Journal of Psychotherapy*, 46, 485–491.

Workshop 4

**Thursday, October 5
8:00 a.m.-9:30 a.m.**

**WORKING TOGETHER: COMMUNITY
MENTAL HEALTH AND CRIMINAL
JUSTICE AGENCIES**

APA Corresponding Committee on Jails and Prisons

Henry C. Weinstein, M.D., *Clinical Professor of Psychiatry, New York University School of Medicine, 1111 Park Avenue, New York, NY 10128*; William Arroyo, M.D.; Monica Anzaldi; Cassandra F. Newkirk, M.D.; Erik J. Roskes, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe the contact points at which criminal justice and mental health professionals may interact to assist individuals with mental illness in remaining in their communities; and discuss the policy changes that must be considered to reduce the chance that individuals with mental illness will come in contact with the criminal justice system.

SUMMARY:

Over two million individuals are incarcerated in the U.S., and at least 320,000 (16%) of them have mental illnesses. The criminal justice system generally is ill-equipped to address the needs of these individuals, and mental health professionals are often unprepared to work

with clients with criminal justice histories. In 2002, the Council of State Governments published its Criminal Justice/Mental Health Consensus Project Report to address this alarming problem. This landmark document, developed with the assistance of over 100 advocates and professionals, outlined a series of interventions and policy recommendations designed to assist jurisdictions in keeping individuals with mental illness out of the criminal justice system, and in returning those already in the criminal justice system to their communities.

This workshop will describe this issue and offer possible policy solutions and interventions that build off of those recommended in the report. One jurisdiction's approach to collaboration between the criminal justice and mental health systems will be presented in detail, and the panel members will highlight the specific roles that mental health providers and advocates may play in implementing these collaborative efforts.

TARGET AUDIENCE(S):

All mental health professionals (including administrators) working in community settings or criminal justice settings.

REFERENCES:

1. Council of State Governments. Criminal Justice / Mental Health Consensus Project. New York: Council of State Governments. June 2002.
2. American Psychiatric Association, *Psychiatric Services in Jails and Prisons*, Second Edition, Washington DC, American Psychiatric Press, 2000.

Workshop 5

**Thursday, October 5
8:00 a.m.-9:30 a.m.**

FORMING EFFECTIVE THERAPEUTIC ALLIANCES WITH POLICE OFFICERS

Frank G. Dowling, M.D., *Medical Advisor, POPPA, and Clinical Associate Professor of Psychiatry, State University of New York at Stony Brook, 26 Broadway, Suite 1640, New York, NY 10004*; Geraldine Abelson, L.C.S.W.; Gene Moynihan, L.C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify psychological complications of police work and personal and cultural barriers to seeking assistance; discuss common pitfalls to avoid when forming therapeutic alliances with law enforcement personnel; and discuss strategies to form and maintain effective therapeutic alliances with police officers throughout treatment.

SUMMARY:

Because of work related stressors and exposure to multiple traumatic incidents, police officers suffer from high rates of post-traumatic stress, alcohol abuse, marital and family problems, and suicide. Due to fears of stigmatization, job-related consequences, and perceptions of personal weakness or failure, officers avoid departmental psychological services. Distrust of the mental health community prevents officers from seeking outside assistance. While treating police personnel has many parallels to traditional therapeutic interactions, there are many differences. For mental health professionals to provide effective therapeutic interventions for law enforcement personnel, they must understand these differences and address them during each phase of treatment.

Since 1996, POPPA (Police Organization Providing Peer Assistance), an independent, confidential, non-departmental assistance agency has been providing confidential assistance to NYPD officers. Based on experiences of POPPA Peer Support Officers and clinicians, an overview of law enforcement mental health issues is presented. Therapeutic interactions with police officers are compared and contrasted with other traditional therapeutic interactions. Common pitfalls to avoid in forming therapeutic relationships with police officers are discussed. Strategies to form and maintain effective therapeutic alliances during each phase of treatment are shared. To illustrate key take home lessons, case vignettes from POPPA's and the audiences' experiences are discussed.

TARGET AUDIENCE(S):

Psychiatrists, psychologists, social workers, addiction counselors, program administrators, EAP personnel, emergency responders.

REFERENCES:

1. Miller, L. (1995). Tough Guys: Psychotherapeutic Strategies with Law enforcement and Emergency Services Personnel. *Psychotherapy*, 32, 4, 592-600.
2. Dowling, FG, Moynihan EM, Genet W, Lewis J. (2006). A peer based program for NYPD officers: report on the effects of 9/11/01. In Press, *American Journal of Psychiatry*, January 2006.

Workshop 6

**Thursday, October 5
10:00 a.m.-11:30 a.m.**

UNITED STATES AIR FORCE SUICIDE PREVENTION PROGRAM: A COMMUNITY AND ORGANIZATIONAL APPROACH TO PREVENTION

APA Corresponding Committee on Psychiatry and the Workplace and the Academy of Organizational and Occupational Psychiatry

Steven E. Pflanz, M.D., *Chief, Air Force Suicide Prevention Program, United States Air Force, 6249 Auburn Leaf Lane, Alexandria, VA 22312*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize and apply both community and organizational concepts to suicide prevention.

SUMMARY:

Suicide is the eleventh leading cause of death in America, claiming roughly 30,000 lives each year. On average, someone takes his or her own life every 17 minutes in the United States. The greatest tragedy of suicide is that it is often preventable. However, both communities and organizations can take action to prevent suicide. The Air Force Suicide Prevention Program (AFSPP) has received international recognition as one of the few community suicide prevention programs to achieve proven results. Air Force suicides are down by one third since the inception of the program in 1996. The 11 initiatives of the AFSPP represent a state-of-the-art-integrated system of policy and programs that incorporates both community and organizational elements. The cornerstone of the AFSPP is the recognition that suicide prevention is a community responsibility. The Air Force cultivates a culture that encourages and supports early help seeking behavior for personnel suffering from distress. The AFSPP trains Air Force personnel to better recognize individuals suffering from suicidal ideation and to immediately refer these individuals for necessary psychiatric care. The majority of this workshop will be devoted to a discussion of community and organizational approaches to suicide prevention.

TARGET AUDIENCE(S):

Psychiatrists and other mental health professionals.

REFERENCES:

1. Mann JJ et al: Suicide prevention strategies: A systematic review. *JAMA* 2005; 294:2064–2074.
2. Knox KL et al: Risk of suicide and related adverse outcomes after exposure to a suicide prevention program in the U.S. Air Force: A cohort study. *BMJ* 2003; 327:1376–1378.

Workshop 7

**Thursday, October 5
10:00 a.m.-11:30 a.m.**

CHALLENGES AND SUCCESS IN TRANSFORMING PUBLIC MENTAL HEALTH SYSTEMS

Sharon E. Carpinello, R.N., Ph.D., *Commissioner, New York State Office of Mental Health, 44 Holland Avenue, Albany, NY 12229*; Lewis A. Opler, M.D., Ph.D.; John B. Allen; Cathy A. Cave

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify rationale for public mental health systems to include strategies, that when implemented, will promote wellness and resiliency for individuals and communities. Participants should also be able to identify strategies that will advance: achievement of person-centered recovery goals; cultural and linguistic competence; public health promotion and prevention; and acceleration of adoption of evidence-based practices.

SUMMARY:

This presentation will assist individuals who are responsible for clinical management of public mental health systems, and provide them with specific strategies for system transformation as called for in the President's New Freedom Commission Report on Mental Health. The workshop's panel members will share their unique perspectives and include a Commissioner, Chief Medical Officer, Director of Recipient Affairs, and Director of Multicultural Affairs of a state mental health authority. Each will address challenges and strategies that have proven successful in promoting systemic transformation. Presenters will focus on strategies that:

- Improve public health outcomes, wellness and resiliency, through an effective public education function;
- Improve outcomes through use of proven, effective treatments;
- Reduce the burden of illness through strengthened ties with the scientific community engaged in both basic and applied research;
- Improve the quality of mental health services currently available;
- Increase access to appropriate and effective services, with an emphasis on access for vulnerable and/or underserved populations;
- Increase accountability for improvements in access to services, quality and appropriateness of services, and cost of services; and
- Increase delivery of a coordinated array of medical, self-help, social, supportive, and rehabilitative services designed around the needs and desires of the individual.

REFERENCES:

1. New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*. Final Report. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.
2. US Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

Workshop 8

**Thursday, October 5
10:00 a.m.-11:30 a.m.**

**INTERNATIONAL MEDICAL GRADUATE
TRAINEES AND VIOLENT PATIENTS:
CULTURAL AND TRAINING ISSUES**

Ramaswamy Viswanathan, M.D., D.Sc., *Director, Consultation Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue #127, Brooklyn, NY 11203-2098*; Michael D. Garrett, M.D.; Ramotse Saunders, M.D.; Pia N. Reyes, M.D.; Rajvee P. Vora, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the importance of cultural factors affecting foreign-born physicians' interactions with potentially violent patients; learn ways of enhancing these physicians' competence in recognizing and treating violent patients by reducing cultural barriers and improving communication.

SUMMARY:

Over 25% of the psychiatric trainees in the United States are foreign-born. In the very beginning of their psychiatric training, they are often in acute inpatient units or in the emergency room, where there is increased potential for violence by patients. For many of them this is a period in which they have not sufficiently acculturated to the United States, especially to the subcultures of indigent patient population. They may have unnecessary fear of patients on the one hand, and on the other hand may lack sensitivity to early harbingers of violence. Some patients are mistrustful of physicians who look different, speak with a different accent, and are not conversant with some of the idioms and popular personalities. Cultural factors may also interfere with effective communication between the physician trainees and the nursing staff. Many physician trainees come from cultures where there is less violence, a rigid social hierarchy and idealized respect for physicians. All these factors

can compound to difficulties in dealing with potentially violent patients or family members. This workshop will explore these issues using some case examples. We will discuss ways of enhancing the training and competence of foreign-born physicians in recognizing and dealing with potential for violence including domestic violence, and the importance of providing culturally sensitive training.

TARGET AUDIENCE(S):

Psychiatry residents, their supervisors, nursing staff and other mental health professionals interested in cross-cultural issues.

REFERENCES:

1. Privitera M, Weisman R, Cerulli C, Groman A: Violence toward mental health staff and safety in the work environment. *Occup Med* 2005; 55(6):480-486.
2. Steadman HJ, Mulvey EP, Monahan J, et al.: Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Arch Gen Psychiatry* 1998; 55:393-401.

Workshop 9

**Thursday, October 5
10:00 a.m.-11:30 a.m.**

**PTSD AND AGING: FACTORS TO
CONSIDER IN ASSESSMENT AND
TREATMENT**

Robert W. Hierholzer, M.D., *Associate Chief of Staff, Research, and Education, VA-Central California; and Clinical Professor of Psychiatry, University of California, San Francisco, 2615 East Clinton Avenue, Fresno, CA 93703*; Hani Raoul Khouzam, M.D., M.P.H.; Matthew Battista, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize factors that might affect the course of PTSD as individual age; appreciate the importance of dealing with issues of guilt in the aging combat veteran; and understand how PTSD impinges upon cognitive functioning and, in turn, how age-related cognitive changes might impinge upon adaptation to trauma.

SUMMARY:

Post-Traumatic Stress Disorder (PTSD), especially combat related PTSD, is often a chronic disorder. It has psychological dimensions, but is also associated with biologic (brain) changes. Aging, too, has specific psychological dimensions, and is associated with changes in brain functioning. Hence, one might expect interactions between chronic PTSD and the aging process. This

workshop explores these interactions. It chiefly explores two major areas: the interplay between the Ericksonian tasks of aging and the issues inherent to being in combat; and the interplay between cognitive problems seen in PTSD and those associated with aging. This workshop will highlight the increasing prominence of dealing with guilt as veterans age, in addition to understanding how changes in cognitive capacity can influence adaptive behavior. Assessing and dealing with these issues requires consideration of the biopsychosocial and spiritual dimensions of the patient. The presenters will make reference to their own clinical work, and the established literature. Participants will be asked to participate by reflecting upon their own clinical experiences dealing with aging issues, especially in those with traumatic issues.

TARGET AUDIENCE(S):

Mental health professionals dealing with aging adults and/or those with PTSD.

REFERENCES:

1. Lee DA, Scragg P, Turner S: The role of shame and guilt in traumatic events. *British Journal of Medical Psychology* 2001; 74:451–466.
2. Vasterling JJ, Duke LM, Brailey K, Constans JJ, Allain AN Jr, Sutker PB: Attention, learning, and memory performances and intellectual resources in Vietnam veterans: PTSD and no disorder comparisons.

Workshop 10

**Thursday, October 5
1:30 p.m.-3:00 p.m.**

TEACHING ADDICTION TO MEDICAL STUDENTS

Thomas W. Brouette, M.D., *Director, Undergraduate Education, State University of New York at Stony Brook, Downstate Medical Center, 450 Clarkson Avenue, Brooklyn, NY 11203*; Jack Dehovitz, M.D.; David M. McDowell, M.D.; Stephen M. Goldfinger, M.D.; Michelle Tricamo

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be familiar with the current state of addiction education in U.S. medical students; outline core addiction knowledge; and discuss educational models to bridge this knowledge gap.

SUMMARY:

The LCME has identified medical students' knowledge of substance abuse and addiction as one of the vital fields in medical education that remains deficient. As the expected knowledge base of future physicians

continues to grow, educators are challenged to bridge this gap in addiction knowledge without compromising learning in other fields. Given the prevalence of substance abuse not only in psychiatric patients, but in those whom students will encounter on every rotation from pediatrics to surgery, incorporating understanding of drugs, alcohol and their impact on their patients is an essential area of expertise for students.

In this workshop, we will work collaboratively to identify the core knowledge in this area that medical students should possess before graduation. We shall discuss the commonalities and discrepancies between the defined core competences as accessed by psychiatrists and other medical specialties. We will begin by outlining our school's experiences with changes within the psychiatry curriculum and highlight their impact on not only the student's addiction knowledge, but also their understanding of general psychiatry. Together with the audience we will strategize on how to broaden medical students' knowledge and attitudes about treating substance using patients, and share strategies for effectively teaching this subject using clinical, didactic, and case-based learning methods.

TARGET AUDIENCE(S):

Medical educators, although students are also welcome.

REFERENCES:

1. Christison GW, Haviland MG. Requiring a one-week addiction treatment experience in a six-week psychiatry clerkship: effect on attitudes toward substance-abusing patients. *Teach Learn Med.* 2003 Spring; 15(2):93–97.
2. Johnson TP, Booth AL, Johnson P. Physicians belief about substance misuse and its treatment; findings from a U.S. survey of primary care doctors. *Subst Use Misuse.* 2005; 40(8):1071–84.

Workshop 11

**Thursday, October 5
1:30 p.m.-3:00 p.m.**

CHILDREN WITH COMPLEX TRAUMA: ASSESSMENT IN COMMUNITY SETTINGS

Paula G. Panzer, M.D., *Associate Director, Center for Trauma Innovation, Jewish Board of Family and Children's Services; and Former Chair, APA/IPS Scientific Program Committee, 142 West End Avenue, Apt. 1-S, New York, NY 10023-6115*; Susan Paula, Ph.D., *120 West 57th Street, New York, NY 10019*; Robert H. Abramovitz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe complex trauma in children;

describe the impact of chronic, interpersonal violence on children; describe the varying diagnoses that children exposed to chronic trauma often receive; and identify assessment instruments for assessing complex trauma.

SUMMARY:

Children present to mental health clinics, early intervention programs and child welfare prevention programs with disruptive behaviors and dysregulated affect. Far too often, these children have experienced multiple types of trauma and neglect. Their behavior may be the only clue to this significant history. "Complex trauma", as defined by the National Child Traumatic Stress initiative, describes both the high dose of trauma exposure and the varied consequences in children of different ages. This workshop will introduce participants to the concept of complex trauma. Participants will learn about the impact of trauma exposures on children's long-term emotional, social, and academic functioning by discussing community case studies. Participants will also discuss how, in their experience, these children are typically diagnosed when they come for treatment. Participants will also learn about the most effective ways to assess for trauma exposure and impact using structured instruments specifically designed for children and adolescents. Finally, participants will discuss the obstacles to effective assessment, such as reluctance on the part of both clients and clinicians to discuss traumatic events. This workshop will be participatory through the use of clinical vignettes and instrument rehearsal.

TARGET AUDIENCE(S):

Community clinicians.

REFERENCES:

1. Cook, A., Blaustein, M., Spinazzola, J., & van der Kolk (2003). White Paper: Complex Trauma in Children and Adolescents. National Child Traumatic Stress Network.
2. van der Kolk, B. A. (2002). The Assessment and Treatment of Complex PTSD. In R. Yehuda (Editor) *Treating Trauma Survivors with PTSD*. Washington, DC: American Psychiatric Press, Inc.

Workshop 12

Thursday, October 5

1:30 p.m.-3:00 p.m.

TORTURE: CONFRONTING ALLEGATIONS BY DEVELOPING A POLICY AND STANDARD

APA Committee on Ethics

Spencer Eth, M.D., *Local Arrangements Consultant, APA/IPS Scientific Program Committee; and Vice Chairman, Department of Psychiatry, St. Vincent's Hos-*

pital, 144 West 12th Street, Room 174, New York, NY 10011; Henry C. Weinstein, M.D.; Paul S. Appelbaum, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to explain how the APA addressed the public and medical controversy over allegations of psychiatrist participation in the torture of detainees by developing a consensus policy statement and ethical standard for this organization and its members.

SUMMARY:

In June 2005 major newspaper and medical journals published articles disclosing the possible involvement of American psychiatrists in the alleged abusive interrogation of detainees at Guantanamo Bay. These accusations prompted a determination of whether our ethical code specifically prohibits these practices. In fact, the word torture does not appear in the APA Ethics Annotations or Opinions. This workshop will describe the process by which the APA, as a professional organization composed of psychiatrist members addressed this public and professional controversy by formulating a clear policy statement and ethical standard. To accomplish this task, it was necessary to convene members of the APA and New York County District Branch Ethics Committees, the APA Council on Psychiatry and the Law, and representatives of other constituencies within the APA. This workshop, composed of the Chairs of these three APA components, will highlight the resolution of conflicts that arose from incorporating the wide variety within the APA of professional practices (including those of correctional, military and law enforcement psychiatrists) and roles (treating, consulting and advising), the difficulty defining critical terms (particularly torture), and the moral ambivalence associated with extraordinary cases (e.g., the ticking bomb scenario).

REFERENCES:

1. Bloche MG, Marks JH. Doctors and Interrogators at Guantanamo Bay. *N Engl J Med* 2005; 353:6-8.
2. Rubenstein L, Pross C, Davidoff F, Iacopino V. Coercive US Interrogation policies: a challenge to medical ethics. *J Am Assn* 2005; 294:1544-1549.

Workshop 13

Thursday, October 5

1:30 p.m.-3:00 p.m.

DEVELOPING A CRISIS RESPONSE TEAM FOR YOUR COMMUNITY

APA Council on Quality Improvement

Joseph C. Napoli, M.D., *Assistant Clinical Professor, Department of Psychiatry, Columbia University, 2185*

Lemoine Avenue, Fort Lee, NJ 07024; V. Alex Kehayan, Ed.D., Co-Director Resiliency LLC, 2185 Lemoine Avenue, Fort Lee, NJ 07024

Workshop 14

Thursday, October 5
3:30 p.m.-5:00 p.m.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe the development and basic elements of a crisis response team (CRT); cite various methods, lessons-learned, and pitfalls in developing and maintaining CRT's; apply information to improve the performance of existing CRT's; and develop a CRT.

SUMMARY:

Mitigating the impact of trauma and violence in our communities requires a multi-systemic, multi-modality, multidisciplinary approach. This workshop focuses on the Crisis Response Team (CRT) as a key component of any broad-based effort. CRT's are usually comprised of mental health professionals, clergy, and peer counselors. They should be dedicated to providing quality, evidence-based, best practices outreach crisis/disaster mental health services to the community.

Two brief presentations will highlight CRT development and basic elements—including organization, the National Incident Management System, credentialing, training, policies and procedures, documentation, interventions, and teamwork.

The presenters have extensive CRT experience. In 1989, Dr. Kehayan co-founded a school-based community CRT and developed a training program for peer crisis counselors. Dr. Napoli initiated and has led a local Office of Emergency Management CRT since 2000. As chairperson of the New Jersey APA District Branch Disaster Committee, Dr. Napoli has spearheaded the participation of psychiatrists in disaster mental health outreach.

Individuals who are beginning CRT's and those with extensive CRT experience are welcome. The presentations are designed to provoke questions, stimulate discussion, and promote the exchange of experiences among all participants. Discussion will focus on methods, innovative programs, pitfalls, and lessons-learned in developing and maintaining CRT's.

TARGET AUDIENCE(S):

All Institute attendees.

REFERENCES:

1. Kehayan V A and Napoli J C. Resiliency in the Face of Disaster and Terrorism: 10 Things to Do to Survive. Personhood Press, California, 2005.
2. Napoli, J C. The Generic Manual for Crisis Response Teams © copyright 2002.

APA-ABPN DIAGNOSTIC EVALUATION PROJECT TO ASSIST ABPN RECIDIVISTS: A PRELIMINARY REPORT

Nyapati R. Rao, M.D., *Director of Residency Training, Department of Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, P.O. Box 1203, Brooklyn, NY 11203*; Deborah J. Hales, M.D., *Director, Division of Education, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209*; Stephen C. Scheiber, M.D., Stephen M. Goldfinger, M.D.; Ellen Berkowitz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will learn the training experiences and the post-residency career paths of candidates who have failed the oral board examination multiple times; understand the common reasons for failure; learn the strategies needed to both identify and remediate candidates, and examine the obstacles encountered in trying to pass the boards while still in residency training.

SUMMARY:

In 2004, only 54% of candidates passed the ABPN Part 2. There is a significant subset of the candidates who are unable to succeed despite repeated attempts, and data regarding the factors that contribute to these repeated failures such as candidates' lack of knowledge, ineffective test preparation, poor training, performance anxiety, disorganization, personal characteristics or cultural and linguistic impediments are not available. Many psychiatric educators feel that these factors must be studied so that candidates can remediate their deficits appropriately before their next Board exam.

The APA, in collaboration with the Department of Psychiatry at SUNY Downstate Medical Center, evaluated 36 candidates in a mock-board exam format using current and former Board examiners of the ABPN. The goal was to "diagnose" the candidates' deficits in the areas mentioned above using the classic ABPN format, followed by a one-hour feedback session with the examiners. Each candidate received a detailed written evaluation by mail after the conclusion of the exercise. Each candidate provided extensive information regarding their education and training experiences, as well as their history of the ABPN attempts, and this data was analyzed to help elucidate factors that contributed to candidates' failures.

In this workshop, an analysis of the demographics of the candidates and their training experiences, and career paths will be presented. In addition, candidates' performance on specific variables in the live-interview and the

video exam that resulted in their passing the exercise will be elaborated upon. The panel will discuss the implications of the findings of this project for training and practice of psychiatry.

REFERENCES:

1. Val E, Quick S. Foreign medical graduates and board certification: Myths and realities. *American Journal of Psychiatry* 1983; 140(2): 184–188.
2. Juul, D, Scully JH Jr., Scheiber SC. Achieving board certification in psychiatry: A cohort study. *American Journal of Psychiatry* 2003; 160 (3): 563–565.

Workshop 15

Thursday, October 5
3:30 p.m.-5:00 p.m.

A WINDOW IN THE CEILING: THE EXPERIENCES OF AFRICAN AMERICAN WOMEN LEADERS IN THE AMERICAN PSYCHIATRIC ASSOCIATION

Michelle O. Clark, M.D., *Chief Psychiatrist, South Central Health and Rehabilitation Programs, 10921 Wilshire Boulevard, Los Angeles, CA 90024-4001*; Donna M. Norris, M.D.; Altha J. Stewart, M.D.; Annette B. Primm, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to learn about the personal experiences of some of APA's African American women leaders; and understand the APA's organizational structure and methods of advancement.

SUMMARY:

It has been said that culture is most influenced by sub-culture activity. The culture of medicine has changed dramatically in the last half-century and a significant change has been the shifting statistics on providers' gender and ethnicity. African Americans initiated efforts to have the APA address the needs of ethnic sub-groups within the organization. Several women leaders have emerged as a result of these and other efforts. Hear some of them tell their stories and share their experiences.

REFERENCES:

1. Giddings, Paula *When and Where I Enter: the Impact of Black Women on Race and Sex in America* 1996.
2. Spurlock, Jeanne M. *Black Psychiatrists*, American Psychiatry 1999.

Workshop 16

Thursday, October 5
3:30 p.m.-5:00 p.m.

TEACHING THE WORKING ALLIANCE AS A CORE PROCESS ACROSS THE PSYCHOTHERAPIES

APA Committee on Psychotherapy by Psychiatrists

Eric M. Plakun, M.D., *Director of Program Development and Admissions, Erikson Institute for Education and Research, Austin Riggs Center, and Instructor of Psychiatry, Harvard University Medical School, 25 Main Street, P.O. Box 962, Stockbridge, MA 01262*; Norman A. Clemens, M.D.; Donna M. Sudak, M.D.; M. Katherine Shear, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be familiar with three approaches to teaching the working alliance in psychotherapy, including from a "common factors" perspective, and from Cognitive Behavioral Therapy and psychodynamic perspectives.

SUMMARY:

Recognizing the importance and the difficulty of teaching psychotherapy to residents, the APA Committee on Psychotherapy by Psychiatrists has developed a teaching model that unifies the five psychotherapy competencies into one integrated whole. The stem of the resulting "Y-shaped" structure includes the core processes of all psychotherapies, which form the foundation for three of the previous competencies: Supportive Psychotherapy, Brief Psychotherapy, and Combining Psychopharmacology and Psychotherapy, as well as various "common factors" that are part of all schools of psychotherapy. The Y-model then diverges into Cognitive Behavioral Therapy (CBT) and psychodynamic branches that are comprised of core features of CBT or psychodynamic therapy derived from the comparative psychotherapy process research literature. In the Y-model, CBT and psychodynamic therapy are conceptualized as two divergent therapies that build on basic skills, with differentiated approaches to managing therapist activity, the role of the unconscious, the therapeutic relationship, symptoms and affects. This workshop offers a brief overview of the Y-model, and then focuses on its implementation as a teaching tool by illustrating an approach to teaching the working alliance from three perspectives: a common factors approach, and CBT and psychodynamic approaches. A portion of the workshop will be reserved for audience discussion.

TARGET AUDIENCE(S):

Residents, training directors, practicing psychiatrists and other mental health professionals.

REFERENCES:

1. Blagys MD and Hilsenroth MJ. 2000. Distinctive features of short-term psychodynamic-interpersonal psychotherapy: A review of comparative psychotherapy process literature. *Clinical Psychology: Science and Practice*; 7:167–188.
2. Blagys MD and Hilsenroth MJ. 2002. Distinctive activities of cognitive-behavioral therapy: A review of comparative psychotherapy process literature. *Clinical Psychology Review*; 22:671–706.
3. Plakun, EM. Finding Psychodynamic Psychiatry's Lost Generation, *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, in press.

Workshop 17

**Thursday, October 5
3:30 p.m.-5:00 p.m.**

TRAUMATIC ENCOUNTERS: OUR PATIENTS, OURSELVES

Mary Helen Davis, M.D., *Associate Clinical Professor of Psychiatry, Integrative Psychiatry, 105 North Lyndon, Suite 106, Louisville, KY 40223*; Thomas A. Grieger, M.D., *Associate Professor of Psychiatry, Uniformed Health Sciences University, B3068, 4301 Jones Bridge Road, Bethesda, MD 20814*; Mark H. Townsend, M.D.; Priscilla Ray, M.D.; Elizabeth A. Garcia-Gray, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the impact of post-traumatic stress on patients, providers, and the community; understand concepts of vicarious traumatization; recognize issues of vulnerability in health care providers; and review resources and treatment recommendations targeted at acute and post-traumatic stress.

SUMMARY:

Traumatic experiences are generally thought of occurring in the aftermath of natural or technological disaster, accident, interpersonal violence or threatening physical or mental illness. Many psychiatrists have had experiences dealing with individuals who have experienced trauma and resultant PTSD from injury, rape and sexual abuse. Fewer of us have dealt with widespread or systematic trauma resulting from global disaster accompanied by loss of infrastructure, severe resource limitation and other problems that create difficulty in delivery of care. Furthermore, global traumatic experience has a greater tendency to impact providers both personally and professionally. This workshop will provide a forum to discuss and share the narratives of this experience.

Presenters will provide summaries of data derived from studies of communities exposed to trauma and

health care workers who have returned from deployment to disaster settings or war. They will also describe and discuss their personal experiences of working with victims of terrorism and natural disasters. Discussion will include difficulties encountered, solutions to problems and positive and negative personal changes experienced as a consequence of their involvement in these traumatic events or their work with survivors.

TARGET AUDIENCE(S):

Psychiatrists and other mental health professionals interested in the psychological impact of disasters.

REFERENCES:

1. Shalev AY, Tuval-Mashiach R, Hadar H, Post Traumatic Stress Disorder as a Result of Mass Trauma, *J Clin Psychiatry*, 2004 65, p 4–10.
2. Grieger TA, Staab JP, Cardena E, et. al., Acute Stress Disorder and subsequent PTSD in a group of exposed disaster workers, *Depress Anxiety* 2000 11(4) p 183–4.

Workshop 18

**Friday, October 6
8:00 a.m.-9:30 a.m.**

TOUCHED BY SUICIDE: BRIDGING THE PERSPECTIVES OF CLINICIANS AND SURVIVORS

Michael F. Myers, M.D., *Clinical Professor, Department of Psychiatry, University of British Columbia, St. Paul's Hospital, 1081 Burrard Street, Vancouver, BC, Canada V6K 4L9*; Carla Fine, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the impact of suicide on clinicians; appreciate the facilitating and inhibiting factors when survivors seek treatment for themselves; and understand the need for mutual respect between clinicians and survivors.

SUMMARY:

Understanding suicide remains a perplexing challenge for mental health professionals and for loved ones who are left behind. The authors are committed to the notion that advancing our knowledge is best achieved by professionals and survivors working together. Dr. Myers is a psychiatrist who has been treating suicidal patients and their families for over three decades. Ms. Fine is a survivor (widowed by a physician who killed himself in 1989), writer, and speaker. For the past five years they have collaborated as co-researchers in studying therapists who have lost patients to suicide and families who have lost loved ones to suicide. In this presentation,

they will summarize this work which includes: their observations of similarities and differences of the groups; their efforts in reaching out to both professional and lay audiences (grand rounds, public forums, and writing together); their insights about tensions and disconnections between therapists and survivors, including concerns about litigation; their recommendations about maintaining dialogue and repairing rifts between the groups; and their thoughts about future directions. At least one third of the workshop time will be protected for active interaction with the audience.

TARGET AUDIENCE(S):

Mental health professionals (including trainees) and survivors of suicide (including clinician-survivors).

REFERENCES:

1. Fine C. No Time to Say Goodbye: Surviving the Suicide of a Loved One. Broadway Books/Doubleday, New York, 1999.
2. Myers MF, Fine C. Touched By Suicide: A Guide to Hope and Healing After Loss. Gotham/Penguin Books, New York, 2006.

Workshop 19

Friday, October 6
8:00 a.m.-9:30 a.m.

HEALING THE HEALER: THE TREATMENT OF THE ADDICTED PROFESSIONAL

APA Corresponding Committee on Treatment Services for Patients With Addictive Disorders

Petros Levounis, M.D., M.A., *Director, The Addiction Institute of New York, 1000 Tenth Avenue, New York, NY 10019*; Aileen H. Clucas, R.N., *Nurse, Addiction Institute, 1000 Tenth Avenue, New York, NY 10019*; Ronald B. Lonesome, M.D.; David J. Mysels, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the unique circumstances of addictive disorders among professionals and provide appropriate treatments.

SUMMARY:

In this workshop, we will explore the unique challenges that the impaired physician, nurse, or other health care professionals present in addiction treatment. Clinical, ethical, legal, regulatory, and interpersonal considerations often complicate the delivery of optimum health care to our colleagues who suffer from substance use disorders. We will discuss the problem of increased access—and physical exposure—to controlled substances, as well as the vicarious trauma to which profes-

sionals are exposed in their daily lives. A nurse in our Nurses Helping Nurses Program at The Addiction Institute of New York recently said: “I know how I dealt with everything I saw. I did drugs.” We will also address the conundrum of balancing the public good (i.e., the safety of our patients) with the basic civil rights of the impaired professional (i.e., her or his right to obtain treatment and resume professional responsibilities when ready).

TARGET AUDIENCE(S):

The workshop is open to all professionals who would like to learn more about the assessment, diagnosis, and treatment of the addicted professional, but is particularly targeted towards physicians-in-training and early career psychiatrists.

REFERENCES:

1. Mansky PA: Impaired Physicians. In Textbook of Substance Abuse Treatment, 3rd Edition, edited by Galanter M, Kleber HD, Washington, DC, American Psychiatric Publishing, 2004, pp 575–583.
2. Catanzarite AM: Managing the Chemically Dependent Nurse: A Guide to Identification, Intervention, and Retention. Chicago, IL, American Hospital Publishing, 1992.

Workshop 20

Friday, October 6
8:00 a.m.-9:30 a.m.

DO NO HARM? DEALING WITH DIABETES AND SECOND GENERATION ANTIPSYCHOTICS

American Association of Community Psychiatrists

Kenneth S. Thompson, M.D., *Associate Professor of Psychiatry, University of Pittsburgh, and Former APA/Bristol-Myers Squibb Fellow, 6108 Kentucky Avenue, Pittsburgh, PA 15206*; Richard Petty, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to develop a greater understanding of the metabolic effects of second generation antipsychotics and discover ways to effectively address the risks involved.

SUMMARY:

The relationship between antipsychotic medications and a variety of metabolic effects is becoming clearer. Strategies for effectively communicating the risks of these medications and to manage these potentially dangerous side effects are being elucidated, but are not well known or implemented effectively in the field. We now have the data to craft a rational risk-benefit analysis that

can be used in day-to-day practice. We need to be aware of a number of concepts that are not familiar to all psychiatrists: over and above poor lifestyle choices, our patients may fall victim to a number of specific illnesses; that schizophrenia and bipolar disorder and system illnesses with cerebral manifestations; and clinicians need to be able to tease apart the separate but inter-linked issues of obesity, insulin resistance syndrome, diabetes mellitus, diabetic ketoacidosis, and sometimes catastrophic hypertriglyceridemia. We also need this information to make informed decisions about the differential efficacy of antipsychotic medications on cognitive, negative and mood symptoms and on social adjustment. This workshop will look at what is now known about the metabolic effects of these medications, what the risks appear to be, and what approaches to practice mitigate these risks most effectively so "no harm is done."

TARGET AUDIENCE(S):

Practicing psychiatrists.

REFERENCES:

1. American Diabetes Association; American Psychiatric Association; American Association of Clinical Endocrinologists; North American Association for the Study of Obesity. *Diabetes Care* 2004; 27(2): 596-601
2. Ader M, Kim SP, Cataiano KJ, Ionut V, Hucking K. et al. (2005). Metabolic dysregulation with atypical antipsychotics occurs in the absence of underlying disease a placebo-controlled study of Olanzapine and Risperidone in dogs. *Diabetes* 54:862-71

Workshop 21

**Friday, October 6
8:00 a.m.-9:30 a.m.**

A PRACTICAL APPROACH TO DISASTER PSYCHIATRY: LESSONS LEARNED FROM 9/11 AND HURRICANE KATRINA

2005-2007 APA/Bristol-Myers Squibb Fellows

Tatiana A. Falcone, M.D., *2005-2007 APA/Bristol-Myers Squibb Fellow, and Child and Adolescent Psychiatry Fellow, Cleveland Clinic, 1310 Forest Hills Boulevard, Cleveland, OH 44118*; Christina V. Mangurian, M.D., *2005-2007 APA/Bristol-Myers Squibb Fellow, and Chief Resident, Department of Psychiatry, Columbia University and New York State Psychiatric Institute, 457 West 57th Street, New York, NY 10019*; Yvette Drake-McLin, M.D.; David E. Post, M.D.; Craig L. Katz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the risk factors involved

in developing psychological problems in populations exposed to disasters.

SUMMARY:

In the last five years the world has been impacted by multiple disasters (9/11, Hurricane Katrina, and Hurricane Rita, the Asian tsunami, the Pakistan earthquake). In this workshop, we will review the development and implementation of mental health services during 9/11 and Hurricane Katrina. We will compare and contrast these events to determine which aspects of disaster mental health services were universal, which were site specific, and why these differences existed. Since the impact of disasters varies dependent on exposure to trauma, premorbid conditions, previous history of trauma, support systems, age, etc., these aspects of developing comprehensive services will also be examined.

Another critical aspect of this workshop is a focus on individual providers. In both of these disasters, individual mental health providers from around the country wanted to offer their services. Unfortunately, many were unable to provide services for several seemingly irrational reasons. At the end of this workshop, we will attempt to share with the participants practical approaches for individual providers to be able to help communities in the event of any future disasters.

TARGET AUDIENCE(S):

Psychiatrists, residents, and mental health professionals.

REFERENCES:

1. Brown EJ, Bobrow AL. School entry after a community wide trauma. *Lessons learned from 9/11/01 ClinChild and Family Psych Rev* 7 (4) 211-21, 2004 Dec.
2. Brown EJ. Mental Health Trauma response to the events of Sept 11th. *Challenges and lessons learner. J Child and Adolescent Psychopharmacology* 12 (2) 77-82 (2002).

Workshop 22

**Friday, October 6
10:00 a.m.-11:30 a.m.**

INTERNATIONAL PERSPECTIVES ON RECOVERY

American Association of Community Psychiatrists

Kenneth S. Thompson, M.D., *Associate Professor of Psychiatry, University of Pittsburgh, and Former APA/Bristol-Myers Squibb Fellow, 6108 Kentucky Avenue, Pittsburgh, PA 15206*; George Witte, M.D.; Alan Rosen, M.D.; Alan Yates, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe the similarities and differences in the meaning of the term “recovery” between Europe, America, and Australia and recognize its impact on the redesign of mental health services.

SUMMARY:

For the past several years, the Institute on Psychiatric Services (IPS) has sustained an ongoing conversation between European, North American, and Australian psychiatrists on topics such as the role of comparative studies and policy translation, culture and practice, and quality and standards of care. The concept of recovery from mental illness now serves on all three continents as one of the primary organizing principles for publicly funded mental health care services. Yet in each locale, what this means for service delivery is still uncertain. In order to develop as broad an approach to the concept of recovery as possible, this workshop will explore what recovery means in Australia, the United States, the Netherlands and the United Kingdom. Participants, including consumer, family members and mental health professionals will engage the presenters in an active dialogue to consider different cultural, political and scientific approaches to recovery, seeking similarities and highlighting differences.

TARGET AUDIENCE(S):

Mental health professionals, psychiatrists, consumers and families.

REFERENCES:

1. Mueser, K et al: Illness Management and Recovery: A Review of the Research Psychiatric Services Oct 2002 Vol 53 #10 1272–1284.
2. Noordsy, D et al: Recovery from Severe Mental Illness: An Intrapersonal and Functional Outcome Definition Int Review of Psychiatry 14/4 2002 325–326.

Workshop 23

**Friday, October 6
10:00 a.m. - 11:30 a.m.**

**GETTING TO YES: INDUCING
TREATMENT COMPLIANCE IN
ASSERTIVE COMMUNITY TREATMENT
PROGRAMS**

Paul S. Appelbaum, M.D., *Past President, American Psychiatric Association; Professor of Psychiatry, and Director, Division of Psychiatry, Law, and Ethics, Department of Psychiatry, Columbia University College of Physicians and Surgeons, 1051 Riverside Drive, #122, New York, NY 10032-1007*; Stephanie Lemelle, M.D.; Molly T. Finnerty, M.D.; Anthony D. Mancini, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the results of several studies of techniques used by Assertive Community Treatment teams to encourage patient compliance with treatment; and discuss the ethical implications of these approaches.

SUMMARY:

Assertive community treatment (ACT) has established itself as one of the most important mechanisms for delivering services to a subset of persons with severe and persistent mental illnesses who have difficulty engaging in traditional services, and consequently have high rates of inpatient hospital utilization and other adverse outcomes. ACT’s model of repeated outreach, continuous availability, integrated services, and small caseloads has made it the evidence-based approach of choice for this population. However, some critics have expressed concerns regarding the techniques used by ACT teams to encourage compliance with treatment plans, alleging that the model itself is inherently coercive. As one ACT psychiatrist asked, “Is a clinician who can’t be fired ethical?” This session will draw on the existing literature and newly generated data to characterize the techniques used by ACT teams to encourage compliance and to consider the ethical challenges to the model. Data will be drawn from a survey of staff members from more than 70 ACT teams in New York State, which asked about compliance-inducing approaches, and a series of focus groups with ACT team staff members and clients. The audience will be encouraged to engage with the ethical questions and to reflect on their own experiences.

TARGET AUDIENCE(S):

Community-based clinicians.

REFERENCES:

1. Neale MS, Rosenheck RA: Therapeutic limit setting in an assertive community treatment program. Psychiatric Services 2000; 499–505.
2. Stovall J: Is assertive community treatment ethical? Harvard Rev Psychiatry 2001; 9:139–143.

Workshop 24

**Friday, October 6
10:00 a.m. - 11:30 a.m.**

**DOING MORE WITH LESS: CHALLENGES
AND REWARDS OF A PSYCHIATRIST
EXECUTIVE**

APA Committee on Psychiatric Administration and Management and the American Association of Psychiatric Administrators

Sy Ateaz Saeed, M.D., M.S., *Professor and Chairman, Department of Psychiatry, Brody School of Medicine,*

600 Moye Boulevard, Greenville, NC 27834; Arthur L. Lazarus, M.D., M.B.A.; Nalini V. Juthani, M.D.; Brian M. Hepburn, M.D.; Lydia E. Weissner, D.O.

chiatry, Boston Medical Center, 34 East Newton Street, #6, Boston, MA 02118

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will be fully aware of the career options for psychiatrist executives, the skills required to become an effective clinical leader, and the challenges and rewards that accompany this role.

SUMMARY:

Increasingly, psychiatrists are assuming executive roles as health systems consolidate operations and the complexity of care delivery increases. The psychiatrist executive's position may be viewed as the hub around which the many spokes of the wheel of the mental health system turn. The psychiatrist executive is responsible for integrating the needs of the patients and the physicians in the community into the vision, mission and goals of the health system. Psychiatrist executives face a variety of challenges. The critical skills of a successful psychiatrist executive include strong leadership, technical expertise, and management know-how. Managing change has become one of the most critical competencies of psychiatrist executives. Asking to do more with less is a common problem that psychiatrist executives face today. With this predicament come a set of challenges and rewards.

This workshop will take an interactive, case consultation approach. The workshop will start with a case presentation, followed by brief case-relevant discussions by the faculty. Faculty, representing a broad range of administrative and leadership roles and experiences will facilitate collaborative discussions involving case conceptualization and formulation; problem identification and analysis; and strategies for selecting effective interventions. Participants will be invited to actively participate by sharing their difficult and challenging cases in administrative psychiatry.

REFERENCES:

1. Reid, WH; Silver SB (eds). Handbook of Mental Health Administration and Management. New York, NY: Brunner-Routledge, 2003.
2. Rodenhauer P (ed). Mental Health Care Administration: A Guide for Practitioners. Ann Arbor MI: University of Michigan Press, 2000.

Workshop 25

Friday, October 6
10:00 a.m.-11:30 a.m.

BRAIN IMAGING: CAN VIOLENCE BE PREDICTED?

2005–2007 APA/Bristol-Myers Squibb Fellows

Christopher J. Hummel, M.D., 2005–2007 APA/Bristol Myers Squibb Fellow, and Resident, Department of Psy-

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate knowledge of various brain imaging modalities; demonstrate knowledge of how these brain imaging modalities are being used to understand and predict behavior; critically discuss the literature on brain imaging and violence; and understand the current application of brain imaging in a courtroom setting.

SUMMARY:

This workshop will address the use of brain imaging in the context of understanding and predicting violent behavior. The first portion of the workshop will consist of a presentation aimed at orienting the participants to various imaging modalities and their potential role in predicting violent behavior. To this end, the presentation will consist of a brief overview of recent literature on the topic accompanied by a series of images. Following the presentation the participants will be divided into small groups and each small group will review an actual court case in which brain imaging was presented as evidence of a violent predisposition. Each small group will then briefly summarize their case to the larger workshop and a discussion around the role brain imaging played in the case will ensue.

There are no special background requirements needed to attend this workshop.

TARGET AUDIENCE(S):

Health care practitioners with an interest in the application of brain imaging in forensic psychiatry.

REFERENCES:

1. Raine A, Meloy JR, Bihrlle S, et al. Reduced prefrontal and increased subcortical brain functioning assessed using positron emission tomography in predatory and affective murderers. Behavioral Sciences and the Law. 1998; 16:319–332.
2. Amen DG, Stubblefield M, Carmichael B, Thisted R. Brain SPECT findings and aggressiveness. Annals of Clinical Psychiatry. 1996; 8:129–137.

Workshop 26

Friday, October 6
1:30 p.m.-3:00 p.m.

HELPING SHOULDN'T HURT: ASSAULT RISK TRAINING AND SUPPORT OF CLINICIANS AFTER ASSAULT

Therapeutic Education Association

Karen A. Landwehr, M.C., Clinician and Educator, Comprehensive Mental Health Community Education

Partnership, 514 South 13th Street, Tacoma, WA 98402; Garry M. Vickar, M.D., Chair, Department of Psychiatry, Christian Hospital, 11125 Dunn Road, Suite 213, St. Louis, MO 63136

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe the assault risk training clinicians receive, and clinicians' perceptions of its helpfulness for avoiding assault; describe how supported assaulted staff members feel supported by supervisors and peers; discuss ways to improve assault risk training; and provide better support staff when efforts to avoid assault fail.

SUMMARY:

Numerous research studies have shown that individuals working with psychiatric patients are at risk of being assaulted. Usually these studies have focused on the assault risk for nurses working in inpatient or residential settings. Few studies have included the risk of assault for non-medical staff working in these settings or in community mental health centers. Many studies have focused on those patient and staff factors that increase assault risk and staff perception of level of risk. A few studies have attempted to determine the amount of training nurses receive in conflict resolution and assault risk reduction, both before and after beginning employment. However, the perception of support from management and peers experienced by the assaulted staff member following an assault has been largely unexplored. This workshop includes presentation of a recent survey of medical and non-medical clinicians regarding the assault risk training they have received, their perception of its usefulness for avoiding assault, and the degree to which they feel supported by peers and the management of the agency for which they work following an assault. Following the presentation, participants will discuss their experiences regarding the issues raised and the implications these findings have for training and supporting clinical staff.

TARGET AUDIENCE(S):

Private and community psychiatrists, social workers, therapists, nurses, and agency and institution administration

Workshop 27

**Friday, October 6
1:30 p.m.-3:00 p.m.**

CULTURAL ISSUES IMPACT DOMESTIC TERRORISM TOWARD WOMEN

Leah J. Dickstein, M.D., M.A., *Professor Emeritus, Department of Psychiatry and Behavioral Science, University of Louisville, 3006 Dunraven Drive, Louisville, KY*

40222; Marilyn L. Martin, M.D., 44104 Wynfield Drive, Owings Mills, MD 21117-7141; C. Deborah Cross, M.D.; Nalini V. Juthani, M.D.; Silvia W. Olarte, M.D.; Geetha Jayaram, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will learn and understand more clearly the unique issues impacting domestic terrorism towards women with different cultural backgrounds in our communities.

SUMMARY:

Leaders in the clinical care of women victims of domestic terrorism in our communities will present often unsought yet vital and unique major cultural factors which may and do impact these patients' experiences and treatment.

Racial, ethnic, faith-based, socioeconomic, geographic and educational factors will be discussed from the vantage points of first seeking this history and then of how to use the information wisely to offer our women patients the best care for potential recovery and avoidance of recurrent abusive and terroristic experiences.

All forms of the media continue to show domestic terrorism primarily impacting women from lower socioeconomic and educational environments.

However, the occurrence of domestic terrorism behind subdivision glass doors, gated communities and metropolitan apartments guarded by doormen is all too common. Often not reported because of shame, guilt and fear, these victims suffer similar and different experiences yet remain in the situation too long until their deaths or other tragedies may intervene.

Statistics, specific questions to ask of each and every woman patient regardless of age, address, dress, initial chief complaint, denial of victimization, and financial status will be discussed in this workshop.

REFERENCES:

1. Dickstein, LJ Domestic Violence Tardiff, Kenneth, MD Psychiatric Clinics of North America.
2. Dickstein, LJ; Effects of Mothers as Domestic Violence Victims on Children in Schetky, D & Benedek, E Forensic Psychiatry, August 1999.

Workshop 28

**Friday, October 6
1:30 p.m.-3:00 p.m.**

PSYCHIATRIC CLINICAL KNOWLEDGE ENHANCEMENT SYSTEM: USING STATE ADMINISTRATIVE DATA AS A RESOURCE FOR CLINICIANS

Sharon E. Carpinello, R.N., Ph.D., *Commissioner, New York State Office of Mental Health, 44 Holland Avenue,*

Albany, NY 12229; Thomas White; Molly T. Finnerty, M.D.; Lewis A. Opler, M.D., Ph.D.

through evidence-based practices. *Community Mental Health Journal* 2005; 41(3):347–363.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the value and impact of having access to administrative data to support clinical care and quality improvement; and understand several different ways in which PSYCKES can be used by physicians, clinical supervisors, and quality managers to support clinical decision making and quality improvement.

SUMMARY:

The federal government, states, and large payors have access to a wealth of medical administrative data that represents a largely untapped resource to support clinical decision-making and quality improvement. Such information could be particularly helpful in the management of long-term illnesses like schizophrenia. The New York State Office of Mental Health (NYSOMH) has developed a web-based system for sharing 15 years of state administrative data with clinicians and quality managers called the Psychiatric Clinical Knowledge Enhancement System (PSYCKES). This session will describe the development, implementation, findings, and future directions for PSYCKES, which this year received a national Innovation Award from the Council of State Governments. Data will be drawn from the implementation of the program in the NYSOMH system, with over 700 enrolled PSYCKES users in 20 hospitals, including impact on time and accuracy of physician medication review, and improvement in guideline derived quality of care performance measures. Presentation of future directions will include application of the program to Medicaid data, providing access to consumers and families, and the incorporation of PSYCKES performance indicators into the NYSOMH Balanced Scorecard, which enables real-time monitoring of agency progress on all critical management objectives included in NYSOMH's strategic plan.

TARGET AUDIENCE(S):

Community-based clinicians and public health administrators.

REFERENCES:

1. Finnerty M, Altmansberger R, Bopp J, Carpinello S, Docherty JP, Fisher W, Jensen P, Krishnan P, Mittleman M, Olfson M, Tricarico J, White T, Felton C: Using state administrative and pharmacy data bases to develop a clinical decision support tool for schizophrenia. *Schizophrenia Bulletin* 2002; 28(1):85–94.
2. Rapp CA, Bond GR, Becker DR, Carpinello SE, Nikkel RE, Gintoli G: The role of state mental health authorities in promoting improved client outcomes

Workshop 29

Friday, October 6
1:30 p.m.-3:00 p.m.

RACISM: LEARNED BEHAVIOR OR PSYCHOPATHOLOGY

Khushro B. Unwalla, M.D., *Vice Chairman, Department of Psychiatry, Arrowhead Regional Medical Center, and Assistant Professor of Psychiatry, Loma Linda University, 6612 Applewood Lane, Highland, CA 92346*; Nada L. Stotland, M.D., M.P.H.; Carl C. Bell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should understand the APA's role in addressing racial and ethnic harmony and combating prejudice; and recognize symptoms suggestive of a Pathological Bias Disorder.

SUMMARY:

Dr. Stotland will discuss the genesis of the proposed APA Position Statement: 'Resolution against Racism'. She will help define beliefs and practices of individual versus institutional racism. Attempts towards understanding 'Micro-aggression;' acts that stem from unconscious manifestations of racial superiority. Biopsychosocial factors promoting racial prejudice and impacting both victims and perpetrators will be discussed. Scientific evidence, demonstrating impairments of psychological functioning on individuals subjected to racist attitudes and acts will be presented. Dr. Bell will explore features of an individual's personality dynamics, which may manifest as racist behaviors. Mental illnesses including mood disorders, psychotic spectrum disorders and anxiety disorders, which may include overt and covert racist symptoms will be considered. Axis II pathology, which may predict and be part of the xenophobia associated with a prejudicial and paranoid personality will be discussed. Finally, clinical and scientific considerations towards establishing diagnostic criteria for Pathological Bias Disorder will be proposed.

TARGET AUDIENCE(S):

Psychiatric residents, psychiatrists, and other mental health professionals who work with racially and ethnically diverse populations.

REFERENCES:

1. American Psychiatric Association Research Agenda for DSM V. Washington D.C.: American Psychiatric Press, Inc., 2002, p. 255.
2. Bell C. Racism A Mental Illness. *Psychiatric Services* 2004; 55:1343.

Workshop 30

Friday, October 6
1:30 p.m.-3:00 p.m.

**NICOTINE DEPENDENCE AND
 MINORITIES: ADDRESSING PUBLIC
 HEALTH POLICIES**

APA Minority Fellowships Program

Daniel L. Dickerson, D.O., *Resident, Department of Addiction Psychiatry, Yale University, 1730 State Street, Hamden, CT 06517*; Dauda A. Griffin, M.D.; Luisa A. Gonzalez, M.D.; Jose A. Rey, Pharm. D.; Petros Levounis, M.D., M.A.; Racquel Lugo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize specific public health strategies aimed towards decreasing tobacco use in minority communities; and demonstrate increased awareness with regards to the role of tobacco taxes, counter-advertising, and other policies which influence rates of nicotine dependence among minorities.

SUMMARY:

Nicotine dependence remains the most preventable cause of death among U.S. minority populations. Although overall smoking rates have steadily declined, smoking rates among different ethnic groups continue to remain high, especially in the African-American and Native American populations. Despite the clear conclusions of recent research concerning health inequalities, there has been some difficulty in framing and adopting the policy consequences of this work. Public health interventions aimed towards reducing smoking rates in minority populations is no exception.

Recent tobacco tax initiatives have resulted in a decrease in smoking rates across the United States. Additional focus on the benefits of tobacco taxes in specific minority communities can further elucidate the benefits of this public health intervention. A recent study conducted in Massachusetts found towns with larger minority populations showed significantly greater support for tobacco tax increases.

Counter-marketing campaigns directed towards combating tobacco company advertising strategies in minority communities, and further endorsement of clean air laws could also decrease tobacco use in minority populations. Finally, accessible and affordable tobacco treatment programs in minority communities are limited and must be addressed. Psychiatrists' advocacy for these public health measures may assist in lowering overall tobacco use in the minority population.

TARGET AUDIENCE(S):

General psychiatrists and addiction psychiatrists.

REFERENCES:

1. Hamilton WL, Biener L, Rodger CN. Who supports tobacco excise taxes? Factors associated with towns' and individuals' support in Massachusetts. *Journal of Public Health Management and Practice*. 2005; 11(4): 333-340.
2. Levy DT, Nikolayev L, Mumford E, Compton C. The Healthy People 2010 smoking prevalence and tobacco control objectives: results from the SimSmoke tobacco control policy simulation model (United States). *Cancer causes and control*. 2005; 16: 359-371.

Workshop 31

Friday, October 6
3:30 p.m.-5:00 p.m.

**THE PROBLEM OF ILLICIT DRUGS:
 PUBLIC HEALTH OR MILITARIZED
 RESPONSE?**

APA Corresponding Committee on Treatment Services for Patients With Addictive Disorders

John A. Renner, M.D., *Associate Professor, Department of Psychiatry, Boston University, 251 Causeway Street, Boston, MA 02114-2148*; Sanho Tree, B.A.; Ximena Sanchez-Samper, M.D.; Gustavo Angarita Africano, M.D.; Ricardo Restrepo-Guzman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should have a better understanding of the implications of what has been called the "War on Drugs," the importance of actively participating in policy decisions that can change the course of how our societies approach this problem, and the greater cultural implications of decisions made in the United States and implemented in other countries.

SUMMARY:

For years, the general public has spoken about the "War on Drugs", with little understanding of its repercussions around the globe. Most of the policies that support this "War," are based on a criminal justice or interdiction model. Because of this, our society has stigmatized this issue and the individuals caught up in the use of these substances. It is apparent that the strategies developed by the U.S. and many Latin American countries over the last 40 years have been insufficient to address this problem. Unfortunately, many policy makers and clinicians still hesitate to admit that substance abuse is primarily a mental illness affecting millions of people.

This workshop will focus on Andean countries and on their relationship with the U.S., the market with the highest demand of illegal substances. In particular, we will look at Colombia, a country recognized for being one of the major suppliers of drugs for the North American market. Through a documentary and live sessions, we will explore the implications of this problem outside of our offices and hospitals. By presenting a general view of the clinical and epidemiological aspects of substance abuse in Andean countries, South American addiction psychiatrists trained in the U.S. will present the similarities and differences between the approach, treatment, and resources available in Andean countries and what we are accustomed to in North America.

REFERENCES:

1. Brecher, EM: Licit and Illicit Drugs: The consumers Union Report on Narcotics, Depressants, Inhalants, Hallucinogens and Marijuana-including Caffeine, Nicotine and Alcohol. Boston, Little Brown and Company, 1972.
2. Thoumi FE: el imperio de la droga: Narcotráfico, economía y sociedad en los Andes. Bogota, D.C, Editorial Planeta Colombiana, S.A., 2002.
3. Torres de Galvis Y, Montoya B ID: II Estudio de Salud Mental y Consumo de Sustancias Psicoactivas. Colombia 1997. Epidemiología del uso indebido de alcohol y otras sustancias psicoactivas, Bogota, D.C, Fondo Nacional de Estupefacientes, Republica de Colombia, Ministerio de Salud, 1997, pp 71–158.

Workshop 32

Friday, October 6
3:30 p.m.-5:00 p.m.

9/11: WHAT HAPPENED TO THE CHILDREN? TRAUMA, LOSS, AND WORKING WITH THE MEDIA

APA Committee of Residents and Fellows

William C. Wood, M.D., *Child Psychiatry Fellow, Department of Psychiatry, Massachusetts General Hospital, S. Linnaean Street, Apartment 9, Cambridge, MA 02138*; Lea E. DeFrancisci, M.D., *Psychiatry Resident, St. Vincent's Hospital, 203 West 12th Street, Room 449, New York, NY 10011*; Harold S. Koplewicz, M.D.; Eugene V. Beresin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the real-life impact of the world trade center attacks on children and also the impact of media on children's reactions to terrorism.

SUMMARY:

The terrorist attacks on September 11, 2001, had the distinction of affecting more children in the United States than any other single act of violence. There were upwards of 5,000 children in New York who suffered either direct exposure to the destruction or the loss of a parent. Children at the World Trade Center site were traumatized by the disaster unfolding. In addition, many children also watched the disaster on television and were therefore traumatized. This workshop will include showing the HBO film "Through a Child's Eyes" for 30 minutes with a discussion afterwards about the impact of media on children's reaction to terrorism. This will be followed by a dialogue about the real-life impact of the World Trade Center attacks on children, featuring clinicians who are on the front line.

TARGET AUDIENCE(S):

Residents and Fellows, but interest in this topic is universal and will appeal to all.

REFERENCES:

1. Through a Child's Eyes: September 11, 2001. Schatz A, director, Nevins S, executive producer. 2003 New York, HBO.
2. Fremont WP, Pataki C, Beresin EV: The impact of terrorism on children and adolescents: terror in the skies, terror on television. In Child Psychiatry and the Media. Beresin EV, Olson C (Editors). Child and Adolescent Clin N America. 2005; 429–453.

Workshop 33

Friday, October 6
3:30 p.m.-5:00 p.m.

MEDICARE PART D: SMART AND COMPASSIONATE OR DUMB AND DEADLY?

APA Council on Social Issues and Public Psychiatry

Jagannathan Srinivasaraghavan, M.D., *Department of Psychiatry, Southern Illinois University School of Medicine, 1000 N. Main, Anna, IL 62906*; Irvin L. Muszynski, J.D.; Jeffrey L. Geller, M.D., M.P.H.; Robert P. Cabaj, M.D.; Jacqueline M. Feldman, M.D.; Benjamin Crocker, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand and appreciate a critical review of the new Medicare Part D Dealing with Prescription Drug Coverage for those eligible for Medicare.

SUMMARY:

Medicare Part D deals with access to prescription drug coverage for everyone with Medicare regardless of income, health status, or prescription drug usage. For those eligible for Medicare the enrollment period ended on May 15, 2006 to join a plan offering coverage for 2006. There are multiple plans offering varying choices that are quite confusing for most physicians, let alone, for the millions of Medicare recipients. In spite of information booklets and Web sites, a lot of people are not well informed about the choices available to them. In this workshop, Irvin (Sam) Muszynski will provide an overview of the Medicare Part D program and instill an insight about how psychiatric patients can approach the subject of a suitable program for their needs. Even though the program promises access to prescription drug coverage, to all those eligible for Medicare, the patients who are eligible for Medicaid and Medicare face tremendous challenges. The three speakers Jeff Geller, M.D., from Massachusetts, Bob Cabaj, M.D., from California, and Jackie Feldman, M.D., from Alabama, will present the promises and pitfalls of this program from their patients' point of view in addition to the 'hidden' cost shifting to states and counties, and the creation of unfunded mandate.

TARGET AUDIENCE(S):

Psychiatrists, psychologists, social workers, and other health care workers.

REFERENCES:

- Centers for Medicare and Medicaid Services, US Department of Health and Human Services. Medicare. <http://www.medicare.gov/pdphome.asp>.
- Mental Health Part D Org Coalition, American Association of Community Psychiatrists, American Psychiatric Association, et. al: Mental Health Part D: An Essential Resource for the Mental Health Community. (<http://www.mentalhealthpartd.org/>).

Workshop 34

**Friday, October 6
3:30 p.m.-5:00 p.m.**

**WORKABLE HOUSING: DEVELOPING
AND MAINTAINING APPROPRIATE
RESIDENTIAL SETTINGS FOR THE
CHRONICALLY MENTALLY ILL**

Marilyn Seide, Ph.D., *Division Chief, Los Angeles County Department of Mental Health, 7660 Beverly Boulevard, Suite 446, Los Angeles, CA 90036*; Richard A. Miller, M.D.; Suzanne Wagner, M.S., L.M.S.W.; Dorene Toutant, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to recognize what elements are desirable to successfully implement innovative supportive housing options for the chronically mentally ill.

SUMMARY:

As the pressure to discharge the chronic mentally ill from institutions increases and more localities look towards developing the supports these people will need in the community, the need for adequate and appropriate housing becomes ever more paramount. Interest in developing the skills needed to generate such housing and, once in place, to facilitate the success of clients in maintaining these less restrictive settings has greatly increased over the past several years. This workshop will address these issues, and present models of the kinds of supportive setting that have worked, elucidate the kinds of supports that assist clients in maintaining their housing, and look at what are the ingredients necessary for generating, funding and implementing housing opportunities for people who are chronically mentally disabled.

TARGET AUDIENCE(S):

Those involved in evaluating, placing, and maintaining clients in supportive housing.

REFERENCES:

- Corp. for Supportive Housing: Developing the Supportive Housing Program. U.S. Dept. of Housing & Urban Development. 2003.
- Ford, J., Young, D., Perez, B. Obermeyer, R., Rohner, D. Needs Assessment for Persons with Severe Mental Illness. *Com. Mental Health Journal*, 28(6), 1992.

Workshop 35

**Saturday, October 7
8:00 a.m.-9:30 a.m.**

**PSYCHIATRIC CARE AFTER A NATURAL
DISASTER: THE ASTRODOME KATRINA
CLINIC**

Jennifer E. Pate, M.D., *Instructor, Department of Psychiatry, Baylor College of Medicine, Harris County Hospital District, 6655 Travis, Suite 700, Houston, TX 77030*; John W. Burruss, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to define the basic needs of evacuees who come to a community shelter following a natural disaster and recognize essential elements of post-disaster psychiatric care to be provided at a community shelter.

SUMMARY:

On August 29, 2005, Hurricane Katrina struck the Louisiana Gulf coast leaving over 1000 people dead and hundreds of thousands of people displaced from their homes. Approximately, 25,000 New Orleans residents were evacuated from the Superdome and were brought to the Astrodome in Houston, where they received shelter as well as medical and psychiatric care. In this interactive workshop, intended for all mental health professionals, we will discuss the design of our clinic and the services we provided in the immediate aftermath of this devastating natural disaster. Specific challenges we encountered including providing care and supervision for geriatric patients, as well as ensuring continuity of care for patients on methadone maintenance will also be discussed. Participant involvement will be encouraged as we explore strategies to address mental health needs following future natural disasters.

TARGET AUDIENCE(S):

All mental health professionals including psychiatrists, psychologists and social workers.

REFERENCES:

1. Ursano, RJ, Fullerton, CS. and Norwood, AE. (2003). *Terrorism and Disaster, Individual and Community Mental Health Interventions*. Cambridge, England: Cambridge University Press.
2. Katz, CL, Pellegrino, L. Pandya, A., Ng, A. and De Lisi, LE. (2002). Research on psychiatric outcomes and interventions subsequent to disasters: a review of the literature. *Psychiatry Research*, 110(3), 201-217.

Workshop 36

**Saturday, October 7
8:00 a.m.-9:30 a.m.**

**REDUCING BARRIERS TO EFFECTIVE
COLLABORATION BETWEEN
PSYCHIATRISTS AND COMMUNITY-
BASED CASE MANAGERS**

Scott R. Masters, M.D., *Director of Education, Department of Psychiatry, St. Luke's-Roosevelt Hospital, 1090 Amsterdam Avenue, Suite 169, New York, NY 10025*; Oana Guran; Christine Mogle; Daniel Johansen

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the five most common barriers to effective collaboration between a prescribing psychiatrist and a case manager based at a community-based organization; and immediately apply six ways of overcoming these barriers to allow a safer, more beneficial treatment for the chronically mentally ill client.

SUMMARY:

For over 25 years, the APA and many researchers/clinicians have sought to establish guidelines for psychiatrists who work in relationships with other non-medical care providers. The challenges are great for the psychiatrist who functions as one member of a multidisciplinary psychiatric rehabilitation team along side with care providers with different training, expectations, organizational structures, and even clinical languages. Prescribing psychiatrists are being asked to function in increasingly complex organizational systems involving many caretakers of their chronically mentally ill clients. This workshop explores the barriers to effective collaboration between prescribing psychiatrists in clinic settings and case managers in community-based settings and how to overcome these barriers. An easily adopted model curriculum used with psychiatry residents and community-based case managers will be presented. In this curriculum, members of the treatment team talk openly with one another and discuss expectations, then "shadow" one another in their work to understand one another's clinical world. Results of a survey of change in attitudes of both care providers will be briefly presented showing the advantages of this curriculum. Succinct guidelines for improving collaboration between prescribing psychiatrists and case managers that were derived from our experience will be distributed. Presenters will include: the program director who created the cross-experience curriculum; a psychiatry prescriber; and a case manager from the community who took part in the experience; and a director of the community-based organization. Participants will be encouraged to share their own solutions leading to improved collaboration between hospitals/clinics and community-based organizations.

TARGET AUDIENCE(S):

Psychiatrist working on multidisciplinary teams, other care providers who interact with these psychiatrists, and program leaders.

REFERENCES:

1. Sederer, LI, Ellison, J, Keyes, C. Guidelines for Prescribing Psychiatrists in Consultative, Collaborative, and Supervisory Relationships. *Psychiatric Services* 1998; 49:1197-1202.
2. Liberman, RP, Hilty, D, Drake, RE, Tsang, HWH. Requirements for Multidisciplinary Teamwork in Psychiatric Rehabilitation. *Psychiatric Services*, 2001; 52:1331-1342.
3. Rakich, JS, Longest, BB, Darr, K: *Managing Health Services Organizations*, 3rd Edition, Chapter 15 Communication. Health Professions Press, 1992.

Workshop 37**Saturday, October 7
8:00 a.m.-9:30 a.m.****APA PRACTICE GUIDELINE ON
OBSESSIVE-COMPULSIVE DISORDER:
2006***APA Steering Committee on Practice Guidelines*

John S. McIntyre, M.D., *Past President, American Psychiatric Association; and Vice President for Behavioral Health and Chair, Department of Psychiatry and Behavioral Health, Unity Health System, 81 Lake Avenue, Third Floor, Rochester, NY 14608*; Eric Hollander, M.D., *Department of Psychiatry, Mt. Sinai Hospital, 1 Gustave Levy Place, Room 1230, New York, NY 10029*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the objectives and development process of the APA practice guidelines project; and know how to use the practice guideline on Obsessive-Compulsive Disorder to help determine how to treat patients with Obsessive-Compulsive Disorder.

SUMMARY:

Since 1991, the APA has published 14 practice guidelines using an evidence-based process that results in recommendations that are both scientifically sound and clinically useful to practicing psychiatrists. *Practice Guideline for the Treatment of Patients With Obsessive-Compulsive Disorder* is expected to be published in 2006. Workshop panelists will discuss the development process for APA practice guidelines and the specific recommendations of this guideline. Attendees are invited to comment on the recommendations, implications for the field, and dissemination and treatment strategies.

TARGET AUDIENCE(S):

Psychiatrists who treat patients with obsessive-compulsive disorder.

REFERENCES:

1. American Psychiatric Association. Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006. Washington, DC: APPI, 2006.

Workshop 38**Saturday, October 7
8:00 a.m.-9:30 a.m.****GOSPEL AND BLUES AS THERAPEUTIC
TOOLS IN AFRICAN AMERICANS WITH
THE BLUES***2005–2007 APA/Bristol-Myers Squibb Fellows*

Kimberley R. Bogan, M.D., *2005–2007 APA/Bristol-Myers Squibb Fellow, and Resident, Department of Psy-*

chiatry, Case Western Reserve University, 10835 Grantwood Avenue, Cleveland, OH 44108; David T. Handley, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to appreciate the impact of gospel and blues music as a coping tool in the maintenance of mental health in the African-American community.

SUMMARY:

The purpose of this workshop is to provide a cross-cultural training experience using musical genres, such as gospel and blues music, to favorably impact mental health in African-Americans. Both musical genres will be discussed in terms of their developmental history and inherent characteristics that have made them personal anthems for those seeking cathartic release and hope. Additionally, examples of each genre will be briefly demonstrated to further clarify their role as a unique and effective treatment modality. Pictorial images will also be used as a backdrop to support content and to match music samples. Integrating the latter mediums (i.e., verbal, audio and visual) will create a robust and tangible experience for the audience so as to facilitate their awareness of the power of musically accessing affect, particularly in African-Americans. Although limited, statistical references will be made so as to provide evidence-based information.

TARGET AUDIENCE(S):

The target audience for this workshop should include all mental health professionals who are interested in increasing their cultural competence for managing African Americans and adding a unique and powerful modality to their armamentarium.

REFERENCES:

1. Salzman, J.: *Encyclopedia: The African American Experience*. New York: Macmillan Library Reference USA, [1998].
2. Tyson, F.: *Psychiatric Music Therapy in the Community: The Legacy of Florence*. edited by McGuire, M.G., Barcelona Publishers, Gilsum, NH [2004].
3. Hodge, DR, Williams, TR.: *Assessing African American spirituality With Spiritual Ecomaps*. *Families in Society: The Journal of Contemporary Human Services* 2002; 83 (5/6): 585–595.

Workshop 39**Saturday, October 7
10:00 a.m.-11:30 a.m.****SEX AND SEXUALITY AND SPECIAL
POPULATIONS AMONG GAY, LESBIAN,
AND BISEXUAL PEOPLE***Association of Gay and Lesbian Psychiatrists*

Robert P. Cabaj, M.D., *Director, San Francisco Community Behavioral Health Services, and Associate Clinical*

Professor of Psychiatry, University of California at San Francisco, 1380 Howard Street, Fifth Floor, San Francisco, CA 94103; Robert M. Kertzner, M.D.; Ronald E. Hellman, M.D.; Samantha M. Kelleher, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the complex role that sexuality plays in the lives of lesbians and gay men and describe how it influences mental health.

SUMMARY:

The sexuality of gay and lesbian patients will be discussed with a focus on eating disorders, on patients with major mental illness, LGB sexuality and sexual identity from an adult developmental perspective, and on the connection between sex and crystal methamphetamine use. Dr. Samantha Kelleher will discuss body image distortion in LGBT populations and the cultural influences on the presentation and development of eating disorders. She will present the effects of eating disorders on sexuality, desire, and drive. Dr. Ronald Hellman will discuss sexuality in LGBT patients with major mental illness. He will provide data from research and discuss personal observations. Dr. Bob Kertzner will explore how LGB identity shapes the course of adult experience, including single or partnered-life and sexuality. Based on research and clinical vignettes, he will discuss how LGB adults maintain psychological health over the life span with a focus on mid-life. Dr. Bob Cabaj will focus on the explosive use and abuse of methamphetamine by gay men, and on the debate about the role of sex and drugs in gay men's lives.

REFERENCES:

1. Cabaj RP, Stein TS (eds); *Textbook of Homosexuality and Mental Health*, APPI, Washington DC, 1996, and Hellman RE, Drescher J (eds); *Handbook of LGBT Issues in Community Mental Health*, Haworth Press, New York, 2005.

Workshop 40

**Saturday, October 7
10:00 a.m.-11:30 a.m.**

DISASTER INTERVENTIONS FOR DISADVANTAGED COMMUNITIES

*APA Assembly Committee of Representatives of
Minority/Underrepresented Groups*

Stephen A. McLeod-Bryant, M.D., *Associate Professor, Institute of Psychiatry, University of South Carolina, 67 President Street, Charleston, SC 29425*; Mark H. Townsend, M.D.; Rahn Bailey, M.D.; Elizabeth C. Henderson, M.D.; Jagannathan Srinivasaraghavan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize sociocultural factors increasing the risk of psychological injury following natural or manmade disasters in disadvantaged communities; and identify culturally competent approaches to reducing the risk of PTSD, depression, and substance abuse following disasters in disadvantaged communities.

SUMMARY:

Hurricanes Katrina and Rita hammered the Gulf Coast, wreaking much pain and destruction. Disadvantaged communities were particularly devastated by these storms. People within these communities were already prone to factors which leave them more susceptible to the negative sequelae of natural disasters. However, much has been learned from those and other natural and man-made disasters (e.g., previous hurricanes, the Tsunami of 2004, the genocide in Darfur). There are culturally competent approaches for mental health professionals that will mitigate the damage done to disadvantaged survivors' mental health. Dr. Townsend will introduce the topic with a personal review of his care of the disadvantaged survivors of Katrina in Louisiana. Dr. Bailey will follow by reviewing important sociocultural factors affecting disadvantaged African Americans, which should inform treatment of survivors of disaster. Dr. Henderson will speak on the characteristics of disadvantaged Gulf Coast women which may increase their risk of traumatic symptoms, but also suggest appropriate interventions, Dr. Srinivasaraghavan will speak on the collective experience and mental health consequences of the Asian tsunami from his personal experience of providing education to service providers in India and Sri Lanka.

TARGET AUDIENCE(S):

Psychiatrists and other clinicians interested in disaster relief with diverse groups.

REFERENCES:

1. Barron RA: *International disaster mental health*. *Psychiatric Clinics of North America* 27:505-519, 2004.

Workshop 41

**Saturday, October 7
10:00 a.m.-11:30 a.m.**

STORIES IN LEADERSHIP AND TRANSFORMATION IN THE PUBLIC SECTOR

American Association of Community Psychiatrists

Anita S. Everett, M.D., *Member, APA/IPS Scientific Program Committee; and Senior Medical Advisor, Substance Abuse and Mental Health Services Administra-*

tion, U.S. Department of Health and Human Services, 1 Choke Cherry Drive, #81053, Rockville, MD 20857; Karen H. Rhea, M.D.; Neal H. Adams, M. D., M.P.H.; Cheryll Bowers-Stephens, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify leadership styles and skills, and be inspired to become a more effective leader and transformation agent.

SUMMARY:

The Presidents New Freedom Commission identified a need for transformation of mental health services in the United States in the report released in 2003. Successful transformation is dependent on the active engagement of staff and consumers at all levels. Psychiatrists and mental health professionals often are in leadership positions. This may be by progressive career design, other times this is a more accidental process. Leadership may be associated with a natural interpersonal style, or it may be an acquired set of skills.

This workshop is designed to explore facets of leadership through stories and leadership experiences. Each presenter will choose one leadership story or experience which highlights their leadership style. Participants will gain insight into their potential as a positive change agent. Each of the presenters is a leader and transformation agent in their workplace. Dr Anita Everett is the Senior Medical Advisor for the Federal Substance Abuse Mental Health Services Administration. Dr. Neal Adams is the Director of Special Projects at the California Institute for Mental Health. Dr Cheryll Bowers-Stephens was the Assistant Secretary of the Department of Mental Health in Louisiana and Dr. Karen Rhea is the Vice President for Clinical Affairs of Centerstone Community Services.

REFERENCES:

1. Linskym, Iteifietz Leadership on the line: Staying alive through the Dangers of Leadership; Business School Press
2. New Freedom Commission on Mental Health, Achieving Leadership Transformation in Mental Health Care in America. DHHS Pub # SMA 03-3832 Rockville, MD 2003.

Workshop 42

Saturday, October 7
10:00 a.m.-11:30 a.m.

THE RELEVANCE AND ROLE OF MENTORSHIP IN PSYCHIATRY

Presidential Workshop

Pedro Ruiz, M.D., *President, American Psychiatric Association, and Professor and Vice Chair, Department*

of Psychiatry and Behavioral Sciences, University of Texas Medical School at Houston, 1300 Moursund Street, Houston, TX 77030-3406; Michael Blumenfield, M.D., Speaker, APA Assembly, and Department of Psychiatry, New York Medical College, 16 Donellan Road, Scarsdale, NY 10583; Robert W. Guynn, M.D.; Anu A. Matorin, M.D.; Alicia B. Vittone, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the importance of mentorship on career advancement and professional growth, particularly among women, IMGs, and early career psychiatrists.

SUMMARY:

The number of women, international medical graduate (IMGs) psychiatrists, early career psychiatrists, ethnic minority psychiatrists, and similar groups of mental health professionals in academic, leadership, and organized medicine have not kept pace with the increased number of representatives from these groups who enter in psychiatry and other mental health professionals. It is most appropriate at this time to examine the reasons and factors, which negatively impact on these barriers in career advancements. We also need to examine the factors that may facilitate career advancements among professional members of these groups.

Mentorship, among many other factors, is considered to play a major positive role in this respect. Without doubts, mentorship has long been recognized as an important and relevant tool for professional progress and development. This recognition has been observed in women's professional advancement, as well as with other professional groups, such as international medical graduate psychiatrists, early career psychiatrists, and ethnic minority mental health professionals.

In this workshop, we will examine, address, and discuss the relevance and role of mentorship in psychiatry. Special attention will be given to the groups within psychiatry who also face the major barriers in this regard. Similarly, attention will be given to specific methodologies of mentorship interventions.

TARGET AUDIENCE(S):

Early career psychiatrists, residents, women, IMGs, medical students, and other professionals.

REFERENCES:

1. Matorin AA, Collins DM, Abdulla A, Ruiz P: Women's Advancement in Medicine and Academia: Barriers and Future Perspectives. *Texas Medicine*, 93(11): 60-64, 1997.
2. Delgado AK, Griffith EEH, Ruiz P: The Black Women Mental Health Executive: Problems and Per-

spectives. *Administration in Mental Health*, 12(4):246–251, 1985.

crimination.” *Psychiatric Services* (2005) 156 (5): 570–575.

Workshop 43

**Saturday, October 7
10:00 a.m.-11:30 a.m.**

WHO IS CRAZY? CONFRONTING AND CHANGING THE STIGMA OF MENTAL ILLNESS

2005–2007 APA/Bristol-Myers Squibb Fellows

Lauren W. Swager, M.D., *Resident, Department of Psychiatry, University of North Carolina Hospitals, 10 Little Spring Lane, Durham, NC 27707*; Sarah L. Altman, M.D.; Karen T. Hopp, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify the stigma facing mental health patients, providers, and communities; demonstrate an understanding of selected models of anti-stigma campaigns from the national and international literature; and recognize the impact individuals can have in changing the stigma of mental health in their own communities.

SUMMARY:

Each day mental health providers and patients confront the barriers associated with negative attitudes toward psychiatric illness. The presenters postulate that what truly appears ‘crazy’ are the attitudes of our society toward mental illnesses. This workshop will take an interactive look at the stigma that currently influences our patients, our communities, and the treatment of mental illness, including how mental health providers may also unknowingly be perpetuating current stereotypes and stigma. Various literature, discussing international efforts at anti-stigma campaigns, including those in the United States will be reviewed. There will be an emphasis on how individual providers and consumers can address and combat stigma in their own communities. Following the presentation, attendees are invited to participate in a discussion about their own experiences with strategies at confronting stigmas in their own backyards.

TARGET AUDIENCE(S):

Mental health providers, consumers, and family members.

REFERENCES:

1. Jorm, A.F. “Mental Health Literacy: Public knowledge and beliefs about mental disorders.” *The British Journal of Psychiatry* (2000) 177:396–401.
2. Warner, R. “Local Projects of the World Psychiatric Association Programme to Reduce Stigma and Dis-

Workshop 44

**Saturday, October 7
1:30 p.m.-3:00 p.m.**

COLLABORATION BETWEEN PSYCHIATRY AND PRIMARY CARE

National Alliance for the Mentally Ill

Benjamin Crocker, M.D., *Medical Director, Maine Medical Center, 443 Congress Street, SFU Floor, Portland, ME 04101*; Suzanne E. Vogel-Scibilia, M.D.; Neil Korsen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to stimulate awareness of practice that promote access and quality in collaborative psychiatric and primary care service.

SUMMARY:

This workshop targets an audience of psychiatrists practicing in rural and underserved areas where collaboration between psychiatry and primary care is essential.

We will discuss a standard of practice that encourages collaboration between psychiatrists and primary care physicians (PCPs) and continuity of care between mental health and the general health systems. Details regarding availability of the psychiatrist, community involvement and liaison with primary care, especially in rural areas, will be discussed. A model of practice a consumer-operated mental health clinic in a semi-rural area of Western Pennsylvania, which has a severe deficiency of practitioners and a large number of consumers, will be compared to the efforts of a general health system in Maine to improve mental health service delivery in the primary care setting.

MaineHealth is an integrated delivery system that has been working on a depression in primary care program for four years, with support from the MacArthur and the Robert Wood Johnson Foundations. Tools are provided to help primary care clinicians recognize and diagnose depression, as well as evidence-based changes in systems of care, consistent with the Chronic Care Model, to achieve better outcomes. Better linkages between primary care and behavioral health specialists is an important and challenging component of this effort.

REFERENCES:

1. Lowe, B., Unutzer, J, Callahan C.M., Perkins, A.J. and Kroenke. (2004) Monitoring Depression Treatment Outcomes with the PHQ-9, *Medical Care*, 42 (12), 1194–1201.

2. Callahan, C. and Berrios, G. (2005) *Reinventing Depression, a History of the Treatment of Depression in Primary Care, 1940–2004*, Oxford U. Press.

Workshop 45

**Saturday, October 7
1:30 p.m.-3:00 p.m.**

REALIZING THE LIBERATORY GOALS OF PSYCHIATRY

Carl I. Cohen, M.D., *Department of Psychiatry, State University of New York, Health Sciences Center, 450 Clarkson Avenue, Brooklyn, NY 11203–2012*; Kenneth S. Thompson, M.D.; Astrid N. Rusquellas, M.D.; Bradley E. Lewis, M.D.; Sami Timimi; Amjad Hindi, M.D.; Ramotse Saunders, M.D.; Ipsit V. Vahia, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand four social psychological models that are potentially compatible with the liberatory goals of psychiatry; and synthesize a theoretical perspective that is compatible with the liberatory vision of psychiatry.

SUMMARY:

Pinel's unchaining of the Parisian insane has been a metaphor for the dual liberatory underpinnings of psychiatry: it can free persons from social, physical, and psychological oppression, and it can assist persons to be what they can be (i.e., self-realization), and to lead self-directed lives. Thus, psychiatry assists people to be both "free from" and "free to." These goals link psychiatry to medicine and science, but also to sociopolitical elements. Hence, two foundational points guide our work: (1) The project of psychiatry has always been one of liberation; (2) Psychiatry's principal object, the mind (i.e., the psychological sphere), is inherently biological and social. This means that psychiatry has a critical role to play in social struggles that further liberation. Western psychiatry has focused primarily on the biological and individual elements, and has had a much narrower view of liberation. Recently, there have been dramatic transformations in global social structures. Problems related to domination, alienation, commodification class, gender, religion, race, and ethnicity are becoming more universal. The psychological ramifications of these changes have been pronounced, although they have not been adequately addressed. During this workshop, an international group of panelists will encourage participants to conceptualize a variety of approaches towards realizing a liberatory psychiatry.

TARGET AUDIENCE(S):

Clinicians, and social and community psychiatrists.

REFERENCES:

1. Cohen CI: Overcoming social amnesia: the role for a social perspective in psychiatric research and practice. *Psychiatric Services* 51:72–78, 2000.
2. Double D: The limits of psychiatry. *British Medical Journal* 324:900–904, 2002.

Workshop 46

**Saturday, October 7
1:30 p.m.-3:00 p.m.**

THE INFLUENCE OF CULTURE ON PSYCHOTHERAPY TRAINING

Nyapati R. Rao, M.D., *Director of Residency Training, Department of Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, P.O. Box 1203, Brooklyn, NY 11203*; Michael D. Garrett, M.D., *Vice Chairman, Department of Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, P.O. Box 1203, Brooklyn, NY 11203*; Stephen M. Goldfinger, M.D.; Azziza Bankole, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should understand the cultural factors that influence residents' receptivity to learning psychotherapy; and learn about the attitudes of residents toward psychotherapy core competencies.

SUMMARY:

The ACGME required that psychiatry residents must demonstrate competence in five types of psychotherapy (Brief, Supportive, Psychodynamic, CBT, and Combined therapies) to graduate from residency training and in the current review of the RRC special essentials for Psychiatry, this issue is being closely debated by the training community. In this context, it is germane to examine the residents' receptivity to learning psychotherapy. This is important because 45% of current psychiatry residents are International Medical Graduates (IMGs) who come from cultural backgrounds vastly different from those born and raised in the United States. The theory and practice of psychotherapy is very much influenced by the values of the culture it emanates from, and the American cultural values underlying psychotherapy practice and training may engender conflict in IMGs and may effect their learning. In this workshop, intended for educators, practitioners and residents, a national survey of psychiatry residents of their attitudes towards various cultural values that impinge on psychotherapy training will be presented. When a similar workshop with survey results from three training programs in Brooklyn,

NY were presented at the APA annual meeting in 2005, it was well received and participants welcomed research on this important issue. Consequently, we have surveyed residents from training programs outside of New York State to obtain a more representative sample and we will be sharing this data at this meeting. Using this expanded survey as a springboard, supervisory and training issues pertinent to psychotherapy education of IMGs will be discussed. The attendees will be encouraged to share their programmatic and individual experiences.

REFERENCES:

1. Mellman LA, Beresin E: Psychotherapy Competencies: Development and Implementation. *Academic Psychiatry* 2003, 27:149–153.
2. Wen-Shing Tseng, Strelzer J (Eds): *Culture and Psychotherapy: A Guide to Clinical Practice*. Washington DC, American Psychiatric Press, Inc., 2001.

Workshop 47

**Saturday, October 7
1:30 p.m.-3:00 p.m.**

BIOPSYCHOSOCIAL CONSEQUENCES OF CHILDHOOD VIOLENCE

APA Task Force on the Biopsychosocial Consequences of Childhood Violence

Richard J. Loewenstein, M.D., *Medical Director, Trauma Department, Sheppard & Enoch Pratt Hospital, 6501 N. Charles Street, Towson, MD 21204*; Paul J. Fink, M.D., *Past President, American Psychiatric Association, 191 Presidential Boulevard, C132, Bala Cynwyd, PA 19004*; Vincent J. Felitti, M.D.; William W. Harris, Ph.D.; Carl C. Bell, M.D.; Frank W. Putnam, M.D.; Carole L. Warshaw, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should appreciate the impact of trauma and violence on many aspects of biopsychosocial functioning; and understand the critical role the psychiatric profession has in organizing a systematic approach to assessment and treatment of trauma-related problems and disorders.

SUMMARY:

This workshop summarizes the work of the APA Task Force on the Biopsychosocial Consequences of Childhood Violence. Interpersonal violence, especially child maltreatment and domestic violence, is the largest single preventable cause of mental illness. Over a third of the general population may have suffered an interpersonal trauma, and as many as 15–20 percent of the general population may have suffered multiple traumatic events. High-risk groups may have very high rates of trauma related to poverty, frequent violent crime, family dys-

function, and pervasive substance abuse. General population and clinical sample studies in children, adolescents, and adults repeatedly find that high rates of intrafamilial violence result in significant morbidity, including post-traumatic stress disorder (PTSD), mood disorders, suicidality, somatoform symptoms, substance abuse, and increased utilization and/or costs of medical care. For example, multiple reviews and meta-analyses find that child maltreatment triples the risk of major depression and increases risk for suicide 10- to 12-fold. Current estimates of prevalence of PTSD in the general United States population is about 6–7 percent, making it among the most common psychiatric disorders. In addition to psychiatric disorders, histories of interpersonal violence are highly associated with substance abuse, HIV-risk behaviors, and major medical illness.

REFERENCES:

1. Felitti, VJ, D. Nordenburg, et al. (1998). "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The adverse childhood experiences (ACE) study." *American Journal of Preventative Medicine* 14(4): 245–258.
2. Kessler, R. C. (2000). "Posttraumatic stress disorder: The burden to the individual and to society." *Journal of Clinical Psychiatry* 61(suppl 5): 4–14.

Workshop 48

**Saturday, October 7
3:30 p.m.-5:00 p.m.**

MANAGED CARE: WHERE ARE WE NOW AND WHERE ARE WE GOING?

APA Committee on Managed Care

Paul H. Wick, M.D., *Medical Director, Trinity Clinic, 3300 S. Broadway Avenue, #102, Tyler, TX 75701*; David K. Nace, M.D.; Robert C. Bransfield, M.D.; Irvin L. Muszynski, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify key techniques used to manage costs, utilization, and quality; describe future reimbursement trends; describe techniques of pharmaceutical benefit management; identify strategies to assist patients to obtain necessary medications; describe managed care techniques utilization in the public sector; understand trends regarding Medicaid mental health services; and identify advocacy opportunities.

SUMMARY:

This workshop will identify key issues and the impact of managed care on costs, utilization and quality in both private and public sectors. Reimbursement trends of the

future including consumerism, chronic disease management and pay for performance will be discussed.

Managed care, which initially focused on reducing hospital care and psychotherapy, now has increasing trends towards reducing access to psychotropic medication. The techniques of pharmaceutical benefit management will be reviewed. Strategies to assist patient access to medically necessary medications that emphasize accountability of all parties will be reviewed. An overview of how states are presently managing their Medicaid mental health services and formularies will be presented. Key topics will include Medicaid managed care models, payment methodologies (i.e., capitation versus fee-for-service); the federal oversight role and discussion of key issues for advocates. Interactive audience participation will follow the presentation.

This workshop will be introduced and moderated by Paul H. Wick, M.D.; there will be three presentations: Current and Future Trends (Dr. Nace); Pharmaceutical Benefit Management (Dr. Bransfield); and Managed Care in the Public Sector (Mr. Muszynski), of approximately 20 minutes each. Time will be allotted for discussion.

TARGET AUDIENCE(S):

Mental health professionals engaged in public and private psychiatry.

REFERENCES:

1. New AMA Principles and Guidelines for Pay-for-Performance. Chicago, American Medical Association, 2005.
2. The Provision of Mental Health Services in Managed Care Organizations: DHHS Publication (SMA) 03-3797, Rockville, Md, SAMHSA, Center for Mental Health, 2003.

Workshop 49

Saturday, October 7
3:30 p.m.-5:00 p.m.

WORKPLACE CRISIS AND DISASTER INTERVENTION

APA Committee on Business Relations

Norman A. Clemens, M.D., *Department of Psychiatry, University Suburban Health, 1611 S. Green Road, Suite 301, Cleveland, OH 44121*; Alan Langlieb, M.D.; Jeffrey P. Kahn, M.D.; Michael Kaminsky, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the role of disaster mental health services in the workplace setting; characterize, through historical context and outcomes research, the current landscape of crisis intervention practices; and

identify a new model for providing a full continuum of care in disaster mental health and crisis interventions and the important role of employee assistance programs.

SUMMARY:

This workshop will introduce a new paradigm on workplace crisis and disaster intervention. Psychological intervention subsequent to mass disasters and trauma has historically been characterized by reactive, event-centered practices with little or no appreciation for the temporal trajectory of the human response. A growing critique of this strategy is that not everyone exposed to a disaster will require assistance and not everyone will benefit from the same type of assistance. In addition to providing an historical context for why a new vision is necessary, we will present a newly developed tri-phasic, outcome-oriented model for disaster mental health services that uses resistance, resilience, and recovery as a basic framework for organizing care. Lessons learned from experiences after 9/11 and Hurricane Katrina from a psychiatrist's perspective will be presented.

REFERENCES:

1. Kaminsky M, McCabe L, Langlieb AM, Everly GS. Resistance, Resilience, & Recovery: An Outcome-Oriented Continuum of Care for Disaster Mental Health Services. In CDC Special Monograph (2005) Mental Health Impact of Disaster: A Working Guide for Public Health Professionals.
2. Kahn, JP; Langlieb, AM (eds.) Mental Health and Productivity in the Workplace (2nd edit.) Jossey-Bass, San Francisco, CA; 2003.

Workshop 50

Saturday, October 7
3:30 p.m.-5:00 p.m.

DEMONS, SATAN, SCIENCE, AND HOMOSEXUALITY: A FILM ANALYSIS *Association of Gay and Lesbian Psychiatrists*

David L. Scasta, M.D., *Film Task Force, Association of Gay and Lesbian Psychiatrists, 115 Commons Way, Princeton, NJ 08540-1507*; Alicia J. Salzer, M.D., *Film Director, 9 Barrow Street, Apt. 8-F, New York, NY 10014-3864*; Mary E. Barber, M.D.; Reverend Larry Waltz

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should gain familiarity with religious precepts which make the coming out process difficult for LGBT people and compel efforts to effect sexual orientation change.

SUMMARY:

Psychiatrists have been at the forefront of depathologizing and destigmatizing homosexuality. Many conservative religious groups have passionately opposed this process, holding to the view that homosexual behavior is immoral and mutable, citing statistics and findings that have little support in the secular scientific community. Gay, lesbian, bisexual, and transgendered people (LGBT) have become scapegoated in the cultural wars: the line in the sand drawn by conservative people of faith fighting for a conservative "Biblical" view about how society should be structured and who should be empowered in that society. The workshop uses a film, "Can I change?" produced by the Association of Gay and Lesbian Psychiatrists, as a vehicle to understand how LGBT individuals of faith wrestle with their religious precepts and renegotiate their relationship with their deity. Psychiatrists often fail to appreciate the intensity of this internalized and very personal conflict because of their discomfort in addressing matters relating to religious faith. The goal of the workshop is to heighten this appreciation. No special background is needed.

TARGET AUDIENCE(S):

Psychiatrists working with people of faith.

REFERENCES:

1. "Professional Associations' statements about homosexuality." Religious Tolerance.Org. www.religioustolerance.org/hom_prof.htm.
2. "Straight Answers: Exposing Myths and Facts About Homosexuality." Focus on the Family. <http://www.family.org/cforum/fosi/homosexuality/maf/a0028248.cfm>.

Workshop 51

**Saturday, October 7
3:30 p.m.-5:00 p.m.**

VULNERABLE PATIENTS AND SEXUAL TRAUMA

Nada L. Stotland, M.D., M.P.H., *Vice President, American Psychiatric Association; Past Speaker, APA Assembly; and Professor of Psychiatry and Obstetrics and Gynecology, Rush Medical College, 5511 S. Kenwood Avenue, Chicago, IL 60637-1713*; Ann Marie T. Sullivan, M.D.; Donna M. Norris, M.D.; Wendy Chavkin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to help individuals with mental illnesses; and identify and address their vulnerabilities to sexual violence and trauma and the ramifications of these unfortunate, but common events when they occur.

SUMMARY:

Among the violent and traumatic events that befall our communities and our patients, sexual violence and trauma loom large. Mental illnesses, including substance abuse, can impair the cognition, mood, self-esteem, social networks, and finances necessary for people to make decisions about sexual behavior and protect themselves from victimization. Individuals in the midst of episodes of serious psychiatric illness can be vulnerable to sexual assault, sexually transmitted diseases including HIV/AIDS, unintended pregnancy, and loss of custody of their children. These events can reciprocally interfere with treatment and recovery. Administrators and clinicians responsible for patients in both the public and private sectors therefore need to help patients identify and address their vulnerabilities and deal with the ramifications when they occur. This help should include: education about sexuality and reproduction; discussions about patients' behaviors, values, and preferences; referral for routine reproductive health care and follow-up; and therapy to reduce the sequelae of sexual violence. To provide the information necessary for the provision of this help, this workshop offers the expertise of a public health obstetrician/gynecologist, a psychiatrist administering a large public mental health system, a child and adolescent psychiatrist, and a psychiatrist specializing in reproductive health issues.

TARGET AUDIENCE(S):

Mental health clinicians and educators.

REFERENCES:

1. Allen, JG. *Coping with Trauma: Hope through Understanding*. 2nd ed. APPI, Washington DC, 2005.
2. Burt VK, Hendrick VC. *Women Victims of Violence*, pp 155-159 in *Concise Guide to Women's Mental Health*, 2nd ed, APPI Washington DC, 2001.

Workshop 52

**Sunday, October 8
8:00 a.m.-9:30 a.m.**

CONCOMITANT MEDICATION IN SCHIZOPHRENIA: WHAT WE KNOW, DON'T KNOW, AND IGNORE

Miranda H. Chakus, M.D., *Department of Psychiatry, State University of New York, Downstate Medical School, 450 Clarkson Avenue, P.O. Box 1203, Brooklyn, NY 11203*; Ira D. Glick, M.D., *Department of Psychiatry, Stanford University, PBS #2200, Room 2122, Stanford, CT 94308*; Jayendra K. Patel, M.D.; Pia N. Reyes, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to better understand the prevalence and

correlates of concomitant psychotropic medication use in the treatment of patients who have been diagnosed with schizophrenia in both the acute and stable phases of illness, and appreciate the potential risks and benefits of this practice.

SUMMARY:

Many clinicians struggled to improve outcome in treating schizophrenic patients by augmenting antipsychotic medication with so-called ancillary or concomitant psychotropic medications (CPMs). These included combining antipsychotics, or combining an antipsychotic with antidepressants, mood stabilizers, anxiolytic agents or sedatives. The use of CPMS in people with schizophrenia is common. There is a lack of controlled scientific data that demonstrates the effectiveness of many of these agents in this population. In addition, CPMs may worsen quality of life, induce side effects and create drug interactions, increase cost and lower adherence. Presenters in this workshop will discuss prevalence and correlates of CPMs in schizophrenia. Data on CPM use in schizophrenia from the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) trial study, data on CPM discontinuation in stabilized schizophrenic patients, and data on use of CPMS and rehospitalization rates at Kings County Hospital will be presented for discussion by the workshop panelists. Participants will better understand clinical correlates of CPM use including association with illness severity, functional impairment and neurocognitive impairment and the benefits and risks of CPM use.

TARGET AUDIENCE(S):

The target audience is clinicians who treat schizophrenic patients who are partially responsive to treatment with first and second generation antipsychotic medications.

REFERENCES:

1. Stahl, SM & Grady, M.M. A critical review of atypical antipsychotic utilization: comparing monotherapy with polypharmacy and augmentation. *Current Medicinal Chemistry*, 11(3), 313–327, 2004.
2. Chakos MH, Glick ID, Miller AL et al. Concomitant Psychotropic Medications: Baseline Use in the Catie Trial. *Psychiatric Services*, In Press.

Workshop 53

**Sunday, October 8
8:00 a.m.-9:30 a.m.**

PSYCHIC PLASTICITY, RESILIENCE, AND REACTIONS TO MEDIA VIOLENCE

Stuart W. Twemlow, M.D., *Professor, Department of Psychiatry, Baylor College of Medicine, 2801 Gessner Drive, P.O. Box 809045, Houston, TX 77280*; Tanya J.

Bennett, M.D., *Instructor, Baylor College of Medicine, 2801 Gessner Drive, P.O. Box 809045, Houston, TX 77280*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate an understanding of the risk and protective factors that may precipitate violent behavior and how they may interact with specific reference to the topic of media violence and the concepts of neuroplasticity and resilience; and gain some knowledge of research challenges and programs to promote resiliency and decrease violent behavior.

SUMMARY:

Media violence is a popular topic of both research and debate, however, defining its role in the etiology of violent behavior continues to be problematic at best. The co-chairs have recently written a paper entitled “Psychic Plasticity, Resilience and Reactions to Media Violence: What is the Right Question?” for an upcoming issue of *The American Behavioral Scientist*, focusing on media violence. In this workshop, we will review risk and protective factors related to destructive aggressiveness, including biological, individual, environmental and sociocultural factors. Media violence constitutes one type of environmental exposure on a very long list of precipitants to violent behavior. We will discuss how these factors interact, and perhaps synergize, and emphasize the concept of resiliency. We will emphasize youth as a risk factor and the importance of considering developmental stages. Drawing from some of our own work examining violence in schools, we will illustrate how social factors relate to aggression. We hope to address this topic from multiple perspectives, including those of psychiatrists, parents and teachers.

TARGET AUDIENCE(S):

Adult and child/adolescent psychiatrists, psychologists and mental health professionals, especially those who work in a community and/or school setting or are interested in preventative care and public policy.

REFERENCES:

1. Twemlow, SW, Bennett TJ (2006) “Psychic Plasticity, Resilience and Reactions to Media Violence: What is the Right Question?” *The American Behavioral Scientist*, In press.
2. Twemlow, SW, Fonagy, P, Sacco, FC (2005) “A developmental approach to mentalizing communities: II The Peaceful Schools experiment” *Bulletin of the Menninger Clinic*, 69(4), 281–303.

Workshop 54

**Sunday, October 8
8:00 a.m.-9:30 a.m.**

PROBLEM COUPLES IN GERIATRIC PSYCHIATRY

Sheila M. Loboprabhu, M.D., *Assistant Professor of Psychiatry, Michael DeBakey VA Medical Center, 2002 Holcombe Boulevard, Houston, TX 77030*; Theron C. Bowers, M.D., *Department of Psychiatry, VA Medical Center, 2002 Holcombe Boulevard, Houston, TX 77030*; Victor A. Molinari, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to appreciate the complexity of treating patients with dementia who have spousal caregivers with various problems, assess the dynamics of the caregiver-patient relationship, and tailor treatment in a situation-specific manner to meet the needs of both the patient and the caregiver.

SUMMARY:

Caregiving for older adults poses many demands and challenges. Caregivers of patients with dementia are commonly spouses and adult children. In this workshop, we discuss five case examples of couples in which one spouse has dementia. Each case example illustrates a different problem in the relationship between patient and caregiver. Cases illustrated are those of caregiver abuse of the patient, financial exploitation of the patient, enmeshment between caregiver and patient, the caregiver with dementia, and a case of folie a deux. These cases illustrate the importance of a multidisciplinary team in assessing problems in the caregiver-patient relationship, and in addressing the needs of both caregiver and patient. Abuse and exploitation of the patient by the caregiver requires the intervention of local or state authorities. Cases where the caregiver has dementia or psychosis may also pose special challenges in the form of legal and ethical issues. In all cases, we try to illustrate how the treatment team can ensure that the patient with dementia and the caregiver receive safe and effective clinical care.

TARGET AUDIENCE(S):

Psychiatrists, psychologists, social workers, and other geriatric health care professionals.

REFERENCES:

1. Burke, D, Dolan, D, Schwartz, R. Folie a deux: three cases in the elderly. *Int Psychogeriatr.* 1997 June; 9(2):207-12.
2. Mace, N, Rabins, P. *The 36-Hour Day: A family guide to caring for persons with Alzheimer's disease, related dementing illnesses, and memory loss in later life.* Baltimore, Johns Hopkins Press, 1999.

Workshop 55

**Sunday, October 8
10:00 a.m.-11:30 a.m.**

EVIDENCE-BASED TREATMENT OF IMPULSIVE AGGRESSION IN YOUTH

Daniel T. Matthews, M.D., *Corporate Director of Neuropsychiatry, UHS Neurobehavioral Systems, 12710 Research Boulevard, Suite B320, Austin, TX 78759*; Glenda W. Kroll, M.D.; Larry Fisher, Ph.D.; John Seals, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the subtypes of aggressive behavior most likely to benefit from pharmacological intervention; explain the role of neurophysiological testing in the assessment of impulsive or explosive aggression in youth; recognize which medications will target the underlying neurological dysfunctions; and describe comprehensive, long-term psychiatric management for irritable and explosive youth.

SUMMARY:

Designed for child/adolescent psychiatrists, this workshop, which combines neuropsychiatry, behavioral neurology, and neuropsychology, will review the research base, the current community standard of care, and innovative approaches to the management of irritable and explosive children. A vast scientific literature has shown that impulsive aggression is more biological than premeditated aggression, and more responsive to medication. Children and adolescents who commit impulsive aggression are different in both neuropsychological and neurophysiological measures. Consistent evidence indicates that irritable and explosive youth have neurocognitive vulnerabilities. They also demonstrate a high degree of electrophysiological abnormalities. Irritability is a non-specific symptom that is common to a number of psychiatric diagnoses, including Attention Deficit Hyperactivity Disorder, Bipolar Disorder, Major Depressive Disorder, and Autistic Spectrum Disorders. A youth with impulsive aggression who is irritable or explosive should have a comprehensive evaluation, including measures of brain function, before planning for behavioral, psychotherapeutic, or pharmacological interventions. This is particularly important in cases where several disorders co-occur or when monotherapy fails to manage the symptoms. While it may be premature to speculate that impulsive aggression shares a common biological pathway, regardless of diagnosis, there are some common principles for the pharmacological and neuropsychological management of irritable and explosive youth.

TARGET AUDIENCE(S):

Child and adolescent psychiatrists.

REFERENCES:

1. Citrome, L., Nolan, K., and Volavka, J. (2004). Science-Based Treatment of Aggression and Agitation. In *The Science, Treatment, and Prevention of Antisocial Behaviors*, Vol. II, Civic Research Institute, New Jersey.
2. Connor, D. (2002). *Aggression and Antisocial Behavior in Children and Adolescents: Research and Treatment*. The Guilford Press, New York.

Workshop 56

**Sunday, October 8
10:00 a.m.-11:30 a.m.**

**TRAUMA IN MARGINALIZED
COMMUNITIES: INSIDER/OUTSIDER
DILEMMAS**

Joy D. McQuery, M.D., *Psychiatric Resident, Department of Psychiatry, Cambridge Hospital, 26 Central Street, Somerville, MA 02143*; Mary R. Harvey, Ph.D.; Nicola Brown, Ph.D.; Jasmine Clare, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize some of the common dilemmas practitioners face when working in marginalized communities and have increased understanding of an alternative model, the ecological model of trauma, which will assist them in navigating these difficulties.

SUMMARY:

Trauma has its greatest impact on marginalized communities (Harvey, 1996). Yet, as the Surgeon General's report indicates, it is our most marginalized communities that are most poorly served by our current practice (U.S. DHHS, 2001). Three threads will be addressed in this workshop: a failure of mainstream theory to conceptualize the nuances of social power as it relates to violence; a failure of mainstream services to integrate culture in a way that produces interventions grounded in the realities of communities of color; and an example of a group designed to address the impact of trauma for multi-disadvantaged survivors. Panelists will be drawing on their respective work with public sector mental health clients, sexual-minority women partners of female-to-male transsexuals, and incarcerated women for this discussion.

This workshop will examine the limitations of our current theories, political movements and practices for marginalized groups, demonstrate use of the ecological model of trauma (Harvey, 1996), and illustrate the importance of an interdisciplinary approach to trauma. Dis-

ussion of changes needed in our current practice models and exploration of common dilemmas faced by practitioners practicing in marginalized communities will be included in the interactive question and answer segment.

TARGET AUDIENCE(S):

General psychiatrists, and policy makers. No specific background needed.

REFERENCES:

1. Harvey, M.R: An ecological view of psychological trauma and trauma recovery. *Journal of Traumatic Stress* 1996; 3-23.
2. U.S. Department of Health and Human Services: *Mental Health: Culture, race and ethnicity-A supplement to Mental Health: A report of the Surgeon General, Rockville, MD: U.S., Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 2001.*

Workshop 57

**Sunday, October 8
10:00 a.m.-11:30 a.m.**

**INTEROPERABLE ELECTRONIC HEALTH
RECORDS AND PSYCHIATRY**

APA Corresponding Committee on Electronic Health Records

John J. Boronow, M.D., *Department of Psychiatry, Sheppard Pratt Hospital, 11101 Falls Road, Lutherville, MD 21093*; Zebulon C. Taintor, M.D.; Laura J. Fochtmann, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe the current status and major initiatives of the national Electronic Health Records (EHR) movement; describe the current activities of the APA involving EHR and identify resources for learning more about and staying abreast of further developments; and make a clinically and legally informed decision about the what, why, and how of assigning patient information to an open versus confidential section of an EHR.

SUMMARY:

In response to the growing political and consumer demand for electronic health records (EHR), the Secretary of the Department of Health and Human Services released, in July 2004, the first outline of a ten-year plan to build a national health information infrastructure in the U.S. This effort has been consolidated under the Office of the National Coordinator for Health Information Technology (ONC), which is funding several large-

scale efforts to accomplish this goal. It is important that psychiatrists have an understanding of, and contribute to, this rapidly accelerating movement, ensuring that concerns such as privacy are addressed while optimizing advantages such as reduction in medical errors, enhanced continuity of care, and improved efficiency. This workshop will review the status of the EHR movement, privacy and confidentiality issues, and the processes that are being utilized to develop standards and requirements for EHR that promote national interoperability. Participants will be asked to review and/or develop psychiatric “use cases,” real-world scenarios that are an effective tool for communicating to clinicians, standardization partners, and vendors the complexities and requirements that are needed for a psychiatry-compatible EHR.

TARGET AUDIENCE(S):

Clinicians who have an interest in EHRs (standards, adoption, interoperability).

REFERENCES:

1. Institute of Medicine: Key Capabilities of an Electronic Health Record System. Washington, D.C., The National Academies Press, 2003.
2. Connecting for Health: Achieving Electronic Connectivity in Healthcare. New York, NY, Markle Foundation, 2004.
3. “Health Information Technology,” Health Affairs, September/October Issue, Vol 24, Number 5, 2005.

Workshop 58

**Sunday, October 8
10:00 a.m.-11:30 a.m.**

REACTIONS TO NATIONAL DISASTERS BY PATIENTS ON AN ASSERTIVE COMMUNITY TREATMENT TEAM

Theodora G. Balis, M.D., *Assistant Professor, Department of Psychiatry, University of Maryland Medical School, 630 West Fayette Street, Baltimore, MD 21210*; Ann L. Hackman, M.D.; Curtis N. Adams, Jr., M.D.; David T. Potter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify the various reactions possible for patients with severe mental illness in an Assertive Community Treatment team after exposure to a national

disaster and learn about ways to help these patients cope with this stressor.

SUMMARY:

There is literature on patients’ reaction to disaster, but very little on how patients with severe mental illness react to disasters that affect the nation as a whole.

The Baltimore Assertive Community Treatment (ACT) team, which currently treats 150 patients has been providing intensive psychiatric outreach services since 1990 to a population of individuals with SMI. Many of our patients face multiple traumas in their lives, including 50% with past homelessness, and these have often affected their symptoms, hospitalizations, and coping. ACT patients are also exposed to the stress of national disasters via the media, family directly affected by the disaster, and discussion of the effects of various disasters in their community in general. Our patients have discussed their feelings about the 9/11 disaster and the hurricane disasters individually with their clinicians and in a Women’s Group at the Baltimore ACT team. Reactions have varied from increased symptoms of existing psychiatric illness to anxiety disorders. A chart review was conducted to look at the frequency of hospitalizations and other evidence of decompensation following the 9/11 attacks and the gulf coast hurricanes.

After briefly reviewing literature on disaster psychiatry and describing ACT services, the panel will describe our experience in working with patients on an ACT team after recent national disasters. The audience will be invited to discuss their experiences with their patients.

TARGET AUDIENCE(S):

Psychiatry residents, medical students, trainees, psychiatrists, social workers, nurses, and other mental health professionals working in community settings.

REFERENCES:

1. Jones, K; Olmscheid, B; Boyle, B: World Trade Center Disaster: Reactions in an HIV Clinic Near Ground Zero, *AIDS Read* 11(11):541–554, 2001.
2. Benedek, D; Benedeck, M; et al: Terrorism and Disaster- What Clinicians Need to Know: Emergency Mental Health After a Suicide Bombing. *Medscape CME*, 2005.
3. Lacy, T; Benedeck, D: Terrorism and Weapons of Mass Destruction: Managing the Behavioral Reaction in Primary Care. *South Med Journal* 96(5):394–399, 2003.

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