San Francisco

OCTOBER 27–30, 2011

Comprehensive and Coordinated Care: Bringing it all Back Home

2011 CME SYLLABUS AND PROCEEDINGS SUMMARY

63rd Institute on Psychiatric Services

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

Drexel UNIVERSITY

Co-sponsored with Drexel University College of Medicine/ Behavioral Healthcare Education

American Psychiatric Association

CONTINUING MEDICAL EDUCATION

2011 CME SYLLABUS AND PROCEEDINGS SUMMARY

FOR THE

63rd Institute on Psychiatric Services

October 27-30, 2011
San Francisco, California

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

Institute on Psychiatric Services
American Psychiatric Association
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209-3901
1-888-357-7924

American Psychiatric Association
63rd Institute on Psychiatric Services

The 2011 Institute on Psychiatric Services Scientific Program Committee and APA Leadership Welcome You to San Francisco!

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Front Row – Seated Left to Right: Wesley E. Sowers, M.D., (Program Chair), Altha J. Stewart, M.D.

Not Pictured: Stephanie LeMelle, M.D., Anita S. Everett, M.D., Stephen M. Goldfinger, M.D., Jennifer Kraker, M.D., M.S., John M. Oldham, M.D. *(APA President)*, James H. Scully, Jr., M.D. *(APA Medical Director)*

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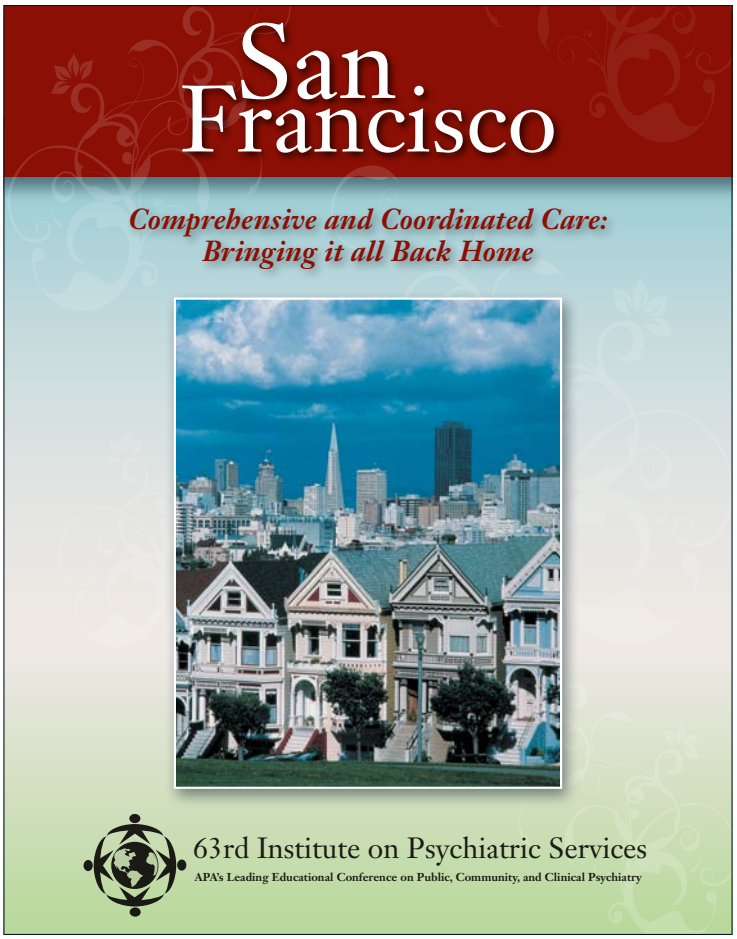

CE Credits for Other Disciplines

Conference Objectives

At the conclusion of the **2011 Institute on Psychiatric Services**, participants will be able to:

1.) Identify and improve mental health disparities in the community;

2.) Demonstrate and apply new skills that will be useful in public psychiatry settings;

4.) Examine how the current health care system affects patient care;

5.) Describe how to transform systems of care; and

6.) Recognize how to bring new innovations into a variety of treatments to improve patient care.

Target Audiences

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

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

Accreditation Statement:

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

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

APA (Psychology):

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

ASWB (National Social Work):

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

NAADC (National D&A):

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

NBCC (National Counselors):

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

PA Nurses:

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

CEUs for all others:

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

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

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

63rd Institute on Psychiatric Services

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

DAILY LOG

FOR YOUR RECORDS • FOR ATTENDANCE AT **CME** SESSIONS

Obtain your Certificate for the 2011 Institute of Psychiatric Services at www.psych.org/IPSCME

NOTE: This form is for your records and not for submission. Use this page to keep track of your attendance. Reporting is on an honor basis; claim one credit for each hour of participation. The APA designates this live activity for a maximum of *27 AMA PRA Category 1 Credits™*.

All scientific sessions listed in this ***Program Book*** are designated for *AMA PRA Category 1 Credits™*, except for Discussion Groups and Poster Sessions which are designated for *AMA PRA Category 2 Credits™*.

DATE	TITLE OF SESSION	# OF HOURS
	TOTAL:	

63rd Institute on Psychiatric Services

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

MISSION STATEMENT

VISION, MISSION, VALUES, AND GOALS

of the

INSTITUTE ON PSYCHIATRIC SERVICES

VISION

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

MISSION

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

VALUES AND GOALS

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

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

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

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

IMMERSION COURSES

IMMERSION COURSE 01

Thursday, October 27; 1:30 p.m.–5:00 p.m.

ADHD in Adults: From Clinical Research to Clinical Practice

Craig Surman, M.D., 185 Alewife Brook Parkway, Cambridge, MA, 02472, **Paul G. Hammerness, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Understand when ADHD is and is not a clinically significant diagnosis; 2) Understand efficient methods for assessing ADHD symptoms and impairment; 3) Understand what ADHD symptoms respond, and which do not, to pharmacologic therapies; 4) Personalize treatment for ADHD patients, including optimal pharmacologic and non-pharmacologic supports; 5) Implement evidence based-cognitive behavioral therapy strategies; 6) Understand principles for managing common complex presentations, including patients with non-attention executive function deficits, mood disorders, anxiety disorders, and substance abuse disorders.

Summary: The faculty are practicing clinicians who have contributed to approximately 50 studies of ADHD in the past decade, including studies of the association between ADHD and sleep and eating disorders, novel pharmacotherapies, and a cognitive-behavioral therapy technique recently published in the Journal of the American Medical Association. Up-to-date scientific findings will serve as context for practical, step-by-step training in the art of in-office clinical decision making. Attendees will participate in a virtual patient encounter, learn to identify ADHD symptoms, and practice applying medication and non-medication treatments to virtual cases.

References:

1) Adler LA. Pharmacotherapy for adult ADHD. J Clin Psychiatry. 2009 May;70(5):e12.
2) Adler LA, Spencer T, Brown TE, Holdnack J, Saylor K, Schuh K, Trzepacz PT, Williams DW, Kelsey D. Once-daily atomoxetine for adult attention-deficit/hyperactivity disorder: a 6-month, double-blind trial. J Clin Psychopharmacol. 2009 Feb;29(1):44-50

IMMERSION COURSE 02

Friday, October 28; 9:00 a.m.–4:00 p.m.

Impact of Psychiatric Disorders on HIV Management

Marshall Forstein, M.D., 24 Olmsted Street, Jamaica Plain, NY 02130, **Karl Goodkin, M.D., Ph.D., Lawrence McGlynn, M.D.**

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

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

References:

1) Antinomian A, Arendt G, Becker JT, Brew BJ, Byrd DA, Churner M, Clifford DB, Cinque P, Epstein LG, Goodkin K, Giessen M, Grant I, Heaton RK, Joseph J, Murder K, Mara CM, McArthur JC, Nunn M, Price RW, Pulliam L, Robertson KR, Sacktor N, Valcour V, Wojna V: Updated research oncology for HIV-associated neurocognitive disorders (HAND). Neurology. 2007;69:1789-1799.
2) JC McArthur and BJ Brew. HIV-associated neurocognitive disorders: is there a hidden epidemic? AIDS 2010, 24:1367–1370
3) Cohen MA, Gorman J (eds). Comprehensive Textbook of AIDS Psychiatry. New York, NY. Oxford University Press, 2008.

IMMERSION COURSE 03

Friday, October 28; 9:00 a.m.–5:00 p.m.

Psychopharmacology for Primary Care Providers and Other Non-Psychiatrists

Ronald Diamond, M.D., 6011 Research Park Boulevard, Madison, WI 53719

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand the use of medication, and the balance between benefit and risk; 2) Understand the major classes of psychotropic medication, including antipsychotics, antidepressants, mood stabilizers and sedative hypnotics; 3) Understand how medications work and how mechanism of action influences both efficacy and side effects.

Summary: This workshop will present an overview of psychopharmacology for the non-medical mental health professional. Psychotropic medication is an increasingly important part of comprehensive mental health treatment. The non-medical professional often knows the client better than any physician, and is often in the best position to evaluate the effectiveness of medication that a client is taking. This workshop will present basic information so that the non-medical professional can work effectively with the psychiatrist to optimize medication use for their clients. This overview will cover the major classes of psychotropic medication in common use, including indications for each, side effects, practical issues around use, and dangers. Ways of involving clients and teaching them about their medication will also be discussed.

References:

1) Diamond, RJ Instant Psychopharmacology 3rd edition WW Norton, 2009\
2) Diamond RJ and Scheifler P Treatment Collaboration: Improving the Therapist, Prescriber, Client Relationship WW Norton 2007

IMMERSION COURSE 04

Saturday, October 29; 8:00 a.m.–11:30 a.m.

Psychiatric Emergency Services: A Contemporary Paradigm of Care

Anthony Ng, M.D., 8777-B Piney Orchard Parkway, Odenton, MD 21113, **John Berlin, M.D., Jody Lofchy, M.D., Leslie Zun, M.D.**

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

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

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

References:

1) Allen MH, Currier GW, Carpenter D, et al. The Expert Consensus Guideline Series. Treatment of Behavioral Emergencies 2005. J Psych Pract. 2005;11 Suppl 1:5-108.
2) Currier, G and Allen, M., (2003) Organization and function of academic psychiatric emergency services, General Hosp Psych 25:124-129.
3) Ferns, T., (2005) Terminology, stereotypes and aggressive dynamics in the accident and emergency department. Accid Emerg Nurs., 13(4):238-246. (Epub)
4) Kramer, M. and Schmalenberg, C., (2008) Confirmation of a Healthy Work Environment. Critical Care Nurse. 28:53-68.

IMMERSION COURSE 05

Saturday, October 29; 8:00 a.m.–11:30 a.m.

Creating Your Ideal Job in Psychiatry

Wesley E. Sowers, M.D., 206 Burry Avenue, Bradfordswoods, PA 15015, **Robert S. Marin, M.D.**

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

Summary: This course is intended for residents and early career psychiatrists interested in learning how to plan a satisfying career in psychiatry. It also will be of interest to psychiatrists wanting to increase their involvement with public sector psychiatry. The course will emphasize career opportunities in community psychiatry and publicly funded systems. However,

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

References:

1) Ranz J, Eilenberg J, and Rosenheck S: The Psychaitrist's Role as Medical Director: Task Distributions and Job Satisfaction. Psychiatric Services 48:915-920, 1997.
2) American Association of Community Psychiatry Guidelines for Psychiatric Leadership in Organized Delivery Systems of Treatment of Psychiatric and Substance Disorder: Model Job Descriptions for the System Medical Director.

IMMERSION COURSE 06

Saturday, October 29; 8:00 a.m.–12 Noon

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

Lori Raney, M.D., 281 Sawyer Drive, Durango, CO 81303, **John Kern, M.D., Jurgen Unutzer, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Describe the unmet need for mental health services in primary care; 2) Identify the major components of the IMPACT model of care; 3) Identify the basic skill set necessary for the primary care psychiatrist; 4) Understand how this model can be scaled to meet the needs of health care reform.

Summary: The integration of primary care and behavioral health has gained considerable momentum recently. However, the educational opportunities for psychiatrists have not kept up with this movement although they are highly sought after members of integrated care teams and provide the essential link to our primary care colleagues. This gap in knowledge is hampering the ability of psychiatrists to join these teams in well informed and meaningful ways and has lead to other non-medical specialties assuming the leadership role in this field.

This course will provide the attendee with a practical skill set for the psychiatrist working with primary care at various levels of integration, including at the point of contact in the primary care clinic and in the Community Mental Health Center. This course will begin with Dr. Raney providing an overview of the unmet need in primary care, the mortality issues confronting persons with Serious and Persistent Mental Illness, and make the case for psychiatrists to adopt a mindset for meeting both the mental health needs in primary care and the primary care needs in specialty mental health settings. Dr. Unutzer will present his work on the IMPACT model and discuss how this evidence based treatment model could be utilized to deal with the shortage of psychiatrists to meet both the current and added need that will come with health care reform. Drs Kern and Raney will provide real world examples in both urban and rural settings of application and adaptation of this model and their experiences working in primary care. Dr. Kern will also discuss his experience as a SAMHSA grantee site where he now has a primary clinic located in the mental health center. The second part of this course will consist of the 3 speakers discussing the knowledge and skill set necessary to work as a primary care psychiatrist. Topics that will be discussed include determining the ideal candidate for this work, job description of a primary care psychiatrist, supervision requirements across specialty areas, and opportunities for leadership, among others. Ample time will be provided for discussion throughout this course and a certificate of completion will be provided at its conclusion.

References:

1) Association of State Mental Health Program Directors (NASMHPD) Health Directors Council. Morbidty and mortality in people with serious mental illness. www.nasmhpd.org. October, 2006, 187.
2) Collaborative Care for Depression: A Cumulative Meta-analysis and Review of Longer-term Outcomes. Simon Gilbody, MBChB, MRCPsych, DPhil; Peter Bower, PhD; Janine Fletcher, MSc; David Richards, PhD; Alex J. Sutton, PhD Arch Intern Med. 2006;166:2314-2321

IMMERSION COURSE 07

Saturday, October 29; 8:00 a.m.–5:00 p.m.

Buprenorphine and Office-Based Treatment of Opioid Dependence

Petros Levounis, M.D., 359 West 29th Street, #3A, New York, NY 10001, **Steven Batki, M.D., John Renner, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Discuss the rationale for opioid pharmacotherapy for opioid dependence; 2) Define buprenorphine induction and maintenance protocols; 3) Identify the pharmacological characteristics of opioids; 4) Recognize issues

related to psychiatric and medical comorbidity associated with opioid dependence; 5) Start and set-up an office-based buprenorphine practice.

Summary: This eight-hour course satisfies the federal training requirement that will make a physician eligible to apply to the Secretary of HHS for a waiver to prescribe buprenorphine in an office-based setting for the treatment of opioid dependence, as authorized under the Drug Addiction Treatment Act of 2000. The course will present an overview of opioid abuse, with a focus on the epidemiology of the recent epidemic of the abuse of pain relievers, as well as the legislative changes that authorized a return of an office-based treatment model. There will be a general review of opioid pharmacology, including discussions of buprenorphine, methadone and naloxone, and buprenorphine/naloxone. The research supporting the efficacy and safety of buprenorphine will be presented, along with the criteria for assessing patients to determine their suitability for this treatment modality. Protocols for buprenorphine induction and maintenance will be reviewed, along with an extended presentation of techniques for the long-term clinical management of opioid-dependent patients. There will be a discussion of common psychiatric and medical comorbidities and pain management recommendations. Practical guidance will be presented for setting up an office-based practice, including billing and support staff management. There will be a brief review of evidence-based counseling techniques, with a focus on motivational enhancement therapy. Lectures plus case-based small group discussions will be used to present the course material.

References:

1) Renner, John; Levounis, Petros: Handbook of Office-Based Buprenorphine Treatment of Opioid Dependence, American Psychiatric Publishing, Inc., 2011
2) McCance-Katz EF. Office-based buprenorphine treatment for opioid-dependent patients. Harv Rev Psychiatry 12(6):321-338, 2004.
3) Fiellin D, O'Connor P. Office-based treatment of opioid-dependent patients. NEJM 347(11).Sept 1

IMMERSION COURSE 08

Saturday, October 29; 9:00 a.m.–4:00 p.m.

Essential Psychopharmacology

Alan F. Schatzberg, M.D., 401 Quarry Road, Stanford, CA 94305, **Kiki Chang, M.D., Charles DeBattista, M.D., Ira Glick, M.D., Terence A. Ketter, M.D., Natalie L. Rasgon, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to demonstrate knowledge of treatment for: depressive disorders, bipolar disorders and schizophrenia and child psychopharmacology and special issues associated with disorders in women.

Summary: Rapid advances in neuroscience, drug development and clinical research have made it very difficult to keep up with advances applicable to clinical psychopharmacology, evidence-based practice. This course, designed for psychiatric clinicians, will focus on the cutting-edge issues every clinician needs to know to ensure quality of practice. Advances over the last year will be highlighted. The content focuses on five of the fields most commonly encountered in practice: depressive disorder, bipolar disorders, child/adolescent disorders, women's health disorders and treatment and schizophrenia.

IMMERSION COURSE 09

Saturday, October 29; 1:00 p.m.–5:00 p.m.

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

Stephen Goldfinger, M.D., 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203, **Hunter McQuistion, M.D., Curtis Adams, Jr., M.D., Lada Alexeenko, M.D., Lama Bazzi, M.D., Anthony Carino, M.D., Joanna Fried, M.D., Ifeanyi Izediuno, M.D., Suprit Parida, M.D., Deepan Singh, M.D.**

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

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

References:

1) Schutt, RK., Goldfinger SM "Homelessness, Housing and Mental Illness, Harvard University Press, Cambridge, MA (2011).
2) Homelessness Resource Center, http://homeless.samhsa.gov/default.aspx.

3) Steele, K and Berman C "The Day the Voices Stopped: A Memoir of Madness and Hope", Basic Books, 2001.

IMMERSION COURSE 10

Saturday, October 29; 1:00 p.m.–5:00 p.m.

Culturally Appropriate Assessment Made Incredibly Clear – A Skills-Based Course With Hands-On Experiences

Russell F. Lim, M.D., 2230 Stockton Boulevard, Sacramento, CA 95817, **Francis Lu, M.D.**

Educational Objectives: At the conclusion of this session,the participant should be able to 1) Elicit a cultural identity, using a sociodevelopmental history, and the Addressing outline, Part A OCF; 2) Use Kleinman's questions to elicit an explanatory model, Part B OCF; 3) Elicit stressors and supports, sociodevelopmental history, Part C OCF; 4) Identify ethnocultural transference and countertransference, Part D OCF; 5) Develop a culturally informed differential diagnosis and treatment plan, using "LEARN", Part E OCF.

Summary: Being able to perform a culturally competent assessment is a skill required by current RRC requirements and ACGME core competencies for all graduating psychiatric residents. In addition, the US Census Bureau has predicted that by 2025, Latinos will represent the majority population in California, Arizona, New Mexico and Texas and 33% of all U.S. children. The DSM IV TR Outline for Cultural Formulation (OCF) is an excellent tool for the assessment of culturally diverse individuals, broadly defined to include ethnicity, culture, race, gender, sexual orientation, religion and spirituality, and age, and has been include in the DSM IV since 1994, and in addition, was included in the 2006 APA Practice Guidelines on the Psychiatric Evaluation of Adults, Second edition. The course will also present Hay's ADDRESSING framework, as well as demonstrate Kleinman's eight questions to elicit an explanatory model, and the LEARN model to negotiate treatment with patients.

Clinicians require culturally informed skills to accurately evaluate culturally diverse individuals to treat them both appropriately and effectively. The course will teach clinicians specific skills for the assessment of culturally diverse patients, and give four participants an opportunity to practice these skills on a standardized patient, while the others will watch, assist, and critique their colleagues' skills. Participants will have a small group exercise on their own cultural identities and then mini lectures on the five parts of the DSM IV TR Outline for Cultural Formulation, as well as instruction on interview skills, supplemented by the viewing of taped case examples, in addition to the practical application of those skills with the standardized patient described above. Clinicians completing this course will have learned interviewing skills useful in the culturally appropriate assessment and treatment planning of culturally and ethnically diverse patients.

References:

1) Caraballo A, Hamid H, Lee JR, McQuery JD, Rho Y, Kramer EJ, Lim RF, Lu FG: A Resident's Guide to the Cultural Formulation. In Clinical Manual of Cultural Psychiatry, edited by Lim RF, ed., APPI, Arlington, VA, 2006, pp. 243 269.
2) Lewis Fernandez R, Diaz N. The cultural formulation: A method for assessing cultural factors affecting the clinical encounter. Psychiatric quarterly, 73:4 : 271 295, 2002.

IMMERSION COURSE 11

Sunday, October 30; 8:00 a.m.–11:30 a.m.

Improving the Health Status of Persons With Serious Mental Illness Through Integration: Yes, It Can Be Done!

Anita S. Everett, M.D., 3563 Cattail Creek Drive, Glenwood, MD 21738, **Bernadette Cullen, M.D., Benjamin Druss, M.D., Sharon Praissman, M.D., Kathleen Reynolds, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to recognize and understand the increased medical morbidity and premature mortality found amongst individuals with a chronic and severe mental illness, list and describe current models of integrated medical and psychiatric care for individuals with a chronic and severe mental illness and evaluate the benefits and challenges of the models described and identify which models could be incorporated into their current patient care setting.

Summary: Persons with serious mental illness die an average of 25 years earlier than the general public. These individuals represent the single most health disadvantaged subpopulation of the United States. Causes of premature mortality are similar to the causes of mortality in the general population. In rank order these causes are: cardiovascular, cancer, stroke, pulmonary conditions, accidental death and diabetes. Each of these causes of early death is associated with risk factors that can be modified to improve health outcomes. These modifiable risk factors are associated with personal health determinants such as health literacy and education, healthcare access, poverty and capacity for engagement with positive health behaviors. Healthcare systems issues that are causal include complexity of modern healthcare access, affordability, transportation, and healthcare provider stigma. This course is intended to increase the capacity of participants to improve the health status of individuals with serious mental illness who are served in psychiatric settings. The course will provide a framing of the scale and scope of the problem, a description of a range of interventions that have been found to improve the health status of individuals and a hands-on, how-to experience with experts in actual implementation of integrated services. The range of services will include several examples of the role of peer support specialists as active catalysts in achieving positive health behavior.

References:
1) Danson R. Jones, Ph.D., Cathaleene Macias, Ph.D., Paul J. Barreira, M.D., William H. Fisher, Ph.D., William A. Hargreaves, Ph.D. and Courtenay M. Harding, Ph.D. Prevalence, Severity, and Co-occurrence of Chronic Physical Health Problems of Persons With Serious Mental Illness.Psychiatr Serv 55:1250-1257, November 2004.
2) Benjamin G. Druss, M.D., M.P.H., and Robert A. Rosenheck, M.D. Mental Disorders and Access to Medical Care in the United States.Am J Psychiatry 155:1775-1777, December 1998.

IMMERSION COURSE 12

Sunday, October 30; 8:00 a.m.–11:30 a.m.

Intellectual Disability Diagnosis, Evaluation and Treatment Throughout the Life Cycle

Ramakrishnan Shenoy, M.D., 1309 Port Elissa Landing, Midlothian, VA 23114

Educational Objectives: At the conclusion of this session, the participant will be able to understand the current concepts regarding intellectual disability (formerly known as mental retardation), including diagnosis, classification, treatment modalities and rational current uses of medications. The focus will be on causes that affect the aging brain and rational treatment of those problems.

Abstract: Intellectual disability (ID) is a lifelong condition that affects about 3% of the population in the world. It causes intellectual, physical, behavioral and financial problems for the patient and is a cause of financial and emotional problems for family members. There is no cure for this condition but treatment is very effective when the patient's issues and that of the family's are addressed. The course addresses all aspects of ID including diagnosis, classification, treatment with behavioral methods and rational psychopharmacology. As the patient gets older, several issues emerge and these will be discussed. Genetics plays a role in many persons with ID, which will be covered. The course is meant to be interactive with lively discussion and case studies.

References:
1) Harris, JC; Intellectual Disability; Oxford University Press, 2006.
2) Royal College of Psychiatrists and the Royal Society of MENCAP, 2005.

INNOVATIVE PROGRAMS: SESSION 1

Thursday, October 27; 1:30 p.m.–3:30 p.m.

Prevention Techniques

1. A Practical View of Services Providing Medicinal Cannabis in California/S.F. Bay Area

Lawrence K. Richards, M.D., 714 South Lynn, Champaign, IL 61820, **Amanda Reiman, Ph.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to understand what a legitimate, rational, clinically warranted medicinal cannabis "outlet" would be, what it takes to organize and run such in compliance with state laws and town codes, etc., and make independent contrasts subsequently about other "places."

Summary: This session follows the 2010 Annual Meeting's workshop (Medicinal Cannabis Update) and 2011 Symposium on Cannabinoid Medicine; it differs considerably in that it focuses on day to day practicalities and presents a ground level view of what has to be in place and what it is like to provide the services made legally available to consumers who have prescriptions. The S.F. Bay Area's Berkeley dispensary and civic relationships versus city government are described at length with p.r.n. references to material below. Indications existed by 1986 that the CNS contained a receptor system that reacted to different compounds in the Cannabis sativa plant; research elucidated, and by the end of the 1990s it was known as the Endocannabinoid System (EC or ECS). Basic science research led to clinical research and awarenesses of the different compounds and receptors. (THC, CB1, CB2, were the earliest). Medical literature began to reflect this. Major problems have been twofold: old laws mainly based around the federal narcotics positions going back to 1937 and legitimate availability outside of "street drug resources." The FDA and pharmaceutical companies have been forced by patients' demands (think Multiple Sclerosis) to return abandoned medicines with black box shields from lawsuits since two unexpected deaths in the war on disease can result in all patients losing their medication! For more than a decade this has been happening slowly with state laws legalizing cannabis for medical use; California was the first, and in 2010 there were 14 states with permissive medicinal cannabis laws. This session shows what it takes to comply with California laws and local regulations and have raw marijuana available legally. The 2011 Symposium discussed the history and dynamics around basic science, research, clinical uses, and the forensic, capitalist, and personality problems affecting eventual manufacture and proper availability, said problems being as 2011 began mainly federal narcotics law and the DEA, supplemented by the FDA, NIDA, SAMHSA," big pharma" (in that declining order) and most state laws which essentially copy the federal laws, much as do "highway laws; that Syllabus contains related details for the reader, who should remember all the above is complicated by illegal drug sellers.

References:

1) Martin,BR: Cellular effects of cannabinoids. Pharmacol Rev 1986 38:45-74
2) Razdan,RK: Structure-activity relationships in cannabinoids. Pharmacol Rev 1986 38:75-149.
3) Devane WA, Dysarz FA, Johnson MR, et al: Determination and characterization of a cannabinoid receptor in rat brain. Mol Pharmacol 1988 32: 605-613.
4) Martin BR, Lichtman, AH: Cannabinoid transmission and pain perception. Neurobiol Dis 1998, 5: 447-461
5) Kline TW, Lane B, Newton CA: The cannabinoid system and cytokine network. Proc Soc Exp Biol Med 2000, 225: 1-8.
6) DiMarzo V, Goparaju SK, Wang L, et al: Leptin-regulated endocannabinoids are involved in maintaining food intake. Nature 2001, 410:822-825.
7) Zamora-Valdes D, et al: The Endocannabinoid System in Chronic Liver Disease, Annals of Hepatology, 2005 4 (4): 248-254.

2. Avenues: Work First for Individuals with Co-Occurring Disorders of Mental Illness and Substance Abuse

Connie Tanner, M.S., 300 Harvey West Boulevard, Santa Cruz, CA 95060

Educational Objectives: At the conclusion of this session, the participant should be able to understand that improved medication compliance may be achieved by having natural motivators like employment and/or educational pursuits. This in turn will challenge the doctor-client relationship to communicate, using "Shared Decision making" when discussing medications in hopes of optimizing the participants ability to work with minimal side effects that historically have hindered ones ability to work.

Summary: Avenues is an innovative "Work First" program that targets adults and transition age youth who have co-occurring disorders of mental illness and substance abuse. The project provides a "Work First" Center and works collaboratively with a 15 bed residential program, Casa Pacific. The program integrates an active work program during the day for all participants as a core treatment modality. The innovation is to engage people in active work related activities as an alternative to traditional mental health treatment and substance abuse modalities. Rather than focusing primarily on symptoms, the program will offer, "work first" opportunities. In an effort to address a critical need for improved co-occurring disorder treatment in Santa Cruz County, Avenues was created. Avenues serves adults and transition age youth, particularly those at high risk of homelessness, incarceration, or psychiatric hospitalization. Avenues provides a "Work First" program as the core treatment modality in both North and South Santa Cruz County. Avenues' primary focus is on employment, education, volunteerism and community integration support. While employment is the main focus and attraction, integration and access to 12-step meetings is woven into the overall program design. In addition, alternative treatment including Mindfulness groups

and acupuncture plus peer support are part of the services being offered. By emphasizing "Work First", participants begin to demonstrate accountability and feelings of self-worth while learning to manage and cope with mental health symptoms and substance abuse triggers. Avenues is a client driven program that offers individuals "Avenues of Options" tailored to meet their strengths, experiences, interests and needs. Avenues participants have the opportunity to participate in a 60-day assessment and treatment program that emphasizes return to work skill building and work experience activities. Participants have the option of joining the Work Crew or participating in the structured employment program. Program activities are focused on "Work First" as an alternative to traditional substance abuse and/or mental health treatment. Services include a morning DRA and therapy group, group volunteer activity, outside 12-step meeting, lunch and an afternoon employment readiness workshop. A 12-week session focused on job search, resume building, interview skills, maintaining employment, managing symptoms and triggers, time management, accountability, computer trainings, building self esteem and more, is offered to meet the groups needs. Avenues will also provide medication support, and individual employment counseling as needed. Another component of the Avenues program is Peer Support. Peer Navigators will assist and support program participants with achieving wellness and sobriety, finding volunteer and paid employment and connecting with the community in healthy, positive ways. Peer Navigators are peers in their own recovery from mental illness and substance abuse. They serve as positive role models and support counselors who have "been there and know what it's like." Residential supervised living is also available at a new 15 bed residential program called "Casa Pacific" for those individuals struggling to maintain sobriety and need a supervised setting to stay clean and sober.

References:

Research has not been conducted specifically on this "work first" model for persons with co-occurring disabilities, however the overall design is based upon lessons learned from the Housing First model, demonstrated by NY's Pathways to Housing Inc. Avenues is funded as an Innovative project through the Mental Health Services Act with the intention to try new and innovative ideas never done before, we will be evaluating our success through outcome studies.

3. Early Interventions in Psychosis: Creating a Clinic Designed to Treat Illness Early On and Prevent Relapse

Eric Yarbrough, M.D., 411 West 114th Street, New York, NY 10025, **Michael Birnbaum, M.D., Tia Dole, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Organize a specialty clinic, within a larger clinic framework, that provides the necessary supports for someone in the first years of acquiring a psychotic disorder diagnosis; 2) Understand the framework needed to provide people optimal supports in an effort to decrease symptoms and prevent relapse.

Summary: Early biological and psychosocial interventions are becoming a key part in the treatment of schizophrenia and other psychotic disorders. The structure involved in treating those in their first year of symptom development is of a different intensity and quality than more chronic-based treatments. Using a model developed at St. Luke's Hospital, between the child psychiatry and adult psychiatry program, Dr. Michael Birnbaum and Dr. Tia Dole will discuss their program from an administrative and clinical perspective. We will track the important treatment needs of a first psychotic break from its neurobiology, psychology, and social perspectives.

References:

1) N/A
2) N/A

INNOVATIVE PROGRAMS: SESSION 2

Thursday, October 27; 3:30 p.m.–5:00 p.m.

New Approaches to Pervasive Issues

1. Sustainable Residence – An Innovative Approach to Psychiatric Care of the Homeless

Anne Marie Grube, M.D.

Educational Objectives: At the conclusion of this session, the participant should have insight in the possibilities of a long-term, integrated approach of psychiatric care for this difficult patient group. Several ethical discussion points will be addressed, e.g. living on the streets versus forced admission, and harm reduction versus abstinence.

Summary: Sustainable Residence is a unique long stay hospital in a rural area in the Netherlands. It admits homeless double-diagnosed people with a history of many forced admissions in psychiatric institutes and detention for shoplifting, misdemeanors and misbehavior on the street. Years of previously offered aid in the city of origin has not led to long term improvement in their situation. The uniqueness of this clinic lies in offering a holding environment for those rejected by society because of all kinds of behavioral problems due to their addiction and chronic psychiatric disorder (mostly schizophrenia). It is a new start of "moral treatment". The hospital is financed by care insurance and the municipal government of the two largest cities in the Netherlands (Amsterdam and Rotterdam). Patients are involuntarily admitted to Sustainable Residence for prolonged treatment, by decision of a court order. A multidisciplinary team prepares an individual treatment plan. The first months of stay consist mainly of stabilization, observation and additional diagnostics. Care is primarily aimed at reduction of mental and physical health problems. In this closed facility the patients are kept as much abstinent as possible, as only long term abstinence will change their addiction. Maintaining an optimal therapeutic climate is one of the highest priorities. In the next phase the focus shifts to motivation and education, using activities expanding basic social skills. Where possible, family and other social contacts are involved in the process. Much attention is paid to the cultural background of the patient. Practical skills can be learned or increased, preparing the patient for mean-

ingful daytime activities at the clinic. The final stage of stabilization and rehabilitation focuses on living and working in a protected environment. Emphasis is on relapse prevention, relapse management and maintenance of social networks and learned skills. The ultimate aim is recovery and regaining hope, confidence and new perspectives in life. Patients who have sufficiently improved can choose to return to their home town for follow up treatment or a form of assisted living, but long-term stay is possible as well. During this presentation you are offered an overview of the main characteristics of our clinic, completed by a film documentary. Furthermore, preliminary results from the ongoing treatment outcome study will be presented, including more detailed descriptions of the patient population.

References:

1) Drake RE, O'Neal EL, Wallach MA. A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders. (J Substance Abuse Treatment 2008; 34: 123-38).
2) Brunette MF, Mueser KT, Drake RE. A review of research on residential programs for people with severe mental illness and co-occurring substance use disorders. (Drug Alcohol Review 2004; 23: 471-81).

2. Psychiatric Street Outreach to Homeless Persons: Opening a Door to the Mental Healthcare Home

Richard C. Christensen, M.D., M.A., 280 19th Avenue South, Jacksonville, FL 32250

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Gain a greater understanding of the role assertive psychiatric street outreach can play in cultivating relationships and reconnection and recovery among unsheltered homeless persons; 2) Appreciate the importance of street outreach in creating a "portable door" for homeless individuals in accessing a "mental healthcare home" in Jacksonville, Florida, that provides integrated behavioral health, primary care and case management.

Summary: Individuals who suffer from serious and persistent mental illnesses constitute nearly 25-30% of the homeless population in this country. Perhaps the most vulnerable people in the homeless population are those who are unsheltered and disabled from the trimorbidity of mental illness, substance use disorders and life-threatening medical syndromes. Psychiatric street outreach to this particular segment of the homeless population is commonly justified based upon the need to engage the most severely impaired and most medically underserved individuals in our communities. However, bridging these individuals to desperately needed services requires clinical adaptations that are simultaneously innovative and evidence-based. Recent contributions to the medical literature have attempted to expand the traditional concept of a "medical home" traditionally utilized in primary care settings to the development of a "mental heathcare home" for those individuals unable to consistently access community-based behavioral health care. This presentation will describe the current academic-public sector model of a "mental healthcare home" being utilized in Jacksonville, Florida, that has been designed to increase access, coordinate case management services, provide integrated primary and psychiatric care as well as address issues of addiction for the population of homeless persons who are unsheltered. Central to this model of co-located, integrated, and recovery-oriented care, however, is the creative use of psychiatric street outreach that seeks to provide a "portable door" for homeless individuals to access entry into a stable mental healthcare "home." It is hoped that this model that incorporates assertive street outreach as a critical component of a comprehensive mental healthcare home can be replicated by other agencies throughout the country in serving unsheltered homeless persons.

References:

1) Christensen RC: Psychiatric street outreach to homeless persons: Fostering relationship, reconnection, and recovery. Journal of Health Care for the Poor and Underserved. 20: 1036-1040, 2009.
2) Smith TE, Sederer LI: A new kind of homelessness for individuals with serious mental illness? The need for a "Mental Health Home." Psychiatric Services 60:528-533, 2009.

3. Peer Navigator Services: A Program Developed to Reduce Healthcare Disparities for Individuals with Serious and Persistent Mental Illness

Peggy Johnson, M.D., 85 East Newton Street, Boston, MA 02118

Educational Objectives: At the conclusion of this session, the participant should be able to demonstrate knowledge of and appreciation for an innovative intervention for people with Serious and Persistent Mental Illness (SPMI) delivered by mental health consumers.

Summary: Though well documented, health disparities among people with SPMI have largely been unaddressed. Individuals with SPMI (schizophrenia, bipolar disorder, and depression) have a shorter life expectancy than the general population, with the majority of excess deaths due to cardiovascular disease (CVD), not suicide. National progress in reducing CVD mortality has not proportionately impacted those with SPMI, suggesting the disparity may be due to a lack of access to both primary and secondary prevention and treatment. In an effort to address these disparities and to promote health, the Division of Psychiatry at Boston Medical Center (BMC) implemented an innovative model of Peer Navigator Service (PNS), which combined a patient navigation case management approach with the use of peer delivered services. Patient navigator programs were initially developed to reduce important race and poverty-driven health disparities in areas such as breast cancer. Patient navigators are trained peer health educators who help identify barriers, arrange for needed supports, and provide "high touch" services like accompanying patients to appointments. Navigators also help patients understand and implement treatment plans to increase medication adherence, reduce missed

appointments, and initiate key lifestyle changes. Researchers have found that patient navigation can significantly improve adherence and coordination of care. The Peer Navigator model at BMC drew upon patient navigation models for cancer screening and treatment and expanded them to include the strengths brought by "peers." We enlisted mental health consumers to serve as peer navigators to help other mental health consumers access and follow through with medical care, and educate providers about unique health management issues in this population. Specifically, the PNS was designed to facilitate access to primary care services including assistance with establishing and maintaining a reliable relationship with a PCP, ensuring the receipt of appropriate medical screening tests, following through with health care recommendations, and promoting overall health. All program participants were matched with a peer navigator and provided with a care plan to address their barriers to care. Preliminary evaluation is underway to determine the impact of participation in PNS on client's likelihood of connecting to PCP, and receiving appropriate cardiovascular screening tests.

References:
1) Newcomer JW, Hennekens CH: Severe mental illness and risk of cardiovascular disease. JAMA 2007; 298:1794-1796.
2) Battaglia TA, Posner M, Roloff K, Freund KM: Improving Follow-up to Abnormal Breast Cancer Screening in an Urban Population: A Patient Navigation Intervention. Cancer 2007; 109(2 Suppl):359-367.

INNOVATIVE PROGRAMS: SESSION 3

Friday, October 28; 8:00 a.m.–9:30 a.m.

Integrating Issues in Mental and Medical Health

1. AIDS Babies Come of Age

Ann L. Hackman, M.D., 701 West Pratt Street, Baltimore, MD 21230, **Theodora G. Balis, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Identify some of the challenges unique to transitional aged youth and young adults with perinatally acquired HIV 2) Discuss appropriate psychiatric treatment options and strategies for these individuals.

Summary: Children born HIV positive in the first decade of the AIDS epidemic had life expectancies of only a few years and medical providers often had little more than palliative care to offer. With the advent of HAART, HIV life expectancies changed dramatically and the first wave of "AIDS babies" are now young adults. These individuals have dealt with and continue to experience a variety of challenges which have received scant attention in the psychiatric literature. These challenges include some issues addressed in HIV literature including the stigma surrounding the illness, dealing with sexuality and procreation, chronic illness and the need for ongoing medication. However these are other experiences relatively unique to young adults with perinatally acquired HIV. Many of these children lost a mother or were orphaned at an early age. Extended hospitalizations for life threatening AIDS related illnesses were a common childhood experience, leading to repeated disruptions in homelife and in education. Some children spent many of their early years in a hospital setting. Even the best caregivers for these children did not expect them to reach adolescence much less adulthood and may have given little thought to providing structure, limits and consistency. This innovative program will focus on our experience with transitional aged individuals with perinatally aquired HIV who are receiving treatment in a community mental health setting including extensive discussion of two individuals. We will draw from the existing literature in considering psychiatric treatment issues. We will, with our audience discuss recovery oriented strategies to assist such consumers in achieving their goals.

References:
1) Cournos F. (2002) The trauma of profound childhood loss: a personal and professional perspective.Psychiatr Q. 73(2):145-56.
2) Marhefka SL, Lyon M, Koenig LJ, Orban L, Stein R, Lewis J, Tepper VJ (2009)Emotional and behavioral problems and mental health service utilization of youth living with HIV acquired perinatally or later in life. AIDS Care; 21(11):1447-54.

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

Lewis Mehl-Madrona, M.D., Ph.D., 28 Vermont Street, Brattleboro, VT 05301

Educational Objectives: At the conclusion of this session, the participant should be able to 1) List three key elements of osteopathic manipulation for pain control; 2) Describe three ways in which narrative psychological methods can be used in conjunction with osteopathy; 3) List three possible neurobiological mechanisms to explain how central pain perception can change as a result of treatment.

Summary: How to best treat pain is puzzling. Within the biomedical approach, the typical therapy is medication. However, the most effective medications are the narcotics, which are addicting. Patients are often referred to pain clinics when their doses of narcotics are quite high. A number of non-pharmacological methodologies are effective, including cognitive behavior therapy, osteopathic manipulation, guided imagery, and hypnosis. This presentation is about the integration of osteopathic manipulation with guided imagery and narrative psychotherapy in a family medicine context. The presenter is both a family physician and a psychiatrist working in pain management. The family medicine context provides a desirable venue within which to treat pain in a manner that integrates touch therapy with talking therapy since family physicians are able to both touch patients and talk to them. This approach to pain is centered around osteopathic manipulation for patient and physician. Within that context it is appropriate to talk, and the talk centers on developing a story for the pain. Pain becomes a character with intent, attitude, purpose, meaning, obstacles, goals, and audience. Through this discursive approach, the per-

son becomes able to dialogue with pain in a manner in which the emotional factors involved in the origination and maintenance of pain syndromes can be expressed without the added difficulty of the perception of a psychiatric setting. This narrative approach can be supplemented with guided imagery and hypnosis to maximize the pain relieving effects of the intervention. The presentation reports on a series of 150 patients treated in this manner with significant reduction in narcotic use for all patients and elimination of narcotics for 59%. These patients had previously exhausted resources in a pain center. The presenter suggests that the combination of somatic/osteopathic treatment with a storied approach integrates emotion and cognition in an embodied manner and permits reshaping of synaptic connections for central pain perception. Patient visits lasted a minimum of one hour and occurred usually three times monthly at minimum for an average of 5 visits. The cost-effectiveness With Conventional Pain Clinic Visits Is Favorable.

References:

1) Osteopath Med Prim Care. 2007; 1: 7. Published online 2007 February 8. doi: 10.1186/1750-4732-1-7. PMCID: PMC1808471 Osteopathic research: elephants, enigmas, and evidence John C Licciardone 1.
2) Biobehavioral Approaches to Pain 2009, 381-408, DOI: 10.1007/978-0-387-78323-9_16 The Use of Complementary and Alternative Medicine for Pain Catherine M. Stoney, Dawn Wallerstedt, Jamie M. Stagl and Patrick Mansky.

3. Metabolic Syndrome in ACT Patients: A Prevalence and Treatment Study

David C. Lindy, M.D., 1250 Broadway, New York, NY 10001, **Neil Pessin, Ph.D., Caroline Williams, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to understand that severely mentally ill patients on assertive community treatment (ACT) teams are at very high risk for metabolic syndrome, that ACT teams are often the "medical home" for their patients and therefore appropriate for treatment of metabolic syndrome, and that ACT teams can provide effective treatment for metabolic syndrome in their patients.

Summary: Metabolic syndrome, a cluster of symptoms associated with elevated risk of heart attack, stroke, and type 2 diabetes, is known to occur at higher rates in people with severe mental illness (SMI)than in the general population (approximately 50% vs 34%, respectively). Probable factors affecting this phenomenon in the SMI population include high rates of poor nutrition, inactivity, cigarette smoking, and use of second generation antipsychotic medications. These risk factors are all potentially modifiable. It could be predicted that SMI patients on assertive community treatment (ACT) teams are at particularly high risk of metabolic syndrome because they are admitted to ACT due to severity of illness. However, to the best of our knowledge, there are no studies specifically examining rates of metabolic syndrome, or of its treatment, in ACT patients. The Visiting Nurse Service of New York's Community Mental Health Services operates 3 ACT teams in New York City, with a combined total of 200 patients. We have presented preliminary data which showed rates of metabolic syndrome of almost 70% in 61 patients, and 50% in 136 patients for 2 of 5 metabolic syndrome diagnostic criteria. Our hypothesis is that a full data set on all 200 VNSNY ACT patients will show at rate of metabolic syndrome of approximately 70% for 3 out of 5 criteria. We will present findings from examining prevalence of metabolic syndrome in all 200 ACT patients, as well as preliminary data from a controlled treatment study targetting modifiable risk factors. This innovative program will facilitate discussion among people dealing with metabolic syndrome in ACT and SMI patients.

INNOVATIVE PROGRAMS: SESSION 4

Friday, October 28; 10:00 a.m.–11:30 a.m.

Mental Health: Stages of Life and Development Issues

1. Diagnostic Advancements in the Diagnosis Mental Disorders in Individuals with Intellectual Disability

Larry J. Barnhill, Jr., M.D., UNC, School of Medicine, Chapel Hill, NC 27599

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Identify the major problems encountered during the differential diagnosis of mental disorders in children with IDD; 2) Analyze the impact of IDD on the clinical presentation and treatment of childhood onset disorders.

Summary: Children with severe Intellectual and Developmental Disorders represent an extremely diverse group. They differ in terms of etiology, temperament, level of functional impairment and sensitivity to environmental challenges. As a result, the recognition of mental disorders based on a developmental trajectory of interpersonal, psychosocial and academic performance is not an easy matter. In addition, these children are also at increased risk for physical and sexual abuse; loss of key caregivers and support systems; special vulnerabilities associated with specific behavioral phenotypes and higher rates of comorbid neurological conditions. In combination, these developmental issues adversely affect risk, course and prognosis of challenging behaviors and mental disorders. Differentiating psychiatric disorders from severe externalizing challenging behaviors requires many modifications to traditional mental health assessments. One set of modifications deals with problems encountered in differential: how to diagnose in the face of increased vulnerability to severe regression in the face of stress; misunderstanding or overcompliance with diagnostic interview techniques; difficulties with verbal expression and self reporting of symptoms and a tendency by some clinician to misattribute severe psychopathology instead of behavioral reactions to adverse environmental or medical conditions. The Diagnostic Manual-Intellectual Disabilities addresses these areas. It also deals with a second problem area: trying to fit children with IDD into existing diagnostic criteria. Even with the DM-ID, problems arise when categorical criteria are applied to such diverse and

clinically heterogeneous conditions. This presentation will address several common behavioral problems from a biobehavioral perspective. This approach relies upon a transactional model based on the interaction between multiple factors. This presentation will address these issues and familiarize mental health clinicians with the process of integrating multiple data sources. This model synthesizes data from functional behavioral analysis and modified psychiatric assessments with neurobiological and behavioral pharmacological data. This model will help the clinician fine tune differential diagnosis and treatment planning.

References:

1) Barnhill LJ, de Koning N, Poindexter A: Other Disorders of Infancy and Childhood. In, Fletcher R, Loschen E, Stavrakaki C, First M (Eds). Diagnostic Manual-Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability. Kingston NY: NADD Press, 2007.
2) Ursano AM, Kartheiser PH, Barnhill LJ: Disorders Usually First Diagnosed in Infancy, Childhood or Adoelescence. In Hales RE, Yudovsky SC, Gabbard GO (Eds). APA Textbook of Psychiatry. Washington DC: American Psychiatric Association Press, 2008.

2. Life Saving Maneuvers: Family Engagement in Geriatric Suicide Prevention

Ashghar-Ali Ali, M.D., 11828 Longwood Garden Way, Houston, TX 77047, **Ellen F. Barr, M.S.W., Sheila Lobo Prabhu, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Assess the elements in a patient's history that address risk for suicide and suicide prevention; 2) Understand different forms of individual and family therapy modalities used in improving a patient's relationships and reduce their risk of suicide; 3) Engage family members in the reduction of a patient's risk for suicide.

Summary: The completed suicide rate is highest in the elderly, who are the fastest growing segment of the U.S. population. The old-old segment (>85 years) is at greatest risk of committing suicide. Involving the family in suicide prevention has some deterrent effect to attempting suicide. Bengston and Treas describe the role of the family of a geriatric individual as providing support, affection, financial assistance, assistance with tasks; and influencing self-concept through social interactions, communications and evaluations of role performance. While many articles in the literature encourage involvement of the family in treating a suicidal patient, they do not identify specific approaches that are the most helpful in distinct circumstances. Recently, the Department of Veterans' Affairs (V.A.) implemented a comprehensive suicide risk reduction initiative in all V.A. Medical Centers nationwide, which has led to closer monitoring of the elderly population. Using a case-based approach, two V.A. psychiatrists and one social worker trained in geriatric psychiatry will present creative techniques to involve the family in geriatric suicide prevention. Special attention will be paid to personality disorders, and the role of personality in strained family relationships.

References:

1) Garand L., Mitchell, A., Dietrich L., Hijjawi, S., Di Pan. Suicide in older adults: nursing assessment of suicide risk. Issues Ment Health Nurs. 2006 May ; 27(4): 355–370.
2) Duberstein PR, Conwell Y, Caine ED. Age differences in the personality characteristics of suicide completers: Preliminary findings from a psychological autopsy study. Psychiatry 1994;57(3):213–224.

3. Identifying and Supporting Adults with Autism Spectrum Disorders in Community Mental Health Settings

Kelly Register-Brown, M.D., M.S.C., 701 West Pratt Street, Baltimore, MD 21230, **Theodora G. Balis, M.D., Ann L. Hackman, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Screen adults for autism spectrum disorders; 2) Identify adults in need of full autism diagnostic evaluations; 3) Educate adults newly diagnosed with autism spectrum disorders and their contacts about the diagnosis; 4) Counsel adults with autism spectrum disorders about strategies for addressing everyday difficulties.

Summary: A significant proportion of the recent increase in the prevalence of autism spectrum disorders (ASDs) among children and adolescents is likely due to changes in diagnostic practices and referral patterns. Although ASDs are generally thought to be lifelong conditions, a similar increase in prevalence of ASDs has not been demonstrated among adults. This suggests that ASDs may be underdiagnosed and inadequately addressed in some adult populations. This innovative program will focus on the methods, benefits, and pitfalls of diagnosing adults with ASDs. The presentation portion of this session will describe our experiences identifying and working with adults with ASDs from among a population of adults with chronic mental illness. We developed educational materials for our newly diagnosed consumers and their contacts by consulting with high-functioning adults with ASDs in the community about their common challenges and self-advocacy strategies. Our high-functioning consultants helped us compile a strengths-based, accessible, and relevant explanation of autism and a list of problem-solving methods for our newly diagnosed consumers. Techniques employed in this session will include 1) presentation of video clips of adults with ASDs; 2) presentation of the educational documents we developed; and 3) group discussion. Topics for discussion will include: the indications and methods for an adult ASD diagnostic evaluation, the potential implications of a new ASD diagnosis for personal relationships and career prospects, and accommodations in workplaces and day programs that can be of particular benefit to adults with ASDs.

References:

1) Brugha T, McManus S, Meltzer H, Smith J, Scott FJ, Purdon S, Harris J, Bankart J. Autism spectrum disorders in adults living in households throughout England: Report from the Adult Psychiatric Morbidity Survey 2007. United Kingdom National Health Service Centre for Health and Social Care, 2009. Available online at http://www.ic.nhs.uk/webfiles/publications/mental%20health/mental%20health%20surveys/APMS_Autism_report_standard_20_OCT_09.pdf.

2) Hintzen A, Delespaul P, van Os J, Myin-Germeys I. Social needs in daily life in adults with pervasive developmental disorders. Psychiatry Research. 2010;179(1):75-80.

INNOVATIVE PROGRAMS: SESSION 5

Saturday, October 29; 8:00 a.m.–9:30 a.m.

Changing the Thinking of Psychiatric Clinicians

1. Anti-Racism and Anti-Oppression: Their Possible Implications for Mental Health Practices

Simon Corneau, Ph.D., University of Quebec, Department of Sexology, CP 8888, Succ. Centre-Ville, Montreal, Quebec, Canada H3C 3P8, **Vicky Stergiopoulos, M.D., Aseefa Sarang**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Understand the theoretical frameworks of anti-racism and anti-oppression; 2) Identify and understand specific strategies for providing comprehensive, holistic care to ethno-racial groups based on the two frameworks; 3) Learn and know more about lessons learned from research underway and from an ethno-racial community mental health program in Toronto (Canada) operating within an anti-oppression/anti-racism framework.

Summary: It has been documented that racism permeates psychiatry and mental health service delivery. Ethno-racial groups are more likely to live in poverty and face health inequities and adverse mental health outcomes. Racism can also create barriers to mental health services access among ethno-racial groups. These barriers are perpetuated by a dominant paradigm in the mental health field that tends to put the emphasis on biological causes of illness over social and cultural factors and tends to individualize social and structural problems. In response to these challenges, some organizations have tried to built programs and services that offer comprehensive and holistic ways to reach healing and betterment for people from ethno-racial groups, using frameworks such as anti-oppression and anti-racism as philosophies of practice. The main theoretical components of these frameworks will be presented, and the specific strategies they use to outline a comprehensive and holistic model of care will be reviewed. This presentation will be an opportunity to stimulate a dialogue on the implications of using those philosophies of practice within the existing mental health service delivery system. The specific example of an ethno-racial community mental health program operating within this framework will be discussed. Lessons learned and opportunities to adopt elements of the model more broadly to address the needs of our population will be detailed.

References:

1) Fernando S: Cultural Diversity, mental health and psychiatry. The struggle against racism. Hove & New York: Brunner-Routledge, 2003.

2) Takeuchi DT, Uehara E, Maramba G: Cultural diversity and mental health treatment, in A Handbook for the Study of Mental Health. Social Contexts, Theories, and Systems. Edited by Horwitz AV, Scheid TL. Cambridge: Cambridge University Press, 1999, pp 550-565.

2. The Recovery Culture Progress Report: A New Assessment Tool

Mark Ragins, M.D., 456 Elm Avenue, Long Beach, CA 90802

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Describe a set of seven domain values in a recovery based program culture; 2) Understand a recovery culture progress report that is built on concrete indicators of each domain value; 3) Understand how the recovery culture progress report can be used for internal self assessment and planning or for external audit and accountability for recovery based program transformation.

Summary: There are major initiatives promoting recovery based transformation all over the country, but because of the subjective and individualized nature of recovery services, it's very difficult to create concrete program transformation goals and measure progress. Recovery's fundamental components in the consensus definition from SMASHA are a collection of values more than concrete practices. The recovery movement tends to emphasize how services are delivered more than what services are delivered. The values and the culture of a program are paramount. Creating a tool that could track progress in a program's changing values and culture is inherently a difficult task. The Recovery Culture Progress Report is an emerging tool created by Mark Ragins MD and Mental Health America – Los Angeles that attempts to do that. The Recovery Culture Progress Report describes seven domain values of a recovery culture: 1) Welcoming and accessibility, 2) growth orientation, 3) consumer inclusion, 4) emotionally healing environments and relationships, 5) quality of life focus, 6) community integration, and 7) staff morale and recovery. In an analogous way to how the Americans with Disabilities Act describes a number of concrete indicators that can demonstrate the value of "handicapped accessibility", the Recovery Culture progress report identifies indicators for each of the seven domain values. The indicators were collected in a series of workshops throughout the country primarily focused on adult, community based, rehabilitation and recovery oriented programs. Every indicator in the progress report is being practiced somewhere. Since none of these domains values are all-or-nothing, we have grouped all of our indicators into a series of progressions (ten for each domain) scored as Exploring, Emerging, Maturing, and Excelling. The progress report produces an overall descriptive score for each

of the seven domains. In this way, a program can be rated on each of the seven domains, have a concrete picture of what next steps might be, and be able to make plans for further progress, and in the future be assessed again for accomplished progress. The progress report is being field tested. We expect it can be used either as an internal self- assessment and planning tool or as an external audit tool.

References:

1) Marianne Farkas, Sc.D,Cheryl Gagne, M.S.,William Anthony, Ph.D., and Judi Chamberlin. Implementing Recovery Oriented Evidence Based Programs: Identifying the Critical Dimensions, Community Mental Health Journal, Vol. 41, No. 2, April 2005.
2) Recovery Oriented Systems Indicators Measure (ROSI) in Measuring the Promise: A Compendium of Recovery Measures, Volume II/Theodora Campbell-Orde, Judi Chamberlin, Jenneth Carpenter, H. Stephen Leff. Cambridge, MA: Human Services Research Institute.

3. Seeing in the Dark: Using Art and Other Mature Defenses in Work with Suicidal Clients

John Martin-Joy, M.D., 365 East Street, Tewksbury, MA 01876

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Identify mature defenses in clients with borderline personality disorder and refractory suicidality; 2) Apply clinical approaches based on empirical evidence for the role of mature defenses in facilitating development over the life span; 3) Identify techniques for maintaining his/her own hope and self-care while working with severely ill clients.

Summary: Working with suicidal patients can be one of the most challenging experiences of a psychiatrist's career. Especially when borderline personality disorder is involved, and when the usual treatments have failed, clinicians may feel left alone to grapple with seemingly unbearable stress and hopelessness. This presentation will emphasize an often-neglected area of hope in clinical work with severely ill clients: identifying and working with areas of strength. Specifically, we will focus on work with mature defenses (a.k.a. ego mechanisms of defense, or coping style under stress). Recent research on resilience and on coping across the life span has emphasized the value of working with psychological strengths. As one example, most teenagers who require psychiatric hospitalization have a poor prognosis. However, those troubled adolescents whose interview narratives contain key themes—including an emphasis on relationships, reflection, or agency—are more likely to show good outcomes 10-15 years later (Hauser et al 2006). Similarly, men who coped with stress using mature defenses at midlife are more likely to show successful aging at age 75 (Martin-Joy and Vaillant 2010). The use of such hidden strengths to guide clinical work is what Stuart Hauser calls "seeing in the dark." To apply this perspective in the presence of severe illness, clinicians need a systematic way to identify strengths. In the first part of this session, the presenter will present a hierarchy of defenses that has been empirically validated through longitudinal research over the life span. Defenses that correlate with mental health include sublimation (creative activity), altruism (helping and being curious about others), anticipation, humor, and suppression (stoicism). These mature defenses will be illustrated with vignettes from the Study of Adult Development, an ongoing 70+ year longitudinal study of mental health (material from Martin-Joy and Vaillant 2010). The goal will be to help clinicians recognize examples of mature defenses in socioeconomically diverse populations. The second part of the session will focus on how clinicians can use mature defenses to facilitate clients' recovery from severe mental illness. Case examples will be drawn from long-term work with hospitalized clients who suffer not only from Borderline Personality Disorder, but treatment-refractory suicidal depression. Typically these clients were trapped in cycles of repeated self-harm and despair despite inpatient hospitalization, constant observation, aggressive psychopharmacology, and individual psychotherapy. The focus will be on examples of how art (sublimation) and relationships with others (altruism) proved to be transformative agents in recovery from episodes of severe mental illness. Examples of art work by clients will be presented with permission. The presenter will conclude with reflections on how clinicians can maintain their own hope and self-care while doing this difficult work.

References:

1) Hauser S et al. (2006). Out of the Woods: Tales of Resilient Teens. Harvard University Press.
2) Martin-Joy J and Vaillant GE (2010). Recognizing and Promoting Resilience. In Depp CA and Jeste DV, eds., Handbook of Successful Cognitive and Emotional Aging. American Psychiatric Publishing.

LECTURES

LECTURE 01

Thursday, October 27; 8:00 a.m.–9:30 a.m.

Challenging Behavior in Intellectual Disability: Is There a Place for Evidence Based Care?

Diana Antonacci, M.D., 905 Johns Hopkins, Greenville, NC 27834

Educational Objectives: At the conclusion of this session, the participant will be able to: 1) Recognize the definition and key components of evidence based health care and practices; 2) Identify how evidence based practice applies to individuals with ID and explain the potential challenges involved in providing such care; 3) Assess the evidence base for treatment of challenging behavior in individuals with ID; 4) Evaluate prior knowledge and attitudes regarding use of antipsychotic medications for challenging behaviors; and 5) Formulate a plan to integrate this new knowledge into the practice environment.

Summary: There is ever increasing pressure on mental health service providers to demonstrate evidence based practices. The Cochrane Collaboration defines evidence based health care as "the conscientious use of current best evidence in making decisions about the care of individual patients or the delivery of health services. Current best evidence is up-to-date information from relevant, valid research about the effects of different forms of health care, the potential for harm from exposure to particular agents, the accuracy of diagnostic tests, and the predictive power of prognostic factors" They further define evidence based clinical practice "is an approach to decision-making in which the clinician uses the best evidence available, in consultation with the patient, to decide upon the option which suits that patient best." There are significant challenges in providing evidence based mental health care to individuals with intellectual disability (ID). Current best evidence in the field of ID is difficult to find. There are concerns relative to the quality of evidence; including methodological problems, ethical considerations and service delivery issues. Consultation with the patient can be impacted by the ID itself and the need for inclusion of other decision makers can add complexity to clinical decision making. While mental health professionals may embrace evidence based philosophies, evidence based treatment in the field of ID is often lacking. Nowhere is this more evident than in the pharmacotherapy of aggressive, disruptive and challenging behavior. Despite uncertain evidence of effectiveness, the use of drug therapy, especially antipsychotic drug therapy, to treat aggression is quite common. This paper will examine specific challenges to the use of evidence based medicine (EBM) in the field of ID, including lack of training and competence in EBM, lack of access to data sources, lack of critical appraisal skills, differences in ideology, implications to organizations and issues around education. The potential usefulness of evidence based practices to professionals, caregivers, families and consumers will be explored. A review of the current literature on pharmacotherapy of disruptive behavior in individuals with ID will be presented, with an examination of implications for evidence based practice. Appropriate and effective assessment and treatment interventions will be discussed. In the last 20 years, the field of ID has seen large shifts of individuals out of institutional settings and into the community. As a result, medical (including mental health) care is no longer integrated or provided by specialist providers employed by or contracting with large institutions or agencies. Individuals with ID are required to access community based health services, just as the non-ID population. Thus, individuals with ID are subject to decisions regarding care management, provision and allocation of services and use of generalist vs. specialist providers. In this era of evidence based medicine, these decisions are increasingly being based on research evidence and outcome data. For individuals with ID, extrapolation from research with the general population of individuals with mental illness may not suffice. Evidence based strategies can lead to constructive change in service delivery and treatment for individuals with ID and should be of great relevance to psychiatrists practicing in the field.

References:

1) Habler F, Reis O. 2010. Pharmacotherapy of disruptive behavior in mentally retarded subjects: a review of the current literature. Developmental Disabilities Research Reviews 16:265-272.
2) Tsiouris JA. 2010. Pharmacotherapy for aggressive behaviours in persons with intellectual disabilities: treatment or mistreatment? J of Intellectual Disability Research. 54(1):1-16.
3) Oliver-Africano P, Dickens, S, Ahmed Z, et al. 2010. Overcoming the barriers experienced in conducting a medication trial in adults with aggressive and challenging behaviour and intellectual disabilities. 54(1): 17-25.

LECTURE 02

Thursday, October 27; 10:00 a.m.–11:30 a.m.

Role of County Psychiatric Leaders

Roger Peele, M.D., P.O. Box 1040, Rockville, MD 20849

Educational Objectives: At the conclusion of this session, the participant should be able to better understand the role of county leadership in the development of comprehensive, accessible and affordable psychiatric services.

Summary: A wide-range of issues will be discussed concerning the challenges, successes and future plans for psychiatric services available at the county level.

References:

1) The National Association of Counties. http://www.naco.org/Pages/default.aspx
2) Los Angeles County Department of Mental Health. http://dmh.lacounty.gov/wps/portal/dmh

LECTURE 03

Thursday, October 27; 1:30 p.m.–3:00 p.m.

Social Contexts of Hospital Closure: Living With Major Psychiatric Disorders in the Community

Sue E. Estroff, Ph.D., University of North Carolina, Chapel Hill, NC 27599

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) To review recent research on social factors and contexts that influence the epidemiology and outcomes in schizophrenia and other serious psychiatric disorders; 2) To consider the promise and perils of primary prevention, early intervention, and coercion in psychiatric services; 3) To review how services as social context influence the illness-identity process.

Summary: In this lecture, we review recent conceptual and empirical progress in taking account of sociocultural influences on the life course, treatments, and service system approaches to people with serious psychiatric disorders. Mental health service systems are one component of social context, along with the political economy of health, and the interpersonal circumstances in which illness and identity are formulated. Within this framework, a critical appraisal of early intervention, coercion, and service delivery on the front lines raises vexing questions for the present and future.

References:

1) Estroff, Sue E. How Alright Can He Be? Psychiatry 74 (2):184-87., 2011.
2) Estroff, Sue E. Subject/Subjectivities in Dispute: The Politics and Poetics of First Person Narratives of Schizophrenia. In, The Edge of Experience: Schizophrenia, Culture, and Subjectivity. Eds., R. Barrett and J. Jenkins, eds. Cambridge: Cambridge Univ. Press. Pp. 282-302, 2004.
3) Judge, Abigail, Estroff, Sue, Diana Perkins, and Penn, David Recognizing and Responding To Early Psychosis: A Qualitative Analysis Of Individual Narratives. Psychiatric Services. Vol 59 (1):96-99., 2008.

LECTURE 04

Thursday, October 27; 1:30 p.m.–3:00 p.m.

Harm Reduction: A Path to Recovery

Liz Evans, R.N., 20 West Hastings Street, Vancouver, BC, Canada V6B 1G6

Educational Objectives: At the conclusion of this session, the participant should be able to understand the context of low barrier approaches to complex mental health and addictions, within a community setting, including a range of harm reduction approaches and address social disparities, in addition to acting as a gateway for connecting people into treatment and services.

Summary: This presentation will be cover the journey this community organization has travelled over the last 20 years to create a continuum of housing and supports in an attempt to address the complex social and health needs of people living in poverty with complex mental health and addictions. This presentation has been entitled, Harm Reduction; A Path to Recovery, as she intends to outline the strategies and outcomes involved in community based initiatives targeting low barrier approaches to integrating an at risk, and highly marginalized population into housing, supports and health care resources. There have been enormous systemic barriers in attempting to create an alternate system of low threshold services and supports, while attempting to ameliorate suffering for a group of people who have not had access to traditional mainstream psychiatric or addictions services. The PHS Community Services Society has operated in partnership with the Vancouver Health Authority North America's Only Supervised Injection site, which came out of a community with an extremely high rate of HIV infection and drug overdoses. Liz will present on how this intervention fits into the other housing and supports operated by the organization, highlighting the positive outcomes that have been achieved, while outlining the on–going challenges.

References:

1) Select chapters from Raise Shit!, In the Realm of Hungry Ghosts, Globalization of Addiction.
2) Alexander, Bruce (2006) Beyond Vancouver's "Four Pillars." International Journal of Drug Policy. 17(2):118-123.

LECTURE 05

Thursday, October 27; 3:30 p.m.–5:00 p.m.

Public Health Efforts: Successful and Failed

Carl Bell, M.D., 8704 South Constance, Chicago, IL 60617

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand the basic principles of how to practice community psychiatry to make a difference and save lives; 2) Understand various strategies to extend one's influence to shape policy and actual practice; 3) Understand how to become change agents.

Summary: Using himself an example, Dr. Bell will review how one evaluates oneself as a change agent for the Nation. Because an elderly African-American woman once told him "I would rather see a sermon than hear one," Dr. Bell will illustrate his work and the successes and failures of his efforts. Accordingly, he will focus on his work in: 1) helping American Psychiatry to bring a focus of cultural competence into the field; 2) working with three C.E.Os of Chicago Public Schools to reduce violence in that system; 2) bringing attention to childhood adverse experiences; 3) providing leadership to the National Commission on Correctional Health Care; 4) infusing public health technology into the Chicago Department of Public Health; 5) guiding the Illinois Department of Children and Family Services; 6) infusing psychological first aid into various systems (Maine, New Orleans, Child Protective Services, etc); 7) studying and implementing suicide prevention in various

venues; 8) preventing HIV in national and international settings; 9) and infusing prevention and health promotion interventions into the fabric of American health care.

References:
1) U.S. Department of Health and Human Services. Youth Violence: A Report of the Surgeon General. Rockville, MD, U.S. Department of Health and Human Services, 2001. http://www.surgeongeneral.gov.
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, US Public Health Service, 2001 http://www.surgeongeneral.gov.
3) Goldsmith SK, Pellmar TC, Kleinman AM, Bunney WE (Eds), Committee on Psychopathology and Prevention of Adolescent and Adult Suicide (Bunney WE, Kleinman AM, Bell CC, Brent DA, Eggert L, Fawcett J, Gibbons RD, Jamison KR, Korbin JE, Mann JJ, May PA, Reynolds CF, Tsuang MT, and Frank RG). Board on Neuroscience and Behavioral Health, National Institute of Medicine. Reducing Suicide: A National Imperative. National Academy Press: Washington, D.C., 2002.

LECTURE 06

Thursday, October 27; 3:30 p.m.–5:00 p.m.

Vaccines for Addiction

Thomas R. Kosten, M.D., 2002 Holcombe Boulevard, Houston, TX 77030

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) To teach psychiatrists and mental health professionals the mechanism of action for immunotherapies treating nicotine, cocaine, methamphetamine, and opiate dependence; 2) To have mental health professionals learn about the clinical efficacy of human nicotine and cocaine vaccines; 3) To teach psychiatrists and mental health professionals about recent improvements in these vaccines.

Summary: Anti-drug antibodies reduce drug levels in the brain by binding drug before it enters the brain. Because antibodies are much larger than drugs, neither the antibody nor bound drug can get into the brain. Thus, any drug that is bound to antibody cannot cross the blood brain barrier and cannot enter the brain. Active anti-drug vaccines stimulate the body to makes its own antibodies by chemically linking these abused drugs to toxins such as cholera toxin. Alternatively, passive immunotherapy uses monoclonal antibodies that are generated in a laboratory and then administered via intravenous injection. Rapid advances are being made with immunotherapies for nicotine, cocaine, methamphetamine, opiates, phencyclidine and the potential for other drugs of abuse. Both the nicotine and cocaine vaccines have been tested in humans with excellent success. Antibodies can treat drug overdose; reduce drug use relapse; or protect certain at risk populations who have not yet become drug dependent. Immunotherapies have technological limitations that our laboratories are addressing in rodent studies. Technological challenges for vaccines include inadequate antibody responses in 25-30% of individuals and retention in drug abuse treatment during vaccination, which can take 2-3 months for adequate antibody levels to develop. Predicting who will develop adequate antibody responses will be improved as we understand its genetic determinants, and enhancing immune responses should be possible by giving various cytokines and better adjuvants than alum during immunization. Immunotherapies also raise clinical efficacy issues in drug abusers, because large amounts of drug could override the beneficial effects of immunotherapy. Effectiveness of the blockade will also decrease over time, but not at a predictable rate in a particular individual. Blockades that are completely effective either immediately from a monoclonal or progressively from a vaccine will both become progressively ineffective. As the level of blocking wanes, there is no obvious signal to the patient that the blocking effects have diminished after weeks or months of sustained blockade. Toward the end of the "effective" duration of blockade the patient may ingest a relatively large amount of drug that previously had produced minimal effects, but now results in an overdose. Thus, this treatment has promise and limits. Specific projects are related to new vaccine development and include pharmaco-immunology (better vaccine carriers and adjuvants) and behavioral pharmacology in rodents (testing for efficacy and reducing abused drug effects).

References:
1) Martell BA, Orson FM, Poling J, Mitchell E, Rossen RD, Gardner T, Kosten TR. Cocaine Vaccine for the Treatment of Cocaine Dependence: A Randomized Double-Blinded Placebo-Controlled Efficacy Trial. Archives of General Psychiatry. 2009 Oct;66(10):1116-23. PMID: 19805702.
2) Orson FM, Kinsey BM, Singh RA, Wu Y, Kosten TR. Vaccines for cocaine abuse. Hum Vaccin. 2009 Apr;5(4):194-9.

LECTURE 07

Friday, October 28; 8:00 a.m.–9:30 a.m.

Anatomy of an Epidemic: History, Science and the Long-Term Effects of Psychiatric Medications

Robert Whitaker, 763 Massachusetts Avenue, Boston, MA 02139

Educational Objectives: At the conclusion of this session, the participant will be able to: 1) Understand how psychiatric medications act on the brain, and how the brain responds to such drugs; 2) Understand how a review of the history of the outcomes literature can help us understand how medications affect the long-term course of psychiatric disorders; 3) Review the long-term outcomes literature for schizophrenia as an example of this process; 4) Understand how a look at the outcomes in Western Lapland for psychotic disorders as an example of how incorporating the long-term outcomes literature into medication protocols can dramatically improve outcomes; 5) Understand how long-term outcomes in depression and bipolar illness have changed in the past 40 years.

Summary: During the past 20 years, the number of adults in the United States on federal disability rolls due to mental illness has more than tripled, rising from 1.25 million people in 1987 to more than four million in 2007. The number of children receiving a federal disability check due to severe mental illness increased 35-fold during this period, rising from 16,200 to 561,569. This disability data necessarily begs a question. Could our drug-based paradigm of care, in some unforeseen way, be fueling this epidemic of disabling illness? Do psychiatric medications improve or worsen long-term outcomes? Does their use decrease or increase the risk of long-term disability? What does the scientific literature show?

References:

1) M. Harrow. "Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications." Journal of Nervous and Mental Disease 195 (2007):406-14.
2) W. Coryell. "Characteristics and significance of untreated major depressive disorder." American Journal of Psychiatry 152 (1995):1124-29.

LECTURE 08

Friday, October 28; 10:00 a.m.–11:30 a.m.

Financing Primary Care Collaboration: What Are the Options?

Roger G. Kathol, M.D., 3004 Foxpoint Road, Burnsville, MN 55337

Educational Objectives: At the conclusion of this session, the participant will be able to: 1) Understand the mechanics of segregated payment for mental conditions and how they prevent psychiatric service access for primary care patients; 2) Understand clinical and cost outcomes associated with ineffectively treated mental conditions in the physical health setting; 3) Systematically implement strategies that correct reimbursement barriers to psychiatric practice in primary and specialty medical settings.

Summary: The single greatest challenge to providing psychiatric care in the medical setting, where the majority of mental health and substance use disorder ("mental condition") patients exclusively receive treatment, is creating a reimbursement environment in which specialty mental condition service delivery is sustainable. The core of this presentation will describe the mechanics of segregated payment for physical and mental condition services, how they erode support for mental condition care and prevent the addition of psychiatric specialty services for primary care patients, and the changes necessary to allow psychiatric care to become an integral part of total health delivery. Concluding comments will describe the impact of segregated reimbursement practices on health and cost outcomes for comorbid physical and mental condition patients and will suggest strategies for psychiatrists to create alignment between mental condition care in the primary care setting and payment practices.? Does their use decrease or increase the risk of long-term disability? What does the scientific literature show?

References:

1) Melek S, Norris D. Chronic conditinos and comorbid psychological disorders. Seattle: Milliman, 2008 July.
2) Kathol R, Melek S, Bair B, Sargent S. Financing Mental Health and Substance Use Disorder Care within Physical Health: A Look to the Future. Psychiatr Clin North Am. 2008;31(1):11-25.

LECTURE 09

Friday, October 28; 10:00 a.m.–11:30 a.m.

Suicide Behind Bars: The Forgotten Epidemic

Terry A. Kupers, M.D., 8 Wildwood Avenue, Piedmont, CA 94610

Educational Objectives: At the conclusion of this session, the participant will be able to: 1) Understand the extent of suicide behind bars, including prevalence; 2) Understand some of the causes of despair and suicide in prisoners; 3) Understand structural problems in corrections that exacerbate the problem of suicide; 4) Understand the elements of effective crisis intervention in jails and prisons.

Summary: Suicide behind bars occurs much more frequently than in the community. There are personal and situational factors that lead to despair among prisoners. The problem is magnified in solitary confinement, where a disproportionate number of successful suicides occur. The epidemic of suicides behind bars made the headlines in the early 1980s. Screening and treatment standards were instituted and the prevalence has declined in recent decades, but with jail and prison crowding, cutbacks in correctional mental health budgets, ever longer sentences and harsher prison conditions, the tragic deaths continue. Since consumers of mental health services spend considerable amounts of time behind bars, it is important for psychiatrists to have an understanding of the roots of prisoners' despair and some sophistication about clinical work with individuals who have been incarcerated.

References:

1) Lindsey Hayes. (2010). National Study of Jail Suicide: 20 Years Later, National Center on Institutions and Alternatives, available at http://nicic.gov/Library/024308.pdf http://nicic.gov/Downloads/PDF/Library/024308.pdf.
2) Webb RT et al. (2010). National study of suicide in all people with a criminal justice history. Archives of General Psychiatry.
3) Webb RT, Qin P, Stevens H, Mortensen PB, Appleby L, Shaw J. (2010). National Study of Suicide in All People With a Criminal Justice History, Archives of General Psychiatry, 67(1): 69-77.

LECTURE 10

Friday, October 28; 1:30 p.m.–3:00 p.m.

A Progress Report on Mental Health and Reform

Richard Frank, Ph.D., 180 Longwood Avenue, Boston, MA 02115

Educational Objectives: At the conclusion of this session, the participant will be able to 1) Understand the development of U.S. health reform and the likely influence of those developments on behavioral health care; 2) Understand the forces affecting policy makers in making decisions about the design of health reform provisions that affect behavioral health.

Summary: The lecture will review program on implementation of the Affordable Care Act and the implications of that progress on behavioral health care. The lecture will also focus attention on critical upcoming implementation issues likely to affect behavioral health services. I will identify the key choices being faced by policy makers. These issues will be connected to other developments in behavioral health like the continued evaluation of parity regulations and federal and state budget pressures.

References:

1) Barry CL and HA Huskamp (2011), "Moving Beyond Parity—Mental Health and Addiction Care under the ACA" NEJM 365:11 September 15, 2011
2) Buck JA (2011), " The Looming Expansion and Transformation of Public Substance Abuse Treatment Under the Affordable Care Act" Health Affairs 30(8): 1402-1410

LECTURE 11

Friday, October 28; 1:30 p.m.–3:00 p.m.

Of Two Minds: Behavioral and Physical Health Integration

Andrea R. Fox, M.D., 200 J H F Drive, Pittsburgh, PA 15217

Educational Objectives: At the conclusion of this session, the participant will be able to: 1) Name three structural components of the health care system that make integration difficult; 2) Describe two models of integration; 3) Describe pros and cons of co-location of treatment teams.

Summary: Integration of physical and behavioral health is the focus of much activity, particularly within the mental health arena. While models exist and are growing, the chasm between the provision of care for the mind and the body remains great. This session will present some of the reasons for this separation from the point of view of a "psychiatric-friendly" internist. Emphasis will be placed on differences in practice, use of language, funding mechanisms and resistance to change. Potential solutions and successful models will be presented including experiences with newly-funded SAMHSA integration projects.

References:

1) Collins C, Hewson DL, Munger R, and Wade T. "Evolving Models of Behavioral Health Integration in Primary Care." Milbank Memorial Fund, 2010.
2) Druse BG, Maurer BJ. "Health Care Reform and Care at the Behavioral Health/Primary Care Interface." Psychiatric Services 2010 61 (11) 1087-1092.

LECTURE 12

Friday, October 28; 3:30 p.m.–5:00 p.m.

Impact of the Mental Health Services Act (Proposition 63) on California's Public Mental Health System

Sandra Naylor Goodwin, Ph.D., 2125 19th Street, Sacramento, CA 95818

Educational Objectives: At the conclusion of this session, the participant will be able to understand the decision points, political and programmatic, in developing Proposition 63 (California Mental Health Services Act), a voter initiative, which funds mental health services, understand the process for implementing the Mental Health Services Act and transformation through stakeholder planning, understand the impact of the Mental Health Services Act on programs and practices and understand the data collection process, analysis, and clinical outcomes of Mental Health Services Act services.

Summary: This lecture will describe the history and process of enactment of Proposition 63 which resulted in passage of California's Mental Health Services Act and its impact to date on California's county driven public mental health system. Passed by the general electorate in 2004, MHSA placed a 1% surcharge paid by individuals with a taxable income of $1 million to raise new monies that would be dedicated to expansion and transformation of the system. The goals of the MHSA will be presented, as well as evidence indicating progress in expanding access, improving services and systems change including implications for workforce development. Overall, MHSA has had a very significant impact: some of the change has been positive, some not so positive and some has created significant controversy. The political and economic climate in California is extremely dynamic, and ongoing changes to the Act as well as policy implications will also be discussed. There is much to be learned from this experience for other organizations considering similar activities.

References:

1) Millionaires and Mental Health: Proposition 63 in California. R.M.Scheffler, N.Adams, Health Affairs, 2005.
2) State Mental Health Policy: Proposition 63 Should Other States Follow California's Lead? K.Z. Bambauer, Psychiatric Services, 2005, American Psychiatric Association.
3) Transformation of the California Mental Health System: Stakeholder-driven Planning as a Transformational Activity. C. Cashin, R.M. Scheffler, M. Felton, Psychiatric Services, 2008, American Psychiatric Association.

4) The Millionaire's Tax and Mental Health Policy in California. S. Feldman, Health Affairs, 2009, Health Affairs.

LECTURE 13

Friday, October 28; 3:30 p.m.–5:00 p.m.

Women in Psychiatry: The Road Ahead

Carolyn B. Robinowitz, M.D., 5225 Connecticut Avenue, Washington, DC 20015

Educational Objectives: At the conclusion of this session, the participant will be able to better understand the specific challenges facing women in medicine, with particular emphasis on careers in psychiatry; attendees will consider actions and approaches to professional development and career satisfaction for women psychiatrists.

Summary: It has been more than three decades since the numbers of women in the professions began to expand. The growth of women applicants and graduates of medical school mirrored the increased numbers of women in other fields such as law and business, and currently, about 50% of all medical students are female. This rapid growth of women in medicine prompted numerous studies of the impact of women in the profession—their specialty and career choices and compensation, their growth as leaders, their impact on their male colleagues and on patient care, as well as how they managed both professional and personal lives. Not surprisingly, we learned that women had different preferences in the teaching-learning experience, were apt to be less authoritarian and more generative as leaders, and retained the primary responsibility for family and child rearing even while engaging in medical practice—a practice for which they received lower compensation than their male colleagues. We also learned that the brick wall keeping most women from entry to medical school was replaced with a glass ceiling, with women being disproportionately represented in the lower ranks of academia, and less likely to be named to positions of power. Young women—residents and early career psychiatrists—have not experienced these continuing disparities between men and women and have little awareness for what has been termed the "mental models of gender." At the same time, many leaders and administrators have commented "isn't it fixed yet?" while addressing issues other than the persisting gender disparities. This presentation will assess the current status of women in psychiatry, while envisioning a road map with personal and professional options for a successful and satisfying future.

References:

1) Andrews, NC: Climbing Through Medicine's Glass Ceiling, NEJM 2007 357;1887-1889
2) Bickel, J: Women in Academic Psychiatry, Academic Psychiatry 2004 28; 285-291
3) Chin, LE Ed: "This Side of Doctoring: Reflections from Women in Medicine" Sage Publications, 2002 424 pages
4) Hirshbein, LD: History of Women in Psychiatry, Academic Psychiatry 2004 28; 337-343

LECTURE 14

Friday, October 28; 3:30 p.m.–5:00 p.m.

Neuroscience-Informed Computerized Cognitive Training Exercises for Cognitive Deficits of Schizophrenia

Sophia Vinogradov, M.D., University of California, San Francisco, CA 94143

LECTURE 15

Saturday, October 29; 8:00 a.m.–9:30 a.m.

Doing It in Public: Public Policy & the Future of Psychiatry

Kenneth S. Thompson, M.D., 6108 Kentucky Avenue, Pittsburgh, PA 15206

Educational Objectives: At the conclusion of this session, the participant will be able to: 1) Understand the critical role of public policy in the profession of psychiatry; 2) Describe the current set of public policies impacting on psychiatry; 3) Utilize anticipated future trends in public policy to inform their practices and careers.

Summary: Publicly funded mental health care services, the original incubator of the profession of psychiatry and still the primary source for its ongoing support, is entirely the product of public policy. Any consideration of the future of the psychiatry as a science, as a practice and as a profession is very much dependent on the processes that determine the shape and substance of public policy. In the past, psychiatry played a fundamental role in the elaboration of public policy. However, save for a focus on payment, scope of practice issues, and support for research, in recent times psychiatrists have known little and generally done less about the creation of public policy. In particular they have had a very limited engagement in its formulation and implementation. By the same token, government in recent times has done little to engage psychiatrists and psychiatry in initiatives to address the health and mental health of the nation and reshape behavioral health services. In exploring ways psychiatry and psychiatrists might be more engaged and government more receptive, this presentation will review critical aspects of current public policy, such as the implementation of the recommendations of the New Freedom Commission, the Parity Law, Health Care reform, and the role of the states and the federal government. With attention to the emergent circumstances we live in, an agenda will be advanced to ensure that psychiatry is actively engaged in creating and implementing healthy public policies.

References:

1) Frank R. and Glied S., Better But Not Well: Mental Health Policy in the US since 1950. Johns Hopkins University Press 2006.

2) Rowe M., Lawless M., Davidson L. and Thompson K., Classics of Community Psychiatry: Fifty Years of Public Mental Health Outside the Hospital. Oxford University Press, 2011.

LECTURE 16

Saturday, October 29; 10:00 a.m.–11:30 a.m.

Leadership with Altitude: Implementing a Culturally Comprehensive Vision for Professionals, Peers and Policy Makers in Mental Health and Physical Health Care

Margaret J. Park, M.Div., 1 Smithfield Street, Pittsburgh, PA 15222

Educational Objectives: At the conclusion of this session, the participant will be able to: 1) Examine view points and recovery approaches from the integrative systems change approach of Ken Wilber; 2) Analyze and synthesize unified characteristics of leadership for all stakeholder segments as it pertains to mental health care reform; 3) Discuss potential collaborations among psychiatrist, peer mentors and advocates, family members and policy makers; 4) Formulate priorities to implement chosen stakeholder involvement for personal and stakeholder leadership development to advance a recovery and wellness paradigm.

Summary: This lecture and workshop will explore ten characteristics that leaders of change share. A broad based, high level perspective will be explored to define a culturally informed frame work. Using the knowledge gained participants will be encouraged to discuss strategies to advance a recovery and wellness paradigm through collaborating to resolve entrenched barriers to transformation.

References:

1) Reinerstsen, J.L. (1998) Physicians as Leaders in the Improvement of Health Care Systems. American College of Physicians, 128(10), 833-838.
2) Wilber, Ken. (2001). A Theory of Everything: An Integral Vision for Business, Politics, Science, & Spirituality, Berkeley, CA, Shambhala Press.

LECTURE 17

Saturday, October 29; 1:30 p.m.–3:00 p.m.

A Decade After the Surgeon General's Report on Mental Health: Health Care Reform's and Other Policies' Potential Use to Eliminate Disparities

Lonnie Snowden, Ph.D., University of California, Berkeley, CA 94720

Educational Objectives: At the conclusion of this session, the participant will be able to: 1) Name and describe three post Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General key research and policy developments targeting understanding and closing disparities; 2) Name and describe three provisions of the Patient Safety and Affordable Care Act capable of use for understanding and closing mental health treatment disparities.

Summary: Publication of Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General marked a turning point in the decades-long effort to focus attention on minority mental health disparities and to improve minorities' access to high-quality mental health care. Since the Supplement, advances in federal health disparities policy bring unprecedented attention to health disparities, and important developments in disparities-oriented mental health policy analysis and research permit us to better understand mental health disparities and to make inroads in closing these disparities. A supportive context includes maturation of mental health policy analysis and research as fields of scholarly inquiry. The most far-reaching post-Supplement development, with great promise for addressing health disparities and mental health disparities nationwide, was passage of the Patient Protection and Affordable Care Act, popularly known as health care reform. The Act faces legal challenges and implementation barriers but, ultimately, most provisions are likely to be implemented in the foreseeable future, changing the face of general health care and mental health care delivery. Certain provisions seem well-suited to promoting minority access to high-quality mental health care. Especially noteworthy are: universal insurance coverage including expansion of the Medicaid Program, generous funding of "comparative effectiveness research", support of patient-centered medical homes, support of community health workers, and provision for disparities monitoring and tracking to measure progress reduction. By preparing for these developments, we can position ourselves to use the largest reorganization of the health care system ever undertaken to close disparities in mental health treatment access and quality.

References:

1) N/A
2) N/A

LECTURE 18

Saturday, October 29; 1:30 p.m.–3:00 p.m.

Hereditary Schizophrenia: One Family's Personal Perspective

Patrick Tracey

Educational Objectives: At the conclusion of this session, the participant will be able to more fully understand the complexities of schizophrenia through a case study of a multi-generational, multiply-affected Irish-American family.

Summary: Patrick Tracey will speak about his journey of discovery in his family memoir Stalking Irish Madness: Searching for the Roots of My Family's Schizophrenia (Random House: 2008), which follows the hereditary nature of psychosis in his mother's fifth generation Irish-American family, its familial roots in famine-era Ireland, and its pooling downstream in his immediate family with two sisters, Polaroid models, who in

the mid-1970s were severely disabled by the sudden onset of recovery-resistant schizophrenia. From his perspective as a brother, he will discuss going back to Ireland to sort the myths from the madness, the frustrations of stigmatization, and the journey towards acceptance and recovery for sisters and siblings alike. Using his own family's experience as one where nature truly loaded the gun (and nature truly pulled the trigger), Mr. Tracey will discuss an ongoing conversation between his family and other similarly affected families, sparked by his memoir of his own four-month conversation with the Ireland of his ancestors about their madness. It's a fascinating, heartfelt story of a family, a people, and a major and very complicated psychiatric condition.

References:
1) The Roscommon High Density Schizophrenia studies.
2) The Dutch Winter Hunger study.

LECTURE 19

Saturday, October 29; 1:30 p.m.–3:00 p.m.

Turning the Recovery Model Downside Up and Outside In

Courtenay Harding, Ph.D., 90 Broad Street, New York, NY 10004

Educational Objectives: At the conclusion of this session, the participant will be able to: 1) Discuss the eleven long term outcome studies of schizophrenia and other serious and persistent syndromes; 2) Better understand the paradigm shift currently underway around the world; 3) Return to practice with some new approaches.

Summary: There is contemporary worldwide research evidence revealing thateven the worst cases of serious and persistent mental health problems can and do significantly improve and many even fully recover across time. Systems of care around the globe have declared recovery visions, missions, and transformation plans. This lecture will review the 11 long-term studies of two and three + decades in length, which have demonstrated amazing congruence across countries about the possibilities of recovery. Building upon those findings, persons with the lived experience have taken the lead by example as peer providers and increasingly sophisticated advocacy to continually push for changes in policy and programs in order to promote opportunities for wellness. The paradigm shift from the "Dominance of Deficits" to a Recovery Model has been happening slowly but surely for the past 50+ years. Focus will be upon the significant differences between expecting remission vs. expecting recovery and how such distinguishing features can promote or undo all the good intentions and efforts put forth by public policy and clinical programs. This lecture will address a variety of creative approaches to claim improvement and recovery as well as some factors which get in the way of going forward.

References:
1) Harding, C.M.: Changes in schizophrenia across time: paradoxes, patterns, and predictors. In: Carl Cohen (ED.) Schizophrenia Into Later Life: Treatment, Research and Policy. APPI Press, 2003, pp.19-42.
2) Harding CM and McCrory, D: Psychotherapy and Rehabilitation: A Comparison Between Psychotherapeutic Approaches And Psychiatric Rehabilitation For Persons With Serious And Persistent Mental Illness. In: Y.O. Alanen, M. Gonzalez de Chavez, A-L S. Silver, & B. Martindale (Eds.) Psychotherapeutic Approaches To Schizophrenicpsychosis: Past, Present And Future. Brunner-Routledge (in English) and a Spanish translation published at the same time by Fundación Para La Investigation El Tratamiento De La Esquizofrenia Y Otras Psicosis, Madrid, Spain. 2009.

LECTURE 20

Saturday, October 29; 3:30 p.m.–5:00 p.m.

Can Psychiatrists Afford to Be Psychotherapists? Can We Afford Not to Be?

Danny J. Carlat, M.D., 42 Pleasant Street, Newburyport, MA 01950

Educational Objectives: At the conclusion of this session, the participant will be able to: 1) Understand recent trends in medication use and psychotherapy in psychiatric practice; 2) Review research on combination treatment of psychiatric disorders; 3) Discuss the advantages and disadvantages of psychiatrists reintegrating psychotherapy into their practices.

Summary: Over the last two decades, the practice patterns of psychiatrists have changed significantly. The percentage of psychiatric visits involving therapy dropped from 44% in 1997 to 29% in 2005. In 1998, 44% of patients seeking mental health treatment in the U.S. were prescribed medication as their only treatment; in 2007, this percentage of "meds only" patients increased to 57%. Increasingly, psychiatry has become synonymous with psychopharmacology. In this lecture, I discuss this trend and its implications for our profession. Combination treatment (medication plus psychotherapy) has been shown to be more effective than medication alone in almost all psychiatric disorders. I will review some of this research, as well as providing some practical tips for reintroducing therapy into a psychopharmacology practice. Furthermore, I will trace some of the causes of recent practice trends, including: The increasing number of effective psychiatric drugs; the financial incentives to limit a psychiatric practice to medication only; and the medical school-based training model for psychiatrists.

References:
1) Mojtabai R and Olfson M, National Trends in Psychotherapy by Office-Based Psychiatrists, Arch Gen Psychiatry. 2008;65(8):962-970.
2) Olfson and Marcus, National Trends in Outpatient Psychotherapy, Am J Psychiatry August 4 2010, AJP in Advance.

LECTURE 21

Saturday, October 29; 3:30 p.m.–5:00 p.m.

The Ascendancy of Pharmacotherapy in American Mental Health Care

Mark Olfson, M.D., 585 Seventh Street, Brooklyn, NY 11215

Educational Objectives: At the conclusion of this session, the participant will be able to: 1) Describe the average length of time that patients actually stay on antidepressant medication; 2) Identify one group whose use of antidepressants has not significantly increased in the past decade; 3) Describe recent trends in the prevalence of adult major depression in the US and identify states with the highest prevalence of major depressive disorder.

Summary: This presentation will describe the recent national increase in use of psychotropic medications, focusing on antidepressants. A review will be provided of the differential trends of antidepressant use across sociodemographic and clinical groups and the clinical, economic, commercial and cultural factors that are likely to have contributed to these trends. A description will also be provided of the evolving roles of antidepressant therapy in primary care and psychiatric practice and the extent to which prevailing practice patterns align with information concerning the efficacy of these medications. A brief discussion will also be provided of challenges to continuity of antidepressant therapy in the community treatment of mood and anxiety disorders as well as the declining role of combined psychotherapy and antidepressant regimens despite empiric support for their efficacy.

References:

1) Olfson M, Marcus SC: National Patterns in Antidepressant Medication Treatment. Archives of General Psychiatry 2009;66:848-856.
2) Marcus SC, Olfson M: National Trends in the Treatment For Depression From 1998 To 2007. Archives of General Psychiatry 2010;67(12):1265-1273.

LECTURE 22

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

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

Patrick McGorry, M.D., Ph.D., The University of Melbourne, 3010 Victoria, Australia

Educational Objectives: At the conclusion of this session, the participant will be able to: 1) Understand the logic and evidence underpinning early intervention and youth mental health reform; 2) Understand the role for advocacy and community engagement in mental health reform.

Summary: Mental and substance use disorders are among the most important health issues facing society. They are by far the key health issue for young people in the teenage years and early twenties, and if they persist, they constrain, distress and disable for decades. Epidemiological data indicate that 75% of people suffering from an adult-type psychiatric disorder have an age of onset by 24 years of age, with the onset for most of these disorders – notably psychotic, mood, personality, eating and substance use disorders – mainly falling into a relatively discrete time band from the early teens up until the mid 20s, reaching a peak in the early twenties. While we have been preoccupied with health spending at the other end of the lifespan, young people have the greatest capacity to benefit from stepwise evidence-based treatments and better health care delivery.

In recent years, a worldwide focus on the early stages of schizophrenia and other psychotic disorders has improved the prospects for understanding these complex illnesses and improving their short term and longer term outcomes. This reform paradigm has also illustrated how a clinical staging model may assist in interpreting and utilizing biological data and refining diagnosis and treatment selection. There are crucial lessons for psychiatric research and treatment, particularly in the fields of mood and substance use disorders. Furthermore, the critical developmental needs of adolescents and emerging adults are poorly met by existing conceptual approaches and service models. The pediatric-adult structure of general health care, adopted with little reflection by psychiatry, turns out to be a poor fit for mental health care since the age pattern of morbidity of the latter is the inverse of the former. Youth culture demands that young people are offered a different style and content of service provision in order to engage with and benefit from interventions. The need for international structural reform and an innovative research agenda represents one of our greatest opportunities and challenges in the field of psychiatry.

References:

1) McGorry Patrick, et al. Age of Onset and Timing of Treatment for Mental and Substance Use Disorders: Implications for Preventive Intervention Strategies and Models of Care. Current Opinion in Psychiatry 2011, 24:301-306.
2) McGorry, Patrick, et al. Early Intervention in Youth Mental Health. The Medical Journal of Australia, Supplement. October 2007, Volume 187, Number 6.

SYMPOSIUM 01

Thursday, October 27; 8:30 a.m.–11:30 a.m.

Public Sector Challenges in Meeting Patients' Needs

Eve K. Moscicki, Sc.D., M.P.H., 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209

Educational Objectives: At the conclusion of this symposium, participants will be able to: 1) Describe the general clinical complexity of psychiatric patients treated in public inpatient and outpatient settings; 2) Identify potential gaps in continuity of care for patients treated in the public sector; 3) Discuss the challenges and potential approaches in providing appropriate care for psychiatric patients treated in the public sector.

Overall Summary: Psychiatric patients receiving care in public inpatient and outpatient settings may face multiple challenges in obtaining access to appropriate treatment and continuity in their care. This symposium will present a series of empirical papers describing the clinical complexity of publicly insured patients, including dimensional measures of symptom severity in addition to DSM-IV diagnostic categories; existing health disparities in access to care; patterns of polypharmacy; treatment access problems in medication access and continuity, including adverse clinical and life events experienced by associated with prescription drug coverage and formulary restrictions; and potential consequences of disruptions patients, and increased use of emergency departments and psychiatric hospitalization. A formal discussion of the papers will be followed by an audience discussion of the challenges and potential approaches in providing appropriate care for psychiatric patients treated in the public sector.

1. Clinical Complexity of Publicly Insured Patients and Implications for Clinical Practice

William Narrow, M.D., M.P.H., Eve K. Moscicki, Sc.D., M.P.H., Farifteh F. Duffy, Ph.D., Donald S. Rae, M.A., Joyce C. West, Ph.D., M.P.P.

Overall Summary:
Aims: To characterize the clinical complexity of publicly insured patients by examining patterns and combinations of co-occurring DSM-IV Axis I psychiatric diagnoses and psychotic, depressive, anxiety, manic, substance use, and sleep problem symptoms.

Methods: Data from a study of Medicare Part D psychiatric patients were analyzed. Psychiatrists randomly selected from the AMA Masterfile provided detailed data on systematically sampled Medicare/Medicaid dual eligible patients (N= 2,941 patients, 67% response). Respondents listed all DSM-IV-TR Axis I and II disorders and rated the severity level of six symptoms on a simple dimensional scale.

Results: Overall, 39% of patients had a diagnosis of schizophrenia; 29% a major depressive disorder; 16% bipolar disorder; and 11% a substance use disorder. The majority of patients had moderate to severe anxiety, sleep, and depressive symptoms and a substantial proportion had moderate to severe psychotic, manic and substance use symptoms. The symptom ratings crossed diagnostic boundaries and patients frequently had significant symptoms of other disorders, without the corresponding diagnosis being made. For example, 43% (SE=1.5) of schizophrenia patients had moderate to severe anxiety symptoms, while 6% (SE=0.7) had an anxiety disorder reported; 34% (SE=1.5) had moderate to severe depressive symptoms, while 3% (0.5) had a depressive disorder reported.

Conclusion: The use of dimensional symptom measures indicated publicly insured patients have very high rates of psychopathology and comorbidity, particularly when compared to DSM IV categorical measures. The dimensional symptom severity measures revealed a more clinically complex characterization of patients' psychopathology, identifying many heterogeneous patient sub-groups with different, multi-dimensional symptomatology clusters within the major diagnostic groups. Dimensional symptom measures have potential value in assessing publicly and privately insured patients' clinical status and treatment decisions, beyond information conveyed by categorical diagnoses. These findings suggest simple dimensional measures of psychopathology are feasible and potentially useful in routine practice. Consequently, plans for incorporating dimensional assessments in DSM-5 will also be discussed.

2. Race-Ethnicity as a Predictor of Attitudes Toward Mental Health Treatment Seeking

Ruth Shim, M.D., M.P.H., Michael T. Compton, M.D., M.P.H., George Rust, M.D., M.P.H., Benjamin G. Druss, M.D., M.P.H., Nadine J. Kaslow, Ph.D.

Overall Summary:
Objective: Previous research on mental health disparities shows that racial-ethnic minorities have less access to mental health care, engage in less treatment, and receive poorer quality treatment compared to non-Hispanic white persons. Attitudes and beliefs about mental health treatment were examined to determine if they may contribute to these disparities.

Methods: Data from the National Comorbidity Survey-Replication (NCS-R) were analyzed to determine attitudes toward treatment-seeking behavior among people of non-Hispanic white, African American, and Hispanic or Latino ethnicity. Additional sociodemographic variables were examined in relation to attitudes and beliefs toward treatment.

Results: African American race-ethnicity was an independently significant predictor of greater willingness to seek treatment and lesser embarrassment if others found out about being in treatment. These findings persisted when adjusting for socioeconomic variables. Hispanic or Latino race-ethnicity was associated with an increased likelihood of willingness to seek professional help and lesser embarrassment if others found out, but these differences did not persist after adjusting for the effects of socioeconomic variables.

Conclusions: Contrary to the initial hypothesis, people of African American and Hispanic or Latino ethnicity may have

more positive attitudes toward mental health treatment-seeking than people of non-Hispanic white ethnicity. It is crucial to better understand a broader array of individual-, provider-, and system-level factors that underlie problems in access to mental health services among racial-ethnic minorities.

3. Polypharmacy Among Medicaid Psychiatric Patients: Is there a Clinical Rationale for this Treatment?

Farifteh Duffy, Ph.D., Joyce C. West, Ph.D., M.P.P.

Overall Summary:

Background: Increasing polypharmacy among patients with mental illness raises concerns regarding the safety and quality of care.

Study Aims: Examine patterns and correlates of polypharmacy among Medicaid patients treated by psychiatrists and assess whether polypharmacy regimens reflect patients' diagnostic and symptom profiles.

Methods: 4,866 psychiatrists in ten states were randomly selected from the AMA Physician Masterfile: 62% responded; 32% met study eligibility criteria, reported clinically detailed data on 1,625 systematically-selected Medicaid patients. Analyses were weighted and adjusted for the sampling design. Polypharmacy was defined as: concurrent use of two or more psychopharmacologic medications: a) within the same class; or b) in more than one class (between-class).

Results: 26% of patients received 2 or more medications within the same class; 66% received medications in 2 or more different classes. The mean number of medications prescribed was 2.3; the mean number of medication classes was 2.0. Patients with a diagnosis of schizophrenia with moderate-to-severe depressive, anxiety and sleep problems had significantly higher mean number of medications overall (range 2.4 to 2.5) in contrast to those without such symptoms (1.8 to 1.9) ($p<0.05$). Patients with a major depressive disorder diagnosis with moderate-to-severe anxiety symptoms and mild-to-severe psychotic symptoms had significantly higher mean number of medications overall (2.4 to 2.7) in contrast to those without such symptoms (2.0 to 2.1) ($p<0.05$). The overall mean number of medications for patients with bipolar disorders (2.8 to 3.1) and alcohol or substance use disorders (2.4 to 2.8) were generally high but did not vary by symptom severity. Adjusting for patient case mix, factors independently and positively associated with between-class polypharmacy included: age over 45, diagnosis of schizophrenia, bipolar, or anxiety disorders and number of psychiatric symptoms. Factors independently and positively associated with within-class polypharmacy included: female gender and a diagnosis of cognitive disorder.

Conclusions: Findings suggest that psychiatric patients' diagnostic and symptom profile are associated with between-class polypharmacy, providing some evidence of clinically rationale treatment.

4. Homelessness and Incarceration Among Medicaid Psychiatric Patients in 10 States

Eve Moscicki, Sc.D., M.P.H., Joyce West, Ph.D., M.P.P.; Farifteh F. Duffy, Ph.D.; Donald S. Rae, M.A., Maritza Rubio-Stipec, Sc.D.

Overall Summary:

Objective: Examine risk for homelessness and incarceration and identify potential gaps in continuity of care among psychiatric patients in ten states.

Method: 4,866 psychiatrists in ten states were randomly selected from the AMA Physician Masterfile; 61% responded; 34% met study eligibility criteria and reported clinically detailed data on 1,625 systematically-selected patients. Multivariate logistic regression models examined odds of homelessness and incarceration controlling for sociodemographic and clinical characteristics.

Results: Overall rates were 11.6% for homelessness (SE=1.3%) and 13.4 % for incarceration (SE=1.3%), with higher rates among males, non-whites, and young adults 18-30 years. Patients diagnosed with substance use (43% homeless, 38% incarcerated), alcohol use (36% homeless, 25% incarcerated), and schizophrenia (24% homeless, 22% incarcerated) disorders were at higher risk. One-third of public and private inpatients experienced homelessness; one-third of public inpatients experienced incarceration; nearly 1 in 5 experienced both. One-quarter of patients with emergency department (ED) visits also experienced homelessness or incarceration. Patients who were treated in the public sector, with severe substance abuse symptoms or ED visits had a 2.0 (95% CI 1.3-3.1) to 6.1 (95% CI 2.1-17.9) increased likelihood of homelessness or incarceration. Patients who discontinued their medication had 2.4 (95% CI 1.3-4.4) increased odds of homelessness or incarceration.

Conclusion: The findings highlight potential gaps in the mental health treatment infrastructure for patients with substance use, psychotic disorders, and psychiatric symptom exacerbation and suggest inpatient facilities and EDs treating Medicaid psychiatric patients could play a more effective role in preventing homelessness and incarceration through improved discharge planning and care coordination.

5. Clinically Unintended Medication Switches and Inability to Prescribe Preferred Medications Under Medicare Part D

Joyce West, Ph.D., M.P.P., Donald S. Rae, M.A., Ramin Mojtabai, M.D., Ph.D., M.P.H., Maritza Rubio-Stipec, Sc.D., Julie A. Kreyenbuhl, Pharm.D., Ph.D., Carol L. Alter, M.D., and Stephen Crystal, Ph.D

Overall Summary:

Background: While Medicare enrollees have generally experienced improved prescription drug access through Medicare Part D, dual eligible psychiatric patients were reported to have experienced clinically unintended medication switches and other access problems during the first year of the program.

Aims: Characterize medication switches and access problems for dual eligible psychiatric patents and associations with adverse events, including emergency department visits, hospitalizations, homelessness, and incarceration.

Methods: Psychiatrists were randomly selected from the AMA Masterfile. After excluding those not practicing and with undeliverable addresses, 1,556 (62%) responded; 63% met study eligibility criteria of treating dual eligible patients and reported clinically detailed information on one systematically selected patient (N=986).

Results: Overall, 27.6% (SE=2.3%) of patients were reported previously stable, but required to switch medications because clinically indicated and preferred refills were not covered/approved. An additional 14.0% (SE=1.6%) were unable to have clinically indicated/preferred medications prescribed because of drug coverage/approval. Adjusting for case mix, switched patients (p=.0009) and patients with problems obtaining clinically indicated medications (p=.0004) had significantly higher adverse event rates. Patients at greatest risk were prescribed a medication in a different class or were unable to have clinically indicated atypical antipsychotics, other antidepressants, mood stabilizers, or CNS agents/stimulants prescribed. Patients with problems obtaining clinically preferred/indicated antipsychotics had 17.6 increased odds (p=.0039) of adverse events. Patients with problems obtaining clinically indicated and preferred antidepressants had 2.7 times increased odds (95% CI=1.8, 4.2, mean p=.035) of having an adverse event the past year.

Conclusion: These findings support caution in medication switches for stable patients and provide substantiation for prescription drug policies which promote access to clinically indicated medications and continuity for clinically stable patients.

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SYMPOSIUM 02

Thursday, October 27; 8:30 a.m.–11:30 a.m.

Consumers as Colleagues: Working Alongside Consumer Staff—Challenges and Rewards

Mark Ragins, M.D., 456 Elm Avenue, Long Beach, CA 90802-2426

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Understand our progress in working alongside consumer staff including motivations, common progressions, challenges, and rewards; 2) Understand several mature programs using consumer staff in sophisticated and powerful ways; 3) Appreciate the consumer staff's perspective of working alongside psychiatrists; 4) Understand the context in which to place their own experiences with consumer staff.

Overall Summary: Increasingly psychiatrists are being required to work alongside consumer staff including people they have treated or people still in treatment without much preparation. The inclusion of these consumer staff is considered an essential of implementing the Recovery Model. This symposium will 1) Give an overview of the background of consumer staff and the issues involved including the enhancement of programs, breaking down of our stigma and segregation, implementation issues including supervision and support, and common challenges, 2) Describe in detail several programs from around the country including the practical and personal impacts on the psychiatrists involved, 3) Include less formal presentations from consumers working alongside psychiatrists and how we appear to them, and 4) Facilitate discussion with the audience incorporating their experiences working with consumer staff.

1. Being Jackie Robinson's Teammate: Hiring and Supporting Consumer Staff

Mark Ragins, M.D.

Overall Summary: Perhaps the single most important thing we can do to transform into a recovery based system is to hire and work alongside consumer staff. It can break down segregation barriers, alter our view of people with mental illnesses and their capabilities and dramatically enhance our services. There are "affirmative action", "separate but unequal" approaches and "Value added" to all jobs, "integrated" approaches to hiring consumer staff, both of which can be very useful. Consumers

can enhance our services functioning as consumer representatives, peer advocates, peer supporters, peer bridgers, peer counselors/case managers, and peer self-help facilitators. They need supervision and support to succeed. A structure needs to be built including: Engagement, job training, transitional support/role training, hiring, orientation, on job supervision, on job support, and transition to unrestricted jobs/promotion ladder. There are a number of serious challenges including: Staff discomfort and stigma and lack of trust, confidentiality concerns, consumer staff lack of job skills, clinical issues, complex relationship and boundary issues, demoralizing work environments, and resenting them as a symbol of undesirable "recovery transformation." Welcoming consumer colleagues means making a space for them in our programs for them to work and grow comfortably, while knowing full well they may change us in unexpected ways.

2. Consumers as Colleagues in New York's Personalized Recovery-Oriented Services (PROS) Program

Paul Rosenfield, M.D.

Overall Summary: New York State's Personalized Recovery-Oriented Services (PROS) Program offers an integrated set of services that focuses on person-centered care, evidence-based treatments, and recovery. Consumers take an active role in defining their treatment goals and plans, and also play an essential role in shaping the program itself. This presentation will provide a brief historical background of consumer involvement in providing mental health care, and discuss how the current policies of encouraging or even requiring the involvement of consumers are quite a radical shift. I will describe the basics of PROS in general, one community clinic's experience of transitioning to PROS in particular (Riverdale Mental Health Association, RMHA), and the various ways consumers are involved as staff, interns, volunteers, peer recipients, and Consumer Advisory Board members. I will share some of the personal experiences of consumers who work in our program at RMHA as well as the impact on consumers in treatment who work with and learn from their peers. We will look at some of the obstacles encountered in the clinical setting that interfere with this collegiality (traditional boundaries and professional relationship expectations, stigma, and confidentiality concerns are a few). We will finish with a look to the future at what we can work towards.

3. Learning From Our Mistakes – Improving Our Usage of Consumer Colleagues

Ronald Diamond, M.D., Beth Lucht, M.S.W., Jennifer Gagne, M.A.

Overall Summary: Many clinical programs use consumers in a variety of clinical positions, from peer support to therapists and case managers. This is not new. Many staff working in mental health have their own treatment history, but it is new to hire consumers who are open about their own history, and new to hire consumers who may not have formal clinical training. Consumer colleagues can help increase the effectiveness of our clinical programs, but it requires attention to training, supervision, the development of a clear job description, and the preparation of the other members of the clinical team. This workshop will discuss some of the things we have learned in our twelve years of hiring consumers into staff positions. It will also discuss how we have coped with some of the problems we have encountered along the way, and how we have learned to help our consumer colleagues be successful members of the clinical team.

4. How Peers Can Support the Transformation of Clinical Services

James Schuster, M.D., M.B.A.

Overall Summary: Peers can significantly influence the transformation of clinical services as they incorporate a focus on consumers' recovery into programs that historically focused on symptom management. This presentation will highlight how peers can be incorporated into clinical service settings and provide examples of their impact. It begins with an outline of how Pennsylvania's public mental health service system has "set the stage" for a more prominent role for peers in treatment programs through initiatives such as: permitting Medicaid reimbursement for many peer services, creating a certification program for peers and encouraging and creating roles for peers in oversight and management settings. It will then review how a learning collaborative across 49 agencies in 35 counties has incorporated peers. The collaborative members are embedding clinical tools that focus on consumers' recovery goals into clinical services such as outpatient clinics, partial hospital programs, and case management agencies. The four person quality improvement (implementation) teams at each agency include a peer and peers have played key roles in leading implementation at many of the agencies. Their leadership roles have also been recognized in both regional and state meetings of the collaborative members. The presentation will describe how peers are integrated in both administrative and clinical roles and present "case studies" highlighting the role of peers in these clinical settings.

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2) Mowbray C, Robinson E, Holter M: Consumer drop-in centers: operations, services, and consumer involvement. Health and Social Work November 2002
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SYMPOSIUM 03

Thursday, October 27; 8:30 a.m.–11:30 a.m.

Income Inequality and Mental Health: the Implications for Psychiatric Practice

Duncan Wright, M.D., 415 South 19th Street, Philadelphia, PA 19106

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Describe the effect of income inequality on mental health; 2) Summarize the argument that psychiatry can support income inequality; 3) Describe three traditions of response to income inequality, liberation psychology, social medicine and Italian democratic psychiatry; 4) Describe the concept of exclusion and its role in mental health policy; 5) Consider changes in the organization and practice of psychiatry.

Summary: People in countries with greater inequality of income more often become mentally ill. In a study using WHO data, Richard Wilkinson and Kate Pickett note that rich countries with higher income inequality, such as the UK and the United States, have rates of mental illness double those in countries with lower income inequality, such as Spain and Japan. The countries studied are all democracies. One then could ask why the majority of people in a country with higher income inequality would vote to support a system that adversely affects many of them. In addition one would ask what roles psychiatry has played in supporting or in opposing income inequality: 1) Elites in countries with higher inequality use many methods to maintain it. These include persuading the majority of the people that the existing order is based in common sense. Psychiatry sometimes participates in this persuasive effort by defining social problems as personal ones. However there are traditions in which providers of psychiatric and medical care avoid doing this, and speak directly about income inequality and mental health, 2) Three traditions of response to inequality are especially useful, liberation psychology, social medicine and Italian democratic psychiatry. One can learn from these traditions and revise methods of evaluation and treatment. For example Italian democratic psychiatrists "bracket" the question of diagnosis early on, in order to understand the person they are seeing and the conditions under which they live. Later they might remove the brackets and diagnose a psychiatric disorder. 3) One dimension of income inequality is exclusion. Greater inclusion has been a guiding principle in mental health policy discussions in the European Union. It gives us another way to think about the ethics of psychiatry and options for change.

In summary, the speakers aim to carry out what C. Wright Mills calls a task of sociology, to "turn personal troubles and concerns into social issues and problems open to reason." The reasoning then leads to proposed changes in the organization and practice of psychiatry. These changes respond to a central problem, the effect of income inequality on the mental health of a society.

1. Psychiatry as Ideology

Richard Lichtman, Ph.D.

Overall Summary: American economic life is formed by the structure of capitalism, a system in which a handful of individuals control the process of work, the products of work and the remuneration of work. The capitalist organizes this system for the purpose of accumulating profit and is then forced to continue accumulating profit in competition with other capitalists. The worker takes what he can get but is in an inferior position of power, since the capitalist can live off his accumulated wealth much longer than the worker can live off the unpaid labor that would result from such activity as strikes. The system imposes enormous hardships on workers: impoverishment, exploitation, alienation, anxiety and depression. Workers are promised a life of freedom and equality-the American dream- but come to realize that they are of inferior worth in the system that dominates them. In response to these assaults they develop a range of maladies. One of the functions of psychiatry and therapy is to relocate the source of these sufferings from the larger social structure to the interior of the affected individuals. So the unemployed worker blames himself for his failure when the truth is that the factory has closed and moved, since labor is cheaper elsewhere. The "privatization" of the causal explanation is one of the unspoken devices that leave the helpless blaming themselves for their own suffering and lack of remedy.

2. Liberation Psychology as a Response to Income Inequality

Dena Whitesell, M.D.

Overall Summary: Liberation psychology is a concept first described by Ignacio Martín-Baró, a Salvadoran Jesuit priest trained in psychology at the University of Chicago. The idea was developed out of liberation theology, a movement in Latin America that interpreted Christian teachings through the eyes of the poor, encouraging people to free themselves from oppression. Martín-Baró applied this to human psychology, and discussed the ways that the injustices of society impact the mental health of the entire population. Liberation psychology teaches a number of models that are felt to be paramount to decreasing the effects of these injustices on individuals, but more importantly, society at large, so that in time the society will move toward a more just structure. These models include critical consciousness, realismo-crítico, de-ideologization, and a social orientation. It is imperative to look at psychopathology in its social context. Income inequality is a critical piece of our social context that we cannot ignore.

3. Responding to Income Inequality: Social Medicine and Democratic Psychiatry

Duncan Wright, M.D.

Overall Summary: Social medicine and democratic psychiatry began during different eras of revolt against inequality, the eighteen forties and the nineteen sixties. Both traditions continue today. Using their ideas I will describe a revised method of psychiatric evaluation: 1)A recent advocate of social medi-

cine, Howard Waitzkin, has used the methods of anthropology to analyze medical interviews. He argues that doctors subtly encourage compliance with the existing order (I will present a transcript of an interview for discussion) Waitzkin suggests that doctors collaborate with their patients, avoid medical explanations of non-medical problems and analyze the social origins of suffering, 2) A founder of Italian democratic psychiatry, Franco Basaglia, saw psychiatric hospitals as symptoms of an unjust and unequal society. People who were hospitalized were mostly poor. Their poverty had caused suffering and sometimes illness. Psychiatrists defined suffering as illness, and illness as natural. Basaglia argued that hospitals be closed and psychiatry redefined to account for the social causes of suffering, 3) Using ideas from these traditions, I propose a revised method of psychiatric evaluation. It could be called "Go Fast, Then Slow." It has six steps: 1) Assess for emergent conditions such as suicide risk, 2) Temporarily bracket the consideration of additional psychiatric diagnoses, 3) Assess for problems in relationships that may respond to mediation, 4) Assess for social problems, as at work, that may respond to social action, 5) Assess for moral or spiritual conflict, 6) If these approaches do not work, "remove the brackets" and consider other psychiatric problems which may need therapy or medication. In this way, psychiatrists can support social solutions to social problems, including income inequality.

4. Social Exclusion/Inclusion and Psychiatry-Working Toward Equity

Kenneth Thompson, M.D.

Overall Summary: The concept of social exclusion/inclusion has been evolving over the past several decades since it was first used in France. Now it guides much of public policy in the EU and its implications for psychiatry are being traced out. This presentation will review the concept, its implications for psychiatry and its critical role as the first step toward creating an agenda of social justice and human equity. The processes of social exclusion and the policies that ameliorate them and promote social inclusion will be described. Importantly, the desperate need for a public policy agenda informed by the moral practice of psychiatry will be emphasized.

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SYMPOSIUM 04

Thursday, October 27; 1:30 p.m.–4:00 p.m.

Here One Day – a Film About Bipolar Disorder and Suicide

Kathy Leichter, New York, NY, **Stephen M. Goldfinger, M.D.**

Overall Summary: *HERE ONE DAY* tells the story of the filmmaker's mother, Nina, a charismatic public school assistant principal, poet, and mother of two, who was diagnosed with bipolar disorder at age forty-two and died by suicide at age sixty-three. Being the wife of a New York State Senator, Nina's death was reported on the radio, in newspapers, and on television. *HERE ONE DAY* picks up where the mainstream press left off. Shot by the winner of the 2010 Excellence in Cinematography Award at The Sundance Film Festival, this unsensationalized, beautiful film paints a captivating portrait of Nina's experience of being bipolar and her friends' and family's experience of living with Nina, her illness, and her death. There will be a panel discussion and Q&A with the filmmaker and members of her family immediately following the screening.

SYMPOSIUM 05

Thursday, October 27; 2:00 p.m.–5:00 p.m.

The Primary Care and Behavioral Health Integration Continuum: How Psychiatrists Can Function and Lead

David A. Pollack, M.D., UHN-80, Oregon Health and Science University, 3181 SW Sam Jackson Park Rd., Portland, OR 97239, **Lori Raney, M.D.**

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

Overall Summary: Primary Care Behavioral Health (PCBH) Integration is an emerging research supported model for provision of mental health services. Based in a foundation of care management provided at the point of contact in primary care and supported by psychiatrists providing timely consultation to primary care providers, this model has caught the attention of healthcare reform proponents and others. Various models have been implemented around the country, engaging psychiatrists in unique and interesting ways. However, the training and preparation to work in these clinical settings has been lacking, with the exception of psychiatrists learning more by experience than by any formal didactic training or access to clinically relevant materials. This has led to a significant knowledge gap for psychiatrists who want to work in PCBH integrated care settings in informed and meaningful ways. This Symposium will address this knowledge deficit by presenting models of

integration from around the country, focusing on the level of collaboration for each site, the make-up of the care team, the psychiatrist's role, primary care acceptance of the model and any outcome measures collected. Each of the speakers was selected to represent differing levels of PCBH integration as well as geographical variation in the models. These models will offer symposium participants detailed information on programs that could be replicated in other settings and resources to guide them through the process.

1. Overview of Integration Issues: Rationale, Models of Care, and Staffing

David A Pollack, M.D.

Overall Summary: This presentation will provide a brief overview of the importance of integrating behavioral health and primary care. Care for mental health, addiction, and general medical conditions has too often been segregated into separate care settings or systems, resulting in poorer outcomes, less efficient but more costly care, duplication of services, and decreased patient satisfaction. Depending on the level of symptom severity and comorbidity, persons with mental health and addiction conditions are usually better served if their care is provided in a more integrated setting. Much work has been done over the past 10-15 years to identify the most effective models of care and to develop implementation strategies for clinical practices to become more integrated. The presentation will highlight the general conceptual framework for integration of care, the most common models of care that have emerged, some of the implementation challenges in moving towards integration, and staffing considerations that must be addressed. The development of primary medical homes is a key delivery system design component of the current health reform process. Integration of behavioral health and primary care should be promoted throughout the health care system, but, most importantly, such integration should be considered an essential part of these newly emerging primary medical homes.

2. The Colorado Behavioral Healthcare Council's Collaborative Care Mapping Project: Models of Integration for Rural Areas

Lori Raney, M.D.

Overall Summary: The Colorado Behavioral Healthcare Council launched the Collaborative Care Mapping Project in 2010, providing descriptions of over 70 sites around the state where Primary Care Behavioral Health (PCBH) Integration projects have been implemented. Each site has a description of the Level of Collaboration as well as details of the staff and services available. This project provides the viewer with an opportunity to examine different models of PCBH collaboration in both rural and urban areas of Colorado. Dr. Raney, the Medical Director of Axis Health System in Durango, CO and Senior Clinical Instructor in the Department of Family Medicine at the University of Colorado at Denver, will present models from the Four Corners area of Colorado, a rural and frontier setting that has four of the sites included in the Mapping Project. The Level of Collaboration at each site will be described. Dr. Raney will discuss her involvement as the Team Consultant Psychiatrist in these settings, describing ways to provide support for the treatment of mental illness in primary care settings over a large geographical area. This discussion will provide participants with examples of PCBH Integration models that could be implemented in other rural areas.

3. Psychiatric Service in an Urban, Rural Community Health Center

Charlotte N. Hutton, M.D.

Overall Summary: After Hurricane Katrina 2005, New Orleans, Louisiana had no hospital and one city-based clinic to provide medical services. As of January 2006, there were 22 adult and/or child psychiatrists for the growing population returning to abject desolation and no local infrastructure. The sudden loss of all things New Orleans and the protracted recovery were going to be new emotional insults added to evacuation, multiple moves, fluctuating economic resources, and rising emotional health distress. Before Hurricane Katrina, mental health issues were addressed after an episode of physical violence for most residents. Enrollment criteria for community-based services prior to the hurricane matched imminent risk criteria for psychiatric admission. A paradigm shift in service delivery needed to occur. Depression, anxiety, substance abuse, suicide and murder suicides recognized by the federal government pushed for more universal, integrated community based services. DHHS Secretary Levine's support of the medical home model facilitated access. The City of New Orleans and EXCELth, Inc. had been partners in federally qualified community health centers, they were primed and ready to address the integrated health model. A psychiatrist was added to the roster of providers. Subsequent grants led to use of PHQ-9, electronic health record, and universal screening for depression. Challenges arose in the paradigm shift, psychiatric practice guideline integration, collaboration between silos of medicine, and state statutes regarding service delivery were just the beginning of welcoming psychiatry into the primary care fold.

4. Primary Care Integration: the San Diego Vision of System Transformation for the Seriously Mentally Ill

Marshall Lewis, M.D.

Overall Summary: The San Diego vision has been driven by the psychiatric leadership of the County Health & Human Services Agency. This presentation will review key elements, emphasizing the role of physicians in changing inter-organizational relationship paradigms. San Diego County has a population over 3M, and provides care to the seriously mentally ill through independent networks of private Mental Health (MH) clinics and Federally Qualified Health Centers. There had been little if any communication between FQHCs and MH clinics, even about shared patients. Recently, the San Diego County Health and Human Services Agency has embarked on an ambitious 10 year plan to transform the healthcare safety net, emphasizing health system transformation with integration as a central goal. The San Diego vision is unusual in that

it is a "ground up" approach, emphasizing the development of virtual, functional patient-centered medical homes across pairs of existing primary and MH clinics throughout the county, blurring traditional boundaries, in lieu of a more traditional approach of developing specific programs that include integration as a function. The goal is to provide integrated health care for all patients within the disparate primary care and MH clinics, with a special emphasis on assuring primary care access for those with serious mental illness who otherwise suffer a 25 year mortality disparity. County-contracted MH organizations develop relations with specific FQHCs, making arrangements for SMI patients to move seamlessly between the two entities, with accompanying clinical information. MH clinics offer the FQHCs unprecedented access for acute care, as well as psychiatric consultation, education and staff de-stigmatization training, in exchange for easier patient access to the FQHCs. With this support primary care teams are actually encouraged to mainstream selected SMI patients on the stable end of the care continuum, assuming total care in furtherance of their recovery.

5. Integrated Care at Regional Mental Health Center/ North Shore Health Centers: Protocols, Palm Pilot and Phone Support

John Kern, M.D.

Overall Summary: Regional Mental Health and North Shore Health Center share a service location in the rust belt region of northwest Indiana. In 2007, Dr. Kern began a formal relationship with the primary care providers in the clinic, prioritizing immediate psychiatric consultation and toolkits to assist the PCPs without routine patient contact with the psychiatrist. In order to meet the need and provide better care, this model evolved over time to include key aspects of the IMPACT model, incorporating a Behavioral Health Provider (BHP) on the team. In addition, protocols were developed for specific disease states to aid the primary care providers in the provision of mental health treatment. This talk will focus on the key aspects of this evolving model of care. It will demonstrate how to provide effective and efficient psychiatric consultation to a busy primary care clinic with limited psychiatric time. Dr. Kern will also discuss the development of protocols for the treatment of Bipolar Disorder and ADHD in primary care and describe clinical and process outcomes and acceptance by primary care of these guidelines.

References:

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SYMPOSIUM 06

Friday, October 28; 8:30 a.m.–11:30 a.m.

Psychiatric Services the Dutch Way

Ton Dhondt, M.D., Ph.D., Oude Hoeverweg 10, Alkmaar, 1816 BT Netherlands

Educational Objectives: At the conclusion of this session, the participant should be able to identify some unique characteristics of the Dutch mental health care system and should be able to apply this knowledge to his or her own daily practice.

Overall Summary: There is not one system of mental health care in the Netherlands. Each institute organizes its services differently, depending on its catchment area and its partners, both within and outside the health care system. Mental health care organizations are proactive towards their environment and constantly develop their services based on current needs. The mental health care environment is constantly changing, as are the health care system, methods of financing, laws and regulations. Patients, referring doctors, local and federal government, and insurance companies play their role more vigorously. In this symposium we highlight some of the organizational issues mental health care providers are confronted with in the Netherlands. We depict some controversies and proudly present successful programs. We are looking forward to an international audience with whom a fruitful exchange of thoughts about these issues will take place.

1. Seclusion and Restraint: Efforts to Reduce Coercive Measures in the Netherlands

Cecilia Gijsbers van Wijk, M.D., Ph.D.

Overall Summary: The Netherlands has one of the highest seclusion rates in Europe. According to the Health Care Inspectorate, seclusion is applied 6000 times a year and one in every three involuntary admitted patient is secluded. There is an increasing awareness that coercive measures like seclusion should be reduced. Patients report severe negative consequences of seclusion, which negatively influence future care acceptance (Holzhorth & Wills, 1999) and the therapeutic effectiveness is controversial (Seilas & Fenton, 2009). In 2006

a nationwide program subsidized by the Dutch federal government was started in over 42 psychiatric hospitals in an attempt to reduce seclusion episodes by 10% a year. In this lecture we present the 2 year results of an ongoing project on five closed wards (4 acute admission, 1 long stay) of an Amsterdam based mental health care organisation aimed at the reduction of number and duration of seclusion episodes by 10% a year. The nature of the patient staff interaction during the very first minutes of every encounter was considered crucial to the prevention of escalation. Best practices for a number of these situations, e.g. the admission to the hospital and the start of every new shift, were developed and implemented, supplemented with the training of the teams in de escalating behaviour. Psychiatric nurses registered number and length of seclusion episodes in a nationwide registration system developed for this purpose. From 2008 to 2010 the number of seclusion episodes was reduced by 26% (146 vs 108); total seclusion hours did not drop (6927 vs 7280), implying that fewer but longer seclusion episodes took place. This was accounted for by a limited number of long lasting seclusion episodes of complex patients with severe behavioural disturbances. When these were excluded, seclusion hours dropped to 5121 (a reduction of 26%). Important differences between the results of the participating teams were observed. Though our results are encouraging, it proves difficult to change a longstanding, engrained practice like seclusion in Dutch psychiatry. Some of the teams were especially creative in creating alternatives for seclusion (e.g a comfort room). Limitations in our efforts to eliminate seclusion are discussed in the light of patient and staff safety and capacity.

2. Mental Health Care in the Netherlands: Organizational Issues and Health Care Reform

Wouter van Ewijk, M.D., M.B.A.

Overall Summary: There is not one system of mental health care in the Netherlands. Each institute organizes its services differently, depending on its catchment area and its partners, both within and outside the health care system. Mental health care organizations are proactive towards their environment and constantly develop their services based on current needs. The core business of any mental health care organization is cure, recovery and rehabilitation, and prevention. To what extent and for whom depends on the structure and focus of the organization and the patient groups addressed. The Dutch system comprises large scale integrated mental health care organizations, with multidisciplinary teams that offer all possible types of care (apart from forensic psychiatry): outpatient care, community based treatment (ACT), psychiatric emergency services, mental health promotion, acute admission and long stay facilities. Separate regional mental health organizations focus on ambulatory care exclusively, and assisted living facilities provide sheltered housing and assistance for those with severe mental illness. The mental health care environment is constantly changing, as are the health care system, methods of financing, laws and regulations. Patients, referring doctors, local and federal government, and insurance companies play their role more vigorously. The Dutch health care system is partly insurance financed and partly tax financed. Recently, government policy aims at increasing quality of care whilst containing the costs of a growing demand for this care. This is to be achieved by breaking the monopoly of traditional providers and allowing new parties on the market, and by empowering consumer organizations and insurance companies, resulting in a more demand driven competitive system. Organizations that do not comply are held accountable, ultimately by the removal of funding. Finally, the relationship between patients, mental health organizations and its professionals has changed. Consumer boards and organizations have a growing influence on a political level, and new laws strengthen patient's rights. Therapists face the challenge of offering satisfactory care by combining patients' needs with legislation, organizational guidelines, professional standards, and efficiency and economic demands.

3. Geriatric Psychiatry, Collaborative Cure 'Avant La Lettre'

Ton Dhondt, M.D., Ph.D.

Overall Summary: In the Dutch region Noord Holland Noord (600.000 inhabitants, about 100.000 elderly people) geriatric psychiatry is delivered by a regional Mental Health Care Provider in collaboration with General Practicioners, the three general hospitals, nursing homes, homes for the elderly and homecare providers. By focusing on psychiatric disorders, and excluding cognitive disorders, we were able to develop an integrative cure system in which pharmacological and psychotherapeutic interventions are provided by a multidisciplinary team. In our view it is impossible to practice geriatric psychiatry without this network. Combining the expertise of the different organisations and combining the different financial systems leads to an effective and efficient treatment for elderly psychiatric patients. The latest developments include internet based therapy, tailored to the elderly population, and introduction of Assertive Community Treatment ('OldFACT'). In this lecture the network and the efforts to set up and maintain it are described.

4. Stepped and Collaborative Care in the Dutch Mental Health System

Albert Blom, M.D.

Overall Summary: The professional skills combined with the coverage of General Practitioners in the Netherlands is generally acknowledged to be one of the success factors of the Dutch Health system in term of accessibility and costs. On the other hand, knowledge of mental heath problems, disorders and interventions is relatively small compared to the somatic disorders. To bridge the gap between specialized outpatient clinics and the GP we developed a model consisting of professional knowledge, process optimalisation and 'working together'. Fundamentals of this model are low threshold screening and intervention, stepped care and collaborative care. Self management, prevention and 'guided self help' are key terms that apply to the role of the patient/citizen We use this model in the GP office, face to face, but also via internet programs. The profes-

sional interventions, the organizational model and some preliminary results will be presented at this symposium.

5. Some Critical Remarks on Outpatient Psychiatric Care in the Netherlands

Hans Sanders, M.D.

Overall Summary: In the Netherlands most psychiatric care is provided by large mental health care organisations. Not only treatment and care for patients with severe mental illness, but also for patients with problems in the neurotic realm: depressions, anxiety disorders, personality disorders, or adjustment disorders. This is understandable in the more rural areas of Holland where there are very few psychiatric and psychotherapeutic private practices. In the bigger cities though, like Amsterdam and Rotterdam for instance, a large number of psychiatric and psychotherapeutic trained professionals are working in private practice. These practitioners deliver care, psychotherapeutic as well as pharmacological or a combination of both which is faster, easier accessible, more efficient, more flexible, and last but not least, overall much cheaper: they avoid expensive office buildings, long intake procedures, and the switching from one professional to the other. There are no secretarial employees, no management and administrative costs and hardly any cleaning force. Patient files are kept safely locked and no ICT networks and electronic patient files are driving costs sky high. For referring GP's there is a clear advantage in being personally acquainted with the private practitioner. Most psychiatrists in private practice have ample experience in mental health care institutions, and quite a few combine work both in the institution and in their private practice. For both quality of care, efficiency and economic reasons large numbers of patients in mental health care institutions would be much better of in private practice. Outpatient care in those large, and often inflexible institutions should be limited to those patients that need a multidisciplinary approach, patients that need crisis intervention from time to time, patients with multiple co morbid somatic and psychiatric problems, and for immigrant patient groups, who need specialised treatment, often with the help of native speakers.

References:

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4) de Jong FJ, van Steenbergen Weijenburg KM, Huijbregts KM, Vlasveld MC, Van Marwijk HW, Beekman AT, van der Feltz Cornelis CM (2010). The Depression Initiative. Description of a collaborative care model for depression and of the factors influencing its implementation in the primary care setting in the Netherlands.Int J Integr Care. 2009 Jun 15;9:e81.

SYMPOSIUM 07

Friday, October 28; 8:30 a.m.–11:30 a.m.

Innovations in Integrated Assessment, Service Matching, and Recovery Planning for Individuals with Co Occurring Psychiatric and Substance Disorders

Kenneth Minkoff, M.D., 100 Powdermill Road, Acton, MA 01720

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Identify the clinical principles of integrated recovery oriented practice with individuals with co occurring conditions that permit the development of appropriately matched integrated recovery plans; 2) Become familiar with the flexible array of services that can be provided for individuals with co occurring disorders in an integrated continuum of care: 3) Demonstrate the ability to use the ASAM PPC 2R and LOCUS 2010.

Overall Summary: Individuals with co occurring mental health and substance use disorders represent a population with poorer outcomes and higher costs in multiple domains, and often presenting in complex crisis situations with complex needs requiring accurate assessment to determine appropriate program and service matching in the context of developing an integrated person centered recovery plan. Despite the frequency with which this type of clinical situation occurs in adult and child service settings, most systems do not have an organized and systematic approach to help clinicians with the process of integrated assessment and recovery planning throughout the continuum of care. This symposium explores the issue of integrated assessment and recovery planning for individuals with psychiatric and substance use disorders, identifies the clinical principles of successful multi problem, multi dimensional assessment and intervention within a recovery oriented framework of service delivery, and then illustrates structured approaches for application of those principles in real world systems to real world clients. These principles are then illustrated through a description of the most common and widely available tools for integrated assessment and recovery planning which are already available for general system use. First, Dr. David Mee Lee will describe application of the American Society of Addiction Medicine Patient Placement Criteria – Second Edition Revised (ASAM PPC2R) (Dr. Mee Lee is the lead developer of that document) to organizing person centered and integrated program/service matching and recovery planning approaches for individuals with complex mental health and substance use needs. Second, the symposium will discuss the newest applications of

the American Association of Community Psychiatrists Level of Care Utilization System (LOCUS 2010) (presented by Dr. Wes Sowers, the lead developer of that document) to the process of integrated assessment, level of care and service matching, and recovery planning. Finally, Dr. Minkoff will describe an integrated recovery planning template that has been developed and disseminated in system wide projects for developing recovery oriented integrated services using the Comprehensive Continuous Integrated System of Care (CCISC) framework in over 30 states In order to demonstrate the application of these tools, participants will be provided with a complex case example, assisted to use the tools, as well as their own clinical judgment.

1. Using ASAM Criteria's Multidimensional Assessment to Develop Person Centered Recovery Plans

David Mee Lee, M.D.

Overall Summary: This presentation will improve participants' knowledge in providing focused, targeted, individualized behavioral health treatment. It will provide the opportunity to practice assessment and priority identification, and translate that into a workable, accountable treatment plan that makes sense to individuals. Reference will be made to the ASAM Patient Placement Criteria assessment dimensions to help organize assessment and treatment data.

2. LOCUS and the M Power Planner: an Integrated Computer Assisted Approach to Person Centered Assessment, Service Intensity Guidance and Service Planning

Wesley Sowers, M.D.

Overall Summary: As systems move toward transformation, the need to engage consumers and family members in the assessment and planning process has become increasingly recognized. The lack of methods by which to do so effectively and efficiently has been an obstacle to implementation of person centered care in practice. Another force shaping transformation efforts has been the logic of the integration of various elements influencing behavioral health such as substance use, physical health, environmental and developmental issues. The interaction of these elements has not been captured well in most processes designed to guide service intensity decisions. Adult LOCUS was created about 14 years ago with the intention of providing an instrument that was easy to use and understand, and which was comprehensive in describing the service continuum and the elements impacting service needs. A simple format and methodology were created to facilitate collaborative assessment and to make service intensity recommendations. In this symposium, the basic structure of LOCUS will be presented considering its uses in relation to their integrative aspects and participatory approach. This will be followed by a presentation of the LOCUS M POWER adult treatment planning module. Computer assisted translation of assessment elements to planning priorities will be considered. Practical aspects of implementation in systems of care and their use as organizing structures for clinical documentation and participatory service planning will be discussed.

3. Principles of Integrated Assessment and Recovery Planning for Individuals with Co Occurring Disorders

Kenneth Minkoff, M.D.

Overall Summary: Dr. Minkoff will begin with a brief outline of core evidence based principles of successful assessment and intervention for individuals or families with co occurring mental health and substance use conditions, as well as other complex needs. These principles emphasize the importance of identification of multiple primary issues or conditions, focusing in a recovery framework on the person's goals for a happy, hopeful, and productive life, identification of previous periods or efforts to make progress in the context of a strength based longitudinal assessment, and then application – for each issue of stage matched, skill based learning, in small steps, with big rounds of applause for each piece of progress, to help the individual learn how to address multiple issues over time. Within the context of these principles, the presentation will illustrate how to apply this approach to real world clinical situations, and to use a simple template to document integrated stage matched recovery planning for an individual with complex needs and multiple challenges.

References:

1) Minkoff K & Cline C, Changing the World: the design and implementation of comprehensive continuous integrated systems of care for individuals with co occurring disorders. Psychiat Clin N Am 2004, 27: 727 743.
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3) Mee Lee, David (2006): "Development and Implementation of Patient Placement Criteria" in "New Developments in Addiction Treatment". Academic Highlights. J Clin Psychiatry 67:11: 1805 1807
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SYMPOSIUM 08

Friday, October 28; 8:30 a.m.–11:30 a.m.

Innovations in Psychiatric Rehabilitation

Richard Warner, M.B., D.P.M., 2818 13th Street, Boulder, CO 80304, **Robert P. Liberman, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to describe four innovative approaches in psychiatric rehabilitation.

Overall Summary: This session will present a number of innovative approaches in rehabilitation, covering a broad field from family involvement to economic advancement of people with serious mental illness. One presentation will describe the use of errorless learning to supplement the effects of supported employment. Another innovation to be described and discussed is the use of the internet to offer web based psychoeducation to people with schizophrenia and their family members. The current status of social firms, or affirmative businesses, in the US will be described. Social firms are businesses established with a dual mission to market a useful product or service and to employ people with a disability or labor market disadvantage. Finally, an examination of the value of mutual support in consumer sub communities will lead to a discussion of such innovations in the social integration and economic advancement of people with mental illness as business incubators, a consumer credit union and novel approaches to housing.

1. Applications of Errorless Learning for Work Rehabilitation in Schizophrenia

Robert Kern, Ph.D., Roberto Zarate, Ph.D., Kellie M. Smith, M.A., Sharon S. Mitchell, M.A., Christen Waldon, M.S.W., Robert P. Liberman, M.D.

Overall Summary: It is widely accepted that neurocognitive deficits are a core feature of schizophrenia and are linked to impairments in work and social functioning and poor rehabilitation outcome. Given the significance of these impairments and their relationship to functioning, there has been increasing investigative interest in developing new treatments that target neurocognitive impairments in schizophrenia. Errorless learning is a behavioral intervention that putatively compensates for neurocognitive impairments in teaching persons with schizophrenia new skills and abilities. Two principles underlie the errorless learning approach as used in psychiatric rehabilitation. First, training methods are designed to minimize or prevent errors from occurring during training. Second, performance on training exercises is designed to automate performance through repetitive practice of perfect task execution. In practice, training begins on simple, basic tasks in which there is a high likelihood of performance success and then transitions to more complex exercises by very gradually manipulating task complexity. High levels of performance proficiency are maintained across training stages by the gradual manipulation of task demands and the implementation of individually tailored training instructions to address potential errors likely to occur in performing selected tasks. Results will be presented from a series of studies that illustrate our evolution of work with this training approach. An early, laboratory based study applied errorless learning to remediation of performance deficits on a widely used neurocognitive test. Next, we targeted a more clinically meaningful target and adapted errorless learning training procedures to teach persons with schizophrenia how to perform two entry level job tasks in a simulated workshop. In a succeeding study, we addressed two limitations of errorless learning, i.e., limited generalization and narrowness of targeted skills, by examining the feasibility and efficacy of applying errorless learning to impairments in social problem solving. Succeeding efforts have to adapt errorless learning training procedures for community applications. A training manual and accompanying DVD was developed and used to train job coaches who implemented errorless learning training in a transitional employment setting offering part time, time limited employment. Our most recent efforts have been to integrate errorless learning training.

2. Effectiveness of Web Based Family Psychoeducational Therapy Delivered to the Homes of Persons with Schizophrenia and Their Family Members

Armando Rotondi, Ph.D., Carol M. Anderson, Ph.D., Gretchen L. Haas, Ph.D., Shaun M. Eack, Ph.D., Michael B. Spring, Ph.D., Rohan Ganguli, M.D., Christina Newhill, Ph.D., Jason Rosenstock, M.D.

Overall Summary: This study examined the use of a Web site specifically designed to accommodate those with cognitive impairments, and home computers, to deliver online multifamily psychoeducational therapy to persons with schizophrenia and their informal support persons (family and friends). The web based intervention was termed SOAR (Schizophrenia On line Access to Resources).

Methods: Thirty one persons with schizophrenia or schizoaffective disorder and 24 support persons were randomly assigned to the online intervention, SOAR, or the treatment as usual (TAU) condition. At three, six, and 12 months, interviewer administered assessments were conducted with participants. Intention to treat analyses compared persons with schizophrenia in the two study conditions on severity of positive symptoms and knowledge of schizophrenia. Support persons in the two study conditions were compared on knowledge of schizophrenia. Each participant's usage of the Web site was logged.

Results: Only one person with schizophrenia in the SOAR arm (3%) and four support persons (17%) dropped out of the study. Analyses using mixed effects random intercept models, indicated that persons with schizophrenia in the SOAR condition had a large and significant reduction in positive symptoms ($p=.042$, $d=-.88$) and a large and significant increase in knowledge of schizophrenia compared with their counterparts in the TAU condition. Analyses of the association between cumulative SOAR usage and symptom severity indicated that individuals with more severe positive symptoms tended to spend more time on the SOAR site ($r=.65$, $p=.005$) and to access SOAR more frequently ($r=.62$, $p=.009$). This indicated that those who were presumably in more need of treatment sought more treatment. Cumulative Web site usage was weakly associated with magnitude of positive symptom reduction (based on within subject reduction in positive symptoms from baseline to 12 months), but the relationship was not statistically significant. Support persons in the SOAR condition showed a large and significant increase in knowledge about prognosis compared with those in the usual care condition ($p=.036$, $d=1.94$). Persons with schizophrenia

used the Web site to a much greater extent (pages viewed and time spent) than support persons.

Conclusions: These findings suggest that online delivery of psychotherapeutic treatment and educational resources to consumers' homes has considerable potential to improve consumer well being and offers several advantages.

3. Innovations in Employment and Job Creation

Carla Javits, M.P.P.

Overall Summary: The unemployment rate for people with mental illness is signficantly higher than that of other populations, and has been for many years prior to the current economic downturn. Much is known about what works in bringing people with mental illness into the workforce successfully. Supported work has been long identified as an evidence based best practice. Despite the fact that we know what works, high rates of unemployment among people with mental illness persist. Clearly additional opportunities are required. Nonprofits around the country interested in employment for people with mental illness have started businesses as a way to create jobs that are a stepping stone into the workplace for people who might otherwise not have the opportunity to work including people with mental illness. Some have created more permanent jobs as part of the federal AbilityOne program for example and others have created transitional jobs that are meant as a first step toward competitive employment. These work places have the advantage of offering both supports that help people succeed on the job and assistance with finding competitive employment, while earning revenue for the nonprofit to offset the costs of providing these job opportunities. REDF has invested in and supported a portfolio of nonprofits that have experimented with creating these kinds of "social enterprises" and job opportunities for many years. We were recently awarded a federal "Social Innovation Fund" grant to expand the effort in California and develop a scalable model. I will share insights we have gleaned about what works in creating and operating these enterprises, and the evidence about the results for the people employed, as well as ideas about how this 'industry' might grow in the future.

4. Creating Business and Economic Infrastructure in Identity Communities of Adults with Severe Mental Illness Histories

James Mandiberg, Ph.D., M.S.W.

Overall Summary: People with severe and persistent mental illnesses (SMI) may be seen as constituting an "identity community." Identity communities are comprised of people who share salient identities such as race, ethnicity, religion and disability status. The deaf community is an example of the latter. For the most part, the identity community of people with SMI does not recognize their community potential, including their economic potential. The economic assets of people with SMI are underutilized for the benefit of the SMI identity community. That is, when people with SMI make purchases, it is typically in businesses that are outside of their identity community. Those purchases benefit the business owners and employees, who most likely are not themselves members of the SMI identity community. It is possible, however, to develop businesses owned and operated by members of the SMI identity community and the mental health programs that serve them. These businesses could also employ other members of the SMI identity community. In that way, people with SMI who patronize businesses owned by business owners with SMI result in benefiting the SMI identity community as a whole by cycling money among the co members of the identity community. To accomplish this, several things must be recognized: 1) The SMI identity community has financial assets, albeit ones that may be scattered and difficult to identify. This is not unlike other very poor people, 2) These assets can be leveraged to benefit both individuals and the community, 3) People with SMI are capable of successfully owning and operating small businesses, both alone and in collaboration with social service agencies, as long as their disability is dealt with as a business planning issue. This presentation will review some efforts in business and economic development in the SMI identity community, including the development of a credit union by and for people with SMI and small business development experiences by people with SMI.

References:

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3) Warner, R. and Mandiberg, J.M. (2006). An Update on Affirmative Businesses or Social Firms for People With Mental Illness. Psychiatric Services. 57, 1488 1492.
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SYMPOSIUM 09

Friday, October 28; 8:30 a.m.–11:30 a.m.

Integration of Primary Care and Psychiatry: Lessons Learned and Future Directions From California and the Netherlands

Alvaro Camacho, M.D., 2417 Marshall Avenue, Suite 1, Imperial, CA 92251, **Marshall E. Lewis, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Learn how to improve education, referrals and treatment delivered by primary care providers for the most common diagnoses in psychiatry; 2) Empower health providers and build knowledge in the necessary competencies to treat patients beyond anxiety and depression; 3) Identify the important outcomes that a Community Health

Center should track in order to improve the delivery of mental health services to the community.

Overall Summary: Over the last four years, there has been an increased need to integrate mental health treatment into primary care. Most individuals recur to their primary care provider as the first resource to resolve their psychosocial concerns and psychiatric symptoms1. According to the Healthy People report from the Federal Government, integration of mental health and primary care is one of their imperative goals for the next 10 years. Since 2004, when California voted for a more comprehensive integration of mental health into the direct needs of patients, several issues have arisen among different communities; most of these issues are related to the need to improve the patient's level of functioning, vocational rehabilitation and enhancing their overall health. It is a reality that psychiatric patients are now part of the recovery model that has been adopted in the primary care setting for many years. It has been reported that when team of providers consistently communicate with each other and coordinate different clinical activities on the patient's behalf, outcomes tend to improve. An integration model proposed emphasizes training and measuring outcomes in the following areas: a) Primary and psychiatric care focusing on prevention, early detection and effective treatment; b) Improve patient's time in receiving adequate care for medical and psychiatric disorders; c) Implementation of treatment algorithms of psychiatric disorders for primary care providers; d) Use of information technology to enhance communication between primary care and behavioral health providers. Continuity of care after crisis visits and early identification of stressors that cause psychological distress continues to be a problem in community health centers. Most of these psychological stressors are frequently identified by primary care providers. Delay in behavioral health treatment frequently results in crisis visits for emergency psychiatric care and costly psychiatric hospitalizations. Over the last years, several reports have outlined the importance of adequate screening for mental symptoms among patients attending primary care community clinics. There is evidence showing that this approach is crucial to improving the overall well being of patients in the community3. Additionally, the integration model has shown that addressing depression directly in the primary care setting with vocational rehabilitation improves the patient's ability to regain functionality.

1. Transformation of Health Services in San Diego County: Lessons Learned in Building an Integrated Model of Recovery

Marshall Lewis, M.D.

Overall Summary: San Diego County provides care to the Seriously Mentally Ill through independent Mental Health clinics and Federally Qualified Health Centers. In the past there had been little if any communication between MH and FQHC clinics. Recently, the San Diego County Health & Human Services Agency has embarked on an ambitious plan to transform the healthcare safety net, emphasizing health system integration. The San Diego vision is unusual in that it is a "ground up" approach, developing functional patient centered medical homes across pairs of existing primary and MH clinics throughout the county, blurring traditional boundaries, in lieu of a more traditional focus on creating new, specific integrated programs. The goal is to provide integrated health care for all patients within the disparate primary care and MH clinics, in part assuring primary care access for those with serious mental illness who otherwise suffer a large mortality disparity. MH clinics offer the FQHCs unprecedented access and support, and primary care teams are actually encouraged to mainstream selected SMI patients on the stable end of the care continuum, assuming total care in furtherance of their recovery. The "Recovery Movement" has been the province of the traditional MH system, yet the boundary of that system is changing to include supported treatment within primary care clinics. Among challenges, there is resistance for some consumers to shift their locus of care, hesitancy for some MH providers to "abandon" their clients to an unknown FQHC system, and fear among primary care providers who are not used to working with this population. On the other hand, Recovery resonates well with the primary care concept of "chronic disease management," and FQHCs are very open to extending the paradigm. Two measures are being developed to address these challenges: 1) A comprehensive peer staffed recovery approach to bridge systems, and 2) A unique, comprehensive change management and educational approach.

2. Experience of Primary Care Mental Health Integration at Santa Clara Valley Health and Hospital System

Tiffany Ho, M.D.

Overall Summary: Santa Clara County Mental Health Department, the largest county in northern California, provides care to 22,000 persons with mental disorders annually. Historically, integration between mental health care and primary care had not been optimal. Our wish over the past several years has been to forge closer collaboration with primary care to broaden our impact on clients with mild to moderate mental health disorders. We are also very concerned with the early mortality and morbidity faced by clients with serious mental health issues and work to secure more ready access to primary care for clients. We are in a strategic position to plan for and implement integration of care given that Valley Medical Center and the Mental Health Department are under the umbrella of Santa Clara Valley Health and Hospital System and physicians of all disciplines, including psychiatrists, are on the same medical staff. In July 2009, we began our implementation efforts to place eight full time psychiatrists and closely to twenty licensed clinical social workers to work side by side with three medical homes in three different cities: San Jose, Sunnyvale, and Gilroy. We currently provide closely coordinated care for 2400 clients at these sites. In addition, we also employ peer consumers and rehabilitation counselors to provide individual and group peer support, as well as limited case management for those who are in the early phase of their recovery. Our collaboration with primary care is based upon recovery principles and health care

home principles which stress prevention and early intervention, ongoing relationship with clients, interdisciplinary teams who coordinate responsibility for ongoing care, and enhanced access to physical care.

3. Integration of Primary Care and Psychiatry in the Poorest County of California

Bernardo Ng, M.D., Ipist Vahia, M.D.

Overall Summary: In this session, we describe the process of establishing a dedicated psychiatry care infrastructure in Imperial County, CA a rural community that has been designated as a medically underserved area. In 2008 its population was estimated in 160,600 of which 122,124 (76%) were of Latino origin. In 2009, the main city, El Centro, was reported to have highest unemployment rate in the nation. We describe collaboration between this rural clinical initiative with research centers at the University of California at San Diego and Los Angeles, to promote research in this community. We present findings from research projects focusing on rural dwelling older Latinos conducted in Imperial County. The research we present was conducted at Sun Valley Behavioral Medical Center, which was founded in 1998. In 2007, the model was expanded to include a Research Center, which currently serves as a site for two NIMH sponsored projects (one of them in the elderly), 10 clinical industry sponsored trials, and a site for field trials of DSM V. Imperial County is also a major site for studies on the use of telepsychiatry among rural Latinos. This modality holds potential to significantly improve access to care for several rural communities at a low cost. Clinical and research activities using the Imperial County model have so far resulted in 13 original papers (10 related to geriatric issues) and 14 abstracts have been accepted to scientific meetings in the US and Latin America of which 5 are related to geriatric issues. It may be the only center dedicated to studies of rural Latino elderly. Finally, our studies using telepsychiatry hold potential to serve as a model for nationwide implementation of telepsychiatry related clinical and collaborative research projects. While the efforts of SVBMC only covers a minor part of the population in need we believe that this model is worth replicating in other Latino and/or minority underserved communities of seniors across the nation.

4. The Integration of Occupational Care in the Primary Care Setting: Impact on Depression Outcomes and Return to Work – the Netherlands Experience

Christina Van der Feltz Cornelis, Ph.D., M.D. M.Sc.

Overall Summary: In the Dutch Depression Initiative, collaborative care models have been evaluated for (cost) effectiveness. One of the models comprises depression treatment in the occupational health setting, aimed at return to work. In this model the occupational physician collaborates closely with the primary care practitioner and the psychiatric consultant according to a preset algorithm in order to enhance recovery from depression and return to work. Treatment includes Problem Solving Treatment, antidepressant medication following an algorithm, a system intervention in the company with practical advice aimed at return to Work, and close monitoring of progress supported by a web based decision aid. The model has been evaluated in 126 sicklisted employees with major depressive disorder. Also, a qualitative evaluation of feasibility of the model has been performed. In this presentation, outcomes and feasibility of the model will be presented.

References:

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4) Van der Feltz Cornelis CM, Hoedeman R, de Jong FJ, Meeuwissen JA, Drewes HW, van der Laan NC, Adèr HJ. Faster return to work after psychiatric consultation for sicklisted employees with common mental disorders compared to care as usual. A randomized clinical trial. Neuropsychiatr Dis Treat. 2010 Sep 7;6:375 85.

SYMPOSIUM 10

Friday, October 28; 2:00 p.m.–5:00 p.m.

Scope, Current Evidence, and Innovative Approaches in Managing PTSD in the Military

Darrel Regier, M.D., 1000 Wilson Boulevard, Arlington, VA 22209

Educational Objectives: At the conclusion of this presentation, the participant should be able to recognize the scope of mental health problems in military populations; discuss current evidence-based approaches and challenges in the management of PTSD and other related conditions in military populations; and be familiar with innovative national approaches for improving care for service members with PTSD.

Overall Summary: The scope of service members' mental health and cognitive problems associated with the wars in Iraq and Afghanistan is well documented. In a recent study of Army service members, rates of PTSD rose from 5% before deployment to 13% after deployment to Iraq, while depression rose from 5% to 8%; up to 28% of soldiers returning from Iraq may meet criteria for anxiety or depression (Hoge et al, 2004). This session will provide up-to-date information on the extent of mental health problems in military populations; review evidence-based treatment recommendations; and dis-

cuss availability and access to care, and challenges in treating PTSD and other mental health conditions in military populations. Concrete examples of potential innovative national approaches for improving PTSD care in the primary care and specialty mental health sectors, including RESPECT-MIL and the PTSD Care Dissemination Project, will be presented.

1. Epidemiology and Treatment of PTSD Associated With Combat: A Critical Look at the Evidence

Charles W. Hoge, M.D., Gary H. Wynn, M.D.

Overall Summary: Numerous studies have assessed the prevalence of PTSD in service members and veterans of the wars in Iraq and Afghanistan. Although there is considerable variability in sampling methods and case definitions, consistency in results have been obtained when studies have been grouped according to the population sample (combat infantry units versus general population samples). Overall, the prevalence of PTSD has been 3-6% pre-deployment and 6-20% post-deployment, depending largely on the frequency and intensity of combat experiences. Given the high prevalence of PTSD, there is considerable need for effective treatment, and two therapeutic modalities, prolonged exposure and cognitive processing therapy, have become the treatments of choices for PTSD in most Veterans Health Administration (VA) and Department of Defense (DoD) clinics. However, the evidence is mixed as to what components of treatment are most effective and why a large percentage of individuals do not recover from PTSD, either because they drop out of therapy or because these techniques are not as effective as we would like. This talk will review the state of the knowledge on PTSD treatment, what we think we know, what we believe the evidence indicates, what the evidence actually tells us, and where the key opportunities are for improving treatment of combat-related PTSD. The talk will disentangle assumptions/beliefs from facts identified in randomized clinical trials, dismantling studies, and the clinical practice guidelines mental health professionals depend on.

2. Pharmacotherapy and Psychotherapy for PTSD

David Benedek, M.D.

Overall Summary: The APA's Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder was published in October 2004. It supported the use of exposure-based cognitive behavioral therapy and the use of pharmacologic agents—particularly SSRIs—for the treatment of PTSD (1). With large numbers of U.S. military veterans returning from combat in Iraq and Afghanistan, the Institute of Medicine reviewed the evidence supporting treatment for PTSD in 2007, and concluded that existing evidence was sufficient only to establish the efficacy of exposure-based psychotherapies in the treatment of PTSD. While recent studies bolster support for pharmacological intervention in many circumstances, randomized controlled trials have called into question the efficacy of SSRIs for the treatment of PTSD in combat veterans. Other recent studies suggest that in certain patient populations new pharmacological options, such as prazosin, may be more effective than other widely prescribed medications (e.g., selective serotonin reuptake inhibitors) indicated for PTSD. Understanding the relevant psychotherapy research poses unique challenges due to issues such as the difficulty of administering "placebo" therapy (and the need to use of different kinds of control groups) and in blinding patients and providers. However, well designed studies demonstrate efficacy of psychotherapy, and emerging evidence suggests the potential for psychotherapy to be facilitated by at least one recently identified pharmacological agent (d-cycloserine). This presentation will summarize the most recent recommendations for evidence-based psychopharmacological and psychotherapeutic approaches to PTSD with an emphasis on PTSD related to combat exposure.

3. Mental Health Services Delivery in Primary Care: The RESPECT-Mil Experience

Charles Engel, M.D., M.P.H.

Overall Summary: U.S. troops report high rates of anxiety and depression following deployment to armed conflicts. Many personnel in need of services after deploying to Iraq and Afghanistan do not receive them, and stigma and barriers to care are key contributors. This presentation reviewsmilitary and VA efforts to improve early access to and continuity of mental health services through models of primary care integration. One program, the RESPECT-Mil program (Re-Engineering Systems of Primary Care for PTSD and Depression in the Military), is described in detail. RESPECT-Mil was initiated in 2007 and has covered over 1 million soldier visits in 92 participating primary care clinics at 36 worldwide locations. RESPECT-Mil components of care, implementation methods, supporting IT systems, process fidelity, and clinical and safety outcomes are examined. Primary care integration, of course, cannot replace the need for sound specialty care delivered in traditional settings. In the near future, however, integrated mental health models are likely to make key services available to all DoD and VA health care beneficiaries to include family members. Integrated mental health service models must grow in sophistication to meet the momentum anddemand generated with military and VA implementation of primary care-based Patient Centered Medical Homes.

4. DOD/APIRE PTSD Care Dissemination Project

Farifteh F. Duffy, Ph.D., Charles Motsinger, M.D.

Overall Summary: The American Psychiatric Institute for Research and Education (APIRE) was awarded the Department of Defense PTSD Research Program Concept Award in order to convene a team of experts in PTSD to identify and distribute key evidence-based recommendations from four major treatment guidelines for PTSD. Since, traditional continuing medical education approaches have not shown to be particularly effective in changing clinicians' practices, the PTSD Care Dissemination Project sought to apply the Chronic Care Model as the conceptual model and the Institute for Healthcare Improvement Breakthrough Series methodology as the learning approach to enhance the ability of clinicians to plan, test and implement practice-based improvements. Mental health-

specialty clinicians in two military treatment facilities (MTFs) engaged as collaborators along with members of the Workflow Integration/Business Process Reengineering Division of the Air Force Medical Support Agency. This presentation will provide an up-to-date report of activities related to this initiative and provide a preliminary report of its findings.

References:
1) American Psychiatric Association: Practice Guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. Am J Psychiatry 2004; 161 (11 suppl): 1-31
2) Benedek DM, Friedman MJ, Zatzick D, and Ursano RJ. Guideline Watch: Practice Guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder, Focus, 2009 Vol. VII, No. 2, 204-13.

SYMPOSIUM 11

Friday, October 28; 2:00 p.m.–5:00 p.m.

Past and Future of Public Psychiatry: Special 30th Anniversary Presentation of the APA Public Psychiatry Fellowship

Christina T. Khan, M.D., Ph.D., 401 Quarry Road, Stanford, CA 94305, **Eric Vanderlip, M.D.**

Educational Objectives: At the conclusion of this symposium, participants will be able to understand the history of public psychiatry and public psychiatry training in the United States, as well as the current challenges facing the field and the APA public psychiatry fellowship as it proceeds into the future of public sector psychiatry recruitment and training.

Overall Summary: The American Psychiatric Association Public Psychiatry Fellowship Program, founded in 1980, provides experiences that will contribute to the professional development of residents who will play future leadership roles within the public sector psychiatry and heightens awareness of the public psychiatry activities and career opportunities. Since the time it was founded, the fellowship has been awarded to 373 outstanding residents, many of whom are now leaders in the field. This fellowship has a proven track record for facilitating and nurturing future leaders in public and community psychiatry. Each year, ten fellows are selected from residency programs across the United States and Canada for a two-year fellowship. The fellowship has been an active tool for recruitment of members-in-training to mentor with leaders in public psychiatry, and pursue careers as leaders in public psychiatry. As the fellowship celebrates its 30th year, there is an unprecedented drop in funding threatening the future of the fellowship as it currently stands. This distinguished panel of public psychiatry experts and past recipients of the fellowship will present on their perspective on the utility of the fellowship in the development of their careers, and the future of the fellowship for the next 30 years.

SYMPOSIUM 12

Friday, October 28; 2:00 p.m.–5:00 p.m.

Cross Cultural Psychiatry with Indigenous North Americans

Lewis Mehl Madrona, M.D., Ph.D., 28 Vernon Street, Brattleboro, VT 05301, **Robert Crocker, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) List three Native American ceremonies and describe how these are naturalistic psychosocial therapies; 2) Identify three reasons for which participation in sun dance serves as protective mental health to prevent drug and alcohol abuse and other offenses; 3) Describe the concept of hocokah or healing circle; 4) Describe the sweat lodge as purification for other ceremonies and as prayer ceremony in its own right.

Overall Summary: This symposium provides an opportunity for dialogue among mental health practitioners serving Native American (and other indigenous) communities, Native American mental health practitioners, and other minority groups and providers. We begin with a presentation on Native American concepts of mind, mental health, and mental illness elucidated in a qualitative study involving traditional elders. We discuss how the differences in these concepts from conventional psychiatric thought, especially the conventional biomedical model, and how these differences can lead to misconnections between providers and clients. We talk about what elders from the communities believe to be appropriate mental health care delivery for their settings and also what they believe mental health practitioners should experience during their training. Then three presentations follow describing Native American practices that are becoming more and more widely used in addictions treatment and mental health treatment, including the talking circle, the sweat lodge, and the sundance. Talking circles involve circles of talk in which an issue is discussed sequentially without cross talk or reactive conversation and is a favored means for therapeutic communication in Native American contexts. Data is presented on the efficacy showing a large effect size in reduction of symptoms. Sweat lodge ceremonies have become ubiquitous in treatment programs involving Native Americans and are often performed before other ceremonies. Data is presented on their use and risks and benefits. The sundance is a yearly celebratory ceremony that has become crucial to maintaining sobriety and abstinence from drugs for many Native and non Native people. The logic and symbolism behind this ceremony is described along with its use as naturalistic psychotherapy. We conclude with a presentation describing how medical students, residents, and fellows are being taught about Native American ceremony and ritual (and those of other indigenous cultures) at the University of Arizona's Center for Integrative Medicine. This symposium will allow practitioners to gain insight into the 'translation' of Native American healing ceremonies into psychotherapeutic language, and to understand the ways in which including traditional healing has been effective in creating understanding

and positive responding among the Native American population. Practitioners will also be invited to consider the value of including these naturalistic methods.

1. North American Indigenous Models of Mind and Mental Health: Importance and Relevance to Psychiatry

Lewis Mehl Madrona, M.D., Ph.D.

Overall Summary: Based upon a series of consensual discussions with Native American elders, we present a model for Native American concepts of mind and mental health, which include the idea that mind is a story that exists within relationships which may be with other people, elements of nature, spirits, Creator, and others. Identity is described as the story we tell ourselves to make sense of all the stories that have ever been told about us. Mental health is described in terms of balance within relationships, of maintaining harmony and balance within relationship. Suffering occurs when harmony and balance are disrupted. Crucial to the elders was the concept that there are no bad or defective people, only bad stories that people have heard about themselves and come to believe. Most interesting was the Lakota concept of nagi which consists of all the beings who have ever influenced the person together with all the stories that they have told about the person. Nagi can be imagined more as a swarm that surrounds a physical body than as a self that exists within a brain. Examples are provided in which elders encourage those coming to them for healing to cast away the stories that tell them they are bad people or evil or that something is wrong with them and to listen to the traditional stories and to testimonies from others who have overcome adversity in order to be inspired to overcome their own situations and to change the story of their life. The presenter draws parallels between these aboriginal views and the developing narrative paradigm within Western academic traditions, especially the writing of Bakhtin and Volosinov. We will explore how these aboriginal models for mental health influence collaborative work with traditional cultural healers. The author will describe his practice alongside traditional healers, including how to approach healers and how to prepare people to consult with traditional healers.

2. The Sundance and Sacred Drama as Naturalistic Therapies for Mental Health

Barbara Mainguy, M.A., M.F.A., Lewis Mehl Madrona, M.D., Ph.D.

Overall Summary: The Lakota Sundance is a Native American ritual that ceremonially affirms the cultural understandings of healing and health. In the Sundance, healers, elders and specially selected lay people gather together to pray for their people to be well in the coming year. The demands of the Sundance are severe: the sun dancers spend four days and nights without food or water in a circular arbor with a ceremonial tree at its centre, where they sleep, pray and dance through 'rounds' devoted to specific groups or causes – elders, children, warriors, the terminally ill, the young people, the community as a whole. The community members gather around to support the group and sometimes enter the arbor to receive healing from the dancers while they are in the sacred space of the dance. The dancers accept or renew a sacred obligation that operates with a rigorous moral code and binds the healer with the responsibility. The dance is seen as an opportunity for elders and healers to renew their strength, and for those young people who feel the vocation to receive training and guidance. The ceremony is a fundamental requirement for those who wish to be considered as healers. The collectivist cultural healing paradigm has been explored as a working model of a social constructionist 'dialogical self', and the storytelling nature of the ceremony has been compared to narrative psychology. Health care practitioners from a variety of cultures have explored the ceremony both for its transpersonal aspect and for its intention of binding together community in a commitment to wellness. They are also attracted by the psychological effectiveness of the ritual for those who participate. Conventionally hard to treat groups – veterans, addicts, at risk youth – respond to the qualities of the Sun dance with positive decision making and health sustaining behavior.

3. The Sweat Lodge Ceremony – Naturalistic Method for Promotion of Mental Health, Avoidance of Substance Abuse and Its Use in Treatment

Robert Crocker, M.D.

Overall Summary: The sweat lodge ceremony crosses much of the temperate climates of the world with variations found in North America, Siberia, Finland, Scotland, and even in the Southern hemisphere (South America, New Zealand). This paper will focus upon the North American sweat lodge ceremony. In this ceremony, hot stones are carried into a canvas covered dome like structure, built of willow saplings. Water is poured onto the stones. Though variations occur between tribes and even between families within tribes, generally there are four segments, each one punctuated by opening to door flap. The ceremony includes prayers and songs and often a smoking of the sacred pipe (channupa). This paper presents the results of the presenter's qualitative study of attending sweat lodge ceremonies and interviewing participants about their reasons for attending sweat lodges and about what perceived benefit they receive. Many aboriginal participants had previous suffered from alcohol related problems and/or drug problems. The sweat lodge ceremony provided a means for them to avoid alcohol and drugs. The ceremony appeared to represent a way of life and not just an isolated ceremony. Another portion of participants reported resolution of mental health problems through attending ceremonies and through following the way of life that these ceremonies represented. These problems included depression and anxiety disorders. The sweat lodge ceremony tends to represent an intensified form of group psychotherapy, mostly peer peer, but officiated by an elder, a recognized carrier or keeper of wisdom, whose interpretations, discussions, and teachings were highly respected.

4. Talking Circles as Naturalistic Psychotherapy

Magili Quinn, D.O.

Overall Summary: Talking circles, peacemaking circles, or healing circles, as they are variously called, are deeply rooted in the traditional practices of indigenous people (1). In North America, they are widely used among the First Nation people of Canada and among the hundreds of tribes of Native Americans in the United States. They are most notably associated with the Ojibway and Lakota in the Northern Plains. The circle process establishes a very different style of communication. Rather than aggressively debating and challenging each other, which often involves only a few more assertive individuals, the circle process establishes a safe non hierarchical place in which all present have the opportunity to speak without interruptions. Rather than active verbal facilitation, communication is regulated through the passing of a talking piece (an object of special meaning or symbolism to the circle facilitator who is usually called the circle keeper). The talking piece fosters respectful listening and reflection. It prevents one to one debating or attacking. After brief opening comments by the circle keeper about the purpose of the talking circle, listing of ground rules and asking for additional contributions to the ground rules, the circle keeper says a few things about the talking piece and then passes it to the person on the left, clockwise. Only the person with the talking piece can speak. If others jump in with comments, the circle keeper reminds them of the ground rules and re focuses on the person with the talking piece. We report upon 1500 people participating in talking circles in which 415 people completed baseline and end MYMOP2 forms (My Medical Outcomes 2). These talking circles focused upon drugs, alcohol, and mental health with statistically significant changes over baseline and high levels of participant satisfaction. We suggest that the talking circle is a useful tool to use with Native Americans and other indigenous people for resolution of symptoms.

5. Teaching Medical Students, Residents, and Fellows About Ceremony and Ritual and its Importance for Patients: the University of Arizona Experience

Ann Marie Chaisson, M.D., M.P.H.

Overall Summary: Ceremony and ritual are important aspects of healing in cultures throughout the world. Typically medical students, residents, and fellows have little experience with ceremony and ritual and the perspective that going to see a physician, healer or indigenous medicine man or woman is a healing ceremony. At the University of Arizona Center for Integrative Medicine, we have made opportunities available for trainees to participate in ceremony and to learn about ceremony and ritual, both through asking local traditional elders to lead ceremony, and through helping trainees to design their own ceremonies to celebrate important events and transitions. Typically, trainees are initially self conscious, but, with increased time of exposure, trainees begin to become more comfortable with the elements to create ceremony and to begin to use this aspect of healing with their patients. It also allows them a framework to relate to indigenous patients who attend ceremony. This framework is embraced by the students over the course of their experience at the Arizona Center for Integrative Medicine. A schema is presented for teaching and exposing medical personnel to ceremony and ritual from a multicultural perspective.

References:

1) Construction of an Aboriginal Theory of Mind and Mental Health1 Lewis Mehl Madrona, Gordon Pennycook DOI: 10.1111/j.1556 3537.2009.01017.x Anthropology of Consciousness Volume 20, Issue 2, pages 85–100, Fall 2009
2) Explore (NY). 2009 Jan Feb;5(1):20 9. What traditional indigenous elders say about cross cultural mental health training. Mehl Madrona L.
3) Coe, K. & Palmer, C. (2009). How elders guided the evolution of the modern human brain, social behavior and culture. American indian culture and research journal 33(3) 5 21.
4) J Altern Complement Med. 2010 Jan;16(1):89 96. Using traditional spirituality to reduce domestic violence within aboriginal communities. Puchala C, Paul S, Kennedy C, Mehl Madrona L.

SYMPOSIUM 13

Friday, October 28; 2:00 p.m.–5:00 p.m.

Trauma Informed Care and Conronting Structural Racism – A Meaningful Intersection for Community Practice

Paula G. Panzer, M.D., 120 West 57th Street, New York, NY 10019

Educational Objectives: At the conclusion of this session, the participant should be able to articulate the goals and objectives of Trauma Informed Care and Systems of Care that confront organizational racism, identify the steps for program change and staff change to become trauma informed and approach racism in community work, and identify supports needed for these changes.

Overall Summary: Trauma Informed Care (TIC) is an organizational structure and treatment framework that involves understanding, recognizing and responding to the effects of all types of trauma. It emphasizes safety (physical, psychological, social and moral), participation (Bloom 1997) and empowerment for consumers, providers and systems. The essentials require connection (relationships), protection (promotion of safety and trustworthiness), respect (choice and collaboration) and redirection (teaching and reinforcing skills and competencies) (Hummer et al, 2009). "Using a trauma lens" in service delivery requires recognition of the occurrence and impact of violence and neglect on recipients of mental health services, recognizing the trauma contagion to providers and systems, and understanding the varied responses to trauma across presentations, coping skills and diagnoses. Confronting Structural Racism involves recognizing and addressing the impact of racial and cultural identity, power and structural racism in work with clients, staff and systems and countering the burden of silence.

This starts from the stance that race is a social and political construct – not a biological one. It involves examination and understanding of the notions of privilege and subjugation, self-identification, race, culture and class. Clinical care in a system which confronts structural racism includes recognition of the traumatic impact of racism and the cumulative effect of daily racial microaggresions (verbal, behavioral or environmental indignities). Using a "racial lens" in service delivery requires similar essentials as TIC – "connect, protect, respect and rebuild". In this symposium these distinct areas of study, their intersection, and their mutual integration will be examined. This symposium will offer definitions of the areas under discussion to allow participants to engage in dialogue around the same issues. An example of a consortium training on Trauma Informed Care will be described – with a description of the needs assessments and change plans for eight community mental health centers. Examples of addressing race and racism in community mental health care will be described with attention to language and active steps toward change. The third paper will focus on system issues when external demands challenge the provision of safe care. Attendees are invited to bring their questions and examples of Creating Trauma Informed Care and Confronting Structural Racism.

1. Trauma Informed Care Consultation to Systems Interested in Change: Early Learners

Michael Flaum M.D.

Overall Summary: In the spring of 2010, the mental health authority in the state of Iowa, in response to input from stakeholders, identified trauma-informed care as a priority initiative. Eight community mental health centers elected to participate in this initiative. They varied greatly in size, rurality and staff capacity, and included agencies that had essentially no familiarity with the trauma informed care construct, as well as one that had recognized it as a central organizing theme. The process by which these agencies moved forward with this initiative and some of the barriers encountered will be discussed in the context of the other presentations in this symposium

2. Racial Oppression and the Invisible Wounds of Trauma

Kenneth Hardy, Ph.D.

Overall Summary: Expanding our notions regarding trauma is an idea whose time has arrived. For too long the issues of race and trauma have been fairly segregated. Scholars interested in the phenomenology of race and culture have spent considerable time discussing the relationship between these concepts and oppression, but have devoted scant attention to the issue of trauma. Although much of this work has reflected an implicit understanding of the rudiments of trauma, it has not been addressed overtly. Similarly, trauma scholars have devoted increased attention to culture and race in recent years but have done so in a rather cursory way. Racial trauma is a life altering and debilitating experience that affects countless numbers of individuals, families, and groups over multiple generations. It is an affirmation of the interlocking of racial oppression and trauma—the same experiences by different names. Clinicians and scholars insistence on separating the two phenomena, severely limits our collective understanding and ability to work with patients who currently live life along the margins of society by virtue of their racial identities and location. Racial oppression trauma is the inescapable by-product of persistent exposure (directly or indirectly) to repressive circumstances that have emotionally, psychologically, and/or physically devastated one's being and sense of self. It also simultaneously overwhelms, destroys, or neutralizes one's strategies for coping. Because racial oppression by definition is a systemic condition that is sustained and intense occurring over a protracted period of time, there is very little release or relief from trauma. People of color and members of other oppressed group live in the midst of oppressive and traumatic conditions that are injurious to their psyches and souls. Trauma informed work that is oblivious to the subtle but potent impact of racial oppression trauma is work that is probably replete with racially based oversights. This presentation posits that a thorough understanding of the dynamics of racial oppression, as a form of trauma, is a necessary precursor to working across racial/cultural boundaries. This presentation will examine the invisible trauma wounds of racial oppression with specific attention devoted to strategies for effectively addressing them in a variety of settings.

3. Engaging Environments: Components and Challenges of Trauma Informed Settings in Mental Health (Stories from the Field)

Maggie Bennington-Davis M.D.

Overall Summary: Understanding trauma exposure's sequelae of neurobiological changes that influence a person's perception and experience of their environment, and creating safe places (and safe staff) where engagement and treatment can flourish, are essential foundations for Recovery. During the past ten years, many organizations – including hospitals – have improved their environments through trauma education of staff and those they serve. Meanwhile, however, for the last several decades, mental health and addiction services and psychiatric services in hospitals have been incrementally assaulted themselves, with funding cuts, increased costs, increased workloads, increased acuity and severity of symptoms in the people being served, less and less resources for those same people, less and less training for staff, increased pressure from accrediting bodies, demand for higher quality, fragmentation of services, and more. As a parallel process to the trauma the people we serve have experienced, staff in organizations (and the organizations themselves) also develop around this recurrent stress, becoming more and more fearful and rigid, with knee-jerk creation of rules and policies in response to individual events, and causing staff to become disempowered and demoralized. Leaders feel helpless and attacked, and respond by becoming either withdrawn or authoritarian – or both. When traumatized organizations meet traumatized clients, and when demoralized, disempowered staff led by withdrawn, authoritarian leaders meet demoralized, disempowered clients in a fiscally hostile environment, the outcomes are bound to be problematic. How

can trauma-informed approaches flourish in organizations that are in crisis themselves? Recovery of both the organization and clients can only occur with mindful approaches and a clear framework for managing chronic stress, and engaging workers and clients in the creation of safe places. Drawing on the recent work of Sandra Bloom and Brian Farragher (Destroying Sanctuary: The Crisis in Human Service Delivery Systems, 2010. Oxford Press), and on experiences in the field, the process of establishing trauma-informed environments in which to both work and receive services is discussed.

References:

1) Blitz, L. and Pender Greene, M (Eds.) (2006) Racism and Racial Identity: Reflections on Urban Practice in Mental Health and Social Services. New York: Haworth Press.
2) Hopper, E.K., Bassuk, E.L., Olivet, J. (2010.) Shelter from the storm: Trauma-informed care in homelessness services settings. Open Health Services and Policy Journal, 3, 80-100.
3) McGoldrick, M. and Hardy KV. (2008) Re-visioning family therapy: race, culture, and gender in clinical practice. New York: Guilford Press.
4) Bloom, S. and Farragher, B (2011) Destroying Sanctuary: The Crisis in Human Service Delivery Systems. New York: Oxford University Press.

SYMPOSIUM 14

Saturday, October 29; 8:30 a.m.–11:30 a.m.

Changing the World: Strategies for Systemic Implementation of Recovery Oriented Integrated Services: Applications in the San Francisco Bay Area

Kenneth Minkoff, M.D., 100 Powdermill Road, Acton, MA 01720

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Understand the eight principles of a comprehensive continuous integrated system of care and their application to system design within an integrated philosophy, 2) Recognize the 12 steps of implementation for integrated systems and their utilization in real world systems; 3) Understand real world applications and use of top down bottom up CQI strategies for building recovery oriented co occurring capability.

Overall 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 "co occurring conditions are an expectation, not an exception." As a result, there has been increasing recognition of the need for developing a systemic approach to serving these individuals. Minkoff and Cline have developed an implementation process for a model termed Comprehensive Continuous Integrated System of Care, in which within existing resources in any system, all programs can be designed as "recovery oriented co occurring programs" meeting minimal standards of recovery oriented co occurring capability, but each program has a different job, to provide matched services to its existing cohort of cod clients based on a set of consensus best practice principles within an integrated 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 three Bay Area California counties: San Francisco, San Mateo, and Alameda (Oakland). Presentations will review the overarching system wide strategy to utilize quality improvement as a vehicle for implementation of recovery oriented co occurring capability within complex, scarce resourced systems, and then specific strategies by which each county has made progress in improving the county wide delivery of integrated services for individuals and families with co occurring mental health and substance use conditions, and other complex needs. Strategies will include addressing county structure and regulations, developing a county wide CQI approach including the development of a cadre of change agents, improving universal co occurring capability at the program level, and building workforce competency.

1. Comprehensive Continuous Integrated System of Care: Description of the Framework

Kenneth Minkoff, M.D.

Overall 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 system of care with scarce resources, the CCISC model organizes a framework for system design in which every program is a co occurring program meeting minimum standards of co occurring capability within the context of its existing resources, but each program has a different job, based first on what it is already designed to be doing, and the people with 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 co occurring clinician meeting minimal standards of co occurring competency regardless of licensure or job description, to provide properly matched services to the clients in his or her caseload. This presentation summarizes the model, the eight principles, and the twelve step program of CCISC implementation involving a strategically planned CQI process that incorporates a "top down, bottom up and back again" interactive design, in which the system, programs, clinical practices, and clinician competencies all progress together building on existing system strengths and resources.

2. CCISC: Real World Application and Implementation Strategies

Christie Cline, M.D., M.B.A.

Overall Summary: Based on the author's experience with implementation projects in 30 states and three Canadian provinces during the past 10 years, this presentation will discuss the specific strategies by which the CCISC framework can be adapted to the needs of real world systems with complex structures and limited resources. 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 (CO FIT), program self assessment for dual diagnosis capability (COMPASS EZ), and clinician self assessment of attitudes and skills (CODECAT EZ). There will be an emphasis on the fundamental clinical processes of welcoming engagement, integrated relationships, universal integrated screening, integrated longitudinal strength based assessment, and stage specific assessment and treatment 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 US and Canada.

3. Alameda County Co Occurring Conditions Initiative: Partnership for Transformation

Tony Tullys, M.P.A.

Overall Summary: This presentation will describe three years of progress in developing a welcoming, recovery oriented integrated system of care in Alameda County. This process has involved both the development of a process to achieve universal co occurring capability in adult, child, mental health, and addiction programs, as well as an evolving culture change supporting an empowered quality improvement partnership that is informing the organization as a whole, and facilitating movement toward integration with primary health care. The presentation will summarize key accomplishments and lessons learned, including the evolution of a "change agent" team of over 150 individuals, development of a representative steering committee, partnership with the Pool of Consumer Champions, and alignment of adult, child, transitional age youth and older adult population services. There will also be specific attention to the process of creation of practice guidelines for psychiatrists to more effectively engage high risk individuals who do not meet priority population criteria.

4. CCISC Integration in San Mateo County: Transforming the Mental Health and Alcohol & Other Drug Systems

Mary Taylor Fullerton, M.A., M.F.T., Kristin Dempsey, M.F.T.

Overall Summary: In May of 2006 San Mateo County began implementation of CCISC and its significant system transformation. With the goal of improving services to individuals with co occurring disorders San Mateo County Mental Health, and Alcohol & Other Drug Services, together, became San Mateo County Behavioral Health & Recovery Services (BHRS). With many valuable lessons gleaned along the way, San Mateo County BHRS continues efforts to integrate systems and improve service provision to individuals with complex issues. While collaboration between county operated, contracted and community based services has worked to provide recovery oriented, trauma informed, culturally competent and hopeful services, there remains much to be done and the co occurring integration efforts continue.

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) Minkoff and Cline: Dual Diagnosis Capability: Moving from Concept to Implementation. Journal of Dual Diagnosis, 2006
4) Chichester, Bepko, et al. Implementing an Integrated System of Care Model in the State of Maine. Journal of Dual Diagnosis, 2010.

SYMPOSIUM 15

Saturday, October 29; 8:30 a.m.–11:30 a.m.

A Cultural Encounter on the Way To Partnership

Susan V. McLeer, M.D., P.O. Box 45358, Philadelphia, PA 19124 8358

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Delineate advantages and disadvantages of integrating an academic program and community mental health program; 2) Describe the primary cultural conflict encountered in the process; 3) List barriers that may impede the development of an integrated program; 4) Discuss strategies for overcoming conflicts and barriers to insure sustainability.

Overall Summary:
Objectives: To delineate advantages and disadvantages of integrating an academic program and community mental health center (CMHC); to describe the primary cultural conflicts encountered; to list barriers that may impeded the

development of an integrated program and to discuss strategies for overcoming conflicts and barriers to insure sustainability.

Methods: The planning, negotiating and conflict resolution process used in establishing a residency training program at 2 CMHC sites will be compared and variables identified that contributed to successful outcomes. Presentations will include an overview of the process from the perspective of key stakeholders, including the senior management for the academic department and the CMHC, the academic faculty, residents and the consumers of mental health services.

Results: The programs at both sites were initiated in 2004; one successfully traversed many barriers and conflicts inherent in integrating programs in an academic residency training program and a high volume CMHC. The other site had a less successful outcome. Differences in management, relationships and process were notable and will be discussed by key stakeholders during the symposium.

Conclusions: Programmatic sustainability requires a respectful and committed relationship between the CMHC and academic senior and middle managers. Working together in a respectful atmosphere is critical and both institutions believe that the process is equitable for all. Each stakeholder is contributes to the process of integrating programs and their voices must be at the table. Key variables that need constant monitoring include commitment to quality care, CMHC fiscal concerns and the academic program's accreditation requirements.

1. A Clash of Cultures: The Challenges Inherent in Embedding a Residency Training Program Within a Community Mental Health Center

Susan V. McLeer, M.D., Paul R. Sachs, Ph.D., Jeffery D. Bedrick, M.D., LaToya Floyd, M.D.

Overall Summary:
Objective: To delineated advantages and disadvantages of integrating an academic program and community mental health center (CMHC); to describe cultural conflicts encountered in integrating programs; to list barriers that may impede program development and to discuss strategies for overcoming barriers and conflicts and achieve sustainability.

Methods: The planning, negotiating and conflict resolution process used in establishing a residency training program at 2 CMHC sites will be compared and variables identified that contributed to a successful outcome at one site, but a less than successful outcome at the second site.

Results: Both programs were initiated in 2004; one successfully traversed many barriers and conflicts encountered while the other had a less successful outcome. A priori goals and objectives were important in operational management. Anticipating potential conflicts in institutional missions and developing methods for conflict resolution were cornerstones to sustainability. The "we them" dichotomy had to be eliminated. Operational and educational objectives needed to be embraced by both parties to the agreement. Conflict resolution required commitment from senior management and the development of mutual respect among all.

Conclusions: Sustainability requires a respectful and committed relationship between the CMHC and academic senior and middle managers. Both institutions must "win" in the process. Whenever personnel feel that one side has more advantages than the other, the relationship becomes unstable and sustainability is threatened. Key variables needing monitoring include quality of care, CBHC fiscal concerns and accreditation requirements.

2. What's in It for the Community Mental Health Center?

Paul Sachs, Ph.D., M.B.A.

Overall Summary:
Objectives: To examine key variables of importance to a CMHC in the creation of an effective and sustainable community psychiatry training program embedded in a not for profit CMHC; to delineate the process for introducing and integrating a recovery oriented system of care into the joint program.

Methods: The challenges that must be met in order to sustain the relationship between the CMHC and medical school residency training program will be presented from the perspective of the non profit organization. The cultural differences between the medical school and two CMHC sites have been reviewed and compared. The fiscal mechanisms necessary for sustainability identified. The effects of public sector system transformation to a recovery oriented system of care on patient care and training will be described. Three key operational processes, scheduling, documentation and compliance were examined for impact on operations and sustainability as well.

Results: The training sites, established in 2004, are two outpatient clinics in two urban neighborhoods serving primarily African American and Latinos clients and their families. Program operations and sustainability require close collaboration between the academic institution and the not for profit community organization. Essential variables identified in effecting sustainability will be presented from the perspective of the CMHC.

Conclusion: In order to develop a sustainable training program embedded in a CMHC, it is essential to maintain close collaborative ties between both entities. Maintaining sensitivity to the fiscal concerns of the CMHC and the training and accreditation concerns of the medical school is critical to program success. Leaders and managers must be receptive to evolving changes in the health care and behavioral care service systems as well as to changes required by other funding and regulatory agencies at local, regional and national levels.

3. The Residents' and Faculty Members' Journey: Past, Present and Future

Jeffrey Bedrick, M.D., Latoya Floyd, M.D.

Overall Summary:
Objectives: Outline problems encountered by trainees and faculty; delineate conflicts between the CMHC in responding

to service demands and fiscal constraints and procedures that are responsive to training needs and faculty values; describe levels of satisfaction in both faculty and residents.

Methods: The evolution of resident and faculty experiences will be delineated, as will the challenges in generating trainee excitement for a career in public psychiatry.

Results: Over a six year period, faculty satisfaction improved, as has resident enthusiasm. Early it was difficult to retain faculty, a problem that has been resolved. Early, residents were negative about the program and tried to avoid the CMHC; now residents ask to be assigned to the site due to their interest in community psychiatry. Helping residents understand the difference between exploitation as "cheap labor" versus embracing the challenges in a fiscally challenging environment is a critical element in satisfaction. Interest in public psychiatry was enhanced by a seminar series designed to give a perspective on issues at the local, regional and national level. A new problem is that residents are excited about public psychiatry, have enjoyed the training experience and have interest in the CMHC, but the role of the psychiatrist in the CMCH is such residents are unwilling to commit to working in the CMHC after training. Solutions for this problem are being sought.

Conclusions: Problems in moving a training program into a CMHC require commitment from managers and attention to operational issues and didactic areas of interest. A seminar series, which reviews the structure of the county system for providing behavioral health services as well as the CMHC's methods of responding to systems transformation, is an essential element in stimulating resident interest in working in the public sector. The role of psychiatrists in a CMHC continues to be problematic and prevents recruitment to the CMHC.

4. The Consumer's Experience: Impact on Quality of Care and Continuity

LaToya Floyd, M.D., Jeffery Bedrick, M.D., Paul Sachs, Ph.D., Susan V. McLeer, M.D.

Overall Summary:
Objectives: To describe how the program is experienced by consumers of mental health services, both in terms of areas of satisfaction and dissatisfaction with the quality of care provided and the continuity experienced.

Methodology: Data from a patient satisfaction survey comparing clients who received care within the embedded academic program at the CMHC with those who receive care at the CMHC, but not from providers connected with the collaborative program will be presented. In addition, a videotape will be presented in which several consumers describe their experience with the collaborative program between the medical school residency training program and the CMHC.

Results: The impact of the collaborative program on the quality and continuity of care will be described. The collaborative program allows the CMHC to provide more psychiatric services to larger population of clients, which impacts quality in a positive manner. On the other hand, residents leave when their training rotation ended, thus interrupting care. Likewise, not all residents are of the same quality and close supervision is essential in managing the effects of that variable on the quality of care. The importance of active management of the end of the year transfer process is critical to insure continuity of care and enhance quality when care is interrupted by the residents rotating to another program.

Conclusions: In developing a collaborative program between a medical school's residency training program and a CMHC, it is critical to maintain an active monitoring process on quality of care and patient safety issues. Close faculty supervision is important as is the involvement of the chief resident in working with new residents rotating on to the service.

References:

1) Messias, E, Bienvenu, JO, Samuel, J, Nestadt,G, Easton, W Psychiatrists'ascertained treatment needs for mental disorders in a population based sample. Psychiatric Services, 2007, March 58 (3): 373 377.
2) Croze, C. Managed Behavioral Health Care in the Pupblic Sector. Amdinimtration and Policy in Mental Health, 2000, 28: 23 36
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SYMPOSIUM 16

Saturday, October 29; 8:30 a.m.–11:30 a.m.

Field Trials For DSM-5: Outcomes and Impact

Darrel A. Regier, M.D., M.P.H., 1000 Wilson Boulevard, Arlington, VA 22209

Educational Objectives: At the conclusion of this session, the participant should be able to describe the overall strategy and planning process behind DSM-5 field trials to assess select proposed revisions. Participants will also be able to identify the specific methods and techniques being utilized in DSM-5 field trials and will be able to summarize the status of data collection and findings from both large field trial settings and routine clinical practice settings.

Overall Summary: The DSM-5 field trials represent a crucial phase in the revision process wherein proposed changes to the manual are examined in real-world settings. Evaluation of draft criteria is a necessary and vital component to ensuring that DSM maintains its primary function as an effective clinical tool designed to guide patient care, while also providing diagnostic criteria that are empirically sound. This symposium will introduce attendees to the overall implementation strategy and logic behind the field trials for DSM-5. Presentations will describe specific components of draft revisions that are being

examined during the field tests. This includes the diagnostic checklists containing proposed criteria for all disorders and the proposed dimensional measures for assessing cross-cutting symptoms and diagnostic-specific severity ratings. Speakers will also discuss the two designs of field trials being utilized – one for large, academic-medical institutions and a second focusing on solo practitioners and routine clinical care settings. Though these two designs are unique, both were developed to answer specific questions about whether the proposed criteria and measures for DSM-5 are stable over time, are reliably used by different clinicians, perform equally well across different age groups and cultural populations, and are useful in informing treatment decisions as well as making a diagnosis. Where available, select preliminary findings from the initial phase of field testing will be shared.

1. The Purpose and Design of DSM-5 Field Trials

Helena Kraemer Ph.D.

Overall Summary: The overall purpose of DSM-5 development is to use the evidence accrued in the clinical and research use of earlier DSM diagnoses to identify areas of incompleteness or error and to correct them. The goal of such correction is to bring DSM-5 diagnoses to closer association with the corresponding disorders to facilitate clinical decision making, clinical research, and the search for risk factors/causes of those disorders. A "field trial" is an effort to document that the goals of such correction are achieved: feasibility, utility, reliability and validity. The DSM-5 field trials are centrally designed, conducted and analysis, with the results to be returned to the DSM-5 Work Groups for any necessary further modification. The design and expectations of the DSM-5 field trials will be described, and common questions about that design addressed.

2. DSM-5 Field Trials: Implementation in Academic/ Large Clinical Settings

Diana Clarke, M.Sc., Ph.D.

Overall Summary: The DSM-5 Task Force and Work Groups have proposed a number of changes to the diagnostic criteria for many mental disorders. Some changes include amendments to existing disorders, proposals for new disorders, a change in how some disorders are conceptualized, as well as the integration of dimensional measures across diagnostic groups to augment the existing categorical classification of mental disorders. Since DSM is primarily a clinical tool that is used across the variety of clinical settings in which individuals seek help for their mental health problems, it is important that the proposed changes are examined for their feasibility, usefulness, reliability, and, where possible, validity in such settings. As such, field trials were designed and implemented to address these issues. One version of the DSM-5 field trials aims to assess the feasibility, clinical usefulness, test-retest and inter-rater reliabilities and validity of the proposed changes but focused on academic/large clinical settings. This presentation will describe the rationale and implementation strategies behind this field trial design. Attention will be given to describing the study protocol and the ways in which this field trial design was tailored specifically to meet the needs of the large psychiatric, specialty, and general medical clinics.

3. DSM-5 Field Testing in Academic-Medical Centers: Outcomes and Interpretations

Darrel A. Regier M.D., M.P.H.

Overall Summary: One important aspect of field testing of proposed changes to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) involves the collection of data among large, academic-medical institutions across the United States and in Canada. Since DSM is primarily a clinical tool, it is important that we answer questions related to the reliability, utility, and feasibility of proposed changes to DSM-5 in clinical populations, such as diagnosis-specific mental health clinics, general psychiatry clinics, and general medical clinics (i.e., primary care). Outcomes may differ from one clinical population to another, and since DSM is used across a number of disciplines, it is also necessary that FTs reflect these variations as well. The DSM-5 field trials conducted in large, academic-medical clinical settings will accommodate testing of the diagnostic criteria and dimensional measures for mental disorders of high and low prevalence in a variety of clinics (e.g., general medical, Veteran's Administration, specialty adult and child clinics) and in different patient groups (e.g., across the developmental lifespan, across various ethnic groups). This presentation will summarize field trial efforts at the academic-medical centers and will include a discussion of select results and outcomes. Additional attention will be given to discussing the implications of field trials results in terms of improving psychiatric diagnosis, implementing measurement-based care in busy clinical environments, treatment planning, and monitoring illness course and treatment response.

4. Testing DSM-5 in Routine Clinical Practice Settings: Large-Scale Science in Small-Scale Practices

Eve Moscicki Sc.D., M.P.H.

Overall Summary: The DSM-5 Field Trials in Routine Clinical Practice Settings will examine the feasibility, clinical utility, and sensitivity to change of the proposed DSM-5 diagnostic criteria and dimensional assessment measures as used by individual clinicians in routine clinical practice settings. This presentation will provide an overview of the design, sampling, and procedures for this important component of the DSM-5 Field Trials. Study participants will include a representative sample of 1000 randomly selected general psychiatrists, 100 geriatric psychiatrists, 100 addiction psychiatrists, and 200 child psychiatrists; a volunteer sample of 1000 psychiatrists and 500 each of advanced practice psychiatric-mental health nurses, licensed doctoral-level psychologists, and clinical social workers; and 7800 systematically-selected patients. Each clinician will complete web-based DSM-5 training and will enroll one new and one existing patient into the Field Trial, explain the study, and obtain informed consent or assent from the selected patients. Field Trial data collection methods and data security will be described. Data characterizing the representative and volunteer samples of clinicians will be presented, including

sociodemographic characteristics, clinical discipline, specialty, caseload, nature of practice, practice setting, and patient caseload characteristics. The presentation will include a brief discussion of the unique challenges and opportunities found in implementing a large-scale scientific endeavor in small-scale settings.

5. Moving Forward: Implications of the Field Trials for DSM-5 Development

William Narrow M.D., M.P.H.

Overall Summary: The DSM-5 Field Trials hold important implications for the future of psychiatric diagnosis and treatment. This session will provide an overarching summary of the significance of current field trial outcomes to plans for DSM going forward. This includes both immediate and long-range plans for DSM-5, such as the planning for a potential second phase of testing. Emphasis will be placed on planned and completed data analyses and lessons learned to date from the DSM-5 Field Trials process (e.g., methodological issues, clinical outcomes, etc.). Discussion will also include a description of how field trial findings are informing text revisions to the diagnostic chapters as well as possible changes to the organization of DSM's chapter structure itself. Finally, this presentation will briefly address how field trial outcomes relate to International Classification of Disease harmonization activities.

References:

1) Kraemer HC, Kupfer DJ, Narrow WE, Clarke DE, Regier DA. Moving Toward DSM-5: The Field Trials. American Journal of Psychiatry, 2010; 167:1158-1159.
2) Regier DA, Narrow WE, Kuhl EA, & Kupfer DJ (eds). Evolution of the DSM-V Conceptual Framework: Development, Dimensions, Disability, Spectra, and Gender/Culture. Arlington, VA: American Psychiatric Association, 2010.
3) Patient-Reported Outcome Measurement Information System: Dynamic Tools to Measure Health Outcomes from the Patient Perspective. http://www.nihpromis.org/default.aspx
4) Helzer JE, Kraemer HC, Krueger RF, Wittchen H-U, Sirovatka PJ, Regier DA (eds): Dimensional Approaches in Diagnostic Classification: Refining the Research Agenda for DSM-V. Arlington, VA; American Psychiatric Association, 2008.

SYMPOSIUM 17

Saturday, October 29; 2:00 p.m.–5:00 p.m.

Flowering in the Ashes: Promising New Mental Health Services Act Programs in California

Mark Ragins, M.D., 456 Elm Avenue, Long Beach, CA 90802 2426

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Understand an overview of California's Mental Health Services Act including the impact of the financial crisis; 2) Understand Full Service Partnerships for difficult to engage populations; 3) Understand Prevention and Early Intervention and Transitional Aged Youth Program; 4) Understand Innovations and emphasis on employment; 5) Understand a peer education program.

Overall Summary: In November of 2004, Californian voters passed Proposition 63 establishing the Mental Health Services Act (MHSA) which taxed millionaires to fund additional recovery based mental health services. At close to $1 billion dollars annually, the MHSA is likely the largest recovery transformation effort anywhere. The MHSA funds new Community Services and Supports, Innovations, and Prevention and Early Intervention programs throughout the state in four age groups: Child and Adolescent, Transitional Age Youth, Adult, and Older Adult. Unfortunately, the major economic crisis in the past few years has badly damaged California's overall mental health system and distorted the implementation of the MHSA. Nonetheless, significant new programs have been implemented and are the beginnings of establishing a recovery based system. This symposium describes four exemplary MHSA funded Transitional Age Youth and Adult programs to provide concrete and hopeful examples of what is being accomplished and learned even in these difficult times. These programs are: 1) Pathways– A Full Service Partnership program for homeless adults in Sacramento, 2) PREP (Prevention and Recovery of Early Psychosis) – a collaborative Prevention and Early Intervention program in San Francisco, 3) An Innovations Program in Santa Cruz County Mental Health employing people with dual diagnoses, and 4) SOLVE (Sharing Our Lives: Voices and Experiences) a peer education series in which consumers share their first hand experience with audiences in San Francisco.

1. Five Years of the MHSA: An Up and–Down Journey

Mark Ragins, M.D.

Overall Summary: With the passage of Proposition 63 in November 2004, California's voters created the Mental Health Services Act (MHSA. Financed at about $700 million to $1 billion per year of addition funds from taxing incomes in excess of $1million the MHSA laid out a very complex and comprehensive process and structure for creating the system many of us have dreamed of since deinstitutionalization. The planning process itself was extraordinary in its scope and inclusiveness and for many a transformative experience in itself. The core elements of the MHSA have rolled out since then including Community

Services and Supports, Prevention and Early Intervention, Innovative Programs, Capital Facilities and Technology, and Workforce Education and Training. The needs of each of four age groups (Children and Adolescents, Transitional Aged Youth, Adults, and Older Adults) are addressed in each of 58 county plans. Over the past five years substantial numbers of exciting new and transformed programs and initiatives have been created serving thousands of people. It was hoped that by this point counties would be able to create integrated plans to actualize a transformed system. Unfortunately, the entire process was badly derailed, distorted, and demoralized by the financial downturn and massive cuts to existing mental health budgets everywhere. California's voters voted down an effort to redirect the MHSA funding out of mental health, but we've been left with a tattered mosaic of cuts and new programs, layoffs and new hires, hope and despair and overall funding levels less than before the MHSA. In some ways this has been a tragic recipe for more rapid transformation than would've occurred otherwise. There are promising new MHSA funded programs throughout the state. There has been substantial transformation in services throughout the state. It is likely that the lessons learned and the successes of these programs, in spite of desperate times, will serve us well as we rebuild our economy and our mental health system. Highlights have included the creation of: 1) Full Service Partnerships – a new concept including the ideas of integrated services (mental health, rehabilitation, and quality of life support services) and collaborative partnerships between consumers and their families and programs and their staff; 2) A new focus on specialized outreach and engagement and services for Transitional Aged Youth to avoid long term disability and destruction in their lives.

2. Full Service Partnerships (FSPS) That Promote Recovery: California's Response to Act Teams

Alexis Bernard, IMFT

Overall Summary: Pathways to Success after Homelessness opened in May 2007, as a supportive housing program run by Turning Point Community Programs (www.tpcp.org). Pathways is designed to help homeless individuals with mental illness succeed in living more independently. It is one of the first major Prop. 63/Mental Health Services Act (MHSA) funded programs to be launched in Sacramento County. The program serves approximately 350 individuals from three populations: adults; emancipated transition aged youth 18 25; and seriously emotionally disturbed children and their families. The Pathways program utilizes numerous locations in Sacramento to provide permanent supportive homes for clients: 1) Fairview Apartments: In 2006 with Homeless Intervention Program funds, Turning Point purchased Fairview Apartments, which opened to Pathways clients in 2007. There are nine 1 bedroom apartments and one 2 bedroom apartment, with a resident manager. 2) Ardenaire Apartments: Pathways also has available, through Mercy Housing and the Sacramento County Division of Mental Health, MHSA Housing Program, 19 apartments at the Ardenaire Apartments: three 2 bedrooms and sixteen 1 bedrooms. This complex is owned and operated by Mercy Housing. 3) Scattered site apartments: Pathways master leases individual apartments to accommodate more Pathways clients. In December 2008, 50 apartments were under lease with various landlords. Funding for these units is provided by Keys To Hope or program subsidies. 4) Martin Luther King Village: Pathways also has 30 dedicated efficiency apartments at Martin Luther King Village for adults. MLK Village was built by Mercy Housing to provide a total of 80 affordable supportive homes for those with disabilities. This is a tax credit property and tenant rents are subsidized by Shelter Plus Care or MHP funds. The Pathways program provides intensive wrap around services to all clients. These include case management, independent living skills training, employment services, mental health services including Turning Point's staff psychiatrist and nurse and referrals to medical, educational, and other community resources. For more information, contact Alexis Bernard, Program Director, Pathways to Success After Homelessness, 916 283 8280, ext. 1271, alexisbernard@tpcp.org.

3. A Community Academic Partnership Approach to Prevention and Early Intervention in Psychosis: The Prep Model

Demian Rose, M.D., Ph.D., Bob Bennett

Overall Summary: As part of the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) mandate, the University of California at San Francisco (UCSF) and several community partner agencies in San Francisco and Alameda Counties, led by Family Service Agency (FSA) proposed and received funding for a novel and systemic programmatic approach to the prevention and treatment of early psychosis. This program, Prevention and Recovery of Early Psychosis (PREP), has now been actively serving clients for over a year. We will present here a summary of our program's structure, mission and outcomes data to date.

4. Avenues: Work First for Individuals With Co Occurring Disorders of Mental Illness and Substance Abuse

Connie Tanner, M.S., Y Jacobs, M.F.T., E. Chance, M.S.W.

Overall Summary: Avenues is an innovative "work first" program that targets adults and transition age youth with co occurring disorders of mental illness and substance abuse. The project provides a "work first" Center that collaboratively partners with a 15 bed residential program, "Casa Pacific" and The Community Restoration Project (CRP) work crew. The program integrates an active work program during the day for all participants as a core treatment modality. The innovation is to engage people in active work related activities as an alternative to traditional mental health treatment and substance abuse treatment modalities. Avenues' primary focus is on employment, education, volunteerism and community integration support. While employment is the main focus and attraction integration and access to 12 step meetings is woven into the overall program design. In addition, alternative treatment including Mindfulness groups and acupuncture plus peer support are

part of the services being offered. By emphasizing, "work first", participants begin to demonstrate accountability and feelings of self worth while learning to manage and cope with mental health symptoms and substance abuse triggers.

Avenues is a client driven program that offers individuals "Avenues of Options" tailored to meet their strengths, experiences, interests and needs. Avenues participants have the opportunity to participate in a 60 day assessment and treatment program that emphasizes return to work skill building and work experience activities. Participants have the option of joining the CRP work crew or participating in the structured employment program. Program activities are focused on "work first" as an alternative to traditional substance abuse and/or mental health treatment. Services include a morning DRA and therapy group, group volunteer activity, outside 12 step meeting, lunch and an afternoon employment readiness workshop. A 12 week session focused on job search, resume building, interview skills, maintaining employment, managing symptoms and triggers, time management, accountability, computer trainings, building self esteem and more, is offered to meet the groups needs. Avenues also provides medication support, and individual employment counseling when needed. Another component of the Avenues program is Peer Support. Peer Navigators will assist and support program participants with achieving wellness and sobriety, finding volunteer and paid employment and connecting with the community.

5. Whose Recovery Is This? : Addressing Mental Health Stigma Via Peer Education in the Solve Program with the Mental Health Association of San Francisco

Michael Gause, M.F.A.

Overall Summary: Michael Gause of the Mental Health Association of San Francisco (MHA SF) will discuss the SOLVE Program, which is funded through MHSA. SOLVE (Sharing Our Lives: Voices and Experiences) is an interactive, stigma elimination program in which Peer Educators share their personal experience with mental illness. Currently, over 20 Peer Educators speak on behalf of SOLVE. In 2010, Peer Educators have given presentations to over 40 organizations and venues, reaching over 600 individuals. Working from the basis that mental illness and mental health issues affect approximately one in four Americans (National Institute on Mental Health, 1988), the explicit mission of SOLVE is to decrease the fear, shame and isolation of those with mental illness through peer education by individuals with a personal connection with mental illness. SOLVE is unique in that it strives to speak to a diverse set of audience members, but we still place a particular focus on service providers and clinicians. These presentations are tailored to address structural stigma within institutions as well as challenge traditional notions of mental illness. It has been particularly empowering for our Peer Educators to speak directly to clinicians and providers and detail their experiences as clients in both inpatient and outpatient settings. This is a key point of SOLVE presentations: to identify recovery and healing in mental health and promote ownership of that by consumers. During the presentation, MHA SF staff will discuss the formation of the program, the effectiveness of the Speakers Bureau, and the data compiled in the first year of its inception with regards to stigma reduction.

References:

1) Mistique C. Felton, Cheryl E. Cashin and Timothy T. Brown. What Does It Take? California County Funding Requests for Recovery Oriented Full Service Partnerships Under the Mental Health Services Act Community Mental Health Journal Volume 46, Number 5, 441 451
2) A Comparison of Satisfaction, Services Characteristics and Outcomes in the Full Service Partnership Programs Relative to Usual Care Petris Report # 2010 1 Nicholas C. Petris Center on Health Care Markets and Consumer Welfare School of Public Health University of California, Berkeley May 2010
3) Cashin, C., Scheffler, R., Felton, M., Adams, N., & Miller, L. (2008). Transformation of the California mental health system: Stakeholder driven planning as a transformational activity. Psychiatric Services, 59(10), 1107–1114
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SYMPOSIUM 18

Saturday, October 29; 2:00 p.m.–5:00 p.m.

Integrating Mind and Body: Psychoeducation Approaches

Karen A. Landwehr, M.A., 1305 Tacoma Avenue South #305, Tacoma, WA 98402

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Recognize the role of psychoeducation in providing patients information concerning health risks associated with mental illness; 2) Describe ways to integrate rehabilitation into clinical practice; 3) Identify requisite content for an integrated peychoeducation program addressing physical and psychiatric health and rehabilitation.

Overall Summary: Much has been written about the need to educate psychiatric patients about rehabilitation and the need to provide whole health solutions in treatment. This need has been poignantly highlighted by research indicating the increased risk of serious, sometimes fatal, medical conditions faced by consumers of mental health services. But how can clinicians, agencies or hospitals meet this challenge within the context of providing comprehensive services? This symposium will focus on the issue of integrating medical education with psychiatric education and rehabilitation. Participants will be provided with examples of programs that are meeting this challenge.

1. Developing a Wellness Program

Karen Landwehr, M.A., Larry S. Baker, M.Div.

Overall Summary: In light of the well documented tendency of individuals with mental disorders to experience major health problems and a consequent shortening of life expectancy, one major factor is frequently cited: the dichotomy between mental health and medical treatment. The question, however, is how to address this issue within the context of existing systems of care. Agencies are attempting to resolve this dilemma in a variety of ways. One creative solution being used in Pierce County, Washington, is the use of a mobile health van to provide on site primary care treatment at four major mental health centers. Bridging the gap between the two types of treatment is the goal of combined psychoeducation/patient education programs focused on the symbiotic, often synergistic, relationship between mental and medical disorders. This presentation will describe the development of one such program, Pebbles in the Pond: Achieving Wellness through a Healthy Lifestyle, offer initial data demonstrating program efficacy, and provide participants with a blue print for developing similar programs.

2. Integrating Wellness into CMHC Services

Patricia L. Scheifler, M.S.W., P.I.P.

Overall Summary: Many people who are recovering from severe persistent mental illness have comorbid medical problems such as obesity, diabetes, and blood pressure. Detecting physical health problems, accessing treatment, enhancing treatment adherence, and managing the potential negative impact of psychiatric medication side effects, all pose significant challenges. The call to action to integrate health and wellness into routine psychiatric services has brought these issues and challenges to the forefront for CMHCs. This presentation will provide participants with multiple "real world" strategies for integrating health and wellness services. Specific services, resources, progress notes, treatment plan elements, policies, procedures, and treatment team member responsibilities will be discussed and practical examples will be given.

3. Integrating Psychiatric Services Within a General Hospital

Garry M. Vickar, M.D.

Overall Summary: Few American general hospitals offer inpatient care. Those that do should provide as full a spectrum of services as possible, eg. inpatient, outpatient, Emergency Dept. evaluations, consultation services, partial hospitalization. This presentation will review how that has been accomplished in one of the only general hospitals that offers such services within the largest Health Care System in the state of Missouri. How it was achieved, received, and nurtured will be addressed, with suggestions on how and why it should be replicated in other settings. Acceptance and appreciation by nonpsychiatric colleagues has been superb, not to mention essential in our success, and how to promote these relationships will be addressed as well. Encouraging a new generation of psychiatrists to work in such settings is a challenge that also will have to be met and will be addressed.

4. Mind Meets Body: Can We Train the Brain to Learn and Discern?

Robert Liberman, M.D.

Overall Summary: Persons with schizophrenia and other serious mental disorders have neurocognitive deficits that interfere with psychoeducational approaches. These deficits are obstacles to learning, sustained attention, problem solving, memory, decision making and social perception all of which are essential for successful participation in psychosocial rehabilitation and recovery. Basic neuronal functioning of various regions of the brain and their myriad interconnections determine individuals' ability to adapt and respond effectively to the challenges of social, family, educational, vocational and independent life. Methods for training the brain have emerged as evidence based practices for psychosocial rehabilitation and recovery. Computer based programs can improve neurocognitive functions, including accurate emotional and social processing of incoming information. When training of basic neurocognitive functions is integrated with social skills training and environmental supports, individuals with mental disabilities are able to perform normally in their communities. Errorless learning is one promising means of integrating mind, brain and environment to compensate for deficient neurocognition. Training the brain enables individuals with schizophrenia and developmental disabilities to acquire a variety of skills for achieving their person centered, recovery oriented goals.

References:

1) Diamond, RJ & Scheifler, PL (2007): Treatment Collaboration: Improving the therapist, prescriber, client relationship. WW Norton & Company, New York.
2) Meyer, JM & Nasrallah, HA (2009): Medical illness and schizophrenia, second ed. American Psychiatric Publishing, Inc., Washington DC.
3) Margen, S, Lashof, JC et al. (1999): Wellness made easy: 365 tips for better health. University of California, Berkeley Wellness Letter, Health Letter Associates.
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SYMPOSIUM 19

Saturday, October 29; 2:00 p.m.–5:00 p.m.

A Primary Care Primer For the Psychiatrist

Sara M. Coffey, D.O., 5841 South Maryland Avenue, MC 3077, Chicago, IL 60637, **George R. Bergus, M.D., M.Ed.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Review a basic physical examination, recognize when to order and interpret screening laboratory testing, and determine when referrals for additional medical care are indicated; 2) Diagnose nicotine dependence, initiate tobacco cessation interventions, and refer for further

tobacco cessation care as indicated; 3) Pursue additional opportunities that enrich participants' capacity to integrate primary care services alongside mental health care.

Overall Summary: In several studies of patients with mental illness, including schizophrenia and other major affective disorders as much as 50% have a general medical condition that goes largely undiagnosed and untreated (1). It has been cited that age adjusted death rates from all cause mortality amongst psychiatric patients are 2 4 times higher than the general population (2) and studies have found that on average psychiatric patients die 20 years earlier than the population at large (3). The majority of deaths in this population are typically due to physical illness, in particular cardiovascular disease, respiratory illness and cancer (4). Several issues play a role in this disparity including, systemic issues, stigma and cognitive complications attributed to severe mental illness (4). These issues are not new to the field of psychiatry, as early as the late 1800's, in an address to the American Medico Psychiatric Association, later to become the APA, Dr. Silas Weir Mitchell warned; "You were the first specialist to [to isolate yourselves] and you have never come back into line" he further went on to state, "too often surprised at the amazing lack of complete physical study of the insane, and even in a certain asylum I could not get a stethoscope or an ophthalmoscope (5). The discussion has continued onto the 21st century. However, many mental health treatment programs are unprepared to assume full responsibility for detecting physical disease, yet for many patients enrollment in a mental health system may be their only contact with the larger health care system (6). With the recent changes in healthcare reform; psychiatrists, other medical providers and policy makers are again examining the role of the medical home and the intricate relationship between primary care and mental health. Today's discussions have the potential to substantially improve the overall medical and mental health of our patients. This symposium will address these important issues, starting with an exploration of physical disease and the physical exam of patients with mental illness. We will further provide demonstrations to improve basic skills in recognition, screening, and potential management of common preventive diseases for practicing psychiatrists, such as hyperlipidemia. Techniques for smoking cessation in patients with mental illness will also be addressed.

1. Medical Aspects of Psychiatric Care: Historical and Current Perspectives

Sara Coffey, D.O.

Overall Summary: The first portion of our symposium will look at the prevalence of medical illness in patients with mental illness. This will include a review of past and more recent literature. Additionally, a review of attitudes of psychiatrists will be discussed in an effort to expand the discussion of the psychiatrist's role in the medical health of their patients.

2. Lipid Monitoring and Treatment in Psychiatric Patients

Erik Vanderlip, M.D.

Overall Summary: In this 30 minute presentation portion of the symposium, we will review risk factors associated with dyslipidemia, evidence based methods of screening and interpreting the fasting and non fasting lipid profile, and offer guidelines for the recognition and basic treatment of lipid disorders within the psychiatric patient population. Additionally, we will provide suggested guidelines for when to refer dyslipidemias to primary care providers for further evaluation and treatment.

3. Smoking Cessation in Psychiatric Practice

Brian Hurley, M.D., M.B.A.

Overall Summary: Techniques for smoking cessation in patients with mental illness will be addressed. An introduction to screening psychiatric patients for tobacco smoking behaviors and performing motivational interviewing for smoking cessation in the context of psychiatric treatment will be provided. Pharamcotherapies for managing nicotine withdrawal and tobacco smoking substitute technologies will be reviewed. Common community mental health based referral resources that support patients to stop smoking tobacco and sustain abstinence will be discussed.

4. Primary Care Skills Every Psychiatrist Should Have

Vanessa Lauzon, M.D.

Overall Summary: Psychiatrists often serve as the de facto primary healthcare provider for patients with serious mental illness. This portion of the sympsium will utilize a practical, case based approach to reviewing the current evidence and guidelines for disease screening, with a particular focus on screening for conditions which disproportionately affect psychiatric patients, including diabetes, hypertension, and cancer.

References:

1) Rothbard, A., Blank, M., Staab, J., Tenhave, T., Young, D.Berry, S., Eachus, S. (2009). Previously Undetected Metabolic Syndromes and Infectious Diseases Among Psychiatric Inpatients. Psychiatric Services, 60 (4), 534 537.
2) Garden, G. (2005). Physical examination in the psychiatric practice. Advances in Psychiatric Treatment, 11, 142 149.
3) Koryani, E. (1982) Undiagnosed Physical Illness in Psychiatric Patients. Annual Review of Medicine, 33, 309 316.
4) Lawerence, D. & Kisley, S. (2010) Inequalities in Healthcare Provisions For People With Severe Mental Illness. Journal of Psychopharmacology, 24 (11) Supplement 4, 61 68.

SYMPOSIUM 20

Sunday, October 30; 8:30 a.m.–11:30 a.m.

There Is No Such Thing as a "Med Check"

Jeffrey Geller, M.D., M.P.H., 55 Lake Avenue North, Worcester, MA 01655

Educational Objectives: At the conclusion of this session, the participant should be able to understand the apparent, current limitations on psychiatrists prescribing medications for patients in outpatient settings and learn ways to make the "medication visit" much more than that.

Overall Summary: For hundreds, if not thousands of years, the clinical needs of the person consulting the healer drove most aspects of the encounter between the two. In the twenty first century, the setting and the payor drive the encounter, with a palpable disregard for the individual patient's needs and the psychiatrist's match of services to needs. No matter what direction health reform takes, there is virtually no chance that we will return to the era when the doctor patient relationship was a relationship between two parties, unencumbered by all manner of third parties. Nor is there any likelihood that this relationship will be an hour session with medication and psychotherapy intermingled. Rather, what we have now are patients seen in organized settings where the psychiatrist is expected to do a "medication visit" at the rate of 3,4,6 or even 8 per hour (double booking for no shows). In this session we will assist participants in transforming the "med visit" into much more. It is quite possible for a 15 minute appointment to be consistently meaningful and therapeutic for a patient. Dr. Mistler will describe "shared decision making", a concept that is fundamental to recovery and to transforming short patient encounters from simple prescription writing to therapeutic encounters. We have examples from three psychiatrists who work in community sites accross the USA as to their experiences in practicing psychiatry in this manner.

1. An Overview of Shared Decision Making

Lisa Mistler, M.D., M.S.

Overall Summary: Following the general health care system, the public mental health system in the United States has been shifting from a paternalistic model of care toward a more collaborative model. This movement was driven in part by a growing realization that providers and consumers often have different views regarding goals, risks and benefits of treatment. While the traditional service system focuses primarily on symptom reduction and client stability, consumers desire to move beyond symptom management in order to live, work, learn, and participate fully in their communities. This has set the stage for changing how mental health treatment decisions are made. Few treatment decisions involve a clear best choice; the typical decision involves trade offs among multiple partially effective interventions with different risks. This is particularly true for mental health medication treatment decisions. This fundamental dilemma gives rise to the paradigm of shared decision making (SDM), which we will describe in more detail during this symposium. SDM includes several essential elements: patient knowledge; explicit provider encouragement of the patient's involvement; time; patient preferences and values; patient and provider knowledge of choices; and appreciation of the patient's responsibility and right to have an active role in treatment decisions. A model SDM system would provide clients and providers with access to correct, clear and concise information that is easily retrieved and updated, as well as the resources necessary to discuss relevant options without significantly draining provider resources. In addition, an SDM system must include legislation that eliminates outdated informed consent rules and replaces them with liability protection language that recognizes the priority of autonomy and the responsibilities of provider and client as a partnership of equals. Providers would no longer have to guess regarding their legal liability and they could improve the health outcomes of their patients by enabling them to be more invested in their treatment choice. Ultimately, when a provider and client collaborate in the treatment decision, they are prioritizing patient autonomy over beneficence. In instances of disagreement after discussion, the client's preference should determine the treatment, since the client has to live with the decision and its implications.

2. A Perspective From California

Bernadette Grosjean, M.D.

Overall Summary: In 2004, California's voters passed Proposition 63 (Mental Health Services Act) to improve the delivery of mental health services to the community. As a result, Full Service Partnership (FSP) programs were implemented. Patients referred to FSP are adults diagnosed with severe mental illness who require intensive delivery of services in the community. The majority are homeless and high utilizers of state and county services: emergency rooms, inpatient units and jails. In order to be enrolled in the program, our "clients" need at least a severe diagnosis on the Axis 1, most often schizophrenia or bipolar disorder. Most of them also present several comorbidities such as addiction and personality disorders. Although these multiple diagnoses almost always imply the need for medication management, the erratic journey of these patients through multiple, fragmented, 15 minute "Med Check" systems demonstrates how inefficient a "philosophy of (managed) care" can be. We at FSP have seen that relatively brief periods of "continuity of care" with "eye to eye", wide ranging and "long enough" encounters with their psychiatrist succeed in solid improvements for a population identified as "impossible to treat". This says a lot about the limits of the "Med Check" approach. Simultaneously, it reminds us of the almost shocking power of a real, flexible and comprehensive inter human encounter. What is no big news for veteran practitioners and generations of healers is today confirmed by neurosciences: relationship is an essential part of the healing process. Concurrently, contemporary, poorly conceived "Med Check" constraints may seriously impede the full deployment of the therapeutic process. An additional concern is that the evolution of the practice of psychiatry, with an emphasis on the quick fix and the myths of miraculous pills has taken over the training of

young physicians who no longer learn about "everything else" (than medication). The question is: will governmental politics, health administrators and academic players realize the relative ineffectiveness of the "Med Check" system before it undermines the art of psychiatry and empties it of its essence, to the detriment of ourpatients.

3. Group Meetings in Behavioral Health that Include Prescribing and Discussing Medication as Part of the Treatment/Recovery Plan

Benjamin Crocker, M.D.

Overall Summary: Group process has long been a fundamental aspect of psychiatric treatment. Springing from the crisis of war and attempts to bring psychotherapy to large numbers of hospitalized patients, groups were a major part of the community mental health response to deinstitutionalization and remain a mainstay of acute psychiatric treatment in IOP and partial hospital settings. This presentation will address the use of groups in ongoing outpatient services that include the prescribing of medication. Groups provide flexibility of scheduling, efficiency of staffing time, "productivity" in fee for service payor systems, but more importantly provide an ongoing social context to treatment that can endure beyond staffing changes and offer the experience of social support that can be generalized in community recovery experiences. Groups can also be an effective way of linking evidence based psychotherapy and psychoeducational treatment to medication treatment across the diagnostic spectrum. We will also discuss the potential use of group BH interventions in the integration of behavioral health and primary care, where group medical visits are part of the Medical Home model.

4. Only in New York: Turning It into 15 Minutes of Fame

Hunter L. McQuistion, M.D.

Overall Summary: As in most states, psychiatric service delivery in New York is undergoing change toward valuing brief, focused, clinical encounters. How public sector behavioral healthcare systems adapt to this takes on additional local community texture, modified by such factors as population characteristics, individual service needs, and clinical setting. Utilizing personal experience, as well as information gleaned from individual providers, the presenter will discuss how psychiatrists in a New York City outpatient and community based delivery system are adapting to increased pressure for "productivity" while optimizing the ability to help a person pursue his or her recovery goals. This will be examined in the context of shifts in public policy, mode of reimbursement, regulatory requirements, and local fiscal demands that may affect high quality service.

References:

1) Milner KK, Healy D, Barry KL, Blow FC, Irmiter C, De Chavez P: State Mental Health Policy: Implementation of Computerized Medication Prescribing Algorithms in a Community Mental Health System. Psychiatric Services, 60: 1010 1012, 2009.
2) Feiner JS, Freese FJ. Recivery in schizophrenia, in Sadock BJ, Sadock VA, Ruiz P: Comprehensive textbook of Psychiatry. Lippincott Williams & Wilkins, Philadelphia, 2009, pp. 1582 1593.
3) Hamann J, Mendel R, Cohen R, Heres S, Ziegler M, Bühner M, Kissling W: Psychiatrists' Use of Shared Decision Making in the Treatment of Schizophrenia: Patient Characteristics and Decision Topics.Psychiatric Services 60:1107 1112, 2009
4) Deegan PE, Rapp C, Holter M, Riefer M: Best Practices: A Program to Support Shared Decision Making in an Outpatient Psychiatric Medication Clinic Psychiatric Services, 59: 603 605, 2008

SYMPOSIUM 21

Sunday, October 30; 8:30 a.m.–11:30 a.m.

Project BETA: Best Practices in Evaluation and Treatment of Agitation

Scott Zeller, M.D., 2060 Fairmont Drive, San Leandro, CA 94578, **Garland H. Holloman, Jr., M.D., Ph.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Recognize the various medical and psychiatric conditions that can lead to agitation; 2) Identify successful approaches for non-coercive de-escalation of agitated individuals; 3) Treat agitated individuals with the most appropriate pharmacologic regimen 4) Understand methods of reducing the need for restraint and seclusion.

Overall Summary: Agitation is a major issue in the USA, with 1.7 million emergency department visits per year involving agitated patients. However, diagnostic and treatment interventions vary widely by facility, while education and training about agitation have been limited at best. In 2010, the American Association for Emergency Psychiatry (AAEP) began a year-long expert guidelines project to establish Best Practices in the Evaluation and Treatment of Agitation. Known as Project BETA, the consulting panels involved dozens of psychiatrists, emergency medicine physicians and crisis professionals. The final guidelines product will be first unveiled at the October 2011 Institute for Psychiatric Services meeting in San Francisco. The guidelines will feature the following subtopics: 1) Rapid Assessment and Triage—Medical Clearance, 2) Rapid Assessment and Triage—Psychiatric Evaluation, 3) De-escalation Techniques, 4) Pharmacologic Management, 5) Restraint and Seclusion. The goal of the project is a national upgrade in quality of care, including therapeutic alliance-based treatment, less coercion, and improved outcomes for agitated individuals. Members of the Project Beta teams will present the recommendations and guidelines for each subtopic while allowing ample time for group discussion.

1. Medical Clearance of the Agitated Patient

Kimberly Nordstrom M.D., J.D.

Overall Summary: There are many practices around the medical clearance of the agitated patient; Project BETA has come up with consensus guidelines to help create a standard of care around this medical clearance. This part of the talk will focus on the basis of the standard, the components of a medical clearance, and the reasoning behind each component.

2. Psychiatric Evaluation of the Agitated Patient

Keith Stowell M.D., M.S.P.H.

Overall Summary: This discussion will present an evidence-driven approach to the clinical assessment and interview of the agitated patient. The emphasis will be on what can practically be done in a typical acute care setting given the limitations of time and resources. Particular attention will be paid both to integrating verbal de-escalation into the assessment and identifying the most urgent issues to be addressed.

3. Verbal De-Escalation of the Agitated Patient in the ED

Janet Richmond M.S.W.

Overall Summary: This presentation will detail advanced techniques in interviewing and verbal de-escalation of agitated patients. Appealing to the patient's desire to stay in control, to be treated with dignity and not be humiliated are the underpinnings of verbal de-escalation. The ability to set limits firmly and securely, to know when help from security and nursing staff are necessary, and the ability to be flexible, direct, and honest with the patient are key elements in de-escalation. Attempting to define and acknowledge the patient's "request" (Lazare) is quintessential, even if the request cannot be granted.

4. The Psychopharmacology of the Agitation

David Feifel, PA-C

Overall Summary: The expanding medications options for the treatment of agitation often leave providers acting out of personal experience or local tradition rather then evidence based medicine. This discussion will focus on the current evidence for the use medications in agitation as well limitations and cautions in certain populations.

5. Use and Avoidance of Seclusion and Restraint

Daryl K. Knox, M.D.

Overall Summary: This presentation on the Use and Avoidance of Seclusion and Restraint is a component of the American Association for Emergency Psychiatry's (AAEP) Project BETA: Best Practices in Evaluation and Treatment of Agitation. The presentation will focus on the issue of seclusion and restraint of psychiatric patients in hospital Emergency Departments and/or specialized Psychiatric Emergency Service (PES) settings. A review of CMS and other regulatory policies surrounding the use of seclusion and restraint will be reviewed, as well as the potential for physical and psychological harm to patients and staff that can ensue when seclusion and restraint are used. An exploration of the existing debate as to whether zero incidence of these procedures is obtainable in a psychiatric emergency setting as opposed to the hospital setting will be discussed. Organizational strategies to significantly reduce episodes of seclusion and restraint that may be applicable to the emergency setting will be presented as well as an algorithm to guide clinicians as to appropriate use of these interventions.

References:

1) Zeller, SL and Rhoades, RW. Systematic reviews of assessment measures and pharmacologic treatments for agitation. Clin Ther. 2010 Mar;32(3):403-25. Review.
2) Fishkind, AB. Agitation II: De-escalation of the Aggressive Patient & Avoiding Coercion. In: Glick RL, Berlin JS, Fishkind AB, Zeller SL. Emergency Psychiatry:Principles and Practice. Philadelphia PA: Wolters Kluwer Health/Lippincott Williams and Wilkins; 2008:125-136
3) Battaglia J. The treatment of acute agitation in schizophrenia. CNS Spectr. 2007 Aug;12(8 Suppl 11):4-5. Review.
4) Rossi J, Swan MC, Isaacs ED. The violent or agitated patient. Emerg Med Clin North Am. 2010 Feb;28(1):235-56, x.

SYMPOSIUM 22

Sunday, October 30; 8:30 a.m.–11:30 a.m.

Updates on Psychological Impacts of the Wars in Afghanistan and Iraq: Best Modalities of Screening and Treatment

Elspeth C. Ritchie, M.D., M.P.H., 10014 Portland Place, Silver Spring, MD 20901, **Carroll J. Diebold, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to identify and treat service members and veterans experiencing the psychological effects of war, to include PTSD and TBI.

Summary: Consumers who use disproportionate amounts of services are a challenge for public mental health systems. This symposium will provide a range of presentations on the care of service members from the battlefield to the military treatment facilities to the VA. The initial focus will be on the acute symptoms of psychological reactions to war. Best practices used at Walter Reed and in the Pacific region will be specifically discussed. Follow up care in the VA system will be discussed. Pitfalls for the clinician will be emphasized, to include family issues, confusing diagnoses, and reluctance of the service member to engage in care.

1. The Pacific Psychological Health Task Force: Enhancing Treatment Through Establishment of Partnerships in the Pacific Region

Carroll Diebold, M.D., Marvin Oleshansky, M.D.

Overall Summary: The Pacific Psychological Health Task Force was established in 2008 with the goal of enhancing access

to psychological health services for Service Members and their Families in the Pacific Region, especially Reserve and National Guard Soldiers on the outer Hawaiian Islands, American Samoa, Guam, and Saipan. The Task Force is comprised of psychologincal health professionals from the Army, Navy, Air Force, and Veterans Administration; Pacific Regional Medical Command Psychological Health leadership; TRICARE contractor; US Army Reserves and Hawaii National Guard; psychological health advocacy organizations; federally funded community health centers; and telehealth subject matter experts. Discussion will focus on the enhancement of psychological health assessment, evaluation, and treatment services for Service Members, Veterans and their Families with emphasis on the utilization of telehealth in conjuction with traditional office based interventions.

1. Managing the Effects of Combat Trauma: The Evolving Practice at Walter Reed Army Medical Center

Scott Moran, M.D.

Overall Summary: As the wars in Iraq and Afghanistan continue, increasing numbers of soldiers continue to need complex, comprehensive medical, surgical, and psychiatric care. As the premier tertiary referral center in military medicine, Walter Reed Army Medical Center (WRAMC) receives the vast majority of the medical and psychiatric casualties. Comprehensive evaluations of the injured patient and evidence based interventions are essential in the treatment of trauma patients. Using a bio psycho social approach in the evaluation and treatment of the trauma patient and his family provides a framework to explore vital issues such as mortality, grief and loss, anger, chronic pain, substance abuse, and suicide. This Discussion will focus on the universal experiences of returning combat veterans as well as the approach to the treatment of psychological casualties returning from a battle zone. Themes will include dimensions of traumatic loss and growth, risk factors for psychological wounds, survivor guilt, family dynamic issues, and how this informs the clinical support. Treatment approaches for the primary psychiatric casualties of wars; the anxious, depressed, suicidal, or psychotic patient as a result of battle will also be highlighted. The authors will also describe the toll that the long term effects of caring for some of the most complex combat trauma patients has had on the health care team and organization after 10 years, and discuss the efforts to mitigate the impact that this secondary stress has caused and improve overall wellness and resilience of clinical staff.

2. The Pacific Psychological Health Task Force: Enhancing Treatment Through Establishment of Partnerships in the Pacific Region

Carroll Diebold, M.D.

Overall Summary: The Pacific Psychological Health Task Force was established in 2008 with the goal of enhancing access to psychological health services for Service Members and their Families in the Pacific Region, especially Reserve and National Guard Soldiers on the outer Hawaiian Islands, American Samoa, Guam, and Saipan. The Task Force is comprised of psychologincal health professionals from the Army, Navy, Air Force, and Veterans Administration; Pacific Regional Medical Command Psychological Health leadership; TRICARE contractor; US Army Reserves and Hawaii National Guard; psychological health advocacy organizations; federally funded community health centers; and telehealth subject matter experts. Discussion will focus on the enhancement of psychological health assessment, evaluation, and treatment services for Service Members, Veterans and their Families with emphasis on the utilization of telehealth in conjuction with traditional office based interventions.

3. Pharmacotherapy for PTSD in Combat Veterans: Challenges and Opportunities

David Benedek, M.D.

Overall Summary: In response to increased concern over the mental health of U.S. military veterans returning from combat in Iraq and Afghanistan, the Institute of Medicine reviewed and summarized the evidence supporting treatment for PTSD in 2007. Their report concluded that existing evidence was sufficient only to establish the efficacy of exposure based psychotherapies in the treatment of PTSD. However, the report included a dissenting opinion by one author about the strength of the evidence for pharmacotherapy (1). Recent studies bolster support for pharmacological intervention in many circumstances, but randomized controlled trials have indeed called into question the efficacy of SSRIs for the treatment of PTSD in combat veterans (2). Emerging evidence suggests the potential for psychotherapy to be facilitated by at least one recently identified pharmacological agent (d cycloserine) but efficacy in combat exposed populations has not been established and studies of combined medication and pharmacotherapy for PTSD are lacking. Other recent studies suggest that in certain patient populations new pharmacological options, such as Prazosin, may be more effective than other widely prescribed medications (e.g., selective serotonin reuptake inhibitors) indicated for PTSD. Increased understanding of the neuromolecular basis for the stress response points to the possibility that new agents with other mechanisms of action may be helpful but clinical trials are needed to demonstrate efficacy. While present pharmacologic options for management of combat related PTSD may be helpful, additional psychotherapeutic and pharmacologic approaches must be explored.

4. Building Dod/Va/State and Community Partnership in Service to OEF/OIF Veterans and Their Families: Military Culture and Community Competence

Harold Kudler, M.D.

Overall Summary: Less than one percent of our nation's population has served in Operation Enduring Freedom in Afghanistan (OEF) or in Operation Iraqi Freedom (OIF) yet these deployments resonate within every American community and across current and future generations of Americans. Ideally, deployment mental health issues would be managed

within the continuum of care offered by the Department of Defense (DoD) and the Department of Veterans Affairs (VA) but a "silent majority" of combat veterans seek care outside of either system and most military family members are also receiving their care within the civilian community. The critical questions are: (1) whether civilian providers have the military cultural competence required to effectively identify, assess, and treat Service Members, Veterans and their family members for clinical and functional problems stemming from deployment stress and; (2) whether civilian providers have the necessary understanding of DoD and VA medical, benefits and support systems needed to appropriately refer to and collaborate with them. This presentation builds upon past experience and current best practices to define a public health response capable of enhancing community competence in deployment health within a nation at war.

5. The Veteran and the Public Mental Health System

Elspeth Ritchie, M.D., M.P.H.

Overall Summary: An ongoing concern is the long term effects of the Long War, for the next twenty, thirty or fifty years. Usually the health care systems of the Department of Veteran's Administration and the Department of Defense talk to each other poorly, if at all. Those who fall between those cracks may end up in the public state mental health system and/or correctional facilities, which have even less connections with federal systems. After the Vietnam War, way too many veterans ended up on the streets, unemployed, homeless, and addicted. We hope that that the interventions described in the first part of this symposium will reduce those veterans who enter those ranks. However that will require a concerted effort by all on the homefront, including civilian psychiatrists, churches, schools, the VA, state and federal agencies.

References:

1) Ritchie EC, Owens M. Military Psychiatry, Psychiatric Clinics, September, 2004.
2) Ritchie EC, Senior Editor, Combat and Operational Behavioral Health, Textbook of Military Medicine, Borden Pavilion. Textbook of Military Medicine. Washington, DC: Office of The Surgeon General, US Department of the Army and Borden Institute; in press.

SYMPOSIUM 23

Sunday, October 30; 8:30 a.m.–11:30 a.m.

State of the Science on Diagnostic Classification: Implications For DSM-5

Darrel A. Regier, M.D., M.P.H., 1000 Wilson Boulevard, Arlington, VA 22209

Educational Objectives: At the conclusion of this session, the participant should be able to describe advances in our scientific understanding of psychiatric nosology and will be able to explain how this evidence is being considered in informing a revised meta-structure for DSM's diagnostic categories.

Overall Summary: One critical element in the next phase of DSM-5 development concerns the clustering of psychiatric diagnoses across all major diagnostic categories. The current DSM-IV provides 16 such categories, but recent advances in our understanding of psychiatric etiology and phenomenology – informed by neuroscience, genetics, and epidemiology in particular – signal the need to re-organize the structure of the manual to better reflect the state of the science, thereby facilitating clinical care and enhancing future research on diagnosis and treatment of mental illnesses. The meta-structure of DSM-5 holds important implications for how psychiatric practice and research are carried out, and the final distribution of disorders is anticipated to also influence approaches by the World Health Organization in revising ICD-10-CM and ICD-11. This symposium will give audiences an opportunity to learn about ongoing efforts of the DSM-5 Task Force and Work Group members to re-organize diagnostic categories in DSM-5 and how the proposed meta-structure may impact research, diagnosis, and treatment. A broad overview of the purpose and goals of such efforts will be provided, followed by presentations on specific diagnostic areas, such as mood disorders, anxiety and trauma-related disorders, childhood disorders, substance use and addictions, and neurodevelopmental disorders and autism.

1. The State of Science on Diagnostic Classification: Implications for DSM-5?

Jan Fawcett M.D.

Overall Summary: A clinical diagnosis must serve many purposes: It should guide treatment, show utility for clinical use, foster reliable diagnoses and if possible be supported by findings which give the diagnoses validity. Recent progress in genetics, functional brain imaging, measures of neurophysiology and temperament have raised the hope that evidence leading to more valid diagnoses would inform our ability to arrive at an improved diagnostic system that would reach for validity as well as reliability. Initial findings in these areas have not supported the Neo-Kraepelinian diagnostic criteria structure that has been developed as an advance since 1980 (DSM-III). This has resulted in a proposal for a structure to guide further research- RDoC (Research Domain Criteria) which would look at findings in various domains (e.g. genetics, temperament) to look for correlations with behavioral dimensions (e.g. depression, anxiety, psychosis) in order to look for new ways (e.g. endophenotypes) to classify psychiatric disorders that might promote the development of more understanding of underlying pathophysiologic mechanisms and improve treatment effectiveness. While we have found that findings in these areas are too disparate or limited to be useful for a clinical classification at this point in time in the DSM-5 process, we are considering adding behavioral dimensions such as severity of illness, impairment, severity of comorbid anxiety symptoms in mood disorders, severity of substance abuse in mood disorders, and severity of suicide risk management needs in mood and perhaps other appropriate disorders to provide a broader clinical view of diagnoses and treatment needs to at least approach the goal

of a reliable and more valid clinical diagnostic classification in anticipation of a change in the diagnostic system which is more based on behavioral dimensions than diagnostic categories.

2. The Metastructure OF DSM-5: Considerations for the Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders

Katharine Phillips M.D.

Overalll Summary: DSM-IV contains 16 groupings, or chapters, of disorders (for example, anxiety disorders, somatoform disorders), which is often referred to as the "metastructure" of DSM. An important question for DSM-5 is whether some of the groupings in DSM-IV, and the disorders included within them, should be changed, given advances in knowledge over the past several decades, since DSM-IV was developed. The metastructure is important for a number of reasons. Disorders that are classified together are presumed to be related, reflecting similarities in clinical features, treatment response, etiology/pathophysiology, or other characteristics. Classifying presumably related disorders together may in turn usefully guide clinical practice. Ideally, the metastructure should be based on empirical evidence of relatedness among disorders as indicated by a range of validators (for example, symptom similarity, comorbidity, familiality, neurobiology, genetic and environmental risk factors, treatment response). The metastructure should also reflect clinical utility considerations. This presentation will discuss considerations for the metastructure of DSM-5 as it relates to anxiety, obsessive-compulsive spectrum, posttraumatic, and dissociative disorders. Research evidence and clinical utility considerations that were reviewed by the DSM-5 Work Group covering these disorders will be presented. Additional considerations and challenges for the development of a metastructure for DSM-5 will be discussed.

3. What's Proposed for the Substance Related Disorders in DSM-V?

Thomas Crowley M.D.

Overall Summary: This talk addresses changes proposed for DSM-V from the Substance-Related Disorders chapter of DSM-IV. Those changes include the following: (1) Move "Pathological Gambling" to this chapter, renaming it "Gambling Disorder". (2) Rename the chapter: "Substance, Gambling, and Related Disorders". (3) Combine the 4 criteria of Substance Abuse and the 7 criteria of Substance Dependence, renaming that combined disorder, "Substance Use Disorder" (SUD); clinicians will specify, e.g., "Cocaine Use Disorder". (4) Remove from the current SUD criterion list, "Recurrent substance-related legal problems". (5) To the current criterion list add a "Craving" item, indicating strong urges or desires to use the drug. (6) Implement two new measures of severity: (6a) A between-person rating of severity based on number of SUD criteria met: 0-1 criteria, No Diagnosis; 2-3, Mild SUD; 4-6, Moderate; >6, Severe; (6b) A within-person rating of changing severity (e.g., improvement during treatment) using available quantity-frequency information such as estimated days used per week or month and estimated doses per day, supplemented when possible with biological measures of drug intake (e.g., urine, breath, saliva, etc.). (7) Add withdrawal as a diagnostic criterion for Cannabis Use Disorder. (8) Add the diagnosis of Cannabis Withdrawal to the Substance Induced Disorders. (9) Move the Substance chapter into same section of the manual with antisocial and conduct disorders. Data supporting these changes will be presented. (Supported in part by NIDA Grants DA- 009842, 011015.)

References:

1) Andrews G, Goldberg DP, Krueger RF, Carpenter Jr WT, Hyman SE, Sachdev P & Pine DS. Exploring the Feasibility of a Meta-Structure for DSM-V and ICD-11: Could It Improve Utility and Validity? Psychological Medicine, 2009; 39: 1993-2000.
2) Goldberg DP, Krueger RF, Andrews G & Hobbs MJ. Emotional Disorders: Cluster 4 of the Proposed Meta-Structure for DSM-V and ICD-11. Psychological Medicine, 2009; 39: 2043-2059.
3) Andrews G, Pine DS, Hobbs MJ, Anderson TM & Sunderland M. Neurodevelopmental Disorders: Cluster 2 of the Proposed Meta-Structure for DSM- V and ICD-11. Psychological Medicine, 2009; 39: 2013-2023.
4) Wittchen H-U, Beesdo K, Gloster AT. A new metastructure of mental disorders: a helpful step into the future or a harmful step back into the past? Psychological Medicine, 2009; 39:2083-2089.

SYMPOSIUM 24

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

Crooked Beauty – A First Person Account of One Individual's Experience with Bipolar Disorder

Ken Rosenthal, San Francisco, CA

Overall Summary: Set against a backdrop of poetic imagery by award-winning filmmaker Ken Paul Rosenthal, the mesmerizing narration of writer-artist Jacks McNamara challenges viewers to explore the psychosocial and personal causes of mental illness, approaches to medication and treatment, and the role extreme emotional states can play in imagination and creativity. A compassionate, transformative and educational resource for mental health professionals, social workers and activists.

WORKSHOP 01

Thursday, October 27; 8:00 a.m.–9:30 a.m.

One Size Does Not Fit All: Culture Counts in Recovery-Oriented Care – Part 1

Raymond M. Reyes, M.D., 10017 Alcosta Boulevard, San Ramon, CA 94583, **Jeffrey Akaka, M.D., Tracee M. Burroughs, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to understand the importance of delivering recovery-oriented services that are relevant to the culture of a patient and some of the pitfalls that may beset a psychiatrist who does not understand a patient's culture and thus, learn approaches for addressing these challenges.

Summary: Recovery values self-direction, empowerment, peer support, respect, and hope. Incorporating these tenets in mental health care creates an environment in which people can manage mental illness and lead fulfilling and productive lives. Recovery-oriented care holds particular promise for patients from diverse and underserved populations. Commonly, people with mental illness in these groups experience disparities in the quality of mental health services they receive, leading to negative outcomes, including misdiagnosis, dissatisfaction with care, involuntary hospitalization, and early treatment dropout. This workshop will explore cultural perspectives on the barriers and facilitators to recovery-oriented care and how to respond to cultural differences in the provision of recovery-oriented care with respect to patients of Native Hawaiian, Asian, and African descent. Speakers will present vignettes that illustrate challenges in the practice of recovery-oriented care that can arise in the encounter between a psychiatrist and a culturally different patient. Ways in which these and other challenges may be addressed will also be discussed.

References:

1) N/A
2) N/A

WORKSHOP 02

Thursday, October 27; 8:00 a.m.–9:30 a.m.

Motivational Interviewing as a Foundation for Recovery-Oriented Care

Michael Flaum, M.D., Psychiatry Research/MEB, Iowa City, IA 52242

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

Summary: While there is now broad and increasing recognition that facilitating recovery is a key, if not the primary outcome that mental health professionals should strive to achieve, practical strategies to actually do so in real world clinical settings remain unclear to many providers. This presentation will attempt to demonstrate that the underlying spirit of Motivational Interviewing, an evidence-based practice initially developed for the treatment of substance abuse problems, is highly consistent with the core concepts of mental health recovery, and that a broader application of this practice in mental health settings may be a practical way for providers to enhance their capacity to facilitate recovery.

References:

1) Miller, W. R., & Rose, G. S. (2009). Toward a Theory of Motivational Interviewing. American Psychologist, 64(6), 527-537.
2) Davidson L, White W. The concept of recovery as an organizing principle for integrating mental health and addiction services. J Behav Health Serv Res 2007 34 109–20

WORKSHOP 03

Thursday, October 27; 8:00 a.m.–9:30 a.m.

Highlighting High Utilizers: How Can Our Systems Better Meet Their Needs?

Margaret Balfour, M.D., Ph.D., 2719 Throckmorton Street, #110, Dallas, TX 75219, **Christie Cline, M.D., M.B.A., Janice Cohen, M.D., Steven Moffic, M.D., Leonard Rosen, M.D., Christina Van der Feltz-Cornelis, M.D., Ph.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Describe research on high service utilization; 2) Describe the relationship between physical illness and behavioral health service utilization; 3) Describe two projects that have attempted to address the needs of this population within their local systems.

Summary: Consumers who use disproportionate amounts of services are a challenge for public mental health systems, both in terms of allocation of limited resources and the poor clinical outcomes among the people our systems are charged to serve. Many studies have attempted to address this problem but there is no easy solution. However, one theme that is emerging is the importance of alignment between the consumers' needs and the services being provided. This workshop will explore this complex issue from a variety of perspectives. We will begin with an overview of past research on high utilizers and recidivism, highlighting several longitudinal studies that underscore the importance of identifying needs and tracking outcomes. Then we will present findings from a recent study from the Netherlands that investigates the relationship between physical illness and utilization of behavioral health services. Next we will describe two projects that are attempting to address the needs of high utilizers within their local public behavioral health systems. The first is a program in Oakland County, Michigan, which was able to dramatically reduce inpatient hospital days for this population using a group case review approach. The second is a project in North Texas that is attempting to use the experiences of high utilizers to identify service-need mis-

matches, which may serve as targets for improvement of the system as a whole. We will conclude with a discussion led by two discussants – one from a managed care perspective, and the other from the perspective of a former director of a state mental health department. We encourage the audience to participate in this discussion and share experiences from their own systems – including both individual cases and systems issues related to the care of this complex population.

References:
1) N/A
2) N/A

WORKSHOP 04

Thursday, October 27; 8:00 a.m.–9:30 a.m.

Intellectual/Developmental Disability and Mental Illness: Raising the Bar on Treatment and Programs

Donna N. McNelis, Ph.D., PO Box 45357, Philadelphia, PA 19124-2399, **Larry J. Barnhill Jr., M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Describe the variation in treatment approaches for persons with IDD/MI among clinicians; 2) Detail the process for clinicians (psychiatrists, psychologists, psychiatric nurse practitioners, etc.) to attain specialty certification in IDD/MI; 3) Describe the benefits of accreditation and certification for enhancing treatment outcomes for persons with IDD/MI.

Summary: NADD (National Association for Dual Diagnosis) is widely recognized as the preeminent North American professional association for education/consultation for persons with intellectual disabilities and autism and co-morbid mental health diagnoses. This organization is developing a credentialing mechanism for clinicians and a certification for programs that work with this challenging population. The literature documents that persons with IDD/MI can be quite expensive to treat and often get in to the most restrictive acute psychiatric settings that are not geared to provide treatment to persons with such communication and behavioral issues. It has also been cited that there are accepted treatment approaches that produce effective clinical outcomes yet these pharmacological and psychotherapeutic approaches may not reach inpatient or outpatient mental health service settings. The credentialing process for clinicians will assist the behavioral health field by identifying practitioners who have expertise with this complex population. Additionally, the program certification will identify facilities that have effective services and supports to assist clinicians and families should community-based treatment be required upon discharge.

References:
1) Fletcher, R., Loschen, E., Stavrakaki, C., & First, M. (Eds.). (2007). Diagnostic Manual—Intellectual Disability (DM-ID): A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability. Kingston, NY: NADD Press. Fletcher, R., Loschen, E., Stavrakaki, C., & First, M. (Eds.). (2007). Diagnostic Manual -- Intellectual Disability (DM-ID): A Clinical Guide for Diagnosis of Mental Disorders in Persons with Intellectual Disability. Kingston, NY: NADD Press.
2) Sevin JA, B.-S. C., Crafton CG. (2003). "Psychiatric disorders in adolescents with developmental disabilities: longitudinal data on diagnostic disagreement in 150 clients." Child Psychiatry Hum Dev 34(2): 147-63.

WORKSHOP 05

Thursday, October 27; 10:00 a.m.–11:30 a.m.

Improving Integration of Care for People with Severe Mental Illness in California: The Calmend Pilot Collaboratives on Integration

J. Ryan Shackelford, M.D., 845 Coventry Road, Kensington, CA 94707, **James Dilley, M.D., Penny Knapp, M.D., Robert McCarron, D.O., Shannon Suo, M.D.**

Educational Abstracts: At the conclusion of this session attendees should be able to understand the data on medical screening and treatment of the severely mentally ill, describe the different models of integration of care that are being tested in California, understand the challenges in integration of care (geographically, financially, organizationally, culturally), and potential solutions to overcome these and recognize the utility of public-academic partnerships to evaluate these integration of care programs and assess their efficacy.

Summary: People with severe mental illness die 25 years earlier than the general population, most frequently from cardiovascular disease. The cause of this increased morbidity and mortality is complex and multifactorial, with contributing risk factors including smoking; sedentary lifestyle; poor eating habits; and substance abuse. Systemic factors, including separation between medical and mental health care (geographically, financially, organizationally, culturally), financial challenges, and difficulties coordinating off-site care further contribute to poor medical care received by this vulnerable population. The California Mental Health Care Management Program (CalMEND) was established in 2005 as a quality improvement project to promote wellness and recovery for individuals with mental illness. Supported by funds from the California Mental Health Services Act (MHSA), CalMEND operates under the sponsorship of the California Department of Health Care Services (DHCS) in collaboration with the Department of Mental Health (DMH). Since CalMEND aims to improve quality and outcomes for publicly funded mental health services, CalMEND leadership is particularly concerned about the high morbidity rates among people with severe mental illness. Because lack of primary care is one of the several factors contributing to this increased morbidity and mortality, CalMEND leadership decided their first goal was to improve health outcomes for persons with severe mental illness and co-occurring chronic medical disorders through improved integration. Programs within six counties in California (Contra Costa, Orange, Placer, Sacramento, San

Mateo, Shasta) received CalMEND Pilot Collaborative on Integration (CPCI) grants to improve primary care treatment for people with severe mental illness. These counties selected specific county clinics to implement integration of care projects. CPCI demonstration program leaders have been meeting quarterly in learning collaboratives to learn from one another about how best to accomplish this challenging task. CalMEND has also developed several public-academic partnerships to help evaluate their work. This workshop will outline the CPCI integration of care demonstration projects and lessons learned so far in the implementation process. Cultural differences between the primary care and psychiatric worlds will be highlighted. How public-academic partnerships can be used effectively to generate an evidence base for implementation of integration programs will be discussed.

References:

1) Colton CW, Manderscheid RW: Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. Preventing Chronic Disease, 3(2):A42, 2006.
2) Dixon LB, Adler DA, Berlant JL, Dulit RA, Goldman B, Hackman AL, Oslin DW, Siris SG, Sonis WA, Valenstein M: Psychiatrists and primary caring: what are our boundaries of responsibility? Psychiatric Services, 58(5):600-2, 2007.
3) Druss BG: Improving medical care for persons with serious mental illness: Challenges and solutions. Journal of Clinical Psychiatry, 68(suppl4):40-44, 2007.
4) Mangurian C, Miller GA, Jackson CT, Li H, Essock SM, Sederer LI: Physical health screening in state mental health clinics: The New York Health Indicators Initiative. Psychiatric Services, 61:346-348, 2010.

WORKSHOP 06

Thursday, October 27; 10:00 a.m.–11:30 a.m.

Testing for Drugs of Abuse: The Science and the Art

Dwight Smith, M.D., Boston Medical Center Dowling 7850 Harrison Avenue, Boston, MA 02118, **Elvin G. Hernandez, M.D., M.P.H., Petros Levounis, M.D., M.A., Kevin A. Sevarino, M.D., Ph.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Describe common methods of testing for drugs of abuse and identify the strengths and weaknesses of each; 2) List several substances which have been associated with false positives or negatives on drug screening tests; 3) Identify the most common methods of defeating drug tests, and list ways in which these methods can be detected.

Summary: Testing for drugs of abuse is common in the United States and throughout the world. Last year, in the United States alone it is estimated that more than 130 million drug tests were performed in diverse settings ranging from our schools, our places of employment, hospitals, correctional facilities, and drug treatment programs. In psychiatry, testing for drugs of abuse is a routine and accepted practice and a recommended component of treatment for those with substance use disorders. Additionally, given the high co-morbidity between several psychiatric conditions and substance abuse, routine screening tests for drugs of abuse are suggested in several published guidelines. Despite the ubiquity of drug testing there is generally little discussion regarding the science behind it as well as the limitations of various testing methods. There is also a paucity of literature on the therapeutic implications and clinical management of patients who undergo drug testing, and in this absence multiple ways, often with little evidence behind them, have been advanced to address the troublesome clinical issues which oftentimes arise, such as the possibility of false negatives or false positives. In this workshop we review the basic biochemical science behind drug testing and describe how various testing methods, including urine, hair, saliva, and sweat, both work and how they can fail. The statistical analysis used in delineating a positive from a negative result, and the clinical implications of this, are discussed. The differences between screening and confirmatory tests, and the role each plays in the management of patients, will be discussed. Common potential pitfalls in the interpretation of test results are examined, including the possibility of an error caused by substances or medications which are known to be associated with false positives. Several myths and misinformation surrounding drug testing will be reviewed in light of the latest scientific studies, and tips for dealing with concerns of patients provided. The role of drug testing in the context of a therapeutic relationship and the challenges this presents will be outlined, and practical suggestions for best practices in patient care will be given. Finally, forensic and legal issues surrounding drug testing will be reviewed, including the detection of those attempting to cheat on drug tests and specific measures which can be taken to ensure the validity and accuracy of drug tests.

References:

1) John B Standridge, Stephen M Adams, and Alexander P Zotos, "Urine drug screening: a valuable office procedure," American Family Physician 81, no. 5 (March 1, 2010): 635-640.
2) Karen E Moeller, Kelly C Lee, and Julie C Kissack, "Urine drug screening: practical guide for clinicians," Mayo Clinic Proceedings. Mayo Clinic 83, no. 1 (January 2008): 66-76.

WORKSHOP 07

Thursday, October 27; 10:00 a.m.–11:30 a.m.

Young Adults, Problematic Online Behaviors and 21st Century Communications Technology

Ann L. Hackman, M.D., 701 West Pratt Street, Baltimore, MD 21201, **Tristan Gorrindo, M.D., Liwei L. Hua, M.D., Ph.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Understand and assess the use of communication technology in transitional aged youth; 2) Identify vulnerabilities and problems that may arise with the

use of communication technology by young people with newly diagnosed mental illness.

Summary: This workshop will consider use of 21st century communications technology, including the internet, cell phones, and social networking websites, among transitional-aged youth (16 to 23 y.o.), particularly those with serious mental illness. The popular press has focused on apparent misuse of communications technology by teens and young adults, such as cyberbullying, sexting, and excessive use. Unlike older adults, people in their mid-teens and mid-twenties have considerable experience with these forms of communication. Due to their developmental stage, they tend to be more impulsive, more naïve, and less aware of more far-reaching ramifications of their actions. Youth may have little understanding of how quickly communications such as "sexts" or verbal/sexual online exposure can "go viral" and be forwarded to hundreds of other people. Furthermore, some youth may use this technology to share feelings and fears to garner attention and support, not being able to differentiate between positive and negative attention, and consequently not realizing the potential dangerous consequences of airing vulnerabilities to strangers. Particularly in youth with burgeoning or formally diagnosed mental illness, inappropriate behaviors with this technology may broadcast evidence of psychiatric symptomatology to a much broader audience. This workshop will provide an overview of communications technology commonly used by teens and young adults today. We will consider some of the problems inherent in the use of communication that is instant, relatively public, and "permanent". We will describe some clinical experience with communications technology reported by some teen and young adult mental health consumers. With our audience, we hope to: 1) explore how to proceed with the treatment of young people, including assessing their use of communication technology and considering special vulnerabilities (such as schizophrenia and other serious mental illness), 2) discuss the application of CBT and recovery-oriented skills to the treatment of problematic technology use, and 3) contemplate the role of this technology in our own youth patient population.

References:

1) Borzekowski DL, Leith J, Medoff DR, Potts W, Dixon LB, Balis T, Hackman AL, Himelhoch S. (2009) Use of the internet and other media for health information among clinic outpatients with serious mental illness. Psychiatric Services. 60(9):1265-8.
2) Pujazon-Zazik M, Park MJ (2010) To tweet, or not to tweet: gender differences and potential positive and negative health outcomes of adolescents' social internet use. Am J Mens Health. 4(1):77-85.

WORKSHOP 08

Thursday, October 27; 10:00 a.m.–11:30 a.m.

Patient Boarding Within the Psychiatric Emergency Department: Identifying the Causes and Developing Solutions

Anthony P. Weiss, M.D., M.B.A., 1 Bowdoin Square, Room 734, Boston, MA 02114, **Grace Chang, M.D., M.P.H., Scott Zeller, M.D., Leslie Zun, M.D., M.B.A.**

Educational Objectives: At the conclusion of this session, the participant should be able to understand the primary causes of patient boarding within the emergency psychiatry setting as well as become aware of potential approaches being developed to mitigate this challenge.

Summary: The growing crisis in emergency care within the United States has been well documented, with the Institute of Medicine recently describing "a widening gap between the quality of emergency care Americans expect and the quality they actually receive." The main symptoms of this systemic affliction include an increase in the length of stay (LOS) within the ED for patients seeking emergency care, overcrowding of existing ED space, and boarding of patients within the ED while they await availability of an inpatient bed. These issues, in turn, may lead to a high degree of provider stress, greater risk for adverse events, and lower levels of patient satisfaction. This issue appears to be particularly acute for patients seeking psychiatric care in the ED. Patients with psychiatric conditions have been shown to have longer overall LOS and a greater percentage of these patients are boarded within the ED, sometimes for days, while awaiting appropriate disposition. When coupled with the fact that psychiatric visits represent a growing proportion of ED visits nationally, the extended LOS of this patient population is fast becoming a major concern for both patients and ED providers alike. In this context, identifying the patient and clinical management factors associated with long LOS for psychiatric patients is critical so that targeted quality improvement efforts can be employed. Prior studies which have examined risk factors for extended EDLOS amongst patients with psychiatric conditions have identified a few common factors which appear to prolong the time spent in the ED, including acute intoxication, a substance abuse diagnosis, and the need for hospitalization. Overall, however, the paucity of data in the peer-reviewed literature on this topic has prompted a recent call to "quantify and monitor the problem" as part of a seven-step solution to this issue. This workshop will discuss the current state of the problem, based on a review of the existing literature as well as a report on recent data from a large system-wide analysis of factors associated with extended ED LOS. Novel approaches to improving the current state will then be described, including efforts to better manage addicted and aggressive patients, as well as the implementation of ED-Based Case Management efforts for frequent ED visitors with psychiatric conditions. A discussion period will allow for questions, as well as sharing of best practices in these areas amongst the attendees.

References:
1) Moskop JC, Sklar DP, Gelderman JM, et al. Emergency department crowding, Part 1 – concept, causes, and moral consequences. Ann Emerg Med. 2009; 53: 605-611.
2) Alakeson V, Pande N, Ludwig M. A plan to reduce emergency room 'boarding' of psychiatric patients. Health Affairs. 2010; 29: 1637-1642.

WORKSHOP 09

Thursday, October 27; 1:30 p.m.–3:00 p.m.

Mental Health Treatment in the Army: a Close Look at Clinicians and Their Patients

Charles Hoge, M.D., 503 Robert Grant Drive, Silver Spring, MD 20910, **Farifteh F. Duffy, Ph.D., Eve K. Moscicki, Sc.D., M.P.H., Joyce C. West, Ph.D., M.P.P.**

Educational Objectives: At the conclusion of this session, the participant should be able to characterize the Army's mental health workforce and the challenges they face, including the clinical complexity of patients, understand patterns and quality of care for service members and be able to identify key factors affecting mental health treatment access and quality.

Summary: This session will highlight new findings from a recent study, "The Army Behavioral Health Practice and Treatment Study." The Walter Reed Army Institute of Research collaborated with the American Psychiatric Institute for Research and Education in surveying the Army's specialty mental health clinicians to provide critically needed workforce and clinically detailed patient-level data for this study. The primary aims of this study were to: 1) Characterize routine practice in Army behavioral health treatment settings, including patient, clinician, setting, and clinical characteristics; 2) Assess the degree to which clinical practice in Army behavioral health settings conforms to treatment guideline recommendations, particularly in regards to PTSD treatment and the assessment and treatment of suicidal ideation and behavior; and 3) Test methods to regularly collect basic practice- and clinical- level data to facilitate tracking practice patterns in Army behavioral health treatment settings. In total, 2,311 specialty mental health clinicians, including psychiatrists, psychologists, and social workers, were invited to participate in this electronic survey which was fielded May-September, 2010. Approximately one-quarter of those clinicians targeted to participate in the study responded. Study participants provided practice level data on their professional activities, patient caseloads, clinical training, and issues related to retention and career satisfaction. In addition, in-depth data were provided on one systematically selected patient to generate clinically detailed information on a representative sample of patients. This session will highlight the key findings from this recent study and will focus on reporting those findings which have significant implications for mental health planning and services delivery in the Army. The five presentations will focus on the following themes: 1) Mental Health Treatment in the Army: Current Status of Mental Health Clinicians, Patients, and Treatment Access; 2) Patterns and Quality of Care for Service Members with PTSD, Depression, and Substance Use Disorders; 3) A First Look at Suicidal Ideation and Behavior among Patients in Army Behavioral Health Settings; 4) What's Working? Identifying Key Factors Affecting Treatment Access and Quality; and 5) What Does This all Mean? Implications for Mental Health Planning and Services Delivery in the Army.

References:
1) Hoge CW, Castro CA, Messer SC, McGurk D, Cotting DI, Koffman RL. Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. N Engl J Med. 2004; 351(1):13-22.
2) Thomas JL, Wilk JE, Riviere LA, McGurk D, Castro CA, Hoge CW. Prevalence of mental health problems and functional impairment among active component and National Guard soldiers 3 and 12 months following combat in Iraq. Arch Gen Psychiatry. 2010; 67(6):614-23.
3) Department of Defense Task Force on Mental Health. (2007). An achievable Vision: Report of the Department of Defense Task Force on Mental Health. Falls Church, VA: Defense Health Board. http://www.taps.org/%5Cdownload%5CDOD%20Mental%20Health%20Task%20Force%20Report.pdf
4) Tanielian T & Jaycox LH. (Eds.). (2008). Invisible Wounds of War: Psychological and cognitive injuries, their consequences, and services to assist recovery. Santa Monica, CA: RAND Corporation. http://www.rand.org/pubs/monographs/MG720.

WORKSHOP 10

Thursday, October 27; 1:30 p.m.–3:00 p.m.

Conundrums of Co-Morbidity: Managing Addiction and Co-Occurring Psychiatric Disorders in Office-Based Practice

Petros Levounis, M.D., M.A., 357 West 29th Street, #3A, New York, NY 10001, **Abigail Herron, D.O.**

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Identify two pharmacological and two psychosocial strategies specifically addressing co-occurring disorders; 2) Analyze the pros and cons of using benzodiazepines in the treatment of patients on buprenorphine; 3) Analyze the pros and cons of using varenicline in the treatment of depressed, nicotine-dependent patients.

Summary: The new millennium has seen the development of many exciting clinical innovations for the treatment of patients who suffer from substance dependence and co-occurring psychiatric disorders. While the science of diagnosis and treatment of dual diagnosis is advancing at a significant rate, the implementation of even the most "tried and true" of these treatment innovations, including Motivational Interviewing, has been slow.

Several lines of evidence suggest that the majority of mental health systems—as well as psychiatrists in private practice—resist adoption of these new practices. In this workshop, we

will review the most recent evidence of safe and effective pharmacological and psychosocial interventions for the dually diagnosed patient. We will then focus on two major controversies in the field of co-occurring disorders: (a) the use of benzodiazepines in the opioid-dependent patient on buprenorphine, and (b) the use of varenicline in the depressed patient who may also be at risk of suicide. In addition, we will discuss motivational techniques for effectively engaging the ambivalent (or even completely disinterested) psychiatric patient in addiction treatment, a common problem in everyday clinical practice. Participants will be invited to bring their own clinical experience treating dually-diagnosed patients and to work with the faculty on formulating creative options for implementing these new approaches in clinical practice. The workshop is open to all psychiatrists who would like to learn more about the effective management of addiction and co-occurring psychiatric disorders but is particularly targeted towards members in training and early career psychiatrists.

References:
1) Renner JA, Levounis P. Handbook of office-based buprenorphine treatment of opioid dependence. American Psychiatric Press, Inc., Washington, DC, 2011.
2) Nunes EV, Selzer J, Levounis P, Davies C. Substance dependence and co-occurring psychiatric disorders: Best practices for diagnosis and clinical treatment. Civic Research Institute, New York, 2010.

WORKSHOP 11

Thursday, October 27; 1:30 p.m.–3:00 p.m.

Integrating Family Support Services with the Role of Public Sector Psychiatrists

Robert S. Marin, M.D., 3811 O'Hara Street, Pittsburgh, PA 15213, **Edith J. Mannion, Lawrence A. Real, M.D., Phyllis Solomon, Ph.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand the rationale and benefits for providing supportive services to families; 2) Identify barriers to psychiatrists and other professionals providing such services; 3) Initiate steps to overcoming these barriers in the context of clinical service, program development, education and training, and policy.

Summary: Although family members often provide essential support and assistance to loved ones with mental illness, there has been little progress in enabling psychiatrists to take full advantage of consumer-family member relationships in their role as recovery oriented providers. The potential value of such work is strongly indicated by evidence that supportive care to family members improves clinical outcomes for consumers and quality of life for family members. The purpose of this workshop is to identify strategies for enabling psychiatrists to support families in these ways and to take full advantage of the knowledge, resources, and relationships that families have with their loved ones. The workshop will present: 1) A review of the rationale and benefits for providing supportive services to families, especially the reasons for enabling psychiatrists to make supportive services an essential part of their roles and responsibilities; 2) Assessments of the barriers to making this possible; and 3) An exploration of strategies to overcome these barriers. Barriers and strategies for change will be presented, first, in relationship to clinical skills, knowledge and attitudes that are important for psychiatrist training and education and, second, in relationship to the policies and services that determine the expectations and opportunities of psychiatrists' everyday work in the public sector.

References:
1) Berman, EM et al. Family-Oriented Patient Care through the Residency Training Cycle. Academic Psychiatry 32:111-118,2008.
2) Dixon, L et al.: Evidence-Based Practices for Services to Families of People With Psychiatric Disabilities. Psychiatric Services 52:903-910, 2001

WORKSHOP 12

Thursday, October 27; 1:30 p.m.–3:00 p.m.

Diagnosis Beyond Disorders: Using the Defensive Functioning Scale to Assess Health in the DSM System

Sheila Hafter Gray, M.D., Box 40612, Palisades Station, Washington, DC 20016-0612, **Farooq Mohyuddin, M.D., Stephen C. Scheiber, M.D.**

Educational Objectives: At the conclusion of this session, participants should be able to 1) Discriminate between healthy adaptation and a personality disorder: 2) Individualize treatment plans to capitalize on the patient's healthy functioning 3) Document briefly and objectively changes in an individual's adaptive style and use these data in clinical research.

Summary: This workshop will focus on a straightforward way psychiatrists and other clinicians may evaluate and code mental health in the DSM system, and apply their findings to enhance treatment planning and outcomes for their patients. All individuals have characteristic ways to maintain optimal balance among internal and external stressors, to achieve and maintain homeostasis within their unique biopsychosocial system. Those adaptive actions – defense mechanisms – develop as the individual matures. Personality is a concept that refers to the pattern into which a person organizes or stabilizes those actions in a continuous, consistent and coherent fashion. Axis II of the DSM from the 3rd edition onward allows us to code Personality Disorders, adaptive efforts that fail; the Defensive Functioning Scale (DFS), which is available in DSM-IV-TR as a research category, is a way to describe and code the healthy defenses that a person uses, and to view those from a developmental perspective. It represents a step between impressionistic and objective diagnosis. Knowledge of the patient's adaptive style and level of emotional maturity helps the clinician interact with the patient in ways that speed the development of a therapeutic alliance. It also supports the selection of treatments that are appropriate not only for a mental disorder but for the specific person who

suffers from it. Documenting adaptive style in a systematic way allows the clinician rapidly to assess the long term effectiveness of any treatment plan – pharmacotherapy alone, a psychosocial intervention, or a complex array of interventions. We shall offer a brief training on how to use and code the DFS, offer clinical illustrations that are relevant to the work of public sector psychiatrists, and consider with participants how we may use this instrument to do research as we care for patients.

References:
1) Porcerelli JH, Cogan R, Markova T, Miller K, Mickens L: The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Defensive Functioning Scale: a validity study. Comprehensive Psychiatry, 52: 225-230, 2011
2) DeFife JA, Hilsenroth MJ: Clinical Utility of the Defensive Functioning Scale in the Assessment of Depression. Journal of Nervous & Mental Disease, 193:176-182, 2005

WORKSHOP 13

Thursday, October 27; 1:30 p.m.–3:00 p.m.

The Different Faces of Global Mental Health: Early Career/Trainee Experiences

Sosunmolu O. Shoyinka, M.D., 5406 Hodgsdon Mill Drive, Columbia, MO 65203, **Neil K. Aggarwal, M.D., M.B.A., Carla Marienfeld, M.D., Alfredo Massa, M.D., Suzan Song, M.D., M.P.H.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Possess a working knowledge of what Global Mental Health work entails; 2) Be encouraged to think of creative ideas about developing careers in Global Mental Health and take available opportunities to get involved in such work at all stages of training, career or practice; 3) Have the opportunity to network with individuals who are working in this area.

Summary: The past few years have brought an increased awareness of, and interest in, the role of mental health in general overall health. This is best captured, perhaps, by the aphorism "no health without mental health" coined by the World Health Organization. With the curent trend towards globalization, there has been an explosion of interest in Global Mental Health, particularly among trainees and early career psychiatrists.

This interest has been fueled by publications such the popular Lancet series on Global Mental Health (1), and workshops such as the recently concluded NIMH – sponsored Research Careers in Global Mental (2). Attempts have being made to clarify what Global Mental Health entails. What and where the opportunities are to get involved, particularly while in training or early in one's career remain more difficult questions to tackle.

This workshop showcases the experiences of psychiatrists-in-training and in their early careers, with the intent of facilitating discussion and stimulating the thinking of individuals contemplating such a career direction.

Target audience: Although this workshop is especially targeted towards trainees and early career psychiatrists who have a desire to do Global Mental Health work, all psychiatrists and individuals in allied professions interested in Global Mental Health work at all levels of training, practice and experience are welcome.

References:
1)Martin Prince, Vikram Patel, Shekhar Saxena, Mario Maj, Joanna Maselko, Michael R Phillips, Atif Rahman. No health without mental health Published Online September 4, 2007 DOI:10.1016/S0140-6736(07)61238-0
2) http://www.nimh.nih.gov/research-funding/scientific-meetings/announcements/careers-in-global-mental-health.shtml

WORKSHOP 14

Thursday, October 27; 1:30 p.m.–3:00 p.m.

Qualitative Research and Evaluation in Psychiatric Services: Introduction and Overview

Rob Whitley, Ph.D., 6875 LaSalle Boulevard, Montreal, Quebec, Canada H2X 2K8

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Comprehend the basic principles and methods of qualitative research; 2) Understand the nature and utility of qualitative research and evaluation in psychiatric services; 3) Prepare and design a small-scale qualitative study of a psychiatric service; 4) Explore available resources that can be deployed to assist in the planning, execution and analysis of a qualitative research or evaluation project in psychiatric services.

Summary: Qualitative methods are an increasingly utilized (and appropriate) approach to generating essential information on the nature, quality and impact of psychiatric services. They have been used to better comprehend a variety of important dimensions of psychiatric services. Examples include understanding why some people engage and others drop-out of a psychiatric service, or elucidating barriers and facilitators to recovery within a specific discrete service. Qualitative research is particularly suited to understanding subjective experience of psychiatric services, especially in the context of health disparities, exploring variations in service experience by age, gender and ethno-racial status. In this workshop, I will provide a descriptive introduction and overview of qualitative research, and its application to research and evaluation in psychiatric services. I will begin by describing the practice and process of conducting efficient and rigorous qualitative research. This will include the process of generating a research question, conceptualizing a design, sampling, implementing and executing a study, data analysis, criteria of rigour and dissemination. I will discuss the advantages and disadvantages of the main methods of qualitative inquiry, notably in depth interviews, focus groups, ethnography, and participant observation. I will also discuss the potential offered by mixed-methods studies. This will allow me to discuss methodological triangulation (using two or more

methods to shed light on a research question). I will also discuss the benefits of respondent triangulation (gathering information from more than one source), for example collecting data from patients, clinicians and family members involved in a discrete psychiatric service. Throughout the session, I will present case studies from my own work, as well as the work of others, of successful (and published) qualitative research and evaluation in the arena of psychiatric services. I will pay particular attention to issues of sampling and data analysis when presenting these examples. Ample time will be given during this workshop to questions and comments from the floor. Participants will be encouraged to talk about their own qualitative experience, as well as presenting ongoing or potential research projects. Time Permitting, I will discuss publishing and funding trends in qualitative research in psychiatry, presenting journals, foundations and other resources.

References:

1) Whitley R and Crawford M (2005) Qualitative Research in Psychiatry. Canadian Journal of Psychiatry 50: 108-114
2) Davidson L, Ridgway P, Kidd S et al. (2008) Using qualitative research to inform mental health policy. Canadian Journal of Psychiatry 53: 137-44

WORKSHOP 15

Thursday, October 27; 3:30 p.m.–5:00 p.m.

Emerging Drugs of Abuse

Joshua J Chiappelli, M.D., 701 West Pratt Street, 4th Floor, Baltimore, MD 21201, **Curtis N. Adams, Jr., M.D., Carla Reese, M.D., M.S., Christopher Wohn, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Identify psychoactive substances that have only recently become recognized as possible drugs of abuse, or have the potential to become problematic within the next decade; and 2) Identify the medical and psychiatric consequences of use of these substances, including the risk for addiction and adverse effects.

Summary: Substance abuse is a leading cause of psychiatric and medical morbidity. The study and treatment of substance abuse problems is complicated by the shifting nature of the problem, as economic, legal, and cultural factors can change the drugs of abuse that are available and problematically used in any particular region. Furthermore, advancements in pharmaceutical science and rapid diffusion of knowledge through media such as the internet have increased the array of potential drugs of abuse that clinicians must be aware of. The focus of this workshop will be to examine some of the factors which dictate how and why certain substances can come to be abused or misused; the discussion will also focus on trends in substance abuse that may be less well known to clinicians. There has been a proliferation of informal reports on the psychoactive effects of various plants, often based on ethnobotanical data, which has led to more widespread use of the 'entheogens,' such as Salvia divinorum and kratom. Some of the plants in this class make use of naturally occurring MAO inhibitors and thus present a concern to psychiatrists prescribing serotonergic medications. The availability and growing information regarding lesser known hallucinogenic plants has contributed to the cultural phenomenon of self-described 'psychonauts,' who experiment with plants and chemicals with the specific goal of identifying potent substances. Another pattern of drug use which may become more prominent in the coming years concerns 'lifestyle' drugs, which are used to enhance sexual, cognitive, or athletic performance. Misuse of amphetamines for academic performance has already been noted as a growing problem. Other cognitive enhancers, such as the racetams, may also present potential for abuse. Psychiatrists should also be aware of trends in which prescribed medications are used to enhance or modify the effects of illicit substances. For instance, medications including quetiapine, promethazine, and clonidine are used to 'boost' methadone. Quetiapine is also sometimes used to ease 'crashing' from cocaine. Finally, we must recognize the potential for new drugs of abuse to originate in laboratories. Recently developed compounds of interest include synthetic cannabinoids and mephedrone. The diversity and patterns of use of these and related 'designer' drugs requires frequent updates for practitioners. Reviewing these trends in the use of psychoactive substances will allow clinicians to make better informed treatment decisions.

References:

1) Cakic, V. 2009. Smart drugs for cognitive enhancement: ethical and pragmatic considerations in the era of cosmetic neurology. Journal of Medical Ethics, 35, 611-615.
2) Sanders B, Lankenau SE, Bloom JJ, Hathazi D. 2008. "Research chemicals": tryptamine and phenethylamine use among high-risk youth. Substance Use and Misuse, 43, 389-402.

WORKSHOP 16

Thursday, October 27; 3:30 p.m.–5:00 p.m.

Designing a Medical Home Within the Psychiatric Continuum of Care

Joseph P Merlino, M.D., M.P.A., 205 East 78th Street, New York, NY 10075, **Tatyana Braslavskaya, M.D., Kendra Campbell, M.D., David Estes, M.D., Milica Stafanovic, M.D., Sheryl Stasiowski, Ph.D.**

Educational Objectives: At the conclusion of this session, the participant will: 1) Understand processes that aid coordination and collaboration of medical and psychiatric practitioners; 2) Recognize the impact that coordination of medical care has on medical outcomes; 3) Understand the complexity of reproductive mental health and the concept of early intervention during pregnancy; 4) Learn strategies to enable mentally ill patients to take control of their medical care.

Summary: On the Behavioral Health (BH) Adult Inpatient Service at Kings County Hospital (KCH) in Brooklyn, NY there is evidence of an increase in the presence of medical co-morbidities to 70-80% in 2010 vs. 33% in 1990.

Access to medical care, from identification, assessment, treatment and follow-up, are key factors in the integration of the medical and psychiatric care of our patients. The impact of having an internist/ NP as part of the treatment team, rather than as an outside consultant, is key to overall well-being. A medical practitioner, familiar with the specific psychosocial needs of mentally ill patients leads to patient buy-in and improved self-care, including increased show rate with medical follow up appointments. As the medical education process begins on the inpatient unit and follows through in our outpatient services, patients gain control of their medical destiny. Poor medical follow up of the mentally ill in outpatient care continues to impact negatively on outcome. Typical no-show rates of 40% jump to almost 90% at KCH for patients discharged from the psychiatric inpatient service. This correlates with decreased life span of 25 years due to co-morbidity from diabetes, hypertension, dyslipidemia and heart disease. The opening of a Primary Care Clinic within BH, utilizing the Medical Home model, was designed to streamline medical follow-up for our BH and Chemical Dependency patients, in an environment familiar to them. Teamwork improves clinical outcomes. With medical providers knowledgeable about metabolic risks and more experienced in their care, better education and compliance by the client is ensured. This will lead to greater communication between the medical primary care MD/NP, their patients and their psychiatrists. By treating the whole individual, physically as well as mentally, we are recognizing that our goal of excellence of care is being met. There is evidence that maternal mental illness is associated with increased risk for mortality and morbidity in mothers and children. Anxiety, depression, psychosis during perinatal and postpartum periods are consistent with the cumulative risk model and may affect maternal and infant outcomes, both short and long term. Research studies have identified changes in the HPA (hypothalamus-pituitary-adrenal) axis as a potential vehicle of vertical transmission of vulnerability, expressed later as traits or psychopathology.

References:

1) Collins C, Hewson DL, Munger R, and Wade T: Evolving models of behavioral health integration in primary care. Milbank Memorial Fund, 2010.
2) Mauer BJ: Behavioral health/primary care integration and the person-centered healthcare home. National Council for Community Behavioral Healthcare, 2009.

WORKSHOP 17

Thursday, October 27; 3:30 p.m.–5:00 p.m.

Performance Measurement in Psychiatry

Robert M. Plovnick, M.D., M.S., 1000 Wilson Boulevard, Arlington, VA 22209, **Deborah J. Hales, M.D., Jerry L. Halverson, M.D.**

Educational Objectives: At the conclusion of the session, participants should be able to 1) Describe the national performance measure enterprise and the potential impact of performance measures on psychiatric clinical practice; 2) Describe the components of a clinical performance measure; 3) Describe the Performance-in-Practice requirement of Maintenance of Certification; 4) Understand the Wisconsin Healthcare Information (WHIO) project undertaken to understand and control costs of psychiatric care in Wisconsin.

Summary: Clinical performance measurement is receiving ever-increasing attention as an approach to improving healthcare quality. Numerous efforts are underway to develop psychiatric performance measures, to attain national recognition for these measures, and to implement them in practice. This trend has been underway for several years with a significant focus on primary care, but there is increasing pressure for more measure development in mental health. Once developed and implemented, psychiatric performance measures have wide-ranging uses and impact, including: maintenance of certification (MOC); financial incentives (pay-for-performance) and penalties; public accountability; quality improvement efforts; and attention to the cost of healthcare. This session will provide an overview of how nationally recognized psychiatric performance measures are developed, and will provide examples of how measures are being applied and having an impact today. Detailed overviews of the Performance-in-Practice (PIP) aspect of MOC and the Wisconsin Health Information Organization (WHIO), a joint venture of providers, insurers and employers that is being undertaken to identify and ultimately reduce the cost of psychiatric care in Wisconsin will be presented. There will be ample time for discussion and questions to the panelists.

References:

1) National Quality Forum (NQF). The ABCs of measurement. url: http://www.qualityforum.org/Measuring_Performance/ABCs/ABCs_of_Measurement.aspx
2) All-Payer Claims Databases: An Overview for Policymakers. By Patrick B Miller, Denise Love, et al. National Association of Health Data Organizations and the Regional All-Payer Healthcare Information Council. May 2010.

WORKSHOP 18

Thursday, October 27; 3:30 p.m.–5:00 p.m.

How to Apply Psychodynamic Principles in 20-Minute Psychiatric Visits

Cesar A Alfonso, M.D., 262 Central Park West, #1B, New York, NY 10024, **Mariam Cohen, M.D., Psy.D., Sheila Hafter Gray, M.D., Laura K. Kent, M.D.**

Educational Objectives: At the conclusion of this workshop, the participant should be able to 1) Understand psychodynamic principles (focus on affect, exploration of conflicts, discussion of interpersonal relations) relevant to brief clinical encounters; 2) Make a psychodynamic formulation during brief visits; 3) Apply psychodynamic principles to foster a therapeutic alliance and encourage adherence in brief medication management visits; 4) Apply psychodynamic principles in the general hospital setting.

Summary: The application of psychodynamic principles can facilitate effective treatment outcomes in general psychiatric practice. This workshop will address practical applications of psychodynamic theory to inform the practice of contemporary psychiatrists, by focusing on the challenge of brief clinical encounters-the 20-minute psychiatric visit, in a variety of settings. The first presenter will demonstrate how a psychodynamic formulation provides for a succinct conceptualization of a case, guides a treatment plan, and anticipates responses to treatment, regardless of treatment duration or brevity of the clinical encounter. The second presenter will address the interface of psychodynamic psychotherapy and psychopharmacology in outpatient psychopharmacology office-based practice, describing how the relevance of the psychodynamics of pharmacotherapy rests in part with the recognition of the importance of establishing a therapeutic alliance, which could ultimately influence treatment adherence. The third presenter will demonstrate how psychodynamic principles (such as focus on affect and expression of emotion, exploration of conflicts, discussion of past experience and present interpersonal relations) can guide the practice of the consultation psychiatrist in a hectic general hospital setting. This workshop will be highly interactive, with only 30 minutes of power point presentation time, allowing for over 45 minutes of audience participation.

References:

1) Alfonso, C. (2009) Dynamic Psychopharmacology and Treatment Adherence. The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry 37:2, 269-286.
2) Cabaniss D, Cherry S, Douglas C, Schwartz A (2011) Psychodynamic Psychotherapy: A clinical manual [How does psychodynamic psychotherapy work? pages 8-13; Formulation, pages 43-51] Wiley Publishing Company.
3) Castelnuovo-Tedesco, P (1962) The "Twenty Minute Hour": An Experiment in Medical Education. New Eng. J. Med. 266: 283-289
4) Kent, LK & Blumenfield, M (2011) Psychodynamic Psychiatry in the General Hospital Setting, The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 40 (1), in press
5) Olarte SW & Alfonso CA (2011) On the Evolution of Psychodynamic Practice, The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 40 (1), in press.

WORKSHOP 19

Friday, October 28; 8:00 a.m.–9:30 a.m.

Health Care Reform: How it Will Impact Medical Practices & What We Can Do to Advocate for Our Patients & Ourselves

Victoria Pham, D.O., 2263 Shady Avenue, Pittsburgh, PA 15217, **Ivonne Bucher, M.B.A., R.N., Mary Diamond, D.O., M.A., James Schuster, M.D., M.B.A.**

Educational Objectives: At the conclusion of this session, the participants should be able to 1) Identify the key features and potential impacts of the 2010 Health Care Reform Bill; 2) Identify new ways to advocate for both patients and medical personnel at the national, state and community level while policies are being implemented.

Summary: With the increased cost for health care and approximately 45 million people in America do not have health care insurance, the federal government identified the need to restructure the current health care system. In March of 2010, policies on health care reform were enacted into two bills, the Patient Protection and Affordable Care Acts. These laws will extend health insurance coverage to approximately 32 million additional citizens by 2019 while transforming the current health care system. While these policies are made public, many of their critical issues remained undetermined. To address the uncertainty surrounding these new laws, a workshop at the APA Institute of Psychiatric Services is indicated to educate medical personnel about the current status of these new policies, to understand the potential impact of these policies on medical practices, and to recruit medical personnel to advocate for mental health policies at the national, state and community levels. The following will be areas for discussion in our presentation: 1) Overview of Health Care Reform with its goals to increase coverage through expansion of public programs (Medicaid), redesign the current health insurance markets, and reform the current delivery system and payment. In addition, timeline and funding of these policies will be discussed; 2) The potential impact of Health Care Reform on Medical Practices, Patient care, Providers, and Employers; 3) Medical personnel can be part of the conversation to influence policies and service delivery model at the federal, state, and local levels. In addition, are there resources through the APA, AACAP, NAMI, etc, that medical personnel can utilize in advocating for our patients and ourselves.

References:

1) Compilation of Patient Protection and Affordable Care Act. Health Care. 2010 Update. http://docs.house.gov/energycommerce/ppacacon.pdf.
2) Federal Government Website managed by the U.S. Department of Health & Human Services. 2010 Update. www.healthcare.gov

WORKSHOP 20

Friday, October 28; 8:00 a.m.–9:30 a.m.

The Management of Violent Incidents on a Psychiatric Ward

Wouter W.T. Teer, M.D., Albrandswaardsedijk 74, Rotterdam 3172DZ, Netherlands, **Johannes J. Hovens, M.D., Ph.D., Els E. A. N. Noorlander, M.D., Peter P. C. van den Berg**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Identify and analyze causes and forms of aggression on a psychiatric ward; 2) Make a proper diagnosis; 3) Use the six domain tool in treatment plans; 5) Consider different choices in reporting to police and public prosecution.

Summary: For decades, aggressive incidents on clinical psychiatric wards have been the subject of extensive investigation in Dutch Psychiatry. This research focuses especially on prevention of aggression, linked to variables of contextual nature, causal relationships with specific psychiatric disorders including addiction, and the effectiveness of the use of coercive measures such as separation and forced medication. Delta Psychiatric Center provides for the city of Rotterdam an acute ward and extended stay facilities. Furthermore, there is a clinical ward for people in need of sheltered housing and work provision. Usually, this concerns patients with a triple diagnosis, who, in the context of degradation and/or nuisance, are placed through an urban independent indication committee. Aggressive incidents are frequent and tied to drug abuse or manipulative goals. The workshop entails the latest insights into the diagnosis of aggression, especially intentional aggression. Also we focus on the policies on the ward in handling this kind of aggression and what to do when a violent incident has actually occurred. The dilemmas it poses for everyday practitioners and nurses will be addressed as well as the collaboration with law forces, such as police and the district attorney. The extensive use and widespread availability of drugs on the hospital site and its relationship to aggressive incidents will be one of the subjects of the workshop.

References:

1) Volovka,J & Citrome,L. Heterogeneity of violence in schizofrenia and implications for long term treatment. Int J Clin Pract, 2008, 62, 1237 – 1245.
2) Goedhard L. E, Stolker, JJ, Heerdink ER, Nijman, HLI, & Egberts, TCG. Pharmacotherapy or the treatment of aggressive behaviour in general adult psychiatry: a systematic review. J Clin Psychiatry, 2006, 67, 1013 1024.
3) Webster C. D., Douglas K. S., Eaves D. and Hart S.D. 1997, Assessing Risk of Violence to Others. In Webster and Jackson: Impulsivity, Theory, Assesment an dTreatment. New York, the Guilford Press pp 251 272.
4) Vogel. De V and Ruiter de C, Differences between clinicians and researchers in assessing risk of violence in forensic psychiatry patients. The Journal of Forensic Psychiatric & psychology, Vol 15 No 1 March 2004 145 164.
5) Jonker E., Goossens P., Steenhuis I. . Patient aggression in clinical psychiatry: perceptions of mental health nurses. J Psychiatric and Mental Health Nursing, 2008, 15.

WORKSHOP 21

Friday, October 28; 8:00 a.m.–9:30 a.m.

Hearts and Minds: Mental Illness and the Popular Media

Michael Yao, M.D., M.P.H., 3181 SW Sam Jackson Park Road, Portland, OR 97239 3098, **Michael A. Ketteringham, M.D., M.P.H., Christina Khan, M.D., Ph.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Critically analyze patterns, trajectory, and impact of popular media depictions of mental illness; 2) Identify strategies and resources that engage media to promote accurate representations of people with mental illness; 3) apply such media strategies to advocate for mental health recovery and community integration.

Summary: Mental illnesses are widely yet problematically depicted in contemporary media. Media sources, from print to internet, from news reportage to popular entertainment, select what and how information is represented to the general public. Mass media has tendencies to simplify complex issues, amplify sensational aspects of a story, and distort reality. With respect to mental illnesses and mental health providers, these tendencies result in inaccurate and unfavorable media representations that reinforce, even propagate, myth and stigma. These distorted media depictions of people with mental illness and their treatment providers influence public opinion and frame social policy agendas regarding mental illness that may further institutionalize stigma and negatively impact mental health care delivery and social supports. However, the media can also be an important ally in countervailing efforts to challenge public perceptions and prejudices, raise awareness of stigma, and advocate for life improvement and recovery of individuals with mental illness. This workshop will focus on the link between mental illness, dangerousness, and violence as depicted in mass media. The methodology will include a review of the literature, analysis of how past and recent representations of mental illness in news and entertainment have impacted policy and public opinion, and presentation of original survey findings on public perceptions of mental illness. The aim will be to delineate the mechanism of media propagation and the impact of such distorted representations on public perception and policy decisions regarding the mentally ill population. Media strategies to challenge public perceptions and prejudices against mental illness, initiate policy debate, and promote resilience and recovery for people living with mental illness will be presented along with examples of current media advocacy efforts.

References:
1) Wahl, OF: Mass Media Images of Mental Illness: A review of the literature. Journal of Community Psychology 1992; 20:343 353.
2) Stuart, H: Media Portrayal of Mental Illness and its Treatments: What Effect Does it Have on People with Mental Illness? CNS Drugs 2006; 20(2): 99 106.

WORKSHOP 22

Friday, October 28; 8:00 a.m.–9:30 a.m.

How Much Do You Smoke? Cannabis: Rolling Through the Lifecycle

Joseph Cerimele, M.D., One Gustave L. Levy Place, Box 1230, New York, NY 10029 6574, **Jay Augsberger, M.D., Corey A. Meyer, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Examine the evidence regarding the relationship between cannabis use and early psychosis in adolescents; 2) Screen for and manage cannabis use disorders in adults in a primary care setting; 3) To examine evidence regarding the use of marijuana and cannabinoids in the elderly.

Summary: The first presentation: A growing literature provides evidence of a relationship between cannabis use and psychosis. This portion of the workshop will explore this evidence, focusing on the nature of the relationship in adolescents and the potential role cannabis plays in development of psychosis. The second presentation: Cannabis use disorders are common in the general adult population. This portion of the workshop will focus on the role of the primary care physician and psychiatrist in screening for and addressing cannabis use disorders in adults. This part will also briefly describe the systemic effects of chronic cannabis use, and discuss the cannabis withdrawal syndrome. The third presentation: Medical marijuana is currently legal in fifteen states. A substantial portion of its use is in the elderly population, and it is usually prescribed for pain or nausea. This portion of the workshop will explore the evidence base for the use of marijuana and cannabinoids in the elderly, especially as it pertains to psychiatric symptoms.

References:
1) Moore THM, Zammit S, Lingford Hughes A, et al: Cannabis Use and Risk of Psychotic or Affective Mental Health Outcomes: A Systematic Review. The Lancet 2007; 370:319 328.
2) Hall W, Degenhardt L: Adverse health effects of non medical cannabis use. The Lancet 2009; 374:1383 1391.

WORKSHOP 23

Friday, October 28; 8:00 a.m.–9:30 a.m.

Integration of Physical Health in a Behavioral Health Setting

Theresa Miskimen, M.D., 11 Graham Place, Millstone Township, NJ 08535, **Michele Miller, M.S.N., Shula Minsky, Ed.D., Sally Mravcak, M.D., Elizabeth Vreeland M.S.N.**

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Evaluate evidence based rationale for integration of physical and psychiatric care; 2) Identify the Substance Abuse and Mental Health Services Administration 10 X 10 Wellness Campaign; 3) Demonstrate the role of the psychiatric team in a multidisciplinary approach to integrated care; 4) Delineate proven organizational changes and initiatives that facilitate the integration of physical health in a behavioral health setting.

Summary: Many consumers face the harsh reality that they or their peers may die an average of 25 years earlier than people without mental illness mostly due to preventable medical conditions. As noted by Auquier et al, "schizophrenia is a life threatening condition". There is evidence that approximately two thirds of the excess mortality among people with schizophrenia is accounted for by deaths caused by natural causes and that people with serious mental illness have approximately 1.5 to 2 times higher prevalence rates of preventable causes of cardiovascular disease such as diabetes, hypertension, dyslipidemia, and obesity. A recent report from the Substance Abuse and Mental Health Services Administration (SAMHSA) states that if these conditions were managed, the resulting care would most likely "make the biggest difference in the health of consumers." Furthermore, this year, the Federal Government launched the SAMHSA 10 x 10 Wellness Campaign with the goal of increasing life expectancy for persons with mental health problems by 10 years over the next 10 years. As the campaign relates to people with mental health problem, the role of the psychiatric team in managing physical integration initiatives is crucial. To this purpose this workshop aims to provide evidence based rationale for physical health integration in a behavioral care setting, describe and characterize SAMHSA's 10 X 10 Wellness Campaign, demonstrate the critical role of the psychiatric team to ensure communication with a primary care team and discuss real life examples on how to incorporate physical health integration into the daily delivery of mental health services by a multidisciplinary psychiatric team. The discussion includes a detailed account of topics such as strategies on how to run a physical health committee and how to determine which physical health outcome measures are needed to guide the physical care and integration of services in a behavioral health organization.

References:
1) Auquier P, Lancon C, Rouillo F, Lader M, Holmes C:. Mortality in schizophrenia. Pharmacoepidemiology and drug safety 2006; 15: 873 879.

2) Druss B, Rohrbaugh R, Levinson C, Rosenheck R: Integrated medical care for patients with serious psychiatric illness. Arch Gen Psych 2001; 58: 861 868.

WORKSHOP 24

Friday, October 28; 8:00 a.m.–9:30 a.m.

One Size Does Not Fit All: Culture Counts in Recovery-Oriented Care – Part 2

Daniel H. Karasic, M.D., 1001 Protrero Avenue, San Francisco, CA 94110, **Mary Kay Smith, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to understand the importance of delivering recovery-oriented services that are relevant to the culture of a patient and some of the pitfalls that may beset a psychiatrist who does not understand a patient's culture and thus, learn approaches for addressing these challenges.

Summary: Recovery values self-direction, empowerment, peer support, respect, and hope. Incorporating these tenets in mental health care creates an environment in which people can manage mental illness and lead fulfilling and productive lives. Recovery-oriented care holds particular promise for patients from diverse and underserved populations. Commonly, people with mental illness in these groups experience disparities in the quality of mental health services they receive, leading to negative outcomes, including misdiagnosis, dissatisfaction with care, involuntary hospitalization, and early treatment dropout. This workshop will explore cultural perspectives on the barriers and facilitators to recovery-oriented care and how to respond to cultural differences in the provision of recovery-oriented care with respect to Hispanic, LGBT, and women patients. Speakers will present vignettes that illustrate challenges in the practice of recovery-oriented care that can arise in the encounter between a psychiatrist and a culturally different patient. Ways in which these and other challenges may be addressed will also be discussed.

References:

1) N/A
2) N/A

WORKSHOP 25

Friday, October 28; 10:00 a.m.–11:30 a.m.

Wraparound for Psychiatrists: Tools for the Early Career Psychiatrist to Thrive in Our Rapidly Changing Healthcare System

Anthony Carino, M.D., 198 East 121st Street, 5th Floor, New York, NY 10034, **Sosunmolu O. Shoyinka, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Treat individuals using principles of recovery oriented practice; 2) Highlight strategies a psychiatrist may use to transform programs and integrate services; 3) Identify how a program may employ professional supports for the early career psychiatrist.

Summary: In the current, rapidly changing health care system, early career psychiatrists face specific challenges to being effective in the community. This workshop uses consumer feedback, clinical case studies, and clinical program models to teach essential skills to ensure the success of the early career community psychiatrist. This program is intended, not only for early career psychiatrists, but also for medical/program directors motivated to recruit, support and retain psychiatrists in community or public settings. Three early career psychiatrists will teach and present novel model approaches that will enhance an early career psychiatrist's ability to deal with the issues of community re-integration after state hospitalization/incarceration, treating and housing individuals with homelessness, and working with rural and chemically addicted populations. This program will also teach early career psychiatrists to become fluent in the following approaches: Recovery Oriented Psychiatric Practice, Integration of Physical Health, Mental Health and Substance Use Services, Program Transformation, and Wrap Around Professional Supports. This workshop will impart practical strategies for incorporating recovery tenets into direct consumer care and systems of care delivery. At the end of this workshop, participants will be able to employ critical skills necessary to excel in community or public settings.

References:

1) Community Mental Health Journal. 2001 Dec;37(6):525-39. The role of the psychiatrist: job satisfaction of medical directors and staff psychiatrists. Ranz J, Stueve A, McQuistion HL.
2) Psychiatric Services. 2006 Nov;57(11):1640-3. The tipping point from private practice to publicly funded settings for early- and mid-career psychiatrists. Ranz JM, Vergare MJ, Wilk JE, Ackerman SH, Lippincott RC, Menninger WW, Sharfstein SS, Sullivan A.

WORKSHOP 26

Friday, October 28; 10:00 a.m.–11:30 a.m.

Teaching Residents Community Psychiatry: Outside the Box and Inside the Shelter

Derri Shtasel, M.D., M.P.H., M.G.H., 15 Parkman Street, WAC 812, Boston, MA 02114, **Leah K. Bauer, M.D., Shane Coleman, M.D., Martha Kane, Ph.D., Mark Viron, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Identify the challenges and opportunities of teaching community psychiatry in a non medical, community based setting; 2) Analyze the complexities of teaching residents to embrace working with trimorbidly ill (severe mental illness, substance use and medical disorders), homeless patients within a Recovery framework.

Summary:
Objectives: To teach and inspire psychiatric residents to learn and practice community psychiatry as team members in non traditional medical settings, become competent and comfortable working with particularly vulnerable psychiatric populations—those who have psychiatric, addictions and

medical comorbidities and to become knowledgeable about the unique systemic, interpersonal and intrapersonal challenges of working with homeless seriously mentally ill individuals.

Methods: A six week PGY2 rotation was initiated at a Department of Mental Health transitional shelter, guided by national academic community psychiatry fellowship curriculum, and focusing on homeless, severely mentally ill individuals. Psychiatric, substance abuse and primary care programs were established within the shelter, and residents work with providers from each of these systems in order to link patients to integrated on site care. Residents' experiences are augmented by participation with street outreach teams. In addition, residents have supervised experience in the traditional clinic settings of the medical, psychiatric and addiction providers. They follow a small number of individual shelter clients, learning about each in as much depth as the client permits, and seeing the complexities of the public mental health system through the eyes of those most vulnerable.

Results: Second year residents are able to learn about the public mental health system through working with a trimorbidly ill and homeless population. They are exposed to a different clinical paradigm (recovery vs cure) and treatment approach (providers come to patients) than in their other rotations, and are able to recognize the multifaceted clinical and administrative roles that future community psychiatrists will assume. Importance: As public sector mental health resources shrink, patients are at increasing risk of falling through the cracks and receiving little or not treatment, and becoming homeless. Creating paradigms of clinical care that are geared to these realities, and establishing required residency training in such settings is an approach to reinventing a mental health work force that embraces the sickest and neediest among us.

References:

1) American Association of Community Psychiatrists. Guidelines for Developing and Evaluating Public and Community Psychiatry Fellowships, 2008. http://www.communitypsychiatry.org
2) Bellack Alan S: Scientific and Consumer Models of Recovery in Schizophrenia: Concordance, Contrasts and Implications. Schizophrenia Bulletin 2006; 32(3):432 442.

WORKSHOP 27

Friday, October 28; 10:00 a.m.–11:30 a.m.

Peer Support Specialists and Psychiatrists: A New Way of Working

Kenneth S. Thompson, M.D., 6108 Kentucky Avenue, Pittsburgh, PA 15206

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Understand the evolution and development of peer support specialists; 2) Appreciate the role of peer support specialists in the recovery process 3) Create effective partnerships with peer support specialists.

Summary: Over the past decade peer support specialists have become an increasingly important component of recovery oriented psychiatric services. This marks a profound transformation in the nature of these services and in what it might take to "help" people with psychiatric disorders. The concept of peer support specialists and there role in providing services is not without controversy. This workshop will consider the experience of Recovery Innovations, a provider of psychiatric recovery services that has redesigned it methods to rely on peer support specialists as the cornerstones of its work. Presenters will discuss how this evolution occurred, what peer support specialists do, how services have been redesigned to support that work and promote recovery and how peer support specialists and psychiatrists, along with other members of the recovery team, are finding effective ways to work together and support recovery in the persons and communities they serve.

References:

1) Peer support of persons with severe mental illness: a review of the evidence by Larry Davidson, Matthew Chinman, Bret Kloos, Richard Weingarten, David Stayner, Jacob Kraemer Tebes Clinical Psychology: Science and Practice Volume 6, Issue 2, pages 165–187, June 1999.
2) Peer support/peer provided services underlying processes, benefits, and critical ingredients by Phyllis Solomon Psychiatric Rehabilitation Journal Volume 27, Number 4 / Spring 2004 Pages: 392 – 401. A1 University of Pennsylvania

WORKSHOP 28

Friday, October 28; 10:00 a.m.–11:30 a.m.

Innovative Strategies to Reduce the Stigma of Mental Illness

Jeffrey C. Eisen, M.D., M.B.A., 1493 Cambridge Street, Cambridge, MA 02139, **Tanishia Choice, M.D., Nicole Quiterio, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) To define public stigma versus self stigma, and ways to decrease stigma through anti stigma programs, legislation and advocacy; 2) To discuss the influence of the church in the maintenance of stigma in the African American community, and developing targeted anti stigma/psychoeducational curricula; 3) To discuss the stigma of incarceration, prevalence of mental illness among the incarcerated, and programs designed to prevent incarceration and overcome post incarceration barriers.

Summary: Many people who would benefit from mental health services choose not to engage or fully pursue these services. One of the reasons for this disconnect is stigma. Stigma can be framed in the social cognitive framework involving cues, stereotypes, prejudice and discrimination. These processes often rob those labeled as "mentally ill" of lifetime goals including finding good jobs, suitable housing, and are negatively impacted in both the criminal justice system and general health care system. Combined these issues yield significant harm to the "mentally ill," diminishing their self esteem and

taking away these social opportunities This portion of the seminar will focus on the characteristics that define public stigma and self stigma and address ways to diminish stigma including current anti stigma programs, legislation and advocacy. Stigma of psychiatric illness is the interaction of knowledge, attitudes, and behavior that when leveraged through a power structure leads to negative social consequences for persons with psychiatric illness. For the African American community, the church is an important organization with a power structure that influences the African American community's view of and interaction with the psychiatry field. A previous study has shown that addressing religion/spirituality concerns in psychoeducational programs targeted for African Americans can have effectiveness in reducing stigmatizing attitudes toward psychiatric illness. However, this intervention was limited by the participants concern that as individuals they could not have significant impact in their church or community. This finding underscores the need to work with the power structure of the church in order to produce lasting decreases in stigma of psychiatric illness in the African American community. This portion of the seminar will review data from focus groups with African American clergy members and discuss ways in which the data can inform psychoeducational curricula for the African American Community. III. The stigma of incarceration is significant and well documented. Individuals with a history of incarceration face significant obstacles following release, which contribute to an increased risk of recidivism. Psychiatric illness further complicates this picture, reinforcing social stigma and making it increasingly difficult to assimilate back into society after imprisonment.

References:

1) 1) Link BJ, Phelan JC. Conceptualizing Stigma. Annual Review of Sociology. 2001;27:363 385.
2) Primm AB, Cabot D, Pettis J, Vu HT, Cooper LA. The acceptability of a culturally tailored depression education videotape to African Americans. Journal of National Medical Association. 2002;94:1007 1016.
3) Cusack KJ, Morrissey JP, Cuddeback GS, Prins A, Williams DM. Criminal justice involvement, behavioral health service use, and costs of forensic assertive community treatment: a randomized trial. Community Ment Health J. 2010 Aug;46(4):356 63. Epub 2010 Mar 10.
4) Lamberti JS, Weisman R, Faden DI. Forensic assertive community treatment: preventing incarceration of adults with severe mental illness. Psychiatr Serv. 2004 Nov;55(11):1285 93.
5) Cooper, A., Corrigan, P. W., & Watson, A. C. (2003). Mental illness stigma and care seeking. Journal of Nervous and Mental Disease, 191, 339–341.
6) Sirey, J. A., Bruce, M. L., Alexopoulos, G. S., Perlick, D. A., Raue, P., Friedman, S. J., & Meyers, B. S. (2001). Perceived stigma as a predictor of treatment discontinuation in young and older outpatients with depression. American Journal of Psychiatry, 158, 479–481.

WORKSHOP 29

Friday, October 28; 10:00 a.m.–11:30 a.m.

Joining Forces: Integrated Care Models for Increasing the Capacity for Mental Health Care During a Recession

John Onate, M.D., 2230 Stockton Boulevard, Sacramento, CA 95817, **Russell F. Lim, M.D., Jeffrey T. Rado, M.D., M.P.H., Shannon Suo, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Become more familiar on evidence based models of integration; 2) Discuss barriers to integration with experts from distinct geographic regions of the United States; 3) Be familiar with evidence based approaches to integration.

Summary: Integration of primary care and psychiatry has been shown to be effective and cost effective for over a decade. In 2009 SAMHSA offered grants to support clinics in this endeavor. In 2010 the APA Assembly approved a position statement supporting integration. Despite this implementation of integration has been limited and there is much variance in the approach. This workshop presents models of integrated and coordinated care and the challenges of implementing such care, based on the experiences of 3 programs from different geographic regions of the United States. In 2005 Sacramento County enacted Integrated Behavioral Health (IBH) to treat psychiatrically ill medically indigent patients in a primary care setting. In 2010, that effort was expanded as an FQHC to treat patients with Medicaid. Staffed by dual boarded internal medicine/psychiatry and family medicine/psychiatry faculty, this site provides care to underserved patients and training to medical students and residents at UC Davis. Physicians provide integrated and coordinate care with community psychiatrists and primary care providers. IBH is a model site for the California Institute for Mental Health, CalMEND, an initiative of the California Departments of Mental Health (DMH) and Health Care Services (DHCS) to improve quality and outcomes for publicly funded mental health services, is influential on integrated care in California. CalMEND is a program designed to develop a process for integration in community health sites throughout California. Rush University Medical Center has produced clinicians specializing in integrated care and has developed an integrated medicine psychiatry clinic in a private model internal medicine outpatient system. Duke University has a successful combined internal medicine and psychiatry residency program and is a consultant for the state of North Carolina on integration of psychiatry into primary care settings particularly in rural and underserved areas. The participants of this workshop will become more familiar on evidence based models of integration and will have the opportunity to discuss issues around integration with experts from distinct geographic regions of the United States.

References:
1) Gonzalez HM, Vega WA, Williams DR, et al. Depression Care in the United States Too Little for Too Few. ARCH GEN PSYCHIATRY/VOL 67 (NO. 1), JAN 2010. 37 46
2) Gilbody S, Bower P, Fletcher J, et al. Collaborative Care for Depression A Cumulative Meta analysis and Review of Longer term Outcomes. ARCH INTERN MED/VOL 166, NOV 27, 2006. 2314 2321

WORKSHOP 30

Friday, October 28; 1:30 p.m.–3:00 p.m.

Improving Quality of Hospital Based Psychiatric Services Through Partnership With Patients, Families, and Community Stakeholders

Charles Saldanha, M.D., 2500 Alhambra Avenue, Martinez, CA 94553, **Anna Roth, M.S., M.P.H., Brenda J. Crawford, David J. Kahler, Teresa C. Pasquini**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Identify benefits of involving community stakeholders in the design of patient and family centered psychiatric services; 2) Describe methods for engaging patients, families and community based organizations in quality improvement; 3) Identify potential barriers to developing relationships with community partners and strategies for overcoming them.

Summary: The American healthcare system, including the mental health system, has serious flaws that cause harm to those it serves. Increasingly, healthcare organizations are recognizing the need for patient, family and community involvement in understanding and addressing the problems with the system of care. In mental health, providers of care are beginning to partner with community stakeholders in redesigning services.

Contra Costa Regional Medical Center (CCRMC), a 164 bed safety net hospital, serves a county of over 1 million residents and provides emergency and inpatient psychiatric services. As part of a systemwide commitment to quality improvement and greater stakeholder inclusion, CCRMC has included community members in performance improvement teams and hospital leadership. This partnership with patients, families and community organizations has led to significant improvements in psychiatric services at CCRMC. Stakeholders have been essential to understanding the problems of the current state, determining priorities and goals for performance improvement, and developing specific initiatives to improve care. As a result, consumers at CCRMC benefit from greater inclusion of families and other social supports, decreased waiting times for service, and improved coordination among team members in the provision of care. The experience at CCRMC demonstrates not only the benefits of stakeholder involvement, but also the need for institutional leadership in setting the stage for partnership and potential barriers and ways of overcoming them. Anna Roth, the Chief Executive Officer of CCRMC and Health Centers will present the rationale for engaging the community in system redesign and the groundwork required for stakeholder engagement to be successful. Brenda Crawford, Executive Director of Mental Health Consumer Concerns will describe shifting her organization from an adversarial to a collaborative stance with respect to CCRMC and the consequences of that change for consumers. Dave Kahler, Treasurer, NAMI Contra Costa will discuss the transition his group has made from advocacy from outside the institution to playing an integral role in changing it. Teresa Pasquini, a relative of a Contra Costa County mental health consumer, will share how she has used her experience as a person harmed by the system to effect change within it. Charles Saldanha, MD will describe the implementation of changes developed in partnership with community stakeholders.

References:
1) Taylor J, Rutherford P: The pursuit of genuine partnerships with patients and family members: The challenge and opportunity for executive leaders. Frontiers of Health Services Management 2010; 26(4):3 14.
2) Johnson B, Abraham M, Conway J, Simmons L, Edgman Levitan S, Sodomka P, Schlucter J, Ford D: Partnering with Patients and Families to Design a Patient and Family Centered Health Care System: Recommendations and Promising Practices. Bethesda, Maryland, Institute for Family Centered Care and the Institute for Healthcare Improvement, April 2008.

WORKSHOP 31

Friday, October 28; 1:30 p.m.–3:00 p.m.

Electronic Health Records: A Brief Review About EHR With 2011 Current Updates

Lawrence K. Richards, M.D., 714 South Lynn, Champaign, IL 61820, **Robert M. Plovnick, M.D., M.S.**

Educational Objectives: At the conclusion of this session, the participants should: be more confident of their understanding of electronic records, their meaningful use, and "how to purchase" the software, plus be able to understand well the need for security of electronic records, the ease with which the astute can victimize the unguarded, and have participated in group discussions regarding their and others encountered experiences, specific concerns, and estimations of patients' responses over such records.

Summary: This session follows that from the Boston IPS with presenters giving some review to aid those who were not there, but mainly giving an expanded up to date standing of information from U.S. Dept. of HHS' Office of National Coordinator (ONC) for Electronic Health Records (EHR) and the Center for Medicare/Medicaid Services (CMS). CMS' Electronic Health Record Incentive Programs began in January 2011. Physicians who treat a significant number of Medicare or Medicaid patients and use EHRs have the opportunity to receive up to $63,000 in financial incentives over a period of several years for "meaningfully" using a "certified" electronic health record by October 2012. This session will provide an overview of these incentive programs and other significant developments

in electronic health records that impact psychiatry. Some specific mentions here of covered topics are the certification process of these software programs being sold, some descriptions of these software programs, any updates about procedures and positions of the Centers for Medicare and Medicaid Services, (CMS has supplanted CMMS) and some review of medical literature regarding these. Additionally covered topics are the need for privacy for patients versus the risks of leaks and hackings. These latter, at the time of this writing, are all too well exemplified by "actions in the news;" at the international level there was Wikileaks' world wide web (WWW) electronic dissemination of US' DODefense and DOState secrets in amounts that weren't "wiki" at all, and at the county level there was the Dec.10 report by P. Solomon Banda, of Associated Press, on a local Mesa County, CO disaster estimated to affect 200K persons' data from April to Nov.24, 2010, including confidential informants and victims as well as the suspects, when names, addresses, and phone and SSN's in the sheriff's electronic files were accessed from within and without the U.S. and found posted on line! Along with presentation and discussion of the above, attendees will be afforded the opportunity to share and discuss their individual experiences plus opinions regarding EHRs and patients, along with having advisory group discussion. Time permitting, those attending will be asked specifically to assess levels of suicidal potential for patients whose personal records get used without authorization.

References:

1) www.healthit.hhs.gov for the Office of the O.N.C. for Health Information Technology and main resource on HIT & EHRs.
2) www.cms.gov for the Centers for Medicare and Medicaid Services, which has additional EHRs usefulness.
3) www.hhs.gov for the entire U.S. Health and Human Services Dept.
4) Psychiatric News has articles of helpful nature.

WORKSHOP 32

Friday, October 28; 1:30 p.m.–3:00 p.m.

Transitioning a Resident from Inpatient to Outpatient Practice: Reflections from Residents and Supervisors to Guide a Better Experience in Training

Eric Yarbrough, M.D., 411 West 114th Street, Suite 4B, New York, NY 10025, **Pesiridou Angeliki, M.D., Justin Capote, M.D., Philip Krick, D.O.,**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Understand the complex training issue of transitioning a resident from inpatient work to outpatient work; 2) Leave with a better understanding of what a resident needs to know to successfully adapt to outpatient practice.

Summary: A complex part of training psychiatric residents is the transition that takes place between inpatient and outpatient practice around the PGY2 year. A great majority of medical and psychiatric training takes place from an inpatient perspective throughout medical school, internship, and the start of residency. The skills and topics that are important to residents may be overlooked by their supervisors who trained, sometimes many, years before. It's important to prepare the resident clinically and administratively. Surveying residents throughout their transition and reflecting on what they feel is important will help strengthen training in future residency classes. This presentation will focus on the differences between what a supervisor thinks the resident should learn and information that the resident thinks would be beneficial. This presentation is the result of following three PGY2 residents in transition to their PGY3 outpatient year at a major metropolitan hospital in New York City. The information provided will be reflections from their journals kept throughout the year.

References:

1) N/A
2) N/A

WORKSHOP 33

Friday, October 28; 1:30 p.m.–3:00 p.m.

Community Health Centers and Community Mental Health Centers: Working Together Towards Integrated Care

Lori Raney, M.D., 281 Sawyer Drive, Durango, CO 81303, **Michael R. Lardiere, L.C.S.W., Carolyn Shepherd, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to describe the FQHC safety net clinic system of care, understand the need for mental health services in these facilities and have a working knowledge of how to put together collaborative experiences with your local FQHC.

Summary: Primary Care Behavioral Health Integration (PCBHI) projects are frequently joint ventures between Federally Qualified Health Centers (often called CHCs) and Community Mental Health Centers (CMHCs) due to overlapping missions of serving as safety net organizations for vulnerable populations. In Colorado, over 40 CMHC/CHC collaboration projects are underway in both CHCs and School Based Health Centers operated by CHCs with contracted support from the CMHCs. In order to work more closely together and facilitate joint learning opportunities, in 2010 the Medical Dirctors of the CMHCs invited the Medical Directors of the CHCs to begin joint meetings. These meeting led to opportunities to pair up medical directors in each catchment area, discuss models that work and have not worked, problem solve and provide education to all parties. A Learning Community was also established through the National Council and the National Association of Community Health Centers (NACHC) with funding from the SAMHSA/HRSA Training and Technical Assistance grant for PCBHI. This workshop will bring together the Medical Director of a CMHC (Dr. Raney), a Medical Director of a CHC (Dr. Shepherd) and the Behavioral Health leader for NACHC (Mike Ladiere, LCSW) to discuss

this joint venture in Colorado and the results of this collaboration. In addition, Mr. Ladiere will present examples from other states that have undertaken similar initiatives, providing the attendee with ideas for projects they can take back to their states.

References:
1) Unützer J, Katon WJ, Williams JW, Callahan CM, Harpole L, Hunkeler EM, Hoffing M, Areán PA, Hegel MT, Schoenbaum M, Oishi SM, Langston CA. Improving primary care for depression in late life: the design of a multi center randomized trial. Medical Care. 2001;39:785 799.
2) Collaborative Care for Depression: A Cumulative Meta analysis and Review of Longer term Outcomes.Simon Gilbody, MBChB, MRCPsych, DPhil; Peter Bower, PhD; Janine Fletcher, MSc; David Richards, PhD; Alex J. Sutton, PhD Arch Intern Med. 2006;166:2314 2321

WORKSHOP 34

Friday, October 28; 1:30 p.m.–3:00 p.m.

Recovery Oriented Practice: A Multidisciplinary Perspective

Annelle Primm, M.D., 1000 Wilson Boulevard, Arlington, VA 22209, **Steven Harrington, Kris A. McLoughlin, D.N.P., A.P.R.N., Mary Jansen, Ph.D., Gwen Foster, M.S.W.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Identify roles of multidisciplinary mental health professionals in implementing recovery oriented practices; 2) Identify examples of benefits of effective collaboration; 3) Identify obstacles to effective collaboration in recovery services and ways to address them.

Summary: Implementation of effective recovery oriented services requires effective collaboration among the team of mental health professionals. A multi-year SAMHSA funded project is aiming to further the understanding and implementation of recovery oriented practice among psychiatrists, psychiatric nurses, psychologists, social workers, and peer specialists. Representatives of the various disciplines will discuss their individual efforts in curriculum development and professional education as part of the project. Discussion will also address the interdisciplinary aspects of recovery oriented practice as well as plans and visions to better align education efforts and to increase coordination and collaboration.

References:
1) Rosen A, Callaly T. 2005. Interdisciplinary Teamwork and Leadership: Issues for Psychiatrists. Australasian Psychiatry 2005; 13(3):234-40.
2) Davidson L, O'Connell M, Tondora J, Styron T, Kangas K.. 2006. The Top Ten Concerns about Recovery Encountered in Mental Health System Transformation. Psychiatric Services 2006; 57(5):640-5.

WORKSHOP 35

Friday, October 28; 3:30 p.m.–5:00 p.m.

Building a Constituency for Public Service Psychiatry: The Experience of Pennsylvania Psychiatric Leadership Council

Jeannette S. Harrison, M.S., 166 Ceramic Drive, Columbus, OH 43214, **David Dinich, M.Ed., Kenneth S. Thompson, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) List three reasons why PPLC was established; 2) List three strategies and three accomplishments of this statewide group; 3) List two challenges 4) Recognize replicable elements.

Summary: In Pennsylvania, as in most of the country, there is a continuing scarcity of psychiatrists in most community behavioral health agencies. Those psychiatrists that do exist in public systems are often isolated from professional contact by distance, caseload sizes, a scarcity of public/community psychiatry opportunities, and an absence of state government leadership. In addition, there has been an absence, within the psychiatric community, of leadership and psychiatric representation in many system deliberations. Routine information, continuing education, and development of Psychiatric leaders are critical to successfully navigate the growing challenges and complexities of the public behavioral health care system. In 2005, Pennsylvania convened the Pennsylvania Psychiatry Leadership Council to provide a focus and voice to issues of public psychiatry and its care and treatment of Pennsylvanians involved in community behavioral health systems. This representative group of community psychiatrists, academic training leaders, behavioral health authorities, providers, associations and families and consumers was appointed by Pennsylvania's Secretary of Public Welfare and charged to discuss, explore, learn and recommend and undertake next steps for Pennsylvania related to emphasizing and improving the practice and administration of Community Psychiatry. This workshop will present the rationale for establishment of this statewide group, its organizational process, its strategies (Academic Training, Recruitment and Retention, Family Collaboration, State Policy Involvement, and Profession Contacts, Networking and Information Sharing) and accomplishments, and future challenges. In addition, the audience will discuss and identify elements that could be replicated in other states.

References:
1) Sowers WE, Thompson KS: Keystones for Collaboration and Leadership: Issues and Recommendations for the Transformation of Community Psychiatry, The American Association of Community Psychiatrists, Pennsylvania Psychiatry Leadership Council, Allegheny County Office of Behavioral Health, Coalition of Psychiatrists for Recovery, 2006.
2) The Community Psychiatrist of the Future, Alan Rosen, Current Opinion in Psychiatry, 2006, posted www.Medscape.com/view article/533620June 8, 2006, Curr Opin Psychiatry

WORKSHOPS

WORKSHOP 36

Friday, October 28; 3:30 p.m.–5:00 p.m.

A Four Factor Model for Training Residents in Systems Based Practices

Jules Ranz, M.D., 11 Riverside Drive, #8NW, New York, NY 10023 2978, **Melissa R. Arbuckle, M.D., Ph.D., Joanna Fried, M.D., Stephanie M. LeMelle, M.D., Hunter L. McQuistion, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to understand how the Four Factor Model provides a valid and reliable definition of systems based practices, and how this model can be used to inform residency training in systems based practices.

Summary: The Mental Health Services (MHS) Committee of the Group for the Advancement of Psychiatry undertook an IRB approved study at 12 psychiatric residency training programs across the country, to test the validity and reliability of a 60 item instrument intended to assess the quality of systems based practices (SBP)training being provided to psychiatric residents. The data from this study reveals that four factors comprising 17 items from the instrument constitute a valid and reliable definition of systems based practices. The MHS Committee has written recommendations for revision of the ACGME Guidelines for SBP based on the four factor model. The Committee has also undertaken an IRB approved study to consult with four directors of psychiatric residency training to help them augment their SBP training. All psychiatric residency training programs will be able to use the results of this consultation to upgrade and document SBP training in their training programs.

This study was predicated on earlier work by the MHS Committee, which published a Psychiatric Services article in November 2007, titled "The Tipping Point from Private Practice to Publicly Funded Settings for Early and Mid Career Psychiatrists" in which the MHS Committee used APA data to demonstrate that early and mid career psychiatrists now work more hours in organizational settings than in private practice. The article concluded with the recommendation that psychiatric residency training programs need to provide more comprehensive training in Systems Based Practices (SBP), one of the six core competencies required by ACGME of all residency training programs.

References:

1) Ranz JM, Vergare MJ, Wilk JE, et al. The Tipping Point from Private Practice to Publicly Funded Settings for Early and Mid Career Psychiatrists, Psychiatric Services 57:1640 1643,
2) ACGME Program Requirements for Graduate Medical Education in Psychiatry, July 1, 2007http://www.acgme.org/acWebsite/downloads/RRC_progReq/400_psychiatry_07012007_u04122008.pdf

WORKSHOP 37

Friday, October 28; 3:30 p.m.–5:00 p.m.

Two Innovative Initiatives Integrating Medical Care, Mental Health Care and Psychosocial Support

Daniel H. Karasic, M.D., 1001 Potrero Street, San Francisco, CA 94110

Educational Objectives: At the conclusion of this session, the participant should be able to understand strategies for organizing multidisciplinary clinics to better reach and serve challenging populations and understand clinical issues in the care of HIV+ women and gender non-conforming children, and how this informed different approaches to organizing care for each population.

Summary: This workshop will present two different approaches by UCSF and its community partners to help integrate medical and mental health care and social support for two challenging populations. One program is the Women's HIV Clinic at San Francisco General Hospital. This clinic serves urban, low income women with HIV, who face challenges with connecting to and prioritizing health care, with complications of substance abuse, psychiatric illness, poor psychosocial support, and unstable housing. These challenges decrease adherence to antiretroviral medications, which leads to faster progression to AIDS and increased mortality. Women with HIV and persistent depression have double the mortality of those without depression, but depression and the other above factors can be addressed to improve outcomes. At the Women's Clinic, physicians, nurse practitioners, a psychiatrist, psychotherapists, case managers, pharmacists, and other staff work together closely to overcome the barriers to care that take a particular toll on this population. A panel including an internist, a nurse practitioner, a psychiatrist, and a social worker will discuss this example of integrating care in one weekly clinic. A different approach is taken in a new UCSF-community initiative to help integrate care for gender non-conforming children and transgender youth. The Bay Area Youth Gender Acceptance Project (BayGap) is an innovative consortium in the San Francisco Bay Area to provide integrated care and assistance to gender diverse and transgender children and youth and their families, including hormone therapies, mental health services, and educational, legal and other forms of advocacy. A panel including representatives from primary pediatrics care, specialty pediatric endocrinology care, psychiatry, psychology, and family support/advocacy will present BayGap's approach to integrate care provided in multiple settings.

References:

1) Ehrensaft, D. Gender Born, Gender Made: Raising Healthy Gender Non-conforming Children. The Experiment, New York, 2011.
2) Perry S, Karasic D. Depression, adherence to HAART, and survival. Focus. 2002 Aug; 17(9): 5-6.

WORKSHOP 38

Friday, October 28; 3:30 p.m.–5:00 p.m.

Psychiatric Care At the Interface of Mental Health and Criminal Justice: Lessons Learned and Emergent Principles from More Than 2500 Letters

William Nunley, M.D., M.P.H., 1526 NE Alberta St, Portland, OR 97211, **Fred C. Osher, M.D.**

Educational Objectives: At the conclusion of this experiential session, the participant should be able to identify the following 1) Their own attitudes concerning psychiatric care provision for individuals with current or previous criminal justice involvement; 2) Current systemic challenges; 3) Areas for improvement at the interface of public safety and mental health.

Summary: The Group for Advancement in Psychiatry (GAP) Committee on Psychiatry and the Community seeks your interest and review of a three year initiative. The group requested "Dear Abby" to solicit individuals and families who had become involved with the criminal justice system as a result of mental illness. Over the course of about two years, more than 2,500 letters were written from across the country. Inspired by the personal stories of clients, parents, advocates, siblings, former spouses, providers, politicians, and police, we seek your collegial review of our effort to improve the willingness and effectiveness of psychiatrists to participate in collaborative strategies. We want to improve the voice of psychiatry at the levels of individual patient care, program and community coordination, and policy definition and implementation. We want to share our understanding developed during a lengthy consideration of an unexpectedly large number of letters defining the over representation of persons with mental illness (and co occurring health, trauma, substance conditions) in the criminal justice system.

References:

1) A Cry for Help. Carol Genengels. Psychiatr Serv 60:726 727, June 2009
2) Jailing Is Failing People With Mental Illness. Committee on Psychiatry and the Community, Group for the Advancement of Psychiatry. Psychiatr Serv 60:723, June 2009

WORKSHOP 39

Saturday, October 29; 8:00 a.m.–9:30 a.m.

Quality Improvement – The Secret to High Performing Mental Health and Addiction Systems

Nick Kates, M.D., 10 George Street, 3rd Floor, Hamilton, Ontario, Canada L9H 1X7

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Use the dimensions of high quality care to measure a systems performance; 2) Use the patient journey to identify changes in the way care is delivered; 3) Introduce rapid cycle tests of change using the improvement model.

Summary: Increasing attention is being paid to the quality of the care that we deliver, with a recognition that many of the seemingly intractable problems that services face are related more to how systems are designed than a lack of will, expertise, resources, or the desire to improve things. Improving these problems requires system re design. This interactive workshop will discuss the dimensions of a high performing mental health service/system, using domains based upon the 2001 report of the National Institute of Health consumer centered, safe, timely, effective, efficient, equitable and transparent and the reasons why services may currently be under performing. It will then present a four step approach to redesigning systems to improve the quality of care, that can be adopted by any program or organization, providing practical examples of each. The first step is to define a vision of what the service is trying to accomplish. Second is the use of improvement tools such as process mapping, understanding the consumer journey and measuring core functions to get to know your system and identify where it is underperforming. The next is to introduce specific changes using the improvement model and PDSA rapid cycle tests of change. Finally we need to find ways to sustain and spread these improvements. The workshop will give attendees an opportunity to learn about and try out simple improvement tools that they can take back to their own setting and ideas for improvements they can implement.

References:

1) Spaeth Rublee B. Pincus H., Huyhn P. Measuring Quality of Mental Health Care: A review of Initiatives and Programs in Selected Countries Can. J. Psych.55 (9) 539 545 Sept. 2010
2) Kilbourner A., Keyser D., Pincus H. Challenges and Opportunities in Measuring the Quality of Mental Health Care Can. J. Psych.55 (9) 539 545 Sept. 2010

WORKSHOP 40

Saturday, October 29; 8:00 a.m.–9:30 a.m.

Staying Alive: Addressing Loneliness in Persons With Mental Illness

Sheila M. Lobo Prabhu, M.D., 2002 Holcombe Boulevard, Houston, TX 77030, **Ellen F. Barr, M.S.W., Theron C. Bowers, M.D., James Lomax, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Understand biopsychosocial and spiritual aspects of loneliness in persons with mental illness; 2) Apply knowledge about loneliness to gain a better appreciation of the full impact of loneliness on the lives of patients with psychiatric illness; 3) Describe the role of cognitive therapy, interpersonal therapy and modified validation therapy in the care of the lonely mentally ill patient.

Summary: Loneliness and mental illness are so reciprocally intertwined that it is difficult to ascertain if mental illness causes loneliness or if loneliness causes mental illness. Gardner and Brewer posited a three part construct of the self: the intimate, relational, and collective self. From this, Cacioppo and Patrick derived three levels of social connectedness; intimate, relational, and collective. In the lonely individual, deficient social networks result in loss of relational and collective connectedness. Instead of reaching out to others, lonely individuals are more likely to engage in tit for tat reciprocity when they perceive others as mistreating them; this exacerbates anxiety and depression. In our clinical experience, we note that severe and prolonged loneliness can adversely affect the intimate level of connectedness, and cause severe damage to the basic self characteristics of the individual. This is often accompanied by cognitive distortions and depression. By adversely affecting mood, cardiovascular risks, and immune function, and by causing suicidal thoughts, loneliness can actually shorten the lifespan. As mental health professionals, we try to reduce the stigma of mental illness and to reach out to the disenfranchised. In doing so, it is important to have a conceptual framework of loneliness and how to address this issue in order to improve clinical outcomes. Cacioppo and Patrick, in their extensive work on loneliness, suggest some important tools to manage loneliness. Feil introduced validation therapy in dementia care. Modified validation therapy can be used to address the most basic emotions of rejection and fear in the lonely. Rather than directly addressing the distorted cognitions in the lonely patient, which may only exacerbate fear and withdrawal, positive reinforcement is continuously given for adaptive and prosocial behavior. In this workshop, we will discuss loneliness from a biopsychosocial viewpoint, and discuss spiritual and ethical aspects of treating loneliness in the mentally ill. We will also discuss two specific cases where an interdisciplinary geriatric psychiatry team used modified validation therapy, cognitive therapy, and interpersonal therapy to successfully and directly address the issue of loneliness in the care of middle aged and geriatric psychiatric patients.

References:

1) Cacioppo JT, Patrick W: Loneliness. New York, NY, W.W. Norton and Company, Inc., 2008.
2) Baumann AE: Stigmatization, social distance, and exclusion because of mental illness: the individual with mental illness as a 'stranger.' Int Rev Psychiatry 2007, 19(2):131 135.

WORKSHOP 41

Saturday, October 29; 8:00 a.m.–9:30 a.m.

Women's Mental Health Following Abortion

Tracy A. Weitz, Ph.D., M.P.A., 1330 Broadway Street, Oakland, CA 94612, **Julia Steinberg, Ph.D., Nada L. Stotland, M.D., M.P.H.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Increase their knowledge of abortion as a mental health issue, 2) Learn how clinics prepare women for abortion in an effort to increase their self efficacy for coping when abortion is a more difficult or destabilizing event, 3) Identify women in need of psychiatric services.

Summary: Almost a third of women in the U.S. have an abortion at some time in their lives. Women's mental health following abortion is increasingly the center of the escalating social debate over abortion. New arguments dominate about whether abortion causes mental health harms or whether those harms result from the stigma and shame surrounding abortion in the 21st century. Likewise, public opinion polls suggest that more Americans believe that abortion is harmful to women, even if they have no personal experience with a woman who has had an abortion. In his decision upholding the Partial Birth Abortion Act of 2003, Supreme Court Justice Kennedy gave voice to that concern when he wrote that "it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained [and that] severe depression and loss of esteem can follow." This highly politicized nature of the abortion debate encourages either the exaggeration or minimization of women's emotional experiences related to undergoing an abortion. On one side, abortion rights advocates often avoid focusing on the phenomenon of regret, often out of concern that it could decrease women's access to abortion services. At the other end of the spectrum, abortion rights opponents have used regret and other negative emotions to justify restrictive laws geared toward affecting women's decision making about abortion. The efficacy of these laws in preventing abortion regret and emotional distress is uninvestigated and unproven. Moreover, these legal interventions mandate clinical interactions that are largely uninformed by current psychiatric or psychological practices. In this workshop, we examine the current debate over women's mental health following an abortion, the laws that govern abortion care under the justification of preventing regret, the scientific evidence of women's experiences with abortion, and the clinical practices involved in providing abortion care. Experts in the field of women's experiences with abortion, abortion care provision, abortion and mental health science, abortion legal regulation, and abortion counseling practices will present both theoretical and empirical research on the topic of women's mental health following abortion. Building from this collective evidence base, participants will increase their knowledge of abortion as a mental health issue.

References:

1) Major, B., Appelbaum, M., Beckman, L., Dutton, M. A., Russo, N. F., & West, C. (2009). Abortion and mental health: Evaluating the evidence. American Psychologist, 64(9), 863 890.
2) Robinson, G. E., Stotland, N. L., Russo, N. F., Lang, J. A., & Occhiogrosso, M. (2009). Is there an "abortion trauma syndrome"? Critiquing the evidence. Harvard Review of Psychiatry, 17(4), 268 290.

WORKSHOP 42

Saturday, October 29; 10:00 a.m.–11:30 a.m.

Challenges and Solutions in Optimizing Consumer Involvement in State Mental Health Authorities

Alan Q. Radke, M.D., M.P.H., 444 Lafayette Road North, St. Paul, MN 55164 0979, **Joseph J. Parks, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Identify the history of consumer involvement with state mental health authorities (state policy, funding and provision of services); 2) Evaluate the evidence supporting consumer involvement; 3) Discuss the different consumer roles in state mental health authorities; 4) Define the challenges and solutions to optimizing consumer involvement.

Summary: Across the nation, the involvement of persons with mental illness in the state mental health authority (SMHA) services and administration has varied greatly. A recent article on "Developing Statewide Consumer Networks" suggested that these networks of mental health consumers could provide direct services, advocacy and technical assistance to smaller consumer operated services but did not address SMHA policy making and oversight of the delivery of the provision of public mental health treatment services. Persons with mental illness are able to positively contribute to the three domains of SMHA responsibility: 1) Treatment/Care Service Delivery; 2) Administration and Management of such programs and 3) Oversight of public policy and funding. The roles these consumers play vary state by state. The involvement of consumers in state operated behavioral health services has been growing over the years. Some states have offices of consumer affairs while others have created state advisory councils to improve consumer involvement. While these efforts have there merits, there continues to be a lack of national guidelines on consumer involvement. There is a clear need to increase involvement of consumers self directing their care and managing the very programs that are built to provide care to them. For the most part, initiatives involving consumers has not been well connected or well coordinated with each other and with the SMHA. Unfortunately, due to the current economic crisis and continuous changes in leadership some successful initiatives have been eliminated. SAMHSA CMHS, NACSMHA and NASMHPD Medical Directors' Council sponsored a technical report meeting of commissioners, medical directors, office of consumer affairs directors, content experts and consumers on "Consumer Involvement in State Operated Behavioral Health Services" in June 2010. A technical report based on the meeting proceedings will be published fall of 2010. This report includes national, state and local recommendations for the optimum inclusion of consumers in all activities of state operated behavioral health services authorities.

References:

1) Miller,LD, Moore, LR (2009). Developing Statewide Consumer Networks, Psychiatric Services, 60(3), 291 193.

WORKSHOP 43

Saturday, October 29; 10:00 a.m.–11:30 a.m.

The Epidemiology, Etiology, and Treatment of Depression in Lesbian, Gay, and Bisexual Persons

Robert M. Kertzner, M.D., 2154 Broderick Street, San Francisco, CA 94115, **Ellen Haller, M.D., Karin L. Hastik, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Recognize the epidemiology of depression in lesbian, gay, and bisexual (LGB) persons; 2) Identify etiological factors related to an increased rate of depression in this population; 3) Understand the treatment needs and sensitivities of LGB patients seeking help for depression.

Summary: Epidemiologic studies have consistently found increased rates of depression in lesbian, gay, and bisexual (LGB) persons. Historically, such findings would have been attributed to bisexuality and homosexuality being mental illnesses with inherent psychopathology. However, for the past 30 40 years, the literature has clearly demonstrated that living in a heterosexist and homophobic society and being a victim of resultant discrimination and lack of equal civil rights accounts for much of the increased risk of depression in this population. Among LGB persons, women, members of ethnic racial minority groups, and older adults experience additional stigmatization and psychosocial stressors. Working within a developmental and social framework, mental health providers can optimize the care of depressed LGB persons by recognizing etiological factors and treatment considerations specific to LGB persons. This workshop will feature a case presentation by Karin Hastik, M.D., of a patient with depression, substance abuse, and other developmental issues pertinent to LGB persons. Ellen Haller, MD, will concentrate on discussing special treatment issues in treating lesbians and bisexual women with depression. Robert Kertzner, MD, will focus on depression in gay and bisexual men.

References:

1) Meyer IH: Prejudice, social Stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. Psychological Bulletin 2003; 129(5): 674–697.
2) Bieschke KJ, Perez RM, DeBord KA: Handbook of Counseling and Psychotherapy with Lesbian, Gay, Bisexual, and Transgender Clients (2nd Edition). Washington, DC, American Psychological Association, 2006.

WORKSHOP 44

Saturday, October 29; 10:00 a.m.–11:30 a.m.

How Do We Implement Culturally Competent Collaborative Care?

Ashley K Miller, M.D., 126 Michigan Avenue NE #N 41, Washington, DC 20017, **Patricia A. Arean, Ph.D., Jason E. Cheng, M.D., Thomas Cicciarelli, Psy.D., Robert Cabaj, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Learn about different models of mental health care delivered in primary care settings; 2) Understand ways of making collaborative care culturally relevant to individual patient needs; 3) Examine regional differences to approaching collaborative care; 4) Learn how to address barriers to implementing collaborative care.

Summary: Millions of Americans suffer from mental health disturbances with an estimated 26.2 percents of adults over the age of 18. Up to 50% of individuals seen in primary care clinics can be affected. These numbers are so great that many do not have access to psychiatrists or other mental health professionals. A Surgeon General's report indicated that problems of access are particularly apparent in various minority groups, due to both lack of availability of and stigma against specialty mental health treatment. To address these problems, primary care settings should play a greater role in the delivery of mental health care to minority and under served patients. This makes the most sense for patients with less severe psychiatric disorders and for those who already obtain treatment for co morbid non psychiatric conditions. Collaborative care, i.e., mental health treatment delivered in primary care settings, has been demonstrated to improve mental health treatment access and outcomes in various low income, minority, and non English speaking populations. However, significant challenges remain. Issues such as finance and stigma are only a few of the reasons that collaborative care work happens sparingly outside of research protocols and other specific grant programs. Therefore, future goals include finding ways to make collaborative care more broadly available across the country. The goal of this workshop is to discuss the utility and practicality of culturally competent collaborative mental health care work. We will provide an overview of collaborative care. We will then review specific implemented collaborative care programs that serve minority and/or underserved populations. Furthermore, we will discuss administrative, financial, and other barriers to more widespread culturally competent collaborative care, including illustration by case study. The workshop will end with a panel discussion taking questions from the audience.

References:

1) Kessler RC et al. Prevalence, severity, and comorbidity of 12 month DSM IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry. 2005 Jun;62(6):617 27.
2) Kisely S & Campbell LA. Taking consultation liaison psychiatry into primary care. International Journal of Psychiatry in Medicine. 2007;37(4):383 91.
3) Mental Health: Culture, Race and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: US Dept of Health and Human Services, Office of the Surgeon General; 2001.
4) Position Statement on Interface and Integration with Primary Care Providers. American Association of Community Psychiatrists. October 2002.
5) Gilmer TP et al. Improving treatment of depression among Latinos with diabetes using project Dulce and IMPACT. Diabetes Care. 2008 Jul;31(7):1324 6.
6) Yeung A et al. Integrating psychiatry and primary care improves acceptability to mental health services among Chinese Americans. General Hospital Psychiatry. 2004 Jul Aug;26(4):256 60.
7) Sarvet BD & Wegner L. Developing effective child psychiatry collaboration with primary care: leadership and management strategies. Child Adolescent Psychiatry Clinics of North America. 2010 Jan;19(1):139 48.

WORKSHOP 45

Saturday, October 29; 1:30 p.m.–3:00 p.m.

Exploring Suicidal Ideation in Physician Patients: Toward Building Resilience and Saving Lives

Michael F. Myers, M.D., 450 Clarkson Avenue, Brooklyn, NY 11203

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Discuss why physicians are an at risk group for suicide 2) Summarize ways of exploring self destructive thinking in physicians 3) Demonstrate increased confidence in treating suicidal physician patients.

Summary: Research shows that physicians kill themselves more frequently than others of their gender and age in the general population and in other professions. The presenter, a specialist in physician health, has been treating physicians for 40 years. His findings include the following: mood disorders and substance abuse are not uncommon in physicians but can be missed when physicians deny or camouflage their symptoms; most physicians have had thoughts of suicide and many have considered a means of how they would end their lives; autonomy and self control are common traits in physicians and can inform their decision making about suicide; most physicians have treated patients who have attempted suicide (e.g. emergency physicians, intensivists, neurosurgeons, orthopedic surgeons, pathologists, primary care doctors, psychiatrists) and this work affects them in differing ways; most physicians' plans of suicide are fool proof and with high intent to die; physicians are generally deeply affected when a medical colleague dies by suicide and worry about contagion; physicians are perfectionistic by nature – perceived medical error, lawsuits or reports to the medical licensing board can catapult the physician into a spiral of shame, guilt and frightening despair; physicians

approach treatment with great ambivalence, especially a deep seated wish for help but with a concomitant feeling of terror and embarrassment. The author's premise is that most physicians welcome talking about their suicidality and feel great relief when they can do this in a safe and trusting therapeutic relationship. Several disguised examples will be presented. One half of the allotted workshop time will be protected for case exploration and discussion with attendees.

References:
1) Myers MF, Gabbard GO. The Physician As Patient: A Clinical Handbook for Mental Health Professionals. American Psychiatric Publishing, Inc., Washington, DC 2008.
2) Simon RI. Preventing Patient Suicide: Clinical Assessment and Management. American Psychiatric Publishing, Inc., Washington, DC 2010.

WORKSHOP 46

Saturday, October 29; 1:30 p.m.–3:00 p.m.

Four Perspectives on the Mental Health Needs of Transgender People

Christopher A. McIntosh, M.D., M.S.C., 250 College St, Toronto, Ontario, Canada M5T 1R8, **Christopher Daley, M.D., Ronald R. Holt, M.D., M.P.A., Nathaniel G. Sharon, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Appreciate the mental health and medical/ surgical needs of transgender people, and the recognized standards for their care; 2) Understand the role of mental health providers in care of transgender people from the perspective of medical ethics; 3) Understand the political context of psychiatry's involvement in transgender care.

Summary: The mental health needs of transgender people are quite varied. In addition to the range of mental health challenges that any group can face, transgender people have needs that relate specifically to the process of changing one's gender. The workshops participants will provide four different perspectives on the involvement of psychiatric professionals in the care of transgender people. Dr. Christopher McIntosh will describe his perspective on conducting outpatient assessments that evaluate a transgender person's eligibility and readiness for hormonal and surgical interventions to change their gender. He will briefly discuss standards of care in this area and then examine psychiatry's involvement in transgender care from a political perspective and from the perspective of biomedical ethics, specifically looking at the ethical principles of patient autonomy and beneficence/ non malfeasance. Dr. Ronald Holt is a psychiatrist with Kaiser Permanente (KP), the largest non-profit prepaid healthcare organization in the United States. KP promotes transgender mental health through their diversity initiatives to end transgender mental and physical health care disparities. These initiatives will be discussed to stimulate discussion of how other healthcare organizations and institutions can improve the mental health of their transgender population by adapting some of the KP diversity initiatives. In the psychiatric inpatient setting staff members face unique challenges when striving to provide culturally competent care to transgender patients under the pressure of high symptom acuity. Seemingly small details, such as which gender side of the unit to assign a patient, can carry significant meaning. Dr. Christopher Daley, inpatient leader of the LGBT inpatient program at San Francisco General Hospital, will share his experiences providing education about transgender mental health to the inpatient unit staff. Finally, Dr. Nathaniel Sharon is a third-year psychiatry resident at UCSF and an open trans man. He transitioned during medical school, providing a unique experience as both patient and provider. Dr. Sharon will discuss his own personal experiences with transgender mental health care during medical school and residency as well as the continued need for psychiatry residency education, cultural awareness and research.

References:
1) Coleman, E. 2009. Toward Version 7 of the World Professional Association for Transgender Health's Standards of Care: Hormonal and Surgical Approaches to Treatment. International Journal of Transgenderism 11: 141 145.
2) Hebert, P.C. 2009. Doing Right: A Practical Guide to Ethics for Medical Trainees and Physicians. 2nd ed. Toronto: Oxford University Press Canada.

WORKSHOP 47

Saturday, October 29; 1:30 p.m.–3:00 p.m.

The Role of the Psychiatrist in Integrating Primary Care and Behavioral Health Care: Stories from the Front Lines

Ruth S. Shim, M.D., M.P.H., 720 Westview Drive, Atlanta, GA 30310, **Kenneth S. Thompson, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Identify the evidence basis for integrating primary care and behavioral health: 2) Determine the barriers to integration of primary care and behavioral health care; 3) Recognize the psychiatrist's role in integrated care; 4) Evaluate lessons learned from successful and unsuccessful attempts at integrating care; 5) Consider common themes in successful integrated care models.

Summary: Primary care settings are usually the first point of contact and the treatment site of choice for minority and low income consumers, with mental health problems constituting upwards of 40% of consumers' presenting complaints. Many consumers view mental health treatment in primary care settings as less stigmatizing than care received in specialty behavioral health settings. However, a great deal of evidence has demonstrated that primary care practitioners have difficulty recognizing and treating the mental health challenges of their patients. Unfortunately, fewer than half of the depression cases seen in primary care are correctly diagnosed, and only half of those diagnosed receive appropriate clinical care. At the same time, persons with mental illness often have high levels of early

mortality and a heavy burden of medical morbidity. Often, consumers seen by behavioral health practitioners do not receive needed primary care. Perhaps the most promising approach for improving rates of evidence-based treatment in primary care and behavioral health care settings has been with the use of multidisciplinary, team-based, integrated models of care. Such evidence-based treatment models have proven to be effective in clinical trials. There are clear examples of successfully integrated behavioral health and primary care models (IMPACT, RESPECT-D, and PROSPECT). Unfortunately, many programs that have attempted to integrate behavioral health and primary care have been met with failure, or only partial success. By sharing "stories from the front lines" we can begin to identify themes of what leads to effective implementation, as well as discuss challenges and barriers in the implementation of integrated care programs.

In addition, the role of the psychiatrist in integrated models of care is crucial to the effective implementation of these models. This workshop aims to address the need create stronger collaborations with primary care providers, while addressing the barriers that prevent these collaborations.

References:

1) Ayalon L, Areán P, Linkins K, Lynch M, Estes C. Integration of mental health services into primary care overcomes ethnic disparities in access to mental health services between black and white elderly. American Journal of Geriatric Psych. 2007;15(10):906.
2) Kathol R, Butler M, McAlpine D, Kane R. Barriers to Physical and Mental Condition Integrated Service Delivery. Psychosomatic medicine. 2010;72(6):511.
3) Pomerantz A, Cole B, Watts B, Weeks W. Improving efficiency and access to mental health care: combining integrated care and advanced access. General hospital psychiatry. 2008;30(6):546-551.

WORKSHOP 48

Saturday, October 29; 2:00 p.m.–5:00 p.m.

President's Interactive Session With Residents and Early Career Psychiatrists

John M. Oldham, M.D., 2800 Gessner Drive, Houston, TX 77080

WORKSHOP 49

Saturday, October 29; 3:30 p.m.–5:00 p.m.

Interactive Theater: A Tool to Educate, De Stigmatize and Create Awareness: A South African Perspective

Leverne Mountany, M.D., M.Med., P.O. Box 127, Fourways 2055, South Africa, **Zubeida Z. Mahomedy, M.D., M.Med., Mashadi M. Motlana, M.D., M.Med.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Discuss the concept of Interactive Theatre and the role it can play in destigmatising mental illness and education; 2) Use the concept to develop role plays and/or theatre productions in their own environments.

Summary: Theatre and storytelling are powerful ways of touching people getting under the surface and releasing potential. Also, it is compelling entertainment. Theatre has a way of reaching people more effectively as complex issues are easily conveyed without appearing threatening. This creates the concept of "Edu tainment." Psychiatry M Powered is a non profit organization with the primary focus of creating awareness, destigmatising mental health and education related to mental health issues. The organization is directed by three (3) psychiatrists: Dr Shadi Motlana, Dr Zubeida Mahomedy and Dr Leverne Mountany, and further consists of individuals in the mental health care field who are all passionate about mental health and improving the lives of those affected by these conditions. Psychiatry M Powered has been utilizing theatre productions, written and produced by Charlene Sunkel who is a mental health care user, to raise awareness on various issues related to mental illness, and has had great success. "Madness Revealed – Michael's Story," hopes to challenge current views and perceptions. The production is a vehicle to raise awareness and understanding about mental illness, and specifically depression. Many believe that persons with mental illness, who overcome, defy the odds. The playwright chose to write about the true life story of Michael Chatwind's experiences with a diagnosis of major depression.

References:

1) Sommers J Drama and Wellbeing : Narrative Theory and the Use of Interactive Theatre, raising mental health awareness. (sourced directly from the author at Stigma and Discrimination Congress 2009)
2) Sommers J. Creating a Bridge: Interactive theatre and Audience Involvement.

WORKSHOP 50

Saturday, October 29; 3:30 p.m.–5:00 p.m.

Identification of Clinical and Environmental Predictors for Violence on a Forensic Inpatient Psychiatric Service

Elizabeth B. Ford, M.D., 462 First Avenue, New York, NY 10016, **Gareen Hamalian, M.D., M.P.H., Shane Konrad, M.D., Christopher W. Smith, Ph.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to (1) understand the complexity of violence prediction in a forensic inpatient psychiatric setting; (2) identify at least three environmental variables that may increase an inpatient's risk for assault and (3) appreciate the multi disciplinary and multi factorial influences on inpatient violence with an emphasis on safely managing patient aggression.

Summary: The Bellevue Forensic Inpatient Psychiatry Service, providing acute inpatient care in a public hospital setting, offers

treatment and evaluation for the male pre and post arraignment pre sentenced population in New York City, predominantly from Riker's Island. As is common in both inpatient psychiatry and forensic settings, incidents of violence are of concern, for both patient and staff safety as well as for management and treatment. But violent inpatients are not a simple homogeneous group and assessment of risk must consider the environment in which it is applied and differences in treatment goals. The accuracy of validated actuarial and clinical approaches in the prediction of violence in the mentally ill has seen improvement over time but remains limited and characterized by wide variability and population specific results. This study proposes to identify both clinical and environmental predictors of inpatient violence in an acute correctional setting. A retrospective chart review of 81 male inpatients on the Bellevue Forensic Inpatient Psychiatry Service involved in the 140 acts of assault to persons or property over the course of one year will be conducted. This sample will be matched by age and race with an equal number of controls who were not involved in an assaultive incident during admission. Data collected will include includes demographic, clinical, legal and environmental (e.g., unit census, bed assignment, time of incident) characteristics. Univariate screening will be used to identify characteristics which distinguish assaultive and non assaultive subjects. Multivariate analysis will be used to control for common variance between predictors and will identify unique predictors of inpatient violence as well as protective factors predicting non violence. Early results show that 86% of violent incidents occurred during the first three weeks of hospitalization, with Monday being the most common day of the week for violent assaults. Prearraignment detainees accounted for only 8.6% of incidents despite representing 17.8% of admissions during the study year. The majority of incidents were initiated by patients in their 20's. Further analyses will elucidate the relevant clinical and environmental factors that distinguish individuals who are involved in inpatient assaults from those who are not.

References:

1) Douglas, KS, Ogloff JR, Hart SD. Evaluation of a model of violence risk assessment among forensic psychiatric inpatients. Psychiatric Services, 54(10): 1372 9, 2003.
2) Antonius D., Fuchs L., Herbert F., et al. Psychiatric assessment of aggressive patients: a violent attack on a resident. American Journal of Psychiatry, 167(3): 253 9, 2010.

WORKSHOP 51

Saturday, October 29; 3:30 p.m.–5:00 p.m.

Maintenance of Certification: Lessons from the Trenches

Annette M. Matthews, M.D., 3710 SW USVA Hospital Road, Portland, OR 97239, **Melissa Buboltz, M.D., Mary Lu, M.D., Sahana Misra, M.D., Victor Reus, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Outline necessary steps for maintaining board certification (MOC), and understand resources available to complete each; 2) Develop a timeline based on their board certification year for when each step in the MOC process needs to be completed; 3) Describe how they will organize their continuing medical education credits (CME), Self-assessment, and Performance in Practice (PIP) documentation in case of audit.

Summary: This workshop will describe the four components of the maintenance of certification (MOC) process in psychiatry: maintaining professional standing, life-long learning/self-assessment, performance in practice modules, and the cognitive examination. Participants will learn how to develop a timeline for completion of each of these requirements based on their year of initial board certification. They will learn the variety of resources available to complete with the lifelong learning (CME) and self-assessment parts of the maintenance of certification process, and strategies for storing and documenting these activities in case of audit. They will also learn about resources for completing the Performance in Practice (PIP) units and ways that these can be accomplished in different practice settings. Finally one presenter will give tips and tricks from her experience with maintenance of certification. The audience will be provided to share their questions, concerns, and ideas for conducting the MOC process as adapted to their practice setting. Victor Reus, MD, who is the Chair of the American Board of Psychiatry and Neurology (ABPN) Maintenance of Certification Committee, will be available to discuss the content of the presentation, and answer any questions best directed towards the ABPN.

References:

1) American Board of Psychiatry and Neurology, Inc. 2009 report of the American Board of Psychiatry and Neurology, Inc. Am J Psychiatry 2010;167(8):1003-8.

WORKSHOP 52

Saturday, October 29; 3:30 p.m.–5:00 p.m.

Setting the World Ablaze: The Importance of Setting in the Initiation and Treatment of Addiction in the Lesbian, Gay, Bisexual, Transgender Community

David A. Tompkins, M.D., 5510 Nathan Shock Drive, Baltimore, MD 21231, **Robert P. Cabaj, M.D., Petros Levounis, M.D., M.A.**

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand the importance of culturally competent therapies in the treatment of addiction within the LGBT community; 2) Identify funding streams to support culturally competent, affirming therapies; 3) Identify the connection between crystal methamphetamine use among gay men and risk of HIV transmission; 4) Identify the connection between discrimination and increased risk for substance abuse in LGBT college students.

Summary: Research has shown that the Lesbian, Gay, Bisexual, and Transgender (LGBT) populations have a higher incidence of substance abuse disorders. However, in the absence of real or expected discrimination, the risk is similar to heterosexuals. Dr. Petros Levounis, Associate Clinical Professor, Columbia University will speak about "Setting the stage: How crystal meth, sex, and the internet become a deadly recipe for HIV transmission." While the club drugs (ecstasy, ketamine, and GHB), marijuana, and anabolic steroids have traditionally been associated more closely with the LGBT community, it is the crystal methamphetamine epidemic that has defined the past decade. There are no FDA approved medications for methamphetamine dependence, but gay affirmative treatment programs, which address addiction as well as sexuality and identity in psychotherapy, have been most successful. Dr. Levounis will discuss background of the crystal meth epidemic, current treatment strategies and the importance of community involvement in preventing its spread. Robert Cabaj, MD, the medical director for outpatient mental health services for San Francisco County will speak about "Setting high standards: How to meet the substance abuse treatment needs of LGBT patients in the public sector." Clinicians who work with LGBT persons have found that gay sensitive and gay affirmative approaches have greater success than standard methods. In most large public sector systems that provide behavioral health services, meeting the specific needs of LGBT clients can present a challenge. He will describe culturally appropriate services that provide both substance abuse and mental health services for LGBT clients, funding streams that can support those services, and what outcomes can be realized. Dr. D. Andrew Tompkins, Assistant Professor of Psychiatry at Johns Hopkins University School of Medicine will speak about "Setting an example: How college mental health professionals can prevent the spread of addiction in LGBT students." Dr. Tompkins will review the literature showing higher rates of alcohol, tobacco, and illicit drug use amongst LGBT students, as well as the effects of discrimination and lack of support on fueling this use. Specific strategies to counteract drug use on college campuses will also be outlined.

References:

1) Levounis P, Ruggiero JS: Outpatient management of crystal methamphetamine dependence among gay and bisexual men: How can it be done? Primary Psychiatry, 13, no. 2 (February 2006), 75 80.
2) Levounis P, Bachaar A: Handbook of motivation and change: A practical guide for clinicians. Washington, D.C.: American Psychiatric Press, 2010.

WORKSHOP 53

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

Non-Pharmacological Therapies for Bipolar and Psychotic Disorders

Lewis Mehl Madrona, M.D., Ph.D., 28 Vernon Street, Brattleboro, VT 05301, **Ann Marie Chaisson, M.D., M.P.H., Barbara J. Mainguy, M.D., M.F.A.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) List non pharmacological therapies that have been used in the treatment of bipolar disorder; 2) Discuss what makes a person able to manage bipolar disorder without medication; 3) List "red flag" situations in which failure of management without medication is highly probable; 4) Discuss the neurobiology behind a narrative CBT approach to hearing voices and having visions; 5) List three techniques for reducing voices.

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

References:

1) Mehl Madrona L. (2007). Narrative Analysis: alternative constructions of bipolar disorder. Advances 22(2): 12 19.
2) Hungry Researchers: The Tensions and Dilemmas Of Developing an Emancipatory Research Project with Members of a Hearing Voices Group. Snelling, Emma. Journal of Social Work Practice, Volume 19, Number 2, July 2005, pp. 131 147 (17).

WORKSHOP 54

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

Using Recovery Principles as an Integrative Paradigm in Training Community Psychiatrists

Robert S. Marin, M.D., 3811 O'Hara Street, Pittsburgh, PA 15213, **Wesley E. Sowers, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Appreciate the value of recovery principles as means to improve teaching, clinical training, consultation, and supervision; 2) Identify topics whose teaching is enhanced by integrating recovery principles; 3) Provide leadership and support that will enable groups to strengthen their appreciate of recovery principles and their application to behavioral health care.

Summary: The recovery movement has gained significant momentum in the past 5 years. Although systems of care have made commitments to providing recovery oriented services, the behavioral health workforce has not yet achieved the level of competence needed to deliver such services adequately. In response to this need, several initiatives are underway to enhance recovery oriented training in various sectors of the behavioral health system. In this workshop, we describe and demonstrate the application of recovery principles to a community psychiatry education curriculum. We will describe the content and the process that permit use of recovery principles as an educational paradigm allowing a coherent and unified approach to didactic teaching, supervision, consultation, and mentoring. Then we will engage workshop participants by asking them to develop a list of recovery principles and to consider how they might be applied to clinical, academic and administrative settings of the behavioral health system. We will consider applications to clinical interactions, leadership, advocacy, quality improvement, teaching and supervision, and consultation, among others. The workshop will be highly interactive and will create a process that illustrates how psychiatrists can integrate recovery principles in the education and training of residents and fellows.

References:

1) Sowers, W.E., "Transforming Systems of Care: The American Association of Community Psychiatrists' Guidelines for Recovery Oriented Services," Community Mental Health Journal 41:757 774,2005.
2) Peebles, S., et. al., "Immersing Practitioners in the Recovery Model: An Educational Program Evaluation," Community Mental Health Journal45:23 45, 2009.

WORKSHOP 55

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

Psychiatrist Workforce Development: Dilemmas and Possibilities

Alan Q. Radke, M.D., M.P.H., 444 Lafayette Road North, St. Paul, MN 55164 0979, **Michael Flaum, M.D., Joseph J. Parks, M.D., Blaine Shaffer, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Identify the severe deficit in psychiatrists; 2) Quantify the supply and demand dilemma; 3) Review and evaluate potential options; 4) Analyze the role definition of psychiatrists and their interfaces with other health and mental health professionals; 5) Identify mechanisms and infrastructure needed to expand psychiatrists' reach; 6) Evaluate the role of medical education.

Summary: Recent studies and surveys have shown a significant deficit in psychiatrists. Health Resources and Services Administration (HRSA) commissioned a research study by the University of North Carolina at Chapel Hill to estimate the need for mental health professionals in the United States. The study published in the October 2009 edition of Psychiatric Services estimated a current shortage of 45,000 psychiatrists. Furthermore, Konrad et al estimated that three quarter of U.S. counties have "a severe shortage of prescribers, with over half their need unmet". Merritt Hawkins, a physician recruitment and locum tenens company, did a survey tracking more than 2800 physician recruiting assignment between April 1, 2009 and March 31, 2010. The surveyors found a "47% increase in psychiatrist demand from 2009 and a 121% increase from 2007". Possible factors contributing to the increase demand include psychiatric problems related to the economic downturn, the psychological toll of two wars and increase in number of patients as the population grows and ages. U.S. Department of Health and Human Services has designated 3143 Health Professional Shortage Areas for Behavioral Health. Currently 80 million people live in these shortage areas. The Bureau of Health Professionals predicts an increase in demand for general psychiatrist between 1995 and 2020 of 20 % with a 100% increase in need for child and adolescent psychiatrists. Daniel Carlat's article in the August 3, 2010, issue of Psychiatric Times opined that many of the "potential options are undoable." Primary care physicians are currently overwhelmed by their own waiting lists and are unlikely able to pick up any additional cases. Expansion of residency training programs is not probable at the cost of $100,000 per slot and Medicare reducing their support of graduate medical education. Increasing the number of advanced practice nurses and physician assistants may be helpful but has these professionals have their limitations when treating people with severe, complex conditions. Finally, psychology prescribing is a hot button issue for both guilds. It is time for NASMHPD and AACP to address this growing concern. This proposal recommends quantifying the supply and demand dilemma to date; careful analysis of the shortage in

psychiatrists; and development of doable strategies that could address the current and future psychiatry workforce deficits.

References:
1) Konrad T, Ellis AR, el al: County Level Estimates of Need for Mental Health Professionals in the United States. Pyschiatric Services 60: 1307 1314.
2) Thomas KC, Ellis AR, et al: County Level Estimates of Mental Health Professional Shortage in the United States. Psychiatric Services 60: 1323 1328.

WORKSHOP 56

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

ABPN and APA Perspectives on Maintenance of Certification

Victor Reus, M.D., UCSF, School of Medicine, San Francisco, CA 94143, **Deborah J. Hales, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to describe the ABPN's MOC requirements and the APA's programs for meeting those requirements.

Summary: The purpose of this workshop is to present information on the ABPN's evolving Maintenance of Certification (MOC) program and on the APA's related efforts on behalf of its members. As mandated by the American Board of Medical Specialties, the ABPN has developed an MOC program for specialists and subspecialists that has four components: professional standing (licensure); self-assessment and lifelong learning; cognitive expertise (computerized multiple-choice) examination; and assessment of performance in practice. The phase-in schedule for the components and the options that are available for completing them will be presented. The computerized multiple-choice examinations will be described, as will examination results. Related issues such as maintenance of licensure will also be discussed. Representatives of the APA will outline the programs and services the organization has developed to meet the needs of psychiatrists participating in MOC.

References:
1) Ebert MH; Faulkner L; Stubbe DE; Winstead DK: Maintenance of Certification in Psychiatry. Journal of Clinical Psychiatry 2009;70:619-626.

WORKSHOP 57

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

Becoming the Change You Want to See in the System: Teaching Leadership Skills

Serena Y. Volpp, M.D., M.P.H., 462 1st Avenue, New York, NY 10016, **Robert S. Marin, M.D., Jules Ranz, M.D., Patrick S. Runnels, M.D., Samantha A. Stewart, M.D.,**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Identify strategies for teaching leadership concepts to public psychiatry fellows; 2) Identify at least two skills that can be incorporated into didactic curricula.

Summary: Over the last few years, the field has witnessed an explosion of public psychiatry fellowship programs across the country. In a 2010 survey organized by the oldest, the Columbia Public Psychiatry Fellowship, programs both well established and in development consistently rated teaching leadership as one of the most important values of their program. This workshop aims to help programs and interested participants gain knowledge about teaching leadership. Representatives of each of three programs, NYU/Bellevue, Case Western, and the University of Pittsburgh will describe in detail the ways in which leadership is taught in their programs. In addition, each representative will try to teach in vivo a portion of their curriculum. Topics covered will include management styles—task versus relationship oriented behavior; implementing change—supporting development of individualized leadership styles through self reflection, networking, and system analysis, and barriers to change—resistance, control, power, and the political perspective. There will be ample time for discussion led by the Director of the Columbia Public Psychiatry Fellowship.

References:
1) Ranz JM, Deakins SM, LeMelle SM et al. Core Elements of a Public Psychiatry Fellowship. Psychiatric Services 2008;59:718 720.
2) Gilmore T. Dilemmas of Physicians in Administrative Roles: Dealing with the Managerial Other Within. Center for Applied Research 2002. http://www.cfar.com/Documents/physadmin.pdf

WORKSHOP 58

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

The Role of the Psychiatrist in Medical School Admissions: Just Another Vote?

Thomas E. Brouette, M.D., 450 Clarkson Avenue, Brooklyn, NY 11203, **Stephen M. Goldfinger, M.D., Jean B. Tropnas, M.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Learn how a psychiatrist can best contribute to the committee process; 2) Begin to delineate what characteristic about a candidate's past history makes them good or poor candidates to enter medicine; 3) Explore how culture and socioeconomic background influence the interview; 4) Consider how volunteering for the Admissions Committee can promote your value within your institution.

Summary: Many Psychiatrists are heavily involved in medical school admissions, but little has been written on the subject for over 20 years. Psychiatrists add unique contributions. They are not only interviewers, but also serve an advisory and advocacy role. As advisors, Psychiatrist members are asked to review unusual applications, interview non traditional applicants, and recommend options. Although we do not, and should not do, a formal psychiatric assessment, we are charged with predict-

ing success in medical school. In previous meetings we have discussed the role the psychiatrist can play when a applicant has a history of an Axis I diagnosis. What is our role, however, when information in the application implies an Axis II diagnosis? As undergraduate institutions now readily provide not only academic records, but also information about incidents in the community and the dormitories, admissions committees must struggle with evaluating a candidates risk for unprofessional behavior.

References:
1) Willer B, Keill S, Isada C. Survey of U.S. and Canadian medical schools on admissions and psychiatrically at risk students. J Med Educ. 1984 Dec;59(12):928 36.
2) Bendelow G.Ethical aspects of personality disorders. Curr Opin Psychiatry. 2010 Nov;23(6):546 9.

WORKSHOP 59

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

Developing Resident Interest in Public Service Psychiatry – Learning by Doing!

Sourav Sengupta, M.D., M.P.H., 1124 Downlook Street, Pittsburgh, PA 15201

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Explain how a public service psychiatry resident interest group was formed, organized, and successfully engaged in community and legislative advocacy; 2) Explore strategies to utilize experiential learning in mental health advocacy: 3) Develop strategies to increase resident interest in public service psychiatry at their home institutions.

Summary: Over the past year, a group of residents at the Western Psychiatric Institute and Clinic in Pittsburgh, PA, formed GAP Psych (Group for Advocacy in Public Service Psychiatry). GAP Psych is actively engaged in mental health advocacy in our community to "mind the gap" in mental health care for the underserved, integration of physical and behavioral health care, and underfunctioning health systems. We have raised funds and awareness for behavioral health care for the homeless, lobbied our legislators for improved access to mental health care, and developed fruitful collaborations with neighboring community organizations. Through our efforts, we are rediscovering some of the passion that initially brought us to psychiatry. We are also observing increasing professional interest in public service psychiatry. In the workshop, we will trace our steps in the development of this resident interest group, examine how it differs from interest groups in the past, review organizational and recruitment strategies, and highlight successful advocacy activities. We will explore strategies for utilizing experiential learning in mental health advocacy. Finally, we will develop strategies for increasing resident interest and involvement in public service psychiatry at the home institution(s) of one or more of the attendees.

References:
1) Roth EJ, Barreto P, Sherritt L, Palfrey JS, Risko W, Knight JR. A new, experiential curriculum in child advocacy for pediatric residents. Ambulatory Pediatrics. 2004 Sep-Oct;4(5):418-23.

WORKSHOP 60

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

Hurricane Katrina and the Deepwater Horizon Oil Spill: Lessons in Building Resilience Following Technological and Natural Disasters

Howard J. Osofsky, M.D., Ph.D., 1542 Tulane Avenue, New Orleans, LA 70112, **Melissa J. Brymer, M.D., Psy.D., Joy D. Osofsky, Ph.D., Patricia J. Watson, Ph.D.**

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Demonstrate an increased knowledge of mental health benefits of school based resilience building and aid students recovering from disasters; 2) Demonstrate an understanding of Psychological First Aid and Skills for Psychological Recovery and application to post disaster settings; 3) Understand the benefits of and help in the implementation of peer to peer counseling programs to help minimize responders' secondary traumatic stress.

Summary: The Deepwater Horizon Oil Spill well has been capped, however, the mental health effects of the oil spill are far from over, and are likely to be much more enduring. Early mental health symptoms being reported are consistent with those reported after the Exxon Valdez oil spill. Further, in this event many of those most impacted were still recovering from Hurricane Katrina with its severe devastation. Stakeholders and local leaders worry that the impact will increase substantially over time. In public health emergencies, major efforts at long term evaluations typically begin following the emergency response, after the lives have been saved and the crisis mitigated. We have learned important lesson from the Deepwater Horizon Oil Spill including the importance of designing our prospective evaluations and evidence based interventions into immediate response efforts at local, state and national levels with providers from all disciplines being attentive to individual and family medical, mental health, substance abuse, and behavioral concerns/symptoms. Resilience building and self care, the focus of this workshop, will be highlighted on the individual, family, and community levels.

References:
1) Kronenberg ME, Hansel TC, Brennan AM, Lawson B, Osofsky HJ, Osofsky JD. Children of Katrina: lessons learned about post disaster symptoms and recovery patterns. Child Dev. 2010; 81 (4):1241 1259.
2) Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J, Steinberg, A., et al. (National Traumatic Stress Network and National Center for PTSD) (July, 2006). Psychological First Aid: Field Operations Guide, 2nd Edition. [Available on: www.nctsn.org and www.ncptsd.va.gov.].

DISCUSSION GROUPS

DISCUSSION GROUP 01

Thursday, October 27; 8:00 a.m.–11:30 a.m.

Can the Recovery Model of Care Survive the Stigma of a Media Blitz?

Lesley M. Blake, M.D., P.O. Box 800, Medical Lake, WA 99022

Summary: On a sunny day in September 2009, while on a staff escorted field trip to our local County Fair, a patient from one of our inpatient forensics units wandered away from the group. He was located and returned to our facility without incident a few days later. The media reaction to the incident was truly amazing, and was not a favorable one at all. Not only was the story on the front page of our local press, and all over the US media, it was also widely reported in the media worldwide, including the press in Australia, TV news in the UK, and even in a magazine in Germany. Our hospital, which had embraced the recovery model of care, was suddenly faced with rethinking how we provided treatment on many levels, and how to address the increased level of stigma that our patients were experiencing. The ever present challenges of how to provide person centered care to our patients, and yet ensure the safety of the community had to be revisited. To achieve this end we sought consultation from many resources, including academia and law enforcement agencies. There was an urgency to get this done, as our patients had many restrictions placed upon them, and we were eager to study and potentially implement the recommendations. Through all of this process, the media continued to demand to know who was responsible for the incident, who was going to get fired, and would our city ever be safe again? One year later we are definitely yesterday's news, but the scars of the event linger. This session will focus on discussions of the ways to reduce stigma after a media blitz, and return as much as possible to the recovery model of care.

DISCUSSION GROUP 02

Thursday, October 27; 2:00 p.m.–3:30 p.m.

Roles of Peer Specialists on Treatment Teams

Wilma Townsend, M.S.W., 1 Choke Cherry Road, Rockville, MD 20857, **Keris Myrick, Ph.D., M.B.A.**

DISCUSSION GROUP 03

Thursday, October 27; 3:30 p.m.–6:00 p.m.

Public & Community Psychiatry Fellowship Training Directors

Jules Ranz, M.D., 11 Riverside Drive, New York, NY 10023

Summary: This is the annual meeting of representatives of all (currently 15) public and community psychiatry fellowship training programs. The results of a yearly survey of these programs are discussed, as well as other issues of relevance to this group. Prospective Fellows are invited to attend the entire meeting, especially the "FINAL HOUR FROM 5-6" when applicants will have a chance to speak to individual program representatives.

DISCUSSION GROUP 04

Thursday, October 27; 4:30 p.m.–6:00 p.m.

Collaborating With Judicial Partners: The Psychiatric Leadership Group on Criminal Justice

Fred C. Osher, M.D., 1809 Landfall Way, Johns Island, SC 29455, **Marcia Goin, M.D., Judge Steve Leifman, Annelle Primm, M.D., Wesley Sowers, M.D.**

Summary: For the past year, a group of judges and psychiatrists have met with support from the American Psychiatric Foundation to address the overrepresentation of persons with behavioral disorders in the criminal justice system. The judicial members represent an organization formed in 2004; the Judges' Criminal Justice/Mental Health Leadership Initiative (JLI), which consists of hundreds of judges who work at the interface between justice and behavioral health. The APF collaborators recommended the establishment of a parallel organization named the "Psychiatric Leadership Group for Criminal Justice" (PLG). This will be the first meeting of the PLG which hopes to draw upon existing psychiatric leaders from around the country.

DISCUSSION GROUP 05

Friday, October 28; 2:00 p.m.–5:00 p.m.

Primary Care and Psychiatric Providers Working Together: Obstacles and Opportunities

David A. Pollack, M.D., 3181 SW Sam Jackson Park Road, Portland, OR 97239

Summary: This semi-structured discussion group will review the collective experiences of the participants in integrated care settings. Issues addressed will include how psychiatrist/primary care provider relationships evolve in such settings, the variety of activities that each performs (with some discussion of what is effective and what isn't), what expectations primary care providers have for psychiatric consultants and what expectations psychiatric consultants have for primary care providers. Other topics covered will include time allocation, varieties of clinical cases, opportunities for training/learning, managing ad hoc (curbside) consultations and the effectiveness of electronic or distance communications technology.

DISCUSSION GROUPS

DISCUSSION GROUP 06

Saturday, October 29; 2:00 p.m.–5:00 p.m.

VA Chiefs of Psychiatry: Opportunities and Challenges in Service Delivery Across the Life-Span of Returning Military

Laurent S. Lehmann, M.D., 810 Vermont Avenue NW, Washington, DC 20420, **Bryan Ballot, M.D., Peter Hauser, M.D.**

Summary: This session will address clinical issues facing VA psychiatrists including coordination of psychotherapy and pharmacotherapy for patients across diagnostic categories, mental health / primary care integration and psychiatrist involvement in services to remote areas such as rural Community Based Outpatient clinics including use of telemental health. Administrative issues will include forming work groups to address issues such as pros & cons of forming a VA psychiatry chiefs organization comparable to the former NAVAPAL; defining the role of psychiatry as a discipline in VA and resource related metrics.

DISCUSSION GROUP 07

Saturday, October 29; 3:30 p.m.–5:00 p.m.

Sky Captain and the Psychiatrist of Tomorrow: Our Evolving Roles in the Decade of Integrated Care

Lori Raney, M.D., 281 Sawyer Drive, Durango, CO 81303, **Benjamin Druss, M.D., M.P.H., Roger G. Kathol, M.D., Jurgen Unutzer, M.D., M.P.H.**

Summary: This Discussion Group will follow three days of presentations on Integrated Care and will provide an opportunity for participants to wrap up their experience with experts from the field. Drs. Jurgen Unutzer, Roger Kathol and Ben Druss will open the discussion with brief overviews of their vision of the future for psychiatrists in collaborative settings, recognizing the future is now in some parts of the country. Dr. Jurgen Unutzer, Vice Chair Psychiatry at the University of Washington and Principal Investigator of Project IMPACT, one of the most widely used models in outpatient primary care settings, will discuss opportunities for psychiatrists in treating mental illness in primary care. Dr. Ben Druss, Rosalyn Carter Chair in Mental Health, Emory School of Medicine, whose research and advocacy work focuses on improving health and healthcare in persons with serious mental disorders in public sector settings, will describe his vision of psychiatrists' recognizing and treating other health issues in this population. Dr. Roger Kathol, President, Cartesian Solutions, will focus on achieving integrated medical and mental health program sustainability through payment reform and will describe to the audience his ideas of payment models for integrated care and how we might be compensated to work in this field. Dr. Lori Raney, Chair APA Workgroup on Integrated Care, and Medical Director of Axis Health System, will moderate this session. The Discussion Group format encourages and anticipates ample audience participation as these experts answer your questions, pose questions for the audience and imagine as a group what our field may look like in the future. Individuals who have been working in integrated care settings will be encouraged to share their experience with participants to help them appreciate, in real world settings, what it is like to work in this exciting and evolving field.

DISCUSSION GROUP 08

Sunday, October 30; 8:30 a.m.–11:30 a.m.

Suicide and the Golden Gate Bridge

Mel I. Blaustein, M.D., 1199 Bush Street, San Francisco, CA 94109, **John Brooks, Anne Fleming, M.D., Kevin Hines, Ken Holmes, Eve Meyer, M.S.W., M.H.S.A., Denis Mulligan, Mary Zablotny**

Summary: The Golden Gate Bridge—the most photographed man-made structure in the world—is also the number one suicide site in the world. Over 1,200 bodies have been found (not counting those washed out to sea) since the bridge was built in 1937. The toll continues at two per month. Suicide is the number 10 cause of mortality nationally but number three among young people aged 10 to 24. As psychiatrists, we know that suicides are most often impulsive acts of desperate individuals. We know that suicides are preventable. The Psychiatric Foundation of Northern California organized a Bridge Barrier Task Force in 2004 to educate the public about suicide. We addressed the question of whether bridge jumpers would go elsewhere to suicide, as well as whether suicidal individuals are exercising free will. After working cooperatively with family members of victims, mental health advocates and concerned public citizens, we persuaded the Bridge Board to conduct an engineering and environmental impact study. At the time of this session, the Bridge Board of Directors will have made a decision about the installation of a suicide barrier on the Golden Gate Bridge. This discussion group will explore public attitudes, misconceptions and myths about suicide as well as the allure and iconic mystery of the bridge. We will talk about suicide deterrents and concern with the issue of whether barriers work. The panel may include family members of bridge suicides, a jump survivor, and experts in suicide, as well as the Marin County Coroner, and the Chief Engineer of the Golden Gate Bridge.

POSTER 1-1

Clonidine Treatment of Nightmares Among Patients with Comorbid PTSD and Traumatic Brain Injury

Adekola Alao, M.D. (alaoa@upstate.edu)**, Syed Razi, M.D.**

Abstract:

Introduction: Exposure to any event that poses actual or imagined death or injury with production of intense fear, helplessness, or horror can lead to Post traumatic stress disorder (PTSD). National Comorbidity Survey Replication estimated the life time prevalence of PTSD among adult Americans to be Gulf war veterans to be about 6.8 per cent and 13.8% among Veterans of Operation Enduring Freedom/ Operation Iraqi Freedom Autonomic dysregulation is thought to explain many of the physiologic changes seen in patients with PTSD. Medications that decrease adrenergic activity may reduce anxious arousal in patients with PTSD. Since 2-adrenergic receptor agonists such as clonidine act at the noradrenergic autoreceptors to inhibit the firing of cells in the locus ceruleus, they may also be responsible for reducing the release of norepinephrine in the brain and may help in reducing the symptoms of PTSD, Case report Mr. F, a 48 years old man of Bosnian origin developed PTSD symptoms after fighting in the Bosnian war for 15 months. He reported witnessing the loss of his mother, two brothers and a nephew along with friends, neighbors and other relatives He presented with symptoms of depression, flashbacks, exaggerated startled response as well as nightmares of the war events. He was treated with venlafaxine XR 225mg po q daily and olanzapine 10mg po q daily without any relieve of his nightmares. He was later started on clonidine 0.1 mg po qhs. Within 2 weeks of starting clonidine, he reported improvement in the severity and duration of his nightmares and improved quality of his sleep After one month of initiation of clonidine, his dose was increased to 0.1 mg twice daily and patient's olanzapine was slowly discontinued. The patient continues to maintain remission one year after initiation of treatment. Case 2 Mr. H is a 33 year old Iraq and Afghanistan wars active military soldier who was involved in several combat scenarios in which lives were lost. He presented with symptoms of PTSD and TBI including short term memory loss, nightmares, flashbacks, hypervigilance and avoidant behavior. He was treated with cognitive processing therapy, citalopram 20mg po q daily, clonazepam 1mg po bid as well as prazosin 4 mg po qhs. However, his nightmares did not respond significantly until prazosin was replaced with clonidine. He was initially started on clonidine 0.1 mg po qhs which was gradually titrated up to 0.3mg. The patient's nightmares symptoms resolved about 2 weeks after initiation of treatment and the patient remains in remission on a combination of citalopram and clonidine. Discussion SSRIs are regarded as first-line pharmacological treatment for PTSD. However, nightmares are often unrelieved by SSRIs. The lack of effectiveness may be due to the fact that alterations in noradrenergic system in the CNS and sleep dream cycle are the two key processes implicated in the path physiology of PTSD and are not relieved by SSRIs. Clonidine is a centrally acting alpha-agonist agent that is used to treat hypertension stimulates alpha-adrenoreceptors in the brain stem. This action results in reduced sympathetic outflow from the central nervous system. We hypothesize that this central mechanism of action is why clonidine is effective in treating nightmares among patients with PTSD.

Conclusion: With more clinical trials, we believe clonidine will continue to be increasingly valuable in treatment of nightmares.

POSTER 1-2

Concordance Between Psychotropic Prescribing Among Veterans with PTSD and Clinical Practice Guideline Recommendations

Shaili Jain, M.D. (shaili.jain@va.gov)**, Mark A. Greenbaum, M.A., Craig S. Rosen, Ph.D.**

Abstract:

Background: Clinical practice guidelines (CPG) for the pharmacological treatment of Post traumatic stress disorder (PTSD) do not support the use of benzodiazepines (BDZ),recommend second generation antipsychotics (SGA) as adjunct medication and cite insufficient evidence to recommend mood stabilizers (MS).

Objective: This present study uses data from the Longitudinal Veterans Health Study (LVHS), an observational study of Veterans Administration (VA)patients recently diagnosed with PTSD, to examine patient characteristics associated with receiving prescriptions for BDZ and MS, and whether SGA prescribing was consistent with CPG.

Methods: The sample consisted of 482 veterans between the ages of 18 and 69 with a DSM-IV diagnosis of PTSD (309.81) received during any VA outpatient clinic visit between May 31, 2006 and Dec 7, 2007. Veterans from the current conflicts in Iraq and Afghanistan and female Veterans were intentionally oversampled in this national survey. Survey responses were combined with prescription information from VA national pharmacy databases. We assessed the use of eight classes of psychotropics prescribed for patients with PTSD in the year following a new PTSD diagnosis. Multivariate logistic regressions identified demographic, symptom severity, health service use, and attitudinal characteristics associated with prescribing of BDZ, SGA, and MS.

Results: As expected with oversampling, 50.4% were recent returnees from the current conflicts in Iraq and Afghanistan and 47% were female. The average age was 40 years, 68.8% of the sample self-reported race and ethnicity as white, 19.2% as African American and 14% as Hispanic and Latino. First line Selective Serotonin Reuptake Inhibitors (SSRI) and Serotonin Norepinephrine Reuptake Inhibitors (SNRI) were the most commonly prescribed medications in this sample, representing 74% of medications received amongst Veterans receiving at least one prescription. In the absence of a clearly indicated diagnosis, long term BDZ were prescribed to 13%, SGA to

13% and MS to 16% of Veterans with PTSD. BDZ prescribing was associated with symptoms of insomnia. Mental health inpatient stay (OR = 5.78, p < .00) and receiving at least one psychotherapy visit (OR = 3.90, p < .01) were both predictors of being prescribed a SGA. Having a mental health inpatient stay (OR = 2.49, p <.05) and more symptom severity (OR = 1.78, p < .01) were both predictors of being prescribed a MS.

Conclusions: In many respects the prescribing patterns, in our sample, appear consistent with clinical practice guidelines addressing the role of psychotropic medications in PTSD. Also, BDZ appear to be targeted to PTSD related hyperarousal and insomnia (as opposed to core symptoms), and SGA to those who had required psychiatric hospitalization and may have a more complicated disease course. Prescribing patterns not consistent with CPG recommendations were that although MS are not recommended by any PTSD CPG they were prescribed for our sample, particularly for patients with higher rates of mental health services utilization. Finally, BDZ, SGA and MS were often prescribed in the absence of first line treatments in the form of SSRI/SNRI, a practice not recommended by CPG which emphasize the systematic trial of first line pharmacotherapy before resorting to less well studied treatments.

POSTER 1-3

Prevalence and Factors Associated with Irritable Bowel Syndrome Among Medical Students of Karachi: A Cross-Sectional Study

Syed Saad Naeem (syedsaadnaeem@hotmail.com)**, Efaza Umar Siddiqui, Bilal Ahmed, M.Sc., Abdul Nafay Kazi, Sumaiya Tauseeq Khan**

Abstract:

Objectives: Irritable bowel syndrome (IBS) is commonly reported among university students; however, few analytical studies are available on IBS from Pakistan. We investigated the prevalence of and the pattern of symptoms of IBS along with anxiety among medical students of Karachi.

Methods: A cross-sectional study was conducted among 360 students attending three large medical colleges of Karachi recruited in equal proportion. Data was collected using validated tools "Rome III Criteria" and Generalized Anxiety Disorder Questionnaire. Diagnoses were made on the criteria that students had IBS who experienced abdominal discomfort at least 2-3 days/month associated with high level of anxiety. Convenience sampling was done to recruit the participants aged 18 years and above, after getting written informed consent.

Results: The apparent prevalence of IBS was found to be 102 out of 360 (28.3%), with a predominance of 87 (85.29%) female over 15 (14.71%) male students. The psychological symptoms of anxiety were encountered in 57 (55.8%) participants with IBS, among which males were 15.7% and females 84.2% respectively. Stress during examinations, university assignments, clinical rotations, interpersonal relationships, emotional disorders and living environment were few of the major factors found to be associated with IBS.

Conclusion: Students who suffer from more mental stress and anxiety are more prone to IBS. Key health messages and interventions to reduce stress and anxiety among students may help in curtailing the burden of this disease.

POSTER 1-4

Evaluating Site Differences in the Implementation of Collaborative Depression Management in Community Health Centers

Amy Bauer, M.D. (abauer1@uw.edu), **Vanessa Azzone, Ph.D., Howard H. Goldman, M.D., Ph.D., Jürgen Unützer, M.D., MPH, Laurie Alexander, Ph.D., Brenda Coleman-Beattie, M.A., Richard G. Frank, Ph.D.**

Abstract:

Objective: Despite considerable national interest in the dissemination of integrated care models for treating common mental disorders such as depression in primary care settings, little is known about the care provided or the outcomes achieved when such models are adopted by community-based practices, particularly those in resource-poor settings. To address this gap in knowledge and gain understanding of the process of implementing a collaborative care model into community health centers, the Hogg Foundation for Mental Health sponsored a large demonstration project in Texas. The objective of this evaluation is to analyze the role of clinic site on specific process measures of depression treatment (early follow-up and appropriate pharmacotherapy) and on clinical outcomes (depression improvement and remission) that are not accounted for by characteristics of the patients served.

Methods: We report a quantitative evaluation of quality indicators and patient outcomes for 2821 patients treated at six organizations from 2006 to 2009 that implemented collaborative depression care. Our analysis is also informed by qualitative observations derived from the extensive contact of the investigators with the organizations, including loosely structured site visits. All data was obtained from a disease registry in the routine course of delivering care. Outcome data included two quality indicators (receipt of early follow-up or receipt of appropriate pharmacotherapy) and depression improvement (50% reduction in PHQ-9 score or PHQ-9 score < 5).

Results: Multivariate logistic regression models revealed significant differences across clinics in the proportion of patients who received early follow-up (34% to 88%) or appropriate pharmacotherapy (27% to 69%); or who improved during the acute phase (36% to 84%) after adjustment for patient characteristics (age, gender, preferred language, baseline severity of depression and anxiety). Similarly, Cox proportional hazards models revealed that time to improvement differed significantly across clinics (p < 0.0001) after adjusting for patient characteristics. The rate of retention in treatment

across all clinics (82%) closely approximated retention rates achieved in clinical research trials of collaborative care.

Conclusions: Across all sites, a plurality of patients achieved meaningful improvement in depression and in many sites improvement occurred rapidly. Despite receiving similar training and resources, organizations exhibited substantial variability in their ability to enact change in clinical care systems, as evidenced by both quality indicators and outcomes. Although we cannot conclude that performance on quality indicators caused improved outcomes, those sites that performed better on these indicators had better patient outcomes, differences that were not attributable to the characteristics of the patients served.

POSTER 1-5

A Double-Blind, Placebo-Controlled Study of Selegiline Transdermal System (STS) in Depressed Adolescents

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Abstract: Despite consistent evidence for efficacy in adults, the clinical use of monoamine oxidase inhibitors (MAOIs) has declined due to safety concerns about food and drug interactions. Selegiline transdermal system (STS) was developed to overcome some of the dietary limitations of orally administered MAOIs. STS delivers sustained blood levels of monoamine oxidase inhibitor (MAOI) directly into systemic circulation, thereby bypassing inhibition of monoamine oxidase A (MAO-A) in the GI tract and liver and avoiding the need for a tyramine-restricted diet at the 6-mg/24 hr dose. STS has been FDA approved for acute and maintenance treatment of Major Depressive Disorder in adults, and 6 of the 7 clinical trials conducted for FDA approval were conducted without tyramine dietary modifications at any dose. Current labeling states that the 6 mg/24 hr dose carries no dietary modification, while the use of 9 mg and 12 mg patches necessitates dietary modifications. In clinical trials, there were no reports of hypertensive crisis associated with STS. This is the first large study to examine the safety, tolerability, and efficacy of STS in adolescents with MDD.

Methods: Adolescent outpatients (ages 12-17) meeting DSM-IV criteria for moderate to severe MDD without psychotic features were entered into a 12-week double-blind, randomized, placebo-controlled study of flexible dose STS (6 mg/24 hr, 9 mg/24 hr, or 12 mg/24 hr) versus placebo. Primary efficacy measure was change in the Children's Depression Rating Scale- Revised (CDRS-R).

Results: 308 adolescents were randomized to STS (n=152) or placebo (n=156). Patients in both STS and placebo groups had significant reductions from baseline on the CDRS-R, however STS was not statistically superior to placebo. Both groups had similar response rates (58.6% versus 59.3%). The overall incidence of reported adverse events was 62.5% for STS group and 57.7% for placebo group. Most commonly reported adverse events in both STS and placebo groups were application site reactions (STS=24.3%; placebo=21.8%), headache (STS=17.1%; placebo=16.7%), and nausea (STS=7.2%; placebo=7.7%).

Conclusions: STS was generally safe and well tolerated, in adolescents. Although the STS group had significant reductions in depression, it did not demonstrate statistical superiority over placebo.

POSTER 1-6

Selegiline Transdermal System (STS) for Anxious Depression: A Post Hoc Analysis of 3 Randomized, Placebo-Controlled, Double-Blind Studies

Kimberly Blanchard Portland, Ph.D. (Kimberly.Portland@dey.com)**, Sunil Mehra M.D., Donald Robinson M.D.**

Abstract:

Objective: Significant symptoms of anxiety are present in approximately half of patients with major depressive disorder (MDD). Previous studies indicate that patients with anxious depression may take longer to respond to antidepressant treatments and have a lower rate of response than patients with MDD lacking significant anxiety symptoms. This post hoc analysis seeks to compare the efficacy of STS versus placebo in patients with anxious versus nonanxious major depression. STS is FDA approved for MDD and has been shown to be an effective and well-tolerated acute and maintenance treatment for MDD. STS delivers sustained blood levels of monoamine oxidase inhibitor (MAOI) directly into systemic circulation, thereby avoiding the need for a tyramine-restricted diet at the 6-mg/day dose.

Methods: Data from 3 short-term (one 6-week and two 8-week), randomized, double-blind, placebo-controlled clinical trials of STS were pooled for this analysis (N=742). Anxious depression was defined post hoc by a Hamilton Rating Scale for Depression (HAM-D) anxiety/somatization factor score greater than or equal to 7 as measured at baseline. Analysis of covariance (ANCOVA) and logistic regression modeling were used to test the effectiveness of STS versus placebo on the Montgomery Åsberg Depression Rating Scale (MADRS) and 28-item HAM-D at treatment endpoint.

Results: Two-thirds of the sample met the criteria cited above for 'anxious depression' (66.7%, n=494) based on the HAM-D anxiety/somatization score. Both anxious and nonanxious depressed patients receiving STS showed significantly greater improvement at endpoint on MADRS and HAM-D total scores versus patients receiving placebo (all $p<0.05$). Remission rates as defined by endpoint MADRS were significantly better in both anxious and nonanxious patients treated with STS compared with placebo ($p<0.05$), although remission based on 28-item HAM-D did not reach statistical significance ($p<0.1$).

Conclusion: STS is an effective treatment for patients with major depressive disorder presenting with anxious

or nonanxious depression. This study was funded by Dey Pharma, L.P.

POSTER 1-7

Electrophysiological Markers in Bipolarity

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Abstract: Making the differential diagnosis between a bipolar disorder and a schizophrenic pathology with mood disorder is often difficult. The aim the study was to test whether the ERP'S component could differentiate between these two disorders. Twenty seven patients meeting the bipolar disorderI in DSM IV actually in a remission phase of six months minimum were tested with auditory ERP's and CNV. The results were comparated with results obtained with twenty night patients meeting the DSM IV diagnosis of schizo-affective disorder. These schizophrenic patients were also in a remission phase since a minimal of sixth months. There were tested in the same condition with similar ERP'S component. We studied amplitude and latency of N100, MMN, P200, N200, P300 and CNV. We observed same delays of latency and reduction of the amplitude for P300 in both pathologies. That suggests that temporoparietal lobes disturbances underlying by difficulties in the attention processes are similar in the two pathologies. Differences were noticed at the level of N100, MMN, P200 and CNV amplitude. It could be the reflect of a better reactivity in stimuli in bipolarity as well as a better conservation for executive functions.

Results:

	N1Lat	N1A.	MMNLat	MMN A	P2Lat	P2A	N2Lat.
BP	98,0	5,0	148,0	4,8	173,6	7,3	214,9
SCH	105,7	4,4	151,8	3,6	181,0	4,8	214,7

	N2A	P300Lat.	P300A	P50	Inhibition	CNV Lat.	CNV A.
BP	5,4	330,8	9,7	25	Yes	1163,3	21,6
SCH	3,5	325,4	7,0	2	No	1223,8	9,8

POSTER 1-8

Association Between Diabetes, Mood and Anxiety Disorders Among Hispanics Attending a Community Clinic in Rural Southern California

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Abstract:

Background: The literature has emphasized the importance of screening for psychiatric problems among individuals with diabetes. Reports have also underscored the need to improve prevention and treatment of the increased morbidity among patients suffering from mental illnesses. In this regard, Hispanics are particularly vulnerable to the development of diabetes and comorbid psychiatric conditions.

Objective: To describe if there is a significant association between the diagnosis of diabetes, mood and anxiety disorders among Hispanics attending a community clinic in rural southern California.

Methodology: We reviewed records of 110 Hispanic patients that attended a community clinic that provided psychiatric services from January 1st until October 31st of 2010. Psychiatric diagnosis was made using the DSM-IV-TR criteria. Diagnosis of diabetes was made by the patient's treating primary care provider following the ADA guidelines.

Results: The mean age was 55.1 years (SD: 8.73), and 75% were female (83/110). Generalized Anxiety Disorder (GAD) was diagnosed in 75% (82/110), followed by depression in 62% (68/110) and bipolar disorder in 25% (27/110). Fifty seven percent (63/110) of the patients were first diagnosed with diabetes before being referred for psychiatric treatment. Among patients diagnosed with diabetes, 67% (42/63) were later diagnosed with GAD, followed by 65% (41/63) with depression and 18% (11/63) with bipolar disorder. Bivariate analysis showed a significant association between the diagnosis of diabetes and GAD (?2=4.82;df=1;p<0.05) and diabetes and bipolar disorder (?2=3.99;df=1;p<0.05) but not for depression (?2=0.66;df=1;p=0.41). Multiple Regression model showed a significant negative correlation between being first diagnosed with diabetes and then with GAD (Beta=-0.24;t=-2.58;p<0.05) and Bipolar Disorder (Beta=0.20;t=-2.21;p<0.05), suggesting that there is a significant comorbidity between Bipolar, GAD, and diabetes in this rural Hispanic sample.

Conclusions and Clinical Implications: These data from a rural clinic treating Hispanics shows the importance of early screening and detection of mood and anxiety disorders among patients suffering from diabetes to monitor and improve compliance with treatment and quality of life. Additionally, these preliminary data provide further evidence of the importance of implementing a comprehensive integrated model in which psychiatrists and primary care providers work together treating metabolic and psychiatric disorders among patients, especially Hispanics attending community clinics in rural underserved areas.

POSTER 1-9

Validity of the Korean Version of Core

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Abstract:

1) Specific purpose: Parker et al. have developed the CORE, a scale assessing retardation, agitation and non-interactivity by behavioural observation which is able to distinguish melancholia from other depressive disorders. The aim of this study is to evaluate the validity of Korean version of CORE(CORE-K).

2) Content: The CORE is an 18-item scale which assesses features of melancholic depression such us retardation, agitation and non-interactivity by behavioural observation. Each sign is rated on a 4-point scales (0-3) by clinicians or a trained observer. The CORE distinguish melancholia from other residual depressive disorders. Depressed patients will be allocated to the CORE-defined melancholic group if they score 8 or more.

3) Method: Total 45 out-patients, age between 28-72 years, who met DSM-IV criteria for major depressive disorder were entered into the study. The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) was administered by a clinician, and the patients were divided into two groups: 31 melancholic depressive patients and 14 non-melancholic depressive patients. And CORE-K, Hamilton Depression Rating Scale (HAM-D), and Korean version of Mini Mental Status Exam (MMSE-K) were administered.

4) Results: Internal consistency(a=0.729) and test-retest reliability(r=0.859) were psychometrically approvable. The CORE-K and the HAM-D were found to be highly correlated(r=0.877) The Pearson correlation coefficiency between The CORE-K and the HAM-D was 0.877($p<0.001$), and That of the CORE-K and SCID was -0.37($p<0.01$). In Receiver Operating Characteristics(ROC) analysis, Area Under the Curve(AUC) of the CORE was 0.762(95% CI 0.624-0.901)and that of HAM-D was 0.727(95% CI 0.582-0.782). Optimal cut-off score of CORE-K was 6/7, and the sensitivity and the specificity at that score were 0.618 and 0.857.

5) Conclusion: The CORE-K is a valid and reliable sign-based rating tools that can identify patients with melancholia among clinical populations in Korea.

POSTER 1-10

The Efficacy Profile of Vilazodone, a Serotonin Reuptake Inhibitor and 5-HT1A Receptor Partial Agonist, in the Treatment of Major Depressive Disorder

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Abstract:
Objective: Vilazodone, a serotonin reuptake inhibitor and 5-HT1A receptor partial agonist, is approved by the US Food and Drug Administration for the treatment of major depressive disorder (MDD) in adults. This evaluation summarizes efficacy results from two, 8-week, double-blind, randomized, placebo-controlled trials (RCT-1; RCT-2), including demographic and clinical subgroup assessments, and effectiveness data from a 52-week, open-label (OL) study.

Methods: Patients aged 18-70 years with DSM-IV-TR–defined MDD received once daily vilazodone 40 mg/day (titrated with food over 2 weeks) or placebo (RCT-1 and RCT-2) or vilazodone 40 (OL study). The primary efficacy assessment in RCT-1 (N=397) and RCT-2 (N= 462) was change from baseline to end of treatment (EOT) in Montgomery-Åsberg Depression Rating Scale (MADRS) total score using a last observation carried forward (LOCF) approach; additionally, supportive analysis using a mixed-effects repeated-measures (MMRM) approach was performed. Effectiveness analyses in the OL study (N=596) included mean MADRS score change over time. Post hoc and pooled analyses were performed to further evaluate the efficacy of vilazodone. Analyses were based on the Intent-to-treat Population from each study.

Results: In RCT-1 and RCT-2, vilazodone-treated patients compared with placebo-treated patients showed greater improvement from baseline to Week 8/EOT in mean MADRS scores (RCT-1: LSMD, -3.2, P=.001; RCT-2: LSMD, -2.5, P=.009). MMRM analysis of MADRS change from baseline to EOT revealed statistically significant improvement for vilazodone versus placebo at each time point in RCT-1 and at Weeks 6 and 8 in RCT-2. In the majority of subgroups evaluated (ie, demographic and disease characteristic subgroups based on age, sex, race, baseline MDD severity, and previous MDD history), MADRS improvement greater than at least 2 points was shown for vilazodone compared with placebo. In the OL study, mean MADRS score improved from 29.9 at baseline to 11.4 at Week 8 and 7.1 at Week 52.

Conclusions: Vilazodone 40 mg/day resulted in significant improvement in MDD symptoms in 2 pivotal studies (RCT-1 and RCT-2). The efficacy of vilazodone was supported by post hoc and pooled analyses, and 52-week OL effectiveness data.
Supported by funding from Forest Laboratories, Inc.

POSTER 1-11

The Safety and Tolerability of Vilazodone, a Serotonin Reuptake Inhibitor and 5-HT1A Partial Agonist, in Patients with Major Depressive Disorder

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Abstract:
Objective: Vilazodone, a serotonin reuptake inhibitor and 5-HT1A receptor partial agonist, is approved by the US Food and Drug Administration for the treatment of major depressive disorder (MDD) in adults. This report summarizes the safety and tolerability profile of vilazodone 40 mg/day based on 3 Phase 3 studies conducted as part of the clinical development program.

Methods: Pooled data from two, 8-week, double-blind, randomized, placebo-controlled trials (RCT-1; RCT-2) of vilazodone (n=436) vs placebo (n=433) and data from a 52-week, open-label (OL) study (N=616) were analyzed. Patients aged 18-70 years with DSM-IV-TR–defined MDD received once daily vilazodone 40 mg/day (titrated with food over 2 weeks) or placebo (RCT-1 and RCT-2), or vilazodone 40 mg/day (OL study). Safety and tolerability assessments included adverse

events (AEs), laboratory tests, vital signs, electrocardiograms (ECGs), and weight. Changes in sexual function were assessed using the Arizona Sexual Experiences Scale (ASEX; RCT-1) or Changes in Sexual Functioning Questionnaire (CSFQ; RCT-2 and OL study). Analyses were based on the Safety Population from each study, which was defined as all patients who received study drug and had a postbaseline safety evaluation.

Results: The most frequent AEs reported in the pooled 8-week RCTs for vilazodone vs placebo were diarrhea (28.0% vs 9.2%), nausea (23.4% vs 5.1%), and headache (13.3% vs 12.0%); the majority of these events were mild to moderate in severity. The same 3 AEs were also reported most frequently in the 52-week study. In pooled 8-week data, median durations of diarrhea and nausea for the vilazodone group were 8 and 5 days, respectively; of these patients, <5% required a concomitant medication for the AE. Rates of discontinuations due to AEs were 7.1% for vilazodone and 3.2% for placebo. No significant differences in least squares mean change from baseline to end of treatment were observed for vilazodone vs placebo in ASEX total scores (-0.6 vs -0.5; P =.784) and CSFQ total scores (1.3 vs 2.0, P=.262). CSFQ scores increased in the OL study, suggesting improved sexual functioning. In the RCTs, weight change was similar in the vilazodone and placebo groups (0.16 and 0.18 kg); potentially clinically significant weight gain (>7%) was also similar between groups (0.2% in each group); mean change in weight from baseline to end of OL study was 1.71 kg. In these studies, vilazodone had no clinically important effects on vital signs, laboratory measures, or ECGs.

Conclusion: Based on the Phase 3 safety profile, vilazodone was well tolerated during both short- and long-term treatment of MDD. Supported by funding from Forest Laboratories, Inc.

POSTER 1-12

Meta-Analyses of Asenapine Efficacy vs. Placebo in Bipolar I Disorder as Monotherapy and Adjunct Therapy Compared with Selected Antipsychotics

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Abstract:

Objective: Superiority of flexible-dose asenapine (5 or 10 mg twice daily [BID]) monotherapy vs placebo for mania in bipolar I disorder patients was demonstrated in 2 randomized, double-blind, placebo- and olanzapine-controlled 3-week trials. Superiority of flexible-dose asenapine (5 or 10 mg BID) vs placebo as adjunctive therapy in bipolar I disorder patients with incomplete response to lithium or valproate monotherapy was shown in a separate randomized, double-blind, placebo-controlled trial. We describe meta-analyses of asenapine vs placebo and selected antipsychotics based on available placebo-controlled trials.

Methods: The primary endpoint was change from baseline Young Mania Rating Scale (YMRS) total score at week 3 vs placebo. Data for asenapine (5 or 10 mg BID) and comparator antipsychotics were obtained from all monotherapy trials (n=19) or adjunct treatment trials in patients with incomplete response to lithium or valproate monotherapy (n=9) published at the time of the analysis. Meta-analyses used a random-effects model; Cochran's Q statistic assessed study homogeneity. The effect of compound was investigated with (weighted) linear regression.

Results: Combining the asenapine monotherapy studies, the estimated difference in the change in baseline YMRS total score with asenapine was superior to placebo by 4.5 points (95% CI, 2.5–6.4; P<0.0001); results across studies were homogeneous (Q=0.7, df=1, P=0.41). The effect size of asenapine vs placebo was comparable to the overall effect size of antipsychotics (4.8 points; 95% CI, 3.7–6.0; P<0.0001). For the latter analysis study results were not homogeneous (Q=69.5, df=19, P<0.001); a notably large treatment effect was observed for 1 risperidone study (Khanna et al. Br J Psychiatry 2005;187:229–234) and aripiprazole studies tended to have small treatment effects. A potential source of heterogeneity could be a difference across compounds, however, the overall F test for differences among compounds could not be rejected (F(5,15)=1.58, P=0.23). The treatment effect for adjunctive asenapine was superior to placebo by 2.4 points (95% CI, 0.5–4.3; P=0.0257); this was comparable to the overall antipsychotic adjunctive treatment effect vs placebo (2.6 points; 95% CI, 1.9–3.3; P<0.0001). The adjunctive therapy study results across antipsychotics were markedly homogeneous (Q=8.0, df=8, P=0.43).

Discussion: The clinical trial program for asenapine reveals statistical superiority over placebo, as monotherapy or adjunctive therapy to lithium or valproate, for acute bipolar mania. When considered in light of published clinical trials indicating that asenapine appears to be well tolerated in patients with bipolar mania, these meta-analyses are instructive in revealing that the efficacy of asenapine vs placebo for both monotherapy and adjunctive therapy is similar to that of selected antipsychotics. (This research was supported by Merck, Whitehouse Station, NJ.)

POSTERS 1-13, 1-14

WITHDRAWN

POSTER 1-15

Schizophrenia, Creativity and Impact of Treatment

Chandresh Shah, M.D. (cshah1955@yahoo.com)

Abstract: An age-old belief links creativity with psychopathology. There exists an extensive literature which supports such connection. Increased creative drive is noted to be associated with bipolar disorder, depression as well as psychosis. With discovery of various psychopharmacological treatments, some of these illnesses have seen dramatic changes in their course. This has also led to observations that creativity has been affected by such treatments. This is a case-study of a patient with Paranoid Schizophrenia. He describes his hobby as Writing of Poems. He has been in treatment over last 10 years and has been evalu-

ated periodically during various phases of illness – acute exacerbation, subacute during stabilization, early remission and sustained recovery; inpatient and outpatient treatments. One of the assessment tools has been Brief Psychiatric Rating Scale (BPRS). He has been writing poems throughout this period. The poems written within 4 weeks of major change in his illness were selected (and are discussed). Patient, while in sustained recovery, was asked to rate his own work on scale of 1-10. This writer-performed rating was matched against clinician-performed BPRS. The analysis shows that higher BPRS score is highly correlated (r = +0.85) with higher poetry score. This case-study shows that treatment of schizophrenia leading to remission of illness also leads to decrease in creativity.

POSTER 1-16

Complex Regional Pain Syndrome and Comorbid Depression: Treatment Modalities

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Abstract: Complex regional pain syndrome (CRPS) is a chronic progressive disease characterized by severe pain, swelling and changes in the skin. The cause of this syndrome is currently unknown. Precipitating factors include injury and surgery, although there are documented cases that have no demonstrable injury to the original site. No specific test is available for CRPS and in some cases patients improve without treatment. A delay in diagnosis and treatment of this syndrome can result in severe physical and psychological problems. Early recognition and prompt treatment provide the greatest opportunity for recovery. We report a case of a 39 year old, married, unemployed Dominican female with medical history of chronic regional pain syndrome diagnosed since five years after a car accident, no past psychiatric inpatient hospitalization and no formal psychiatric diagnosis with one inpatient hospitilization due to increasing depression and suicidial ideation. Reportedly patient was feeling increasingly depressed for the past four weeks as her pain from CRPS had spread to her left thigh making it necessary for her to ambulate using a cane. During her hospital course patient was given analgesics, antidepressants to resolve her depression. As the main etiology behind her depression was mainly her medical condition CRPS, we did a thorough literature search of the best treatment options for these patients. Physicians use a variety of drugs to treat CRPS, including ketamine, antidepressants, anti-inflammatories such as corticosteroids and COX-inhibitors such as piroxicam, bisphosphonates, vasodilators, GABA analogs such gabapentin and pregabalin, and alpha- or beta-adrenergic-blocking compounds, and the entire pharmacy of opioids. Although many different drugs are used, there is not much supportive evidence for most of them to be effective. Recent research has utilized mirror therapy to significantly reduce pain levels in CRPS patients. The study results suggest that mirror therapy probably reduces pain and disability in people with acute (<3 months) CRPS, but not in those with chronic CRPS. Literature shows that good progress can be made in treating CRPS if treatment is begun early, ideally within 3 months of the first symptoms. If treatment is delayed, however, the disorder can quickly spread to the entire limb and changes in bone, nerve and muscle may become irreversible. Through our case report we recommend further controlled studies with large sample size on safety and efficacy of the usage of the motor imagery in CRPS patients with acute onset, thus preventing the progression of the chronic course leading to the onset of psychiatric symptomatology.

POSTER 1-17

Efficacy and Safety of Adjunctive OPC-34712 in Major Depressive Disorder: A Phase II, Randomized, Placebo-Controlled Study

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Abstract:

Objective: OPC-34712 is a new D2 dopamine partial agonist with a biochemical and pharmacologic profile designed to provide improved tolerability and likely greater efficacy than first-generation partial agonists. This study assessed the efficacy and safety of OPC-34712 as an adjunctive to standard antidepressant therapy (ADT) in patients with major depressive disorder (MDD) who had exhibited inadequate response to 1–3 prior ADTs.

Methods: This was a Phase II, multicenter, randomized, double-blind, placebo-controlled trial (Study 331-08-211) comprised of three phases: a screening phase (7–28 days); a prospective phase (Phase A): 8-week, single-blind, adjunctive placebo to assess response status to ADT (50% reduction in the 17-item Hamilton Depression Rating Scale [HAM-D17] Total score); and a randomized phase (Phase B): 6-week, double-blind, assessment of adjunctive OPC-34712 vs. placebo in patients with an inadequate response to ADT. Randomized subjects had been in the current depressive episode >8 weeks, had a HAM-D17 Total score >18 at baseline and had not responded to ADT in Phase A (<50% reduction in HAM-D17 Total score). Randomization was to daily OPC-34712 (0.15 mg, n=62; 0.50 ± 0.25 mg, n=120; or 1.5 ± 0.5 mg, n=121) or placebo (n=126) adjunctive to ADT. Primary efficacy endpoint was mean change from baseline of Phase B to endpoint on the Montgomery–Åsberg Depression Rating Scale (MADRS) Total score. Primary analysis objectives were to compare the efficacy of the 0.50 mg/day dose vs. the 1.5 mg/day dose of OPC-34712 with placebo.

Results: Of 429 randomized patients, completion rates at Week 14 were 82–85% and were similar for all treatment groups, with a low incidence of discontinuation due to adverse events. Improvements in mean MADRS Total score, from baseline to endpoint, were observed only for subjects receiving adjunctive OPC-34712 at the 1.5 mg/day dose compared with placebo (p=0.0303), whereas subjects receiving the 0.5 mg/

day dose exhibited smaller improvements in MADRS Total score compared with placebo (p>0.05). The 1.5 mg/day dose also showed improvement compared to placebo on secondary endpoints of the Sheehan Disability Scale (p=0.016) and Clinical Global Improvement – Severity scale (p=0.006). Commonly reported adverse events (all doses of OPC-34712 >5%) were upper respiratory tract infection (6.9%, 21/303), akathisia (6.6%, 20/303), weight gain (6.3%, 19/303), and nasopharyngitis (5.0%, 15/303). Mean change from baseline in body weight was 1.6 kg for OPC-34712 (1.5 mg/day) compared with 0.77 kg for placebo.

Conclusions: OPC-34712 was well tolerated and effective as adjunctive treatment for MDD patients with an inadequate response to ADT. In addition, improvements were observed as early as Week 2 after initiation of treatment with the 1.5 ± 0.5 mg/day dose.

POSTER 1-18

Reliability and Validity of Chinese Version Self-Presentation Rating Scales for Patients of Bipolar Disorder

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Abstract:

Aim: This study investigated the reliability and validity of the Chinese version of the short form (21 items) of Depression, Anxiety and Stress Scale (DASS) and the Altman Self-Rating Scale for Mania (ASRM) in patients with bipolar disorder.

Method: A convenience sample of 120 patients who was diagnosed as bipolar I or II disorder, aged ranged from 18–65, completed the self-reported questionnaires "DASS" and " ASRM" when visiting the psychiatric outpatient clinics. Meanwhile, Hamilton Rating Scale for Depression (HAMD-17) and Young Mania Rating Scale (YMRS) were also assessed by the well-trained research assistant to the patients. Reliability was measured by Cronbach's alpha for internal consistency. Validity was assessed by Pearson's correlations among the four scales used and by content analysis. The confirmatory factor analysis (CFA) was performed to check the validity of three factors of DASS.

Results: The average age of 120 patients was 40.14(SD 10.999) (ranged from 18y/o to 64y/o) and male to female ratio was 0.319(M:F=29:91). In the reliability test, the Cronbach's Alpha was 0.864, 0.686, 0.956, and 0.681 for the overall HAMD-17, YMRS, DASS, and ASRM, respectively. In the validity test, Pearson's correlations were high. The convergent validity between HAMD-17 and DASS and between YMRS and ASRM were statistic significant (R=0.813, p<0.001; R=0.442, p<0.001, respectively). The discriminate validity between HAMD and ASRM was also statistic significant (R=-0.311, p=0.001). The results of the CFA analyses indicated that the three factors fits the data, according to the cutoff criteria for relatively good fit (normal fit index [NFI] =0.830, comparative fit index [CFI] =0.915, Incremental Fit Index[IFI]=0.917, and root-mean-square error of approximation [RMSEA] =0.06).

Conclusion: The Chinese version of the DASS and ASRM are reliable and valid measures for bipolar disorder outpatients.

POSTER 1-19

Bipolar Module Project as a Part of the Psychopharmacology Curriculum

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Abstract:

Purpose: Teaching psychopharmacology requires the effective transfer of an ever-changing information base to maximize effectiveness, adherence and satisfaction. At the 2006 American Association of Directors of Psychiatric Residency Training (AADPRT) annual meeting, an ad hoc committee was formed including individuals from the American Society of Clinical Psychopharmacology (ASCP) curriculum committee to help make the ASCP's Psychopharmacology Curriculum more 'resident-friendly". A workshop presented at the 2007 AADPRT meeting introduced the multifaceted schizophrenia module. As a next step the ASCP formed the Committee on Residency and Fellowship, comprised of AADPRT and ASCP leadership and psychiatry trainees. The Committee received nominations from psychiatry residency training directors nationwide, selected 15 members and formed 2 sub-groups in order to work on the development of multi-model training modules for bipolar disorder and depression. This presentation highlights the progress of the bipolar curriculum group.

Methodology: Monthly conference calls have been held since August 2008. Each resident was assigned a specific topic to research and develop. A google group was set up for residents to update their work on the module.

Content: The Bipolar group has developed a list of topics including Epidemiology, Co-morbidities (including ADHD, Substance Use Disorders and Borderline Personality), Bipolar Depression, Atypical Antipsychotics & Mood Stabilizers, Psychosocial Aspects of Treatment. A variety of teaching modalities such as Jeopardy-type game, podcasts, case presentations and team based learning exercises were used.

Importance: The bipolar module is an innovative tool for teaching psychopharmacology which enables psychiatric trainees and other psychiatrists to master a large volume of information.

POSTER 1-20

Safety of Selegiline Transdermal System (STS) in Clinical Practice: Analysis of Adverse Events from Postmarketing Exposures

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Abstract:

Objective: Despite consistent evidence for efficacy, the clinical use of monoamine oxidase inhibitors (MAOIs) has declined because of safety concerns about food and drug interactions. Selegiline transdermal system (STS), FDA approved for major depressive disorder, was developed to overcome some limitations of oral MAOIs—in particular, dietary restrictions. Labeling for STS 6 mg/24hr requires no restrictions, while 9-mg/24hr and 12-mg/24hr doses necessitate dietary modifications. In clinical trials without dietary modifications, there were no reports of hypertensive crisis associated with STS. The objective of this analysis is to present the safety profile of STS in clinical practice post-FDA approval, by analyzing postmarketing adverse events (AEs).

Method: We obtained de-identified data on adverse events (AEs), regardless of causality, as collected by the manufacturer after the launch of STS in the United States. We carefully examined all reports of hypertensive crisis, suicide attempts, and STS overdoses to independently determine relation of the AE to STS.

Results: From April 2006 to June 2010, 29,141 patients were exposed to STS. A total of 3154 AEs in 1516 patients (5.2% of the exposed population) were reported, regardless of causality. The most frequently reported categories of AEs were general disorders (n=1037, 32.9% of the reported AEs), psychiatric disorders (n=575, 18.2%), and central nervous system (CNS) disorders (n=381, 12.1%). Among general disorders, application site reactions (n=577, 55.6%) were most frequent. Cardiac and vascular AEs accounted for approximately 4% of reported AEs (n=127), with palpitation (n=28, <1%) and hypotension (n=25,<1%) being most common. Insomnia (4.4%) was the most frequent psychiatric AE. There were 16 reports (<1%) of manic/hypomanic AEs. There were 13 (0.9%) drug-drug interactions reported, 5 of them classified as serious. There were 266 (8.4%) reports classified as serious AEs (SAEs); psychiatric disorders (n=71, 2.3%), cardiac and vascular disorders (n=44, 1.4%), and CNS disorders (n=40, 1.3%) were most common. There were 5 self-reports of possible hypertensive crisis or hypertension, though objective clinical data were not submitted in any case. There were 28 (0.9%) reports of suicidal ideation, 4 (0.1%) suicide attempts, and 5 (0.2%) completed suicides; no causal role was apparent for STS based on available follow-up information.

Conclusions: To date, the AE profile for STS from postmarketing exposures resembles that observed in clinical trials. The most common AEs were application site reactions and insomnia. Very few reported a hypertensive event, and there were no objectively confirmed reports of hypertensive crisis with food at any STS dose. Serious drug-drug interactions were rare. Therapeutic doses of STS appear to have an excellent safety profile in clinical practice. However, given the relatively modest exposure numbers, continued safety monitoring is recommended. This study was funded by Dey Pharma, L.P.

POSTER 1-21

An Analysis of Treatment Outcomes of Bipolar Disorder Patients at an Academic Medical Center Treated by Psychiatric Resident and Attending Physicians

Panchajanya Paul, M.D., Ronald McGinnis, Angele McGrady, Kary Whearty, Daniel Rapport

Abstract:

Introduction: Every year, a significant number of patients are treated by over six thousand residents and fellows working in the 184 psychiatry residency programs in the USA. In order to maintain optimum quality of patient care, the ACGME mandates that by the end of training, each resident is able to demonstrate patient care skills with complicated patients, in concert with compassionate care and sensitivity to patient needs. There may be a general belief that patients managed by an attending receive better clinical care than those treated by residents. To our knowledge, this is the first study to compare the performance of psychiatric residents and attending physicians based on the outcomes of patients with bipolar disorder. Although studies in the past have compared knowledge between these two groups, the applications of knowledge, and its translation to clinical outcomes, have not been previously studied.

Method: This project was approved by the institutional IRB. The charts of 271 outpatients at the University Of Toledo Department Of Psychiatry coded for Bipolar Disorder for at least 18 months were reviewed and diagnoses were validated. Ultimately demographics and outcomes of 121 patients, 37 women and 84 men treated for a minimum of 12 months were analyzed. Raters determined mood states at the time of each visit based on patient's subjective report and the recorded objective evaluation of the resident or attending treating the patient. The outcomes were divided into four categories: Remission (euthymic mood for 12 consecutive months); Response (Much improved mood, not meeting DSM IV criterion for mild illness for 12 consecutive months), Relapse (remission or response but followed by a recurrence after the 12 month period), and Active illness (failure to achieve any of the above). Statistical analysis was done using SPSS software.

Results: In our cohort of 121 patients, 41 were treated by residents and 80 were treated by attending physicians. Table 1 shows the number of patients in each category separated by provider. Overall, 43.8 % of patients achieved at least 12 consecutive months of remission, response or response

followed by relapse while 56.1% failed to do so (active illness). The mean duration of remission was 32.2months, while the average length of response until the study ended on April 1, 2010 was 25.4 months.

	Remission	Response	Relapse	Active illness
Total (121)	26	12	15	68
Resident (41)	5	6	8	22
Attending (80)	21	6	7	46

Combining the remission, response and relapse groups, and the percentage of resident's patients who improved was 46.34% (19/41). This was marginally more than that of the attending' 42.50% (34/80), but the difference was not statistically significant. In contrast, the comparison of outcome in the remission and response groups, the attending 26.5% (21/80) outperformed the residents 12.20 % (5/21). Thus twice the number of patients seen by attending achieved euthymia as compared to the residents. This difference was statistically significant (chi square = 9.85; p < .002).

Conclusion: Supervised residents can provide quality of care comparable to an attending. However, among the patients who improve, those managed by attending are more likely to achieve euthymia than patients treated by residents.

POSTER 1-22

Service Utilization, Demographic, and Illness Characteristic Correlates of Longitudinal Illness Severity in Bipolar Disorder

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Abstract:

Objective: To evaluate the service utilization, demographic, and illness characteristic correlates of longitudinal illness severity, as assessed by mean prior year (MPY) Clinical Global Impressions-Severity of Illness (CGI-S) scores, in bipolar disorder (BD) patients.

Method: 53 BD patients (26 BD I, 24 BD II, 3 BD NOS, mean±SD [median] current age 47.1±14.5 [45.7] years, 75.5% female, 77.4% Caucasian), receiving naturalistic evidence-based, measurement-based care in the Stanford University Bipolar Disorders Clinic, assessed with the Systematic Treatment Enhancement Program for bipolar disorder (STEP-BD) Affective Disorders Evaluation, and monitored longitudinally with the STEP-BD Clinical Monitoring Form (CMF), had MPY CGI-S scores assessed. Relationships between MPY CGI-S and service utilization, demographic, and illness characteristic parameters were assessed with Pearson correlations for continuous variables and unpaired t-tests or one-way ANOVAs as appropriate for categorical parameters.

Results: Patients had a medication monitoring visit frequency of every 60±39 (46) days, with 8.6±5.1 (8) medication monitoring visits during the 12-month observation period, and were taking 3.9±2.0 (3.4) prescription psychotropic medications. For the entire cohort, CGI-S for prior year was 3.1±0.9 (3), and was significantly positively associated with visit frequency (r = 0.399, df = 51, p = 0.003), number of prescription psychotropic medications (r = 0.398, df = 51, p = 0.003), current age (r = 0.321, df = 51, p = 0.019), and BD illness duration (r = 0.307, df = 43, p = 0.04), but not BD onset age or other demographic (gender, ethnicity, marital status, employment status, and education) or baseline clinical characteristic (BD subtype, anxiety, substance use, personality, eating, and any psychiatric disorder comorbidity, history of psychosis, history of psychiatric hospitalization, history of rapid cycling, and rapid cycling in prior year) parameters.

Conclusions: Greater longitudinal illness severity was associated with increased service utilization (clinic visits and prescription psychotropic medications), older current age, and longer BD illness duration. The latter association (illness severity worsening with longer illness duration) is consistent with the kindling hypothesis for BD. Further studies are warranted to assess environmental (stress) and biological (genetic) correlates of MPY CGI-S.

POSTER 1-23

A Descriptive Analysis of a Cohort of 121 Bipolar Patients Treated at an Academic Medical Center

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Abstract: Bipolar Disorder (BPD) remains a crippling disorder affecting millions of Americans. Treatment is usually complex and requires long term commitment by providers and patients. The purpose of this study was to determine the percentage of patients in an academic medical practice that achieve a clinically meaningful remission or response to treatment.

Methods: This project was approved by the institutional IRB. The charts of 271 outpatients at The University of Toledo Department of Psychiatry billed for BPD over the last 18 months were reviewed and diagnoses were validated. Ultimately, 121 patients, 37 women and 84 men treated for a minimum of 12 months were descriptively analyzed. Three volunteer physicians rated every standardized medication management note from the time of the patient's initial diagnostic assessment to the time of the cutoff date of April 1, 2010. Raters determined mood states at the time of each visit based on the patient's subjective report, the recorded objective evaluation of the attending or resident and the Clinical Global Impression of Improvement Scale rated at the time of each visit. "Euthymia" was arbitrarily defined as 12 consecutive months of euthymic mood. "Response" was defined as "much improved" and not meeting DSM-IV-TR criteria of mild illness for 12 consecutive months. Active illness was defined as failure to achieve 12 consecutive months of either.

Statistics: Analysis consisted of descriptive statistics, analysis of variance and Chi square using SPSS.

Results: In our cohort, 43.8% achieved at least 12 consecutive months of euthymia or response while 56.1% failed to do so. The mean duration of euthymia in months was 32.2 and for response group it was 25.4 months. There were no gender or in age differences among groups. Prescribing patterns of mood stabilizers, atypical antipsychotics and antidepressants, alone or in combination, were no different in any group. Sustained recovery was associated with longer lag times to recovery ($p < 0.05$). Patients in all groups were largely compliant with taking medication but patients who remained actively ill were more likely to have missed appointments ($p < 0.05$).

Conclusion: It appears that antidepressants are commonly prescribed in conjunction with one or two mood stabilizing agents with equal frequency in all groups. However, it does not appear that antidepressants worsen outcomes. We found no medication regimen superior to any other. Instead, prognosis appears to be related to intrinsic factors associated with the phenotype of the illness. Compliance with appointments was a significant factor associated with improvement. Time to recovery may be a factor in maintaining improvement. Further research is needed to explore the association between recovery and specific medicines within a class and the role of adjunctive psychotherapy in this group of seriously ill patients.

POSTER 1-24

Evaluating the Impact of Vilazodone on Sleep in Patients with Major Depressive Disorder

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Abstract:

Objective: Vilazodone, a serotonin reuptake inhibitor and 5-HT1A receptor partial agonist, is approved by the US Food and Drug Administration for the treatment of major depressive disorder (MDD) in adults. This post hoc analysis of placebo-controlled studies of vilazodone assesses the effect of vilazodone on sleep in patients with major depressive disorder.

Methods: Data were pooled from two 8-week, randomized, double-blind, placebo (PBO)-controlled, multicenter studies in adults with DSM-IV-TR–defined MDD. Evaluations of the effect of vilazodone on sleep were based on comparisons with PBO with respect to changes in 17-item Hamilton Depression Scale (HAM-D-17) sleep-related items (early, middle, and late insomnia), HAM-D-17 sleep subscale (total of the 3 sleep items), Montgomery-Asberg Depression Rating Scale (MADRS) reduced sleep item, sleep-related treatment-emergent adverse events (TEAEs), and time to sleep improvement.

Results: Among 891 randomly assigned patients, baseline MADRS and HAM-D-17 total scores were 31.4 and 25.0 (respectively) reflecting, on average, MDD of moderate severity. Most patients reported a baseline score of =4 (sleep reduced or broken by at least 2 hours) on the MADRS reduced sleep item. After adjusting for baseline severity of MDD, vilazodone treatment was associated with significantly greater improvements on the HAM-D-17 sleep subscale (least square mean [LSM] change: -1.8 in vilazodone vs -1.5 in PBO, P=0.048) and numerically greater improvements in each HAM-D-17 sleep item and in the MADRS reduced sleep item. Significantly more vilazodone patients experienced a TEAE related to sleep disorder or disturbance (10.8% in vilazodone vs 3.7% in PBO, P<0.001), with insomnia being the most common. Sleep-related TEAEs were considered mild or moderate (91.5% vs 93.8%) in the majority of both vilazodone and PBO patients, with no patient in either treatment group discontinuing because of a sleep-related TEAE. No statistically significant differences in time-on-treatment to sleep improvement were noted between vilazodone and PBO patients. Additionally, among patients with severe baseline sleep disturbance (HAM-D-17 sleep subscale score of 5 or 6), significantly better improvement in the HAM-D-17 Maier subscale was noted in the vilazodone group (LSM change: -5.5 in vilazodone vs -4.4 in PBO, P=0.005).

Conclusions: Quantitative evaluations demonstrate that treatment with 40 mg/day vilazodone compared with PBO is associated with small but consistent improvements in sleep depth and duration even though patients receiving vilazodone were more likely to experience sleep-related TEAEs. These findings support that vilazodone has a relatively neutral risk/benefit profile with respect to effects on sleep quality. Supported by funding from Forest Laboratories, Inc.

POSTER 1-25

Evaluating the Efficacy and Tolerability of Vilazodone in Patients with Anxious Depression

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Abstract:

Objective: Vilazodone, a serotonin reuptake inhibitor and 5-HT1A receptor partial agonist, is approved by the US Food and Drug Administration for the treatment of major depressive disorder (MDD). This post hoc analysis of placebo-controlled studies was conducted to evaluate the efficacy and tolerability profiles of vilazodone in the treatment of patients with anxious depression.

Methods: Data from two 8-week, randomized, double-blind, placebo (PBO)-controlled, multicenter studies evaluating the safety and efficacy of 40 mg/day vilazodone in adult patients with DSM-IV-TR–defined moderate to severe depression were pooled. Anxious depressed patients were identified as the subpopulation with a 17-item Hamilton Depression Scale anxiety/somatization subscale score of =7 at baseline. Changes from baseline to end of treatment were evaluated for a variety of depression and anxiety severity measures. Changes in overall clinical condition were also assessed.

Results: Of all randomly assigned patients, 82% met the criteria for anxious depression. Patients receiving vilazodone demonstrated significantly greater mean changes from baseline in the Montgomery-Asberg Depression Rating Scale (-12.7 in vilazodone vs -9.9 in PBO; P<.001), Hamilton Anxiety Scale total scores (P=.006), and in the Clinical Global Impression-Improvement score (P<.001) at end point. Similar percentages of patients in both groups discontinued prematurely for any reason; 7.4% and 3.2% of patients receiving vilazodone and PBO, respectively, withdrew because of treatment-emergent adverse events (TEAEs). The most commonly reported TEAEs included diarrhea, nausea, and headache.

Conclusions: In this pooled analysis of 2 placebo-controlled studies, vilazodone 40 mg/day is associated with significant improvements in both depression and anxiety severity in patients with anxious depression. The tolerability profile of vilazodone in anxious depression is similar to that observed in the general major depressive disorder population. Supported by funding from Forest Laboratories, Inc.

POSTER 1-26

Lithium Augmentation in ECT Resistant Unipolar Depression

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Abstract:

Objective: ECT resistant MDD, recurrent, severe, without psychotic features and Generalized Anxiety disorder, responded acutely with Lithium Augmentation.

Method: We describe a case of 65 y/o Caucasian male who has been severely depressed with anhedonia, social isolation, poor sleep and appetite, very poor energy levels and feeling anxious for 3 months. This was also confirmed with his girlfriend Patient was started on Effexor 37.5 mg PO q daily and dose was increased to 150 mg PO q daily. Risperdal 0.5 mg q bedtime was added, and patient reported rested sleep with it. Patient continued to feel severely depressed (8-9-10/10 if 10 is max depression) staying in his bed most of the time isolated and withdrawn. He also received individual supportive and cognitive psychotherapy. Lithium was started on day 15th of his admission at a dose of 450 mg PO at bedtime. Two days after the initiation of lithium, patient started coming out of room, started socializing with peer patients and had a brighter affect. Patient also admitted of feeling better, less depressed (5-6/10) if 10 is severe depression and had improved energy level. After the third dose, patient's depression continued to improve. He joked around and rated his depression as 1-2-3/10 now. Lithium levels were measured on day 11th day, it was 2.2. Lithium was discontinued in the light of high lithium levels. There were no signs and symptoms of toxicity though.

Results: We make a point of Lithium can be dramatically effective in ECT resistant MDD. It can be argued that Effexor could have started effect by that time. But the temporal relationship between the start of lithium and patients response suggests that Lithium can play a pivotal role in patients with MDD resistant to ECT.

Conclusion: Lithium Augmentation should be considered in ECT Resistant Major Depressive disorder.Practicing psychiatrist should be aware of the potential of lithium to induce a therapeutic response in such patient's with MDD resistant to ECT.

POSTER 1-27

Efficacy and Safety of Lisdexamfetamine Dimesylate as Augmentation Therapy in Adults with Major Depressive Disorder Treated with an Antidepressant

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Abstract:

Objective: To evaluate the efficacy and safety of lisdexamfetamine dimesylate (LDX) used as augmentation to an antidepressant in adults with major depressive disorder (MDD).

Method: This multicenter trial enrolled adults (18-55 y) with MDD; comorbid ADHD and other Axis I disorders were excluded. Following an 8-week open-label prospective escitalopram treatment (titrated to 20mg/d), participants with persistent and residual depressive symptoms (17-item Hamilton Rating Scale for Depression [HAM-D17] score >/=4) were randomized to 6-week adjunctive treatment with double-blind LDX (20, 30, or 50mg/d) or placebo. Adults were further stratified as nonremitters (Montgomery-Asberg Depression Rating Scale [MADRS] >10) or remitters at randomization to augmentation (week 8). Efficacy assessments were mean change from week 8 in MADRS total score (primary, analyzed by ANCOVA in nonremitters, with prespecified 2-sided significance level of 0.10); HAM-D17; Clinical Global Impressions-Severity (CGI-S) and -Improvement (CGI-I); and Quick Inventory of Depressive Symptomatology-Self Report (QIDS-SR). Safety assessments included treatment-emergent adverse events (TEAEs), systolic (SBP) and diastolic (DBP) blood pressure, pulse, ECG, and laboratory findings.

Results: Of 246 enrolled adults, 239 received open-label treatment and 173 received randomized treatment: 129 nonremitters (65 LDX; 64 placebo) and 44 remitters (23 LDX; 21 placebo). Of 89 adults withdrawing early, 20 withdrew during randomized treatment (6 [3.5%] due to TEAEs). During randomized treatment, 61.8% (107/173) were female; 76.9% (133/173) were white. The mean (SD) MADRS total scores for nonremitters at point of randomization to augmentation (week 8) were 20.3 (7.16) and 20.8 (6.42) for LDX and placebo groups, respectively. At endpoint (week 14) of randomized treatment, least squares mean (SE) change from week 8 was significantly greater (P=.0902) with LDX (-7.1 [0.93]) versus placebo

(-4.9 [0.94]) in nonremitters). No differences were found for remitters. For adults receiving randomized treatment, 60.2% (53/88) on LDX and 49.4% (42/85) on placebo had TEAEs; 1 serious TEAE during randomized treatment occurred in an adult receiving placebo. TEAEs with an incidence >/=5% for LDX vs placebo, respectively, were dry mouth (11.4% vs 0%); headache (11.4% vs 4.7%); decreased appetite (6.8% vs 2.4%); nasopharyngitis (5.7% vs 3.5%); and insomnia (4.5% vs 7.1%). Mean (SD) change from week 8 to 14 in SBP, DBP, and pulse for LDX was 2.3 (9.04) mmHg, 0.9 (6.61) mmHg, and 3.3 (8.45) bpm, respectively. No clinically significant mean changes were seen in ECG and laboratory findings.

Conclusion: Augmentation with LDX for adults with MDD and residual symptoms on escitalopram met prespecified signal detection parameters. Further studies are needed. The safety profile of LDX was consistent with prior LDX ADHD studies and long-acting stimulant use. Clinical research was funded by the sponsor, Shire Development Inc.

POSTER 1-28

Impact on Health-Related Quality of Life of Selecting Aripiprazole for Treatment of Depression: Results from the National Health and Wellness Survey

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Abstract:

Introduction: Use of atypical antipsychotics (AA) in combination with an antidepressant is recommended as an augmentation strategy for patients with depression. However, there is a paucity of data comparing aripiprazole and other AAs in terms of patient reported outcomes such as health-related quality of life (HRQoL).

Objective: To determine if there are differences in HRQoL between those patients who receive aripiprazole compared to those who receive another AA for treatment of depression.

Methods: Data were obtained from the 2009 and 2010 National Health and Wellness Survey (NHWS), a cross-sectional, internet-based survey that is representative of the adult US population. Only those patients who reported being diagnosed with depression by a physician and taking an antidepressant and AA for depression were included. Patients taking AA for less than 2 months or who were diagnosed with bipolar disorder or schizophrenia were excluded. Patients taking aripiprazole were compared with patients taking another atypical antipsychotic. HRQoL was assessed using the mental and physical component summaries of the Short Form 12-item (SF-12) health survey and the SF-6D health utility. Higher scores indicate a better outcome with differences in component summary scores of 3.0 and health utility differences of 0.03 deemed clinically meaningful. Statistical analyses were conducted by controlling for demographic and health characteristics in ordinary least square regression models.

Results: Of the overall sample (n=320), 59.4% took aripiprazole (n=190) and 40.6% (n=130) took another AA [olanzapine (n=14), quetiapine (n=93), risperidone (n=13) or ziprasidone (n=10)]. Mean scores for bodily pain, general health and emotional role limitations (domains of the SF-12) were found to be significantly higher in aripiprazole users ($p < 0.05$) indicating better HRQoL in these domains compared to other AA. After controlling for demographic and health characteristics, patients taking aripiprazole reported significantly higher mean mental SF-12 component summary (34.5 vs. 31.3, p=0.018) and SF-6D utility scores (0.59 vs. 0.56, p=0.028), and a marginally higher physical component summary score (42.0 vs. 40.3, p=0.215).

Conclusion: Of those patients using an AA for depression, it was found that aripiprazole was independently associated with better (both statistically and clinically) HRQoL and health utilities.

POSTER 1-29

Does Personal Growth Initiative Mediate Treatment Response in Depression?

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Abstract:

Objective: Treatments for depression can have failure rates up to 30% despite stepwise, monitored pharmacotherapy (STAR*D 2006). Research focusing on patient strengths, including markers of resilience and self-efficacy, is needed to better characterize variables affecting outcomes in depression. Personal growth initiative (PGI) has been studied in college students to assess readiness and intentionality towards self-change (Robitschek, 1998, 1999). For students, higher scores on PGI predict better psychosocial functioning (Robitschek & Keyes, 2009). For the current study, researchers hypothesized that PGI might predict severity of depressive symptoms, as well as predict response to treatment.

Methods: Researchers performed a retrospective chart review of patients admitted to the Rhode Island Hospital Partial Hospital Program between January 2008 and January 2010. Inclusion criteria included a diagnosis of depressive disorder presenting with an acute exacerbation meriting partial hospital level of care. Exclusion criteria included presence of psychotic symptoms, comorbid psychotic disorder or bipolar disorder.

Results: Among 1,341 patients admitted to a partial hospital program with depression diagnoses, those with higher PGI scores entered treatment with significantly (and considerably) lower levels of depression than their low PGI counterparts. Levels of depression for patients in the uppermost quartile at admission were similar to patients in the lowest quartile at discharge (M=29.95 and 27.22, respectively), supporting the PGI dimension of Using Resources. All quartiles showed significant, important improvement in depression by discharge.

PGI, however, did not predict treatment response beyond variance accounted for by admission level of depression. Additional analyses report on PGI subscales and diagnostic/demographic subgroups in the sample.

Conclusions: Research has highlighted the need for effective treatments for treatment-resistant depression, which is defined as lack of symptom remission after two trials of antidepressant medication therapy. However, relatively little is known about factors mediating symptom severity and treatment response. Future study in the area of patient strengths is needed to better predict outcomes in depression.

POSTER 1-30

Early Improvement Predicts Later Outcome in Manic or Mixed Episodes Associated with Bipolar I Disorder: Post Hoc Analyses of Asenapine Studies

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Abstract:

Objective: Early symptomatic improvement is a clinically useful indicator of later individual treatment outcome in unipolar depression, bipolar depression, and schizophrenia. We performed pooled, post hoc analyses of 2 asenapine clinical trials to assess whether early improvement of manic symptoms predicts outcome in a population of bipolar I disorder patients experiencing acute manic or mixed episodes.

Methods: Data were pooled from the intent-to-treat populations of two 3-week randomized, double-blind trials [NCT00159744 and NCT00159796]. Patients were administered flexible-dose sublingual asenapine (5 or 10 mg twice daily; n=372), oral olanzapine (5–20 mg once daily; n=391), or placebo (n=197). Early improvement, defined as reductions from baseline Young Mania Rating Scale (YMRS) total score using cutoff values of > or =15%, > or =20%, and > or =25%, was assessed in each patient at days 2, 4, and 7. Week 3 treatment outcomes included response (> or =50% YMRS total score reduction) and remission (YMRS total score < or =12). Associations between early improvement and treatment outcome were calculated using Fisher exact tests; odds ratios classified their relative strength. Sensitivity (SN), specificity (SP), and positive (PPV) and negative (NPV) predictive values were also calculated as previously described by Szegedi et al (J Clin Psychiatry 2009;70:344–353). Missing treatment outcomes for individual patients were treated as treatment failures.

Results: Early improvement was strongly associated with positive treatment outcome in all analyses. The earliest positive associations across all cutoff values studied were observed with asenapine at day 2 for both response (all P<0.04) and remission (all P<0.007), olanzapine at day 4 for response (all P<0.02) and day 2 for remission (all P<0.002), and placebo on day 7 (response, all P<0.003; remission, all P < or =0.0005). Odds ratios for early improvement leading to positive outcome for all cutoff values were higher for asenapine (1.8–9.1) than for olanzapine (1.4–3.5) and placebo (1.3–8.0) in the majority of analyses performed. Respective remission values for SN, SP, PPV, and NPV at day 4 at the > or =15% cut-off were 80%, 58%, 48%, and 85% for asenapine; 76%, 43%, 49%, and 71% for olanzapine; and 50%, 67%, 31%, and 82% for placebo.

Conclusion: Early improvement was strongly associated with response and remission at week 3 in patients treated with asenapine or olanzapine, with the high NPV indicating little chance of stable remission in the absence of early improvement. Thus, information obtained after 2–4 days of treatment with asenapine or olanzapine may be clinically useful for assessing whether a patient will benefit from a recently initiated treatment. (This research was supported by Merck, Whitehouse Station, NJ.)

POSTER 1-31

WITHDRAWN

POSTER 1-32

Transsexualism and Borderline Personality Disorder: A Coerralative Case Study

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Abstract:

Background: The following case illustrates the clinical relationship between GID and BPD, while re-evaluating DSM-IV-TR criteria and research studies associated with these disorders. In a study of personality traits among the transsexual population, a researcher found a direct link between transgender patients and BPD. In a population of 19 transsexual patients, 8 were found to have personality disorders within the Cluster B category. Of the 8 patients, the highest subgroups were found to be male to female transsexuals (MtF) with borderline personality. Another study of 50 patient study aimed to assess the prevalence of Axis II comorbidity in transsexual patients. The researchers found 26 patients (52%) to have personality disorders and 22% to be within Cluster B. Of this population, 20 patients (77%) were MtF and 3 patients were found to have BPD.

Methods: We will discuss the highlights of the above scenario in a case. D.M. is a 25 year old Hispanic, single, transgender male who prefers to be referred to as a female and lives with her friend in Buffalo. She is the biological father of a 5-year-old daughter and works as a part-time female prostitute. She was escorted to the ER by her parents due to depressed mood and suicidal ideation with a plan to overdose on drugs. The patient has a history of mood disorder not otherwise specified and polysubstance abuse. She had two inpatient hospitalizations with her last discharge from Bergen Regional Medical Center in 2006. She is noncompliant with her treatment or follow-up plan. She has a history of self-mutilating behavior such as cutting herself with knives and razor blades whenever she feels depressed or is questioned about his gender. Her last incidence

was when she cut her right thigh two days prior to this visit. Reportedly, the patient admitted to abusing alcohol, cocaine, cannabis, and opiates for five years on and off, and relapsed one month ago after three years of abstinence. She admitted to having auditory hallucinations while intoxicated. The patient reports feeling depressed, hopelessness, helplessness and having decreased energy and sleep. She discloses that these feelings are predominately when she thinks about her current male gender. She had no change in appetite, history of manic or psychotic changes and no homicidal ideations. She has a history of DWI and arrest for public alcohol intoxication. She provided a detailed history beginning with her desire to dress in her mother's clothing at the age of four and suffered childhood sexual abuse. She lived as a male during her adolescence to avoid abandonment from her family and peers. She frequently entered intense interpersonal relationships depicted by her dependence on men for her financial support and drug abuse. She feels that she cannot be content until she completes the gender change, which will stabilize her extreme idealization and devaluation thought processes. She illustrated depressive symptoms predominately when she thinks about her current male gender. She resorted to self-mutilating behavior when she feels hopeless. After treatment, she was compliant with her recommended plan, improved to a satisfactory level, and was deemed no longer a threat to self or others. She was discharged in stable condition and denied any psychotic symptoms.

Result/Conclusion: In this presentation the findings and plan, along with a review of the literature will be discussed.

POSTER 1-33

Acromegaly-Induced Depression: A Case Study

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Abstract:

Background: Different theories have been postulated to find a connection between GH excess and depression and how it affects health-related quality of life. The somatotropic system interacts with cognition, mood, and wellbeing Scientists' have postulated that there is some evidence that Growth Hormone Secretion is influenced by biogenic amines of the hypothalamus; dopamine, serotonin and nor-adrenaline, as well as by many peptides, notably neuropeptides with opiate like activity such as beta endorphin, alpha endorphin, and met enkephalin. The theories have been postulated in finding a link between depression and Acromegaly. Among these includes a theory that suggests that the dopaminergic mechanism in the median eminence, and the nor-epinephrine site in the hypothalamus, may be involved in the regulation of growth hormone secretion. It also postulates that the increase in growth hormones may be due to an imbalance of these neurotransmitters, which is an indicator of depression.

Methods: We will discuss the highlights of the above scenario in a case. The patient is a 58 year old, single Caucasian female of middle socioeconomic class, who previously resided in a suburban neighborhood. At the age of 7 it was first noticed that she was unusually tall, as compared to her peers in her class. Multiple work ups were done but no definite diagnosis had been established at that time. She had noticed changes in her features, such as enlarged facial features, large hands, large feet and her increasingly height of 6feet 5 inches. No treatment nor any further investigations were sought out. Consequently, this made her to become very isolated and her parents to become over protective of her. She then graduated from nursing school and was able to establish a career in a prestigious hospital. To overcome her insecurities and low self-esteem, she joined the "Tall Club" and, as a result, was able to establish and build friendships. The patient had also established a relationship that had lasted 5 years. The patient, who continued to work for twenty years, began to notice feelings of depression once the "Tall Club" had come to an end. Within that same year her mother had become very ill; at this time the patient had started to work part-time. When her mother passed away, the patient felt very alone. Unable to keep up with her medical issues, and unable to pay her rent, the patient was evicted from her home and suddenly found herself homeless. The patient had reported feeling depressed for the past week due to financial stressors. She had suicidal ideation with no plan. Her sleep had decreased for less than 3 hours per night. The patient had reported feelings of helplessness, hopelessness and anhedonia. The patient had no homicidal ideations. No symptoms of mania, psychosis auditory hallucination, visual hallucination, and substance abuse were reported. The patient had already been on antidepressants which she had ran out of eventually due to financial reasons. Neither history of suicidal attempts, nor any homicidal attempts have been reported. The patient has a past medical history of polycystic ovarian disease, hypertension, an over active bladder, and spinal fusion of C4 and C5.The patient is currently being treated with aripriprazole, buproprion extended release and sertraline. The patient has shown improvement and is compliant with her medication.

Result/Conclusion: The case and literature review will be dicussed.

POSTER 1-34

Stress During Development Alters Hippocampal Neurotransmission in a Gender- and Age-Dependent Manner

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Abstract:

Methods: Wistar rats of both genders were deprived (DEP) of the mother on days 3 or 11 of age (DEP3 or DEP11) and submitted to one inescapable foot shock session (2mA, 10s) at 45 days of age. When adults, animals were euthanized

and monoamines and amino-acid neurotransmitters were quantified in the hippocampus using the HPLC method.

Results: DEP3 males exhibited higher GABA concentrations, whereas DEP11 showed increased noradrenaline and decreased taurine and GABA concentrations. In females, maternal deprivation on day 3 decreased noradrenaline, histamine, aspartate and GABA. These alterations were also observed and were more remarkable when maternal deprivation took place on day 11, including a reduction of taurine levels. Foot shock reduced 5-HIAA and glutamate levels in all male rats and glycine in females (medium-term effect).

Conclusion: Maternal deprivation, especially at 11 days of age, resulted in changes in hippocampal neurotransmission that are compatible with the neurobiology of anxiety, whereas foot shock during puberty produced changes compatible with depression. These results suggest that adversity in different periods of the development may represent a vulnerability factor for distinct psychopathologies.

POSTER 1-35

Burnout Among Psychiatrists and Pediatricians at LAC+USC Medical Center

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Abstract:

Objective: To identify the prevalence of burnout among staff and resident psychiatrist and pediatricians at LAC+USC Medical Center.

Methods: The Maslach Burnout Inventory, a 22-question instrument designed to assess three components related to burnout: emotional exhaustion (EE), depersonalization (DP), and personal accomplishment (PA) as well time spent feeling depressed while at work was administered to residents and staff at LAC+USC Medical Center in April 2011 (N=92 with 44 psychiatrist and 48 pediatricians).

Results: There was a statistically significant difference in depersonalization between psychiatrists and pediatricians, with psychiatrists having a higher level of depersonalization. Among all psychiatrists (residents and staff), there were no statistically significant differences among the three categories (emotional exhaustion, depersonalization or personal accomplishment) by level of experience. Within pediatrics, however, there were statistically significant differences among residents and staff in regards to emotional exhaustion ($p = 0.02$) as well depersonalization ($p < 0.01$), and more days depressed at work ($p = 0.02$), with all three being higher among residents than staff. Seventy percent of psychiatrists were categorized as having moderate to high levels of burnout.

Conclusion: Data suggests that the psychiatrists may be at greater risk for burnout than physicians in other specialties. Also, residency may be less of a factor in burnout for psychiatry than other specialties, such as pediatrics. Psychiatrists at LAC +USC have higher levels of burnout than previously reported for psychiatrists which was 66% by Kumar et. al in 2007.

POSTER 1-36

Wife Abuse and Prediction of Menatl Health Among Women in Tabriz, Iran

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Abstract:

Introduction: Domestic violence represents a wide range of social problems in mothers and their children, but most of exposed women never identified by health-care systems. According to researches, female victims of domestic violence experience severe outcomes like depression and suicide, four times more than other women. Regarding the importance and majority of the problem, this study, estimated the prevalence of wife abuse among women referred to urban health clinics affiliated to Tabriz University of Medical Sciences, as well as predicted the possibility of women's mental health dimensions of wife abuse by their deals.

Methods: This descriptive cross-sectional study with a sample size of 600 married women referred to urban health clinics performed using questionnaire containing demographic questions and General Health Quality 28 scale, as well as questionnaire of wife abuse. Covering all districts of socio-economic variety, the whole 34 urban health clinics in Tabriz were used to gather data. Using proportional sampling, each clinic related sample size was estimated. Data analysis was carried out through correlation Tests, U Mann-Whitney Test and Regression, using SPSS 16.

Results: Based on data analysis, prevalence of each of the dimensions of wife abuse, consist of less severe physical abuse(36.8%), verbal-mental abuse(60.3%), rights and divorce related rights(0.8%), sexual abuse(9.3%), financial abuse(13.8%), prohibition of social-educational and development(69.3%). There was statistically significant difference between exposed and non-exposed women ($P<0.01$). According to the Regression Test (Stepwise Method), the variables namely verbal-mental abuse, severe physical abuse, and financial abuse predicted 27% of GHQ-28 variance.

Conclusion: Substantial connection between wife abuse and General Health Quality provokes to commence intellectually actions so as to primary and secondary prevention at the level of individual and society.

Keywords: Wife Abuse, General Health, Tabriz

POSTER 1-37

Clinical and Demographic Profile of Repeatedly Violent Patients in an Acute Psychiatric Hospital: A One-Year Retrospective Study

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Abstract:

Introduction: Despite extensive research on inpatient violence, only a limited number of studies have examined demographic and clinical profiles of psychiatric patients who are repeatedly violent (Lussier et al, 2010, Flannery, 2002, Blow, 1999). Several studies (Quanbeck, 2007, El-Bardi, 2006, Davis, 1991, and Beck et al., 1990) have shown that repeatedly violent patients may have different clinical characteristics from the patients who are less violent. However, these findings are not consistent across setting and patient populations. Given these discrepancies, the objective of this study was to determine if psychiatric patients who engaged in multiple episodes of inpatient violence demonstrate different demographic and clinical profiles from non-violent inpatients.

Method: This study is a retrospective case control study of patients with multiple episodes of violence on inpatient psychiatric units and a randomly selected equal sample of non-violent patients. The data were collected from incident reports filed over the course of one year (January 2009 through December 2009). The sample of repeatedly violent patients on the inpatient psychiatric unit was defined as the patients who committed three or more violent acts in the hospital during the whole period of one or more hospitalizations, within the study period. A violent behavior/act was identified as a completed act or an attempt to physically harm staff and/or other patients and/or damage to property. The record review identified 80 inpatients who committed violent acts within the study period. Thirty of these patients exhibited three or more episodes of violence constituted the repeatedly violent group. Thirty randomly selected non-violent patients who were on the inpatient unit during the same study period was chosen and analyzed for comparison.

Results: The patients with a history of multiple violent episodes are significantly more likely to be male, have a diagnosis of a major psychotic disorder, have a comorbid diagnosis of mental retardation, and have personality disorders. With regard to past history, patients with multiple violent episodes are significantly more likely to have a history of physical/sexual abuse, long-term psychiatric hospitalizations, and multiple past psychiatric hospitalizations. Finally, patients with multiple episodes are more likely to require seclusions and restraints than the control group.

Conclusion: the present study suggests that psychiatric patients who engaged in multiple episodes of inpatient violence have distinct demographic and clinical profile compared to non-violent controls. The results are discussed in light of the literature on the inpatient violence.

POSTER 1-38

Improving Culturally Competent Practice with Underserved Populations: Lesbian Survivors of Intimate Partner Violence

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Abstract: Current domestic violence policy and legislation are grounded in feminist theories that have historically defined domestic violence as a manifestation of a patriarchal culture's sexual dominance of women (Figes, 1970; Millett, 1970). Early feminist domestic violence theory insisted that, as the most pervasive ideology of our culture, sexual domination defines the concept of power, thus declaring the rights of men as superior to the women they control (Figes, 1970). The assertion that the relations between men and women are not merely personal, but are inherently political jumpstarted the feminist movement aimed at naming and criminalizing domestic violence (Dworkin, 1974). Additionally, radical feminism strengthened these arguments by insisting that, globally, the most pervasive form of oppression is sexism and that the dynamics of this oppression can be seen in men's use of violence against women (MacKinnon, 1987). These theories have provided the foundation for the social recognition of a global epidemic of culturally sanctioned violence against women. The resulting intervention has focused primarily on responding to crises and providing shelter to survivors as well as using the criminal-justice system to regulate and mediate violence within intimate relationships (Erez, 2002; Walker, 2002). Unfortunately, this theoretical perspective does little to explain violence within same-sex relationships (Renzetti, 1998; Ristock, 2000). Without a theoretical understanding to frame and validate the abuse, many domestic violence agencies have remained uninformed about the prevalence of same-sex IPV and, as a result, have not effectively acknowledged or addressed it (Ristock, 2003; Simpson & Helfrich, 2005). Despite research that suggests that lesbian IPV is as pervasive as IPV in heterosexual relationships (National Coalition of Anti-Violence Programs, 2002), there continues to be a pronounced disparity in the provision and accessibility of services for lesbian survivors (Jones & Hill, 2002; Renzetti, 1996). Additionally, much of the research that has examined this problem has focused on those lesbians who have been accessible to researchers, for example, women who have access to establishments of lesbian culture and women who have the knowledge to seek out services. Unfortunately, this has resulted in the perhaps unintentional exclusion of lesbians living in rural communities, lesbians of color, immigrant lesbians, and lesbians who have fewer economic resources.

Lesbians have cited a lack of inclusiveness within service agencies as a primary reason for deciding not to seek support (Lie & Gentlewarrier, 1991; Renzetti, 1989; Renzetti, 1992). Preliminary research into the policies and practice of service agencies has confirmed their concerns. For example, in a survey of 566 domestic violence agency staff, Renzetti (1996)

revealed that regardless of agency stance, many service providers avoided the provision of services to lesbians by neglecting to directly address lesbian battering. Over 50% of study respondents reported that they had not received training on same-sex partner violence, despite this being a critical recommendation for enhancing service from leading anti-violence groups (NCAVP, 2002). Subsequent research has revealed that there are a variety of barriers to service providers being able to effectively provide services to lesbian survivors of IPV; including a lack of knowledge, feelings of helplessness and lack of preparedness, misperceptions of the prevalence and dynamics of IPV in lesbian relationships, and limitations imposed by a lack of resources (Simpson & Helfrich, 2005). Additionally, as a result of these barriers, recommendations have been made to service providers on how to improve their ability to provide services to all women, regardless of sexual orientation (Helfrich & Simpson, 2006).

Consistent with the theoretical suppositions of multicultural feminism, there are additional barriers that result when a lesbian, who is oppressed by the heterosexist society in which she lives, is also impacted by other forms of inequality, for example, racism, class privilege or disability status (Butler, 2005; Sokoloff & Dupont, 2005). Although IPV certainly affects all women, there is research to suggest that it may not affect all women equally. For example, Browne & Bassuk (1997) found that a large number of homeless women were survivors of IPV and Lyon (2002) revealed that more than half of women receiving government assistance were also survivors of IPV. Other research has demonstrated that poverty is highly predictive of violence against women (Feldman & Ridley, 1995). This indicates that perhaps IPV has particularly severe consequences for low-income women. Additionally, ethnic and racial minority members' negative experiences with the dominant culture's social institutions influence their views of service accessibility (Jiwani, 2005).

POSTER 2-1

Use of Repeated Physical Restraints on Inpatient Psychiatric Units

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Abstract:

Objective: The use of physical restraints on inpatient psychiatric units is generally considered a last intervention in ensuring patient and staff safety. The aim of our study is to identify clinical and demographic variables that place patients at greater risk of being repeatedly restrained on acute inpatient psychiatric units. We compared the characteristics of patients who were placed in restraints more than twice in a single hospitalization to the characteristics of patients placed in restraints only once during hospitalization.

Methods: We performed a retrospective chart review of patients admitted to Temple University Hospital's Episcopal Campus acute inpatient psychiatric units between September 1, 2004, and September 30, 2010. Patients were categorized by age and gender. They were analyzed by ethnicity, length of hospitalization, Axis I and Axis II discharge diagnoses, reason for restraint, length of restraint time and the total number of restraint episodes. Reasons for restraint included "physical aggression against property", "physical aggression against self", "physical aggression against others" and "disruption of milieu".

Results: We identified 70 patients who were placed into physical restraints on more than two occasions during a single hospitalization. We matched 70 cases of repeated restraints by age and gender to 70 cases of single restraint episodes. Patients who were restrained multiple times averaged 4.9 restraint episodes during their stay. We found the length of stay for patients who were repeatedly restrained to be 2.5 times longer than for those restrained only once. Patients with multiple restraints also remained 1.5 times longer in restraints per episode. Axis I disorders did not affect the number of restraint episodes, but patients with mental retardation were more likely to be restrained multiple times. The single restraint group was more likely to have only one reason for restraint, whereas patients with multiple restraints were more likely to have all four reasons documented throughout their hospitalization. The most common reason for restraint was "physical aggression against others".

Conclusions: Several factors contribute to the use of repeated physical restraints. The correlation with longer lengths of stay raises the possibility that patients who are restrained more frequently tend to have more severe pathology. However, the extended time per restraint episode and the fact that mentally retarded patients are more likely to be restrained multiple times raises the concern of unchecked countertransference and the possible underutilization of other interventions such as behavioral treatment plans which could decrease the frequency and duration of physical restraint. Given the significant morbidity associated with the use of restraints, educational programs which address these factors are essential.

POSTER 2-2

Early Intervention in Suicide Prevention Focusing on Protective Factors

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Abstract: Suicide risk assessment has become increasingly refined and utilized in public and private medical and psychiatric facilities across the nation. This increase is particularly apparent within the Department of Veterans Affairs Medical Centers, where high suicide rates have been reported in the nation's most recent cohort of military veterans, as well as in our population of aging veterans. A detailed "Suicide Risk Assessment" (SRA) is routinely administered by VA service providers at critical times, e.g., during life and psychiatric crises, when a patient reports hopeless feelings and depression symptoms, and on a routine, yearly basis. Identifying and reinforcing a primary care patients suicide protective factors, e.g.,

responsibilities toward children and family, optimism, hope, and positive coping skills, spiritual, moral, and religious factors, social supports and positive therapeutic relationships, etc., may allow clinical staff to lessen the impact of crises and depression, and reduce his/her risk for suicide risk. The current, ongoing study involves screening primary care patients for suicide risk, by way of the PHQ-2. Upon scoring positive on any two SRA items, the patient is invited to a 4 week peer-led therapy group aimed at providing social support and educating patient participants on the importance of these protective factors and ways to integrate the factors more fully into their lives and ongoing awareness. Prior to the entering the group, each participant is administered the "Reason for Living Scale" and the Hamilton PHQ-9 scale, for risk assessment and to identify symptoms and current protective factors. The scales are re-administered after the participant's last session. Data collected thus far are encouraging and show that, by enlisting their participation in a low-intensive, peer-led therapy group, primary care patients can become less vulnerable for suicide.

POSTER 2-3

The Relationship Between Physical Conditions and Suicidal Behavior Among Those with Mood Disorders

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Abstract:

Background: There has recently been increased interest in the relationship between physical illness, mental illness, and suicide. The present study utilizes a large community-based sample to investigate the association between certain physical conditions and suicidal behavior, among those with a history of a mood disorder.

Methods: Data came from the nationally representative German Health Survey (N= 4181, age 18-65). Physical conditions were assessed by a general practice physician. DSM-IV mental disorders were assessed using a modified version of the Composite International Diagnostic Interview. Among those with a lifetime mood disorders, suicidal ideation, plans, and attempts were assessed by self-report. Multiple logistic regression analyses were used to examine the association between physical conditions and suicidal behavior among those with a history of mood disorder.

Results: Anxiety and substance use disorders were significantly positively associated with suicidal behavior [OR 1.61, 95% CI 1.13 – 2.31 and 2.01, 95% 1.34 – 3.00, respective-ly]. After adjusting for anxiety and substance use disorders as well as sociodemographic variables, respiratory illness, hypertension, and number of physical disorders were significantly associated with suicidal behavior [AORs 1.72, 1.68, and 1.16, respectively].

Limitations: The findings of this study are limited to adults with a history of a mood disorder. Personality disorders were not assessed.

Conclusion: The present study suggests that among people with mood disorder, respiratory illnesses, hypertension, and number of physical conditions are associated with suicidal behavior independent of the effects of comorbid mental illness. Clinicians should recognize the contributing risk of physical health problems to suicidal behavior.

POSTER 2-4

WITHDRAWN

POSTER 2-5

Neurological Soft Signs in Nigerian Patients with Schizophrenia and Unipolar Depression: A Controlled Study

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Abstract:

Background: Neurological soft signs (NSS) are subtle motor and sensory anomalies elicited through a comprehensive neurological examination. They are non-localizing of any cerebral lesion and are rather thought to be indicators of diffuse brain damage. Several reports have shown a higher prevalence of NSS in schizophrenic patients compared to normal individuals. However, research also suggests that NSS are to be found in a number of other psychiatric disorders, but to a lesser degree. Some studies of NSS in mood disorders for instance, quote prevalence estimates as high as 52%. Studies of NSS in mood disorders are however very few and most of them employed very small sample sizes. Fewer studies still, have directly compared NSS in schizophrenia and mood disorders and only one such study has been reported from Africa. Studies of NSS in psychiatric disorders can add to our knowledge of the role of brain dysfunction in the evolution of psychiatric morbidity.

Aim and Objectives: This study investigated the prevalence of NSS in schizophrenia compared to unipolar depression. It also explored the relationships between NSS and sociodemographic variables as well as clinical dimensions in schizophrenia.

Method: The study was carried out amongst inpatients at the psychiatric unit of the University College Hospital (UCH) Ibadan, Nigeria. The study sample included 50 patients with schizophrenia, making up the experimental group and a control group of 50 patients with unipolar depression as well as another 50 subjects with no psychiatric morbidity. Patients' diagnoses were established using SCID-IV. NSS was evaluated using the Neurological evaluation scale. Sociodemographic variables were obtained for subjects in the three groups and for subjects with schizophrenia, additional data around clinical dimensions were obtained. Data analysis was done using the statistical package for the social sciences SPSS 12. Mean and standard deviation were used to summarize continuous variables and proportions were used to summarize categorical variables. Prevalence rates were compared with the X 2 test. Odds ratio was used to show the strength of the associations. Neurological evaluation scale (NES) sum scores were

compared with other sub categories of interest between groups using the non-parametric Mann – Whitney and Kruskal – Wallis tests.

Results: Median NES scores were 9.75 for schizophrenia, 5.75 for unipolar depression and 3.00 for normal control subjects. At a cut of point of 2 on the Neurological Evaluation Scale (NES), the prevalence of NSS among subjects with schizophrenia was 76%, compared to 58% in unipolar depression and 42% in normal individuals. The difference was statistically significant. In the 3 Neurological sub-categories of interest – sensory integration, motor coordination and sequencing of complex motor acts, the schizophrenia group performed more poorly than control. Lower socioeconomic class was associated with high NES scores in the schizophrenia group. Clinical dimensions were not significantly associated with high NES scores in the schizophrenia group.

Conclusion: The high prevalence of NSS in schizophrenia and lower preevalence in unipolar depression appear to suggest a stronger influence of neurodevelopmental dysfunction in the pathogenesis of schizophrenia. This influence might be manifest in schizophrenia, as a matter of degree, in that the study showed NSS to be evident in both unipolar depression and normal subjects.

POSTER 2-6

Baseline Prolactin Levels in Patients with Schizophrenia Taking Paliperidone ER, Paliperidone Palmitate, or Risperidone Consta Therapy

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Abstract:

Objective: Existing literature suggests that subjects treated with Paliperidone ER, Paliperidone Palmitate, or Risperidone Consta therapy may have elevated prolactin levels, which may cause certain side effects including sexual dysfunction and galactorrhea. The prolactin screening results of patients with schizophrenia taking Paliperidone ER, Paliperidone Palmitate, or Risperidone Consta are reported here.

Method: We conducted a 4-week randomized, double-blind, placebo-controlled prospective trial with a 4-week follow-up assessment of amantadine 100 mg, 200 mg, or placebo taken twice daily in patients with schizophrenia who are treated with Paliperidone ER, Paliperidone Palmitate, or Risperidone Consta to examine amantadine effects on fasting serum prolactin levels. Prolactin levels were assessed at screening; to meet the study eligibility criteria, subjects' screening prolactin levels had to be = 2x upper limit of normal (ULN) [35.4 ng/mL for men, 58.4 ng/mL for non-pregnant women, 40.6 ng/mL for post-menapausal women].

Results: The mean age at screening was 43.14 years (SD = 10.95); 68.2% (n=15) were male and 31.8% (n=7) were female; 59.1% (n=13) were Caucasian, 31.8% (n=7) were African-American, 4.5% (n=1) were Asian, and 4.5% (n=1) other. The majority (72.7%, n=16) of patients were taking Risperidone Consta, 22.7% (n=5) were taking Paliperidone ER, and 4.5% (n=1) were taking Paliperidone Palmitate. Of the 22 screened subjects, 15 screen-failed because prolactin levels did not meet eligibility criteria (68.2% of screened subjects) and 13 of the 15 screen fails had prolactin levels within the normal range. Among females, 2 (28.6%) were in the normal range and 5 (71.4%) had abnormal prolactin levels. Based on 2xULN, 3 (42.9%) were not eligible and 4 (57.1%) met eligibility criteria. However, among males, 9 (60%) were in the normal range and 6 (40%) had abnormal prolactin levels. Based on 2xULN, 12 (80%) were not eligible and 3 (20%) met eligibility criteria. Regarding antipsychotic medication, there was a statistically significant relationship between antipsychotic medication and meeting eligibility criteria of 2xULN (Fisher's Exact = 6.308, p=.021) where 80% (4) of patients taking paliperidone ER met eligibility criteria whereas 81.3% (13) of patients taking risperidone consta and 100% (1) taking paliperidone palmitate did not meet eligibility criteria. When examining factors that correlated with prolactin levels such as age, length of time on antipsychotic medication, waist circumference, and BMI, only BMI was approaching significance (r =.411, p=.057).

Conclusion: The data give some indication of prevalence of varying degrees of elevated prolactin levels among patients with schizophrenia. Our results indicate the possibility of gender differences in prolactin elevation. Additionally, weight gain is frequently associated with elevated prolactin levels and therefore an increase in BMI may be related to the effects of antipsychotic drug-induced hyperprolactinaemia. Clinicians tend to either reduce the dose or discontinue a patient's antipsychotic medication based on elevated prolactin levels. However, drug discontinuation or dose reduction could greatly increase the risk of relapse or exacerbation of psychiatric symptoms. Therefore, future research is needed to understand the true prevalence of elevated prolactin levels among patients with schizophrenia.

POSTER 2-7

Incidence, Onset, and Duration of Treatment-Emergent Somnolence with Asenapine in Adult Patients with Schizophrenia or Bipolar Disorder

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Abstract:

Objective: Somnolence (including sedation and hypersomnia) may occur with antipsychotic use. This effect may be beneficial in some clinical situations (eg, for managing acute agitation), but when pronounced and prolonged it may be experienced as an adverse event (AE). We assessed somnolence in placebo- and/or active-controlled asenapine schizophrenia and bipolar I disorder trials to understand its incidence, onset, and duration.

Methods: We examined 5 cohorts. Schizophrenia data were from 4 short-term (6 wk) trials (asenapine, n=572; placebo, n=378; risperidone, n=59; olanzapine, n=194; haloperidol, n=115), a long-term (52 wk) safety trial (asenapine, n=908; olanzapine, n=311), and 2 long-term (26 wk) trials in patients with persistent negative symptoms (asenapine, n=485; olanzapine, n=464). Bipolar I disorder data were from 2 short-term (3 wk) trials (asenapine, n=379; placebo, n=203; olanzapine, n=394) and a 12-week trial of asenapine as adjunct therapy to mood stabilizers (asenapine, n=158; placebo, n=166). Treatments were: asenapine 5 or 10 mg BID, risperidone 3 mg BID, olanzapine 5–20 mg QD, haloperidol 4 mg BID. Incidence, time to onset, and duration of treatment-emergent somnolence as an AE were assessed in the treated populations.

Results: For schizophrenia, incidence of somnolence was higher for asenapine vs placebo in short-term trials (asenapine, 13.1%; placebo, 6.9%; active controls, 5–20%) and comparable to olanzapine in 3 long-term trials (asenapine, 18.4–18.5%; olanzapine, 19.6–21.1%). In those reporting somnolence as an AE, severe somnolence was infrequently reported (0–8%). Somnolence onset (median [days]) occurred early in short-term (asenapine, 2.0; placebo, 7.0; active controls, 2–6) and long-term (asenapine, 9.0; olanzapine, 7.5–9.0) trials; median somnolence duration (days) was relatively brief in short-term (asenapine, 15.0; placebo, 4.5; active controls; 3.0–22.5) and long-term (asenapine, 22.0–25.0; olanzapine, 21.0–25.0) trials. For bipolar I disorder, incidence of somnolence was higher for active treatment vs placebo in short-term (asenapine, 23.8%; placebo, 6.4%; olanzapine, 26.4%) and adjunctive therapy (asenapine, 24.1%; placebo, 10.2%) trials. In those reporting somnolence as an AE, severe somnolence was infrequently reported (0–3%). Somnolence onset (median [days]) occurred early in short-term (asenapine, 1.0; placebo, 2.0; olanzapine, 1.0) and adjunctive therapy (asenapine, 1.5; placebo, 2.0) trials and was of brief duration in short-term (asenapine, 7.0; placebo, 5.0; olanzapine, 8.5) and adjunctive therapy (asenapine, 12.5; placebo, 7.0) trials.

Conclusions: With asenapine, treatment-emergent somnolence typically had a median onset of 1–9 days and persisted for 1–4 weeks. The early onset and limited duration of treatment-emergent somnolence associated with asenapine and the active controls from the same trials may be advantageous in a clinical setting. (This research was supported by Merck, Whitehouse Station, NJ.)

POSTER 2-8

Long-Term Safety and Tolerability of Lurasidone in Schizophrenia or Schizoaffective Disorder: A 12-Month, Double-Blind, Active-Controlled Study

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Abstract:

Objective: The objective of this study was to evaluate the long-term safety and tolerability of lurasidone in the treatment of schizophrenia or schizoaffective disorder.

Methods: Adult outpatients who met DSM-IV criteria for chronic, stable schizophrenia were randomized, in a 2:1 ratio, to 12 months of double-blind treatment with flexible-doses, administered once-daily, of lurasidone 40, 80 or 120 mg, or risperidone 2, 4 or 6 mg. Safety and tolerability measures included adverse events (AEs), body weight, lipid parameters, prolactin, and ECGs. Efficacy assessments included the Positive and Negative Syndrome Scale (PANSS) total score and the Clinical Global Impression, Severity scale (CGI-S).

Results: The sample consisted of 427 subjects randomized to lurasidone and 202 subjects randomized to risperidone, of whom 147 (34%) completed 12 months of treatment in the lurasidone group and 89 (44%) in the risperidone group. Discontinuations due to adverse events and insufficient clinical response, respectively, occurred in 17% and 7% of subjects in the lurasidone group, and 11% and 6% of subjects in the risperidone group. The 3 most frequent adverse events in the lurasidone group (vs. risperidone) were nausea (16.7% vs. 10.9%), insomnia (15.8% vs. 13.4%) and sedation (14.6% vs. 13.9%); the 3 most frequent adverse events in the risperidone group (vs. lurasidone) were increased weight (19.8% vs. 9.3%), somnolence (17.8% vs. 13.6%) and headache (14.9% vs. 10.0%). A higher proportion of subjects had >/=7% increase in weight at LOCF-endpoint on risperidone (lurasidone vs. risperidone, 7.3% vs. 13.7%), while a >/=7% weight decrease was observed more frequently on lurasidone (13% vs. 6%). Treatment with lurasidone and risperidone, respectively, were both associated with LOCF-endpoint reductions in median cholesterol (-3.0 vs. -7.0 mg/dL; p=0.321) and triglycerides (-3.5 vs. -1.0 mg/dL; p=0.528). The median endpoint change in glucose was significantly lower for lurasidone vs. risperidone (-0.5 vs. +3.0 mg/dL; p=0.005), with a significantly greater increase in insulin observed for risperidone vs lurasidone (-0.05 vs. +1.25 mU/L; p<0.05). Median endpoint change in prolactin was minimal for lurasidone and significantly higher for risperidone (+0.1 vs. +9.1 ng/mL; p<0.001). LS mean reduction in PANSS total score was -4.7 for the lurasidone treatment group and -6.5 for the risperidone treatment group at month 12. LS mean improvement in the CGI-S was the same (-0.4) for both treatment groups at month 12.

Discussion: During this 12 month, double-blind study, treatment with lurasidone was associated with minimal effects

on weight and glucose, and a small reduction in total cholesterol and triglycerides, suggesting a low metabolic risk. Lurasidone was also associated with minimal elevation in prolactin, and no clinically significant effects on QTc. Study NCT00641745 Funded by Sunovion Pharmaceuticals, Inc.

POSTER 2-9

Inpatient Characteristics and Discharge Antipsychotic Therapy for Schizophrenia Patients Discharged to the Community vs. Other 24-Hour-Care Facilities

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Abstract:

Objective: The objective of this analysis was to describe patient characteristics and discharge antipsychotic therapy for patients with a diagnosis of schizophrenia discharged from inpatient psychiatric facilities to the community or to other 24-hour-care facilities. Secondarily, a pooled readmission rate for community-discharged patients was calculated for use in the statistical analysis plan of a follow-up chart review study of rehospitalization.

Methods: A retrospective review of all discharges for patients hospitalized with a diagnosis of schizophrenia was conducted at participating psychiatric facilities. The index discharge for each patient was defined as the first observed discharge between September 1, 2009, and August 31, 2010. Observed patient characteristics, including demographics, length of stay, and discharge antipsychotic therapy, were compared between patients discharged to the community and patients discharged to a 24-hour-care facility, such as a skilled nursing facility, correctional facility, or another hospital. Two-sample Student t tests and chi-square tests were used to compare continuous and categorical variables, respectively. The readmission rate was defined as the percentage of community-discharged patients with at least 1 readmission to the same facility within 90 days after index discharge. Readmission was not examined for patients discharged to other 24-hour-care facilities. No adjustments were made for multiplicity.

Results: Of the 1104 patients discharged from 8 psychiatric hospitals and meeting study criteria, 911 (82.5%) were discharged to community-based care. Patients discharged to the community were younger than those discharged to other 24-hour-care facilities (mean age, 39.7 years vs 42.6 years, respectively, P=0.005). No significant differences were observed in gender or length of stay preceding discharge. Community-discharged patients were more likely to have discharge antipsychotic therapy that included an injectable antipsychotic (32.7% vs 17.1%, respectively, P<0.001). Among all study patients discharged on injectable antipsychotic therapy, 73.4% also had a concomitant oral antipsychotic therapy, with similar rates observed between community and inpatient discharges (72.8% vs 78.8%, respectively, P=0.461). Approximately one-fifth (19.7%) of patients discharged to the community were readmitted at least once in the first 90 days after discharge.

Conclusions: The majority of patients with schizophrenia discharged from an inpatient psychiatric facility are discharged to the community setting. Those patients tend to be younger and more likely treated with an injectable antipsychotic than those discharged to other 24-hour-care facilities. Further research is planned on the cohort of community-discharged patients to analyze factors affecting rehospitalization. Supported by funding from Ortho-McNeil Janssen Scientific Affairs, LLC.

POSTER 2-10

WITHDRAWN

POSTER 2-11

Cognitive Performance in Patients with Acute Schizophrenia Treated with Lurasidone: A Double-Blind, Placebo-Controlled Trial

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Abstract:

Background: The results of the large.scale CATIE study suggested that atypical antipsychotic medications may not have beneficial effects on cognition. However, the CATIE trial specifically recruited clinically stable patients, did not include placebo controls, and did not require fixed doses of antipsychotic medications. The current study examined cognitive functioning in an international treatment study of unstable patients with schizophrenia (PANSS total score at baseline, mean=97.4, SD=10.5, N=482 in ITT sample).

Methods: Clinically unstable patients with schizophrenia were randomized to once.daily treatment with lurasidone 80 mg (n=125), lurasidone 160 mg (n=121), quetiapine XR 600 mg (n=120) and placebo (n=122). Lurasidone is a newly approved atypical antipsychotic medication with high affinity at D2, 5.HT2A, and 5.HT7 receptors and a side effect profile notable for limited effects on weight and metabolic parameters. Cognitive performance was examined at baseline and after 6 weeks of treatment with the computerized CogState system, which has 7 cognitive tests, including the domains of episodic memory, processing speed, and social cognition.

Results: Task completion rates averaged 94%, but data integrity failures, based on pre.planned criteria, were noted in 23% of the cases. When the entire ITT sample was examined, there were no statistically significant differences in the CogState composite score between lurasidone dose groups, the active control and the placebo group. When patients whose data failed the prespecified integrity checks were excluded, lurasidone at 160 mg was superior on the composite cognitive

functioning measure to both placebo (p=0.05, d=.25) and quetiapine (p<0.01, d=.28), while quetiapine, lurasidone 80 mg, and placebo did not differ from each other.

Conclusions: Secondary analyses of cases meeting prespecified criteria for validity of the data suggest a cognitive benefit for the higher dose of lurasidone compared to placebo and quetiapine treated patients. These findings will require replication, but cannot be attributed to practice effects because of the differential effects compared to patients who were also tested on more than one occasion. Further, the levels of data integrity failures are high compared to that of previous trials that used other cognitive assessments, such as the MATRICS consensus cognitive battery.

POSTER 2-12

Exacerbation of Psoriasis Leading to the First Onset of Psychosis – A Case Report

Deepa Hasija, M.D. (deepahasija@gmail.com)**, Sree Latha Krishna Jadapalle, M.D., Amel Badr, M.D.**

Abstract: Psoriasis is a common, chronic, inflammatory, autoimmune and hyperproliferative skin disease that affects 1.4 % to 2.0 % of the population. Literature suggests that the presence of constant itching, chronic recurrent course of disease and curtailed treatment may contribute to the psychiatric comorbidity in these patients. Depression, suicidality, alcohol abuse and dependence, psychotic disorder, mood disorder with psychotic features and generalized anxiety disorder were found to be the most common psychiatric comorbidities associated with psoriasis. T cells are the primary modulators involved in psoriasis and studies show that the disease is also associated with systemic inflammation causing coronary heart disease, stroke, metabolic syndrome and others. We report a case report of a 29 year old Asian male with history of ADHD, psoriasis and no prior psychiatric hospitalization, was escorted to the emergency room due to psychosis exhibited as disorganized behavior, religious preoccupation and paranoia. At the same time it was noticed that the patient had exacerbation of psoriasis covering most of his body especially on face, scalp, hands and back. Inspite of his non compliance with risperdal for his psychosis, the patient's psychotic symptoms resolved parallel with the resolution of the psoriatic lesions which motivated us to research the association between immune reactions in psoriasis and first onset psychosis. A strong association has been displayed between first onset psychosis and inflammation evidenced by increased serum levels of several cytokines and also S100b, an astrocytic calcium-binding protein which can be identified in seconds after BBB damage. Studies have found increased levels of S100b levels in psoriasis but also a positive correlation between the severity of psoriasis and the serum levels of S100b which further provides the evidence for the immune reaction induced BBB damage in psoriasis. Our case report highlights the association between the psychosis onset with exacerbation of psoriasis, further supporting the extensive research being done regarding the systemic nature of psoriasis.

POSTER 2-13

Risperdal Induced Hypersalivation: Case Report

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Abstract: Sialorrhea or hypersalivation as been reported as a side effect of several anti-psychotics medications. The most known for this side effect is clozaril and numerous articles have been published regarding treatment related to clozaril hypersalivation. Risperidone, on the other hand is one of the antipsychotics that has been reported with the least hypersalivation. Side effects such as sialorrhea can contribute to embarrassment in social settings and the social stigma contributes to patients being less compliant with a medication. We report a case of a 38 year old Caucasian female with bipolar I disorder, most recent episode manic severe and alcohol dependence. The patient was initiated on risperidone pharmacotherapy during her inpatient psychiatric hospitilization. The patient experienced sialorrhea for three days upon the initiation of risperidone. After three days the amount of salivation decreased everyday and completely stopped after a week without being treated with clonidine. Literature review has revealed that postsynaptic adrenergic and muscarinic cholinergic activity of receptors are involved in hypersalivation. In this case, our patient had complete resolution of the hypersalivation without the use of clonidine which is a standard of treatment for postadrenergic activity. This proposes a theory that in some patient populations there is more muscarinic activity especially with M-4 receptor stimulation. If this is the actual case, there will be a complete resolution of symptoms once the patients body adjusts to the medication. These findings support the notion that increased salivary gland muscarinic activity contributes to sialorrhea in some patient populations.

POSTER 2-14

Delusions of Parasitosis and Morgellon's Disease: Strategies to Create a Therapeutic Alliance with Female Delusional Disorder Patients

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Abstract:
Background: Delusions of Parasitosis (DOP) and Morgellons disease are frequently encountered psychotic disorders in dermatology, predominantly seen in elderly women. Morgellon's disease is a pattern of dermatologic symptoms very similar, if not identical, to those of delusions of parasitosis. [1] Patients with DOP have a fixed belief that they are infected with parasites or other organisms. Those with Morgellon's have a fixed belief that they are infested with parasites or some form of mysterious condition, whereby fibers or other inanimate objects are embedded in or extruding from their skin. Sadly, those who are afflicted with these unusual forms of psychosis often end up living a life of solitude, despite the fact that they are otherwise psychologically well functioning individuals.

Furthermore, these patients generally lack complete insight as to the psychiatric nature of their disorder. They may shun the help that they most desperately need, simply refusing to seek to appropriate mental health care. Consequently, these patients go from one physician to another, simply refusing to be open to a therapeutic trial of highly effective psychiatric medications (such as, pimozide and risperdal).[2]

Purpose: Physicians need strategies to help them reach common ground with female patients that suffer from DOP or Morgellon's disease.

Methods: The strategies delineated in this presentation are derived from the experience of the physicians in dermatologic psychiatric and advanced medical dermatology referral practices at University of California, San Francisco.

Results: We have created a step-by-step approach to the female patient with DOP or Morgellon's disease, which includes five phases: pre-visit preparation, how to establish a therapeutic rapport, relevant elements of the history and physical exam, how to initiate therapy, and how to maintain therapy.

Conclusions: Managing and treating patients with DOP or Morgellon's disease can be challenging. Using the described methods can enhance communication and facilitate the creation of a therapeutic alliance in female patients with DOP and Morgellon's disease.

POSTER 2-15

A Prospective, 1-Year, Open-Label, Flexible Dose Study of Lurasidone in the Treatment of Schizophrenia: Safety, Tolerability, and Effectiveness

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Abstract:

Objective: Lurasidone is a new atypical antipsychotic in development for the treatment of schizophrenia and bipolar disorder. The objective of this study was to assess the long. term safety, tolerability, and effectiveness of once.daily 40.120 mg/d lurasidone in a 1.year, open.label study.

Methods: Patients with schizophrenia (ICD.10 with or without acute exacerbation) were enrolled in this study which was conducted in Japan. Lurasidone dosing was initiated at 40 mg/d, and adjusted up to a maximum of 120 mg/d over a 16.week period, and then held fixed from Week 16 to Week 52. The key effectiveness measure was discontinuation of treatment for any cause. Other safety and tolerability outcomes included adverse events (AEs) and laboratory evaluations. Kaplan.Meier and Growth Mixture Model (GMM) analyses were applied.

Results: A total of 182 patients, aged 20.64 years, were treated with a mean dose of 71 (SD 26) mg/d lurasidone. There was an increase in dosage from Week 1 to Week 8 within the mean dose range of 41 to 77 mg/day, while dosages at Week 9 and thereafter were stable (within the mean dose range of 80 to 85 mg/day). One hundred and fourteen (63%) patients completed 16 weeks of treatment, and 80 (44%) completed the 1.year study. Eighteen (10%) discontinued due to AEs before 16 weeks, while 35 (19%) discontinued due to lack of efficacy. Kaplan.Meier analysis showed 17% cumulative discontinuation rate for AE at 6 months and 23% at 12 months. Likewise, K.M discontinuation rate due to lack of efficacy was 25% at 6 months and 28.5% at 12 months. Mean weight change at 1 year was .1.5 (SD 4.8) kg. Long term mean changes (SD) from baseline were: total cholesterol .7.5 (25.8) mg/dL, triglycerides .7.9 (56.9) mg/dL, fasting glucose 0.5 (9.8) mg/dL, and prolactin .12.7 (54.0) (ng/mL). Most of the adverse events were mild or moderate, and only 4.4% were rated severe. The trajectory patterns for the primary outcomes (BPRS and PANSS scores) were consistent, showing greatest improvement in the subgroup with higher baseline severity (GMM mean BPRS .9.9 from baseline 61, n=27), compared to the lower baseline severity groups (mean BPRS .6.8 from baseline 49, n=59; and .3.5 from the baseline 34, n=96).

Conclusions: Lurasidone was well tolerated with no adverse mean changes in weight, lipids and prolactin in this 1.year open.label study in subjects with schizophrenia. In addition, lurasidone was associated with a gradual and sustained improvement in total PANSS and BPRS scores.

POSTER 2-16

A Case of Co-Existence of Capgras, Fregoli, Erotomania and Persecutory Delusions and Its Management Issues

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Abstract:

Introduction: Capgras delusion, Fregoli delusions and other delusional misidentification syndromes (DMS) are of great interest as they are believed to be related to specific functional impairments and particular brain area damage. Capgras and Fregoli delusions are believed to be two antagonistic forms. In practice, we encountered a case of co-existence of these two antagonistic delusions together with erotomania and persecutory delusions.

Case: 42-year-old single Caucasian female with a history of schizoaffective disorder, was admitted to the hospital because she had been yelling at her neighbors at night for 2 weeks. The patient reported not sleeping for that time period together with having racing thoughts. She felt that she could solve the world's problems. She believed that the apartment superintendent wanted to marry her. She also believed that unknown people had come into her house. There was no history of traumatic brain injury or medical problems. A CT scan of the brain, a physical exam, the laboratory results and the vital signs were within normal limits. On admission, she was very guarded, irritable, isolative, and paranoid of staff and other patients. She was started on valproate, quetiapine and

clonazepam. Her mood was more stabilized and her sleep was improved. She became less paranoid. Then, she reported that for the past 20 years she had believed that her brother had been replaced by a twin raised in Germany. She also believed that there was a group of people who were able to change identities and appearance. She believed that these people were following her, digging information up about her, and trying to assume her identity. She reported that she confronted strangers sometimes. Ziprasidone was added to her medication regime. While no longer grandiose and irritable, she had minimal delusions, which no longer impaired her social function. She was discharged after one week to an outpatient program.

Discussion: There have only been a few case reports of coexistence of Capgras and Fregoli syndromes together with erotomania and persecutory delusions. The patient's Capgrass and Fregoli delusions could be independent of manic symptoms, but in our case, the successful treatments with mood stabilizer and neuroleptics of Capgras and Fregoli with other delusions indicate global cognitive impairment of the brain in manic state. Some literature reported treatment resistance of Capgras and Fregoli syndrome. This may indicate the complexity of the causes of DMS. Thus, an individualized treatment approach to patients is suggested.

POSTER 2-17

Weight Change and Metabolic Effects of Asenapine in Placebo- or Olanzapine-Controlled Studies

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Abstract:

Objective: We describe post hoc analyses of weight change and metabolic effects of asenapine in adults.

Methods: Data were pooled from asenapine schizophrenia and bipolar disorder trials that used placebo (n=1748; duration, 1-6 wk) and/or olanzapine (n=3430; duration, 3 to >100 wk) controls. Asenapine dosages were 5 or 10 mg BID (2–20 mg BID in 2 studies); olanzapine dosages were 5–20 mg QD. Inferential analyses using ANOVA assessed change at endpoint from baseline weight, body mass index, and fasting lipids and fasting glucose.

Results: The least squares (LS) mean ± SE weight change with asenapine was small yet statistically greater than placebo (1.2±0.2 vs 0.1±0.2 kg; P<0.0001) and was significantly less than olanzapine (0.9±0.1 vs 3.1±0.2 kg; P<0.0001). LS mean ± SE total cholesterol, LDL, and HDL changes did not significantly differ for asenapine vs placebo, but fasting triglyceride changes did significantly differ (asenapine, 1.8±6.3 mg/dL; placebo, –12.2±5.9 mg/dL; P<0.05). LS mean ± SE changes (asenapine vs olanzapine) significantly differed for total cholesterol (–0.4±1.1 vs 6.2±1.2 mg/dL, respectively; P<0.0001), LDL (–0.3±1.1 vs 3.1±1.2 mg/dL, P<0.05), fasting triglycerides (–0.9±5.4 vs 24.3±5.8 mg/dL, P<0.0001), and HDL (1.3±0.4 vs –0.2±0.4 mg/dL, P<0.01). LS mean±SE changes in fasting glucose with asenapine significantly exceeded placebo (1.9±1.7 vs –1.6±1.5 mg/dL; P<0.05) and were numerically lower than olanzapine (2.0±1.3 vs 3.3±1.3 mg/dL).

Conclusion: These post hoc pooled analyses suggest asenapine was associated with increased weight gain and glucose levels compared with placebo; triglycerides decreased with placebo and did not substantially change with asenapine. Propensity for weight gain or increased serum lipids was lower with asenapine vs olanzapine. (This research was supported by Merck, Whitehouse Station, NJ.)

POSTER 2-18

Lurasidone in the Treatment of Acute Schizophrenia: Results of the Double-Blind, Placebo-Controlled, 6-Week, Pearl 3 Trial

Antony Loebel, M.D. (Antony.Loebel@sunovion.com), **Josephine Cucchiaro, Ph.D., Kaushik Sarma, M.D., Jay Hsu, Ph.D., Jane Xu, Ph.D., Amir H. Kalali, M.D., Steven G. Potkin, M.D.**

Abstract:

Objective: The objective of this study was to evaluate the efficacy and safety of once-daily lurasidone (80 mg/day and 160 mg/day) in subjects with an acute exacerbation of schizophrenia.

Methods: Hospitalized subjects who met DSM-IV criteria for schizophrenia with a PANSS total score >80 were randomized to 6-weeks of double-blind treatment with lurasidone 80 mg (N=125), lurasidone 160 mg (N=121), quetiapine XR 600 mg (QXR; N=120; included to confirm assay sensitivity), or placebo (N=122), administered once-daily in the evening. A mixed model repeated measures (MMRM) analysis was performed for the primary measure, the Positive and Negative Syndrome Scale (PANSS) total score, and the key secondary measure, the Clinical Global Impression-Severity scale (CGI-S). Safety and tolerability measures included adverse events, weight, and lipids.

Results: Treatment with lurasidone was associated with significantly greater endpoint improvement, at 6 weeks, on the PANSS total score vs. placebo (-10.3) among subjects in the 80 mg (-22.2; P<0.001) and 160 mg (-26.5; P<0.001) dosage groups. On the CGI-S, significant endpoint improvement was observed versus placebo (-0.9), during treatment with both the 80 mg (-1.5; P<0.001) and 160 mg (-1.7; P<0.001) doses of lurasidone. Significant separation from placebo occurred by Day 4 for both lurasidone doses on the PANSS total score. QXR produced significantly greater endpoint improvement than placebo on the PANSS total score (-27.8 vs. -10.3; P<0.001) and the CGI-S (-1.7 vs. -0.9; P<0.001). The following adverse events occurred with an incidence =5% and =2-times placebo: akathisia (L80; L160), nausea (L80; L160), parkinsonism (L80; L160), dizziness (L160; QXR), somnolence (L160; QXR), constipation (QXR), dry mouth (QXR), increased weight (QXR), upper respiratory tract infection (QXR), and

arthralgia (QXR). Treatment with lurasidone 80 mg and 160 mg, respectively, was associated with a mean increase in weight that was not clinically significantly different from placebo (+0.6 kg and +0.6 kg vs. +0.1 kg) while the mean increase in weight was higher vs placebo for quetiapine XR (+2.1 kg). Total cholesterol and triglycerides were decreased at endpoint on both doses of lurasidone, but were increased on quetiapine XR.

Discussion: In this short-term, placebo-controlled trial of subjects with an acute exacerbation of schizophrenia, both lurasidone 80 mg and 160 mg, taken once-daily in the evening, demonstrated superiority compared to placebo on the PANSS total score and CGI-S score. Significant improvement in the PANSS total score was demonstrated at day 4, and at all subsequent study visits, for both the lurasidone 80 mg and 160 mg treatment groups. No dose-related increases in adverse events or adverse event-related discontinuations were evident on lurasidone, and short-term treatment with lurasidone was associated with minimal changes in metabolic parameters.

POSTER 2-19

Impact of Lurasidone and Olanzapine on Framingham Ten-Year Coronary Heart Disease Risk Estimate in Schizophrenia

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Abstract:

Introduction: Patients with severe mental illness are at increased risk for coronary heart disease (CHD).related mortality. We conducted a post.hoc analysis to test the significance of treatment effects on Framingham Risk Score (FRS). Estimates of 10.year CHD risk and their changes from baseline to Week 6 endpoint were compared in a double.blind, placebo.controlled study of lurasidone and olanzapine in acute schizophrenia patients.

Methods: At screening, demographics and medical history were measured. Vital sign and fasting lab measures were evaluated at baseline and over the 6.week study. Subjects were randomized to fixed doses of lurasidone 40 or 120 mg/d (LUR), olanzapine 15 mg/d (OLZ), or placebo (PBO). An analysis of covariance model, with terms for treatment, gender, treatment.by.gender interaction, and baseline value was applied.

Results: The FRS analysis sample included 315 subjects aged >30 years. The CHD risk factor prevalence rates in the baseline sample were: diabetes 12%, hypertension 22%, low HDL 45%, and high total cholesterol 17%. Baseline smoking prevalence was overall 68% but significantly higher in males (75%) vs. females (47%) ($p<0.001$). The baseline mean 10.year CHD risk was higher in males (9%) vs. females (5%), per Wilson et al. (1998). Average risk ratio (10.year CHD absolute risk relative to normal reference risk) was 2.3 for males and 1.4 for females. At Week 6, changes from baseline in overall 10.year CHD risk were: for LUR, baseline 8.4% to endpoint 8.3%, for PBO, baseline 6.6% to 7.2%, and for OLZ, 8.5% to 10.3%. Changes were significantly higher in men treated with OLZ (9.4% to 12%) vs. LUR (9.4% to 9.3%) ($p<0.001$) and vs. PBO (7.6% to 8.3%) ($p<0.001$). In contrast, no female group showed significant Week 6 differences (treatment.by.gender interaction effect, $p<0.01$). Changes in CHD risk factors included 23 new diabetes cases (LUR 3.8%, OLZ 14%, and PBO 6.8%) ($p>0.05$). There were elevations of hypertension risk in men receiving OLZ vs. PBO ($p<0.05$). Fasting total cholesterol levels significantly increased among males treated with OLZ (+6.8 mg/ dL) vs. LUR (.9.2 mg/dL) and PBO (.10.6 mg/dL) ($p<0.05$).

Conclusions: These 6.week study results indicate that the acute effect of lurasidone on the 10.year CHD risk is comparable to that of placebo in patients with schizophrenia. Olanzapine was associated with higher risk compared to placebo or lurasidone treatment. Further investigation including longer.term exposure data is warranted to confirm these results.

POSTER 2-20

Association Between Adherence and Persistence with Antipsychotics and Outcomes Among Medicaid Patients with Schizophrenia

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Abstract:

Background: Patients (pts) with schizophrenia often do not take medication as prescribed, which may increase relapse risk, often leading to rehospitalization and higher use of other healthcare services.

Purpose: To examine adherence and persistence rates among pts with schizophrenia experiencing >=2 relapses who were treated with second.generation oral antipsychotics (SGOAs).

Methods: Using a multistate Medicaid database, adult (18.64 y) pts were identified with a diagnosis of schizophrenia and evidence of >=2 relapses (ie, inpatient admission or ER visit with primary or secondary diagnosis of schizophrenia, depression, dementia, or other psychosis) within 1 y after SGOA therapy was initiated. A dichotomous measure of persistence was used, in which pts with therapy interruption (SGOA refill gap of >60 days) or discontinuation were categorized as nonpersistent, and pts with continuous SGOA use (ie, refill gap <=60 days) were categorized as persistent. Adherence to SGOA therapy was measured using the medication possession ratio (MPR), calculated as pts f cumulative exposure to SGOAs during the 12.month period after SGOA initiation, Ndivided by 365 days, and was stratified as adherent (MPR>=0.80) and nonadherent (MPR<0.80). Association between adherence to and persistence with SGOA treatment and psychiatric.related relapses was assessed using a series of negative binomial and Poisson regression models.

Results: The study cohort consisted of 3714 pts with mean age of 42.6 y (SD 11.63); 56% were female and 48% were black.

Overall, 45% of pts were adherent to and 50% persistent with medication. Compared with older pts (mean age ~43.5 y) and pts of other racial groups (ie, white, Hispanic, and other), younger (mean age ~42.0 y) and black pts were significantly less likely to be adherent and persistent with SGOA therapy (P <0.001 for each comparison). Fewer relapses on average were noted in adherent versus nonadherent pts (3.85 vs 4.13; P<0.001) and in persistent versus nonpersistent pts (3.81 vs 4.21; P<0.001). Pts who were adherent (incident rate ratio [IRR]=0.90; 95%CI=0.86.0.94; P<0.001) or persistent (IRR=0.88; 95%CI=0.84.0.92; P<0.001) had significantly lower rates of psychiatric.related relapses.

Conclusion: This analysis reinforces the need for improving treatment adherence and persistence among pts with schizophrenia, which may lower the rate of psychiatric.related relapse. Future research is needed to assess whether newer antipsychotic therapies with less.frequent dosing may improve adherence among pts with schizophrenia therapy.

POSTER 2-21

Characteristics of Participants in Community Behavioral Health Organizations Receiving Two Injectable Forms of Atypical Antipsychotic Medications

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Abstract:

Objective: The aim of this study is to provide information on the characteristics of patients receiving treatment with atypical injectable antipsychotics paliperidone palmitate and risperidone long-acting therapy (RLAT) at community behavioral health organizations (CBHOs) in the United States.

Methods: A longitudinal, noninterventional observational registry, Research and Evaluation of Antipsychotic Treatment in Community Behavioral Health Organizations, OUTcomes (REACH OUT), is collecting information on paliperidone palmitate and RLAT use by patients with schizophrenia or bipolar type I disorder receiving their primary treatment at CBHOs. Patients are followed for up to 1 year with assessments at baseline, 6 months, and 12 months. Sites use a Web-based data collection tool to enter data from patient self-reports, interviewer assessments, and medical records abstractions.

Results: At the time of the analysis for this ongoing study, baseline patient interview data had been collected from 102 patients at 7 sites. Of these 102 patients, 37 (36.3%) received paliperidone palmitate injections, 25 (24.5%) received RLAT injections, and 40 (39.2%) received other antipsychotics at the time of enrollment. Patients receiving treatment with paliperidone palmitate or RLAT injections were on average older than patients receiving other antipsychotics: paliperidone palmitate, 40.2 (SD 13.4) years; RLAT, 42.4 (SD 11.0) years; other antipsychotics, 35.4 (11.8) years. Mean age at first psychiatric hospitalization was similar across the 3 cohorts: paliperidone palmitate, 22.6 (SD 8.1) years; RLAT, 24.7 (SD 8.7) years; other antipsychotics, 20.6 (12.2) years. Patients receiving the two injectable antipsychotics were more likely to be male (paliperidone palmitate, 75.7%; RLAT, 68.0%; other antipsychotics, 55.0%) and single or never married (paliperidone palmitate, 83.8%; RLAT, 72.0%; other antipsychotics, 55.0%). Patients treated with atypical antipsychotic injections were less likely to have private health insurance (paliperidone palmitate, 2.7%; RLAT, 0.0%; other antipsychotics, 27.5%) and more likely to have Medicare (paliperidone palmitate, 64.9%; RLAT, 60.0%; other antipsychotics, 35.0%) and Medicaid (paliperidone palmitate, 81.1%; RLAT, 76.0%; other antipsychotics, 35.0%).

Conclusions: These preliminary results suggest that patients receiving paliperidone palmitate and RLAT may differ from patients receiving other antipsychotics in CBHOs in demographics such as age, gender, marital status, and health insurance type. Once target enrollment is reached, this study will allow for comparison of antipsychotic therapies across a series of clinical, functional, and economic outcomes. Study funded by Ortho-McNeil Janssen Scientific Affairs, LLC.

POSTER 2-22

Effect of Lurasidone on Weight and Metabolic Parameters: Results from Pooled Short-Term Placebo-Controlled and Longer-Term Trials in Schizophrenia

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Abstract:

Objective: The aim of this analysis was to evaluate the safety of lurasidone treatment of schizophrenia on weight and metabolic parameters.

Methods: Data were pooled from seven double-blind, placebo-controlled, short-term (6-week) treatment studies of subjects who met DSM-IV criteria for schizophrenia with an acute exacerbation. The short-term safety analysis sample consisted of subjects treated with lurasidone (dose range, 20-160 mg, total N=1508); haloperidol 10 mg (N=72); olanzapine 15 mg (N=122); risperidone 4 mg (N=65); quetiapine XR (N=119); and placebo (N=708). Longer-term (6-months and longer) open-label treatment data were also available from 19 studies of lurasidone (N=2905 lurasidone-treated subjects) in doses ranging from 40-120 mg/day.

Results: In the short-term (6 week) treatment sample, mean LOCF endpoint weight change was +0.43 kg for the combined lurasidone dosage group, +0.02 kg for haloperidol, +4.15 kg for olanzapine, +0.20 kg for risperidone, +2.09 kg for quetiapine XR, and -0.02 kg for placebo. The proportion experiencing =7% weight gain was 4.8% for combined lurasidone, 4.2% for haloperidol, 34.4% for olanzapine, 6.2% for risperidone,

15.3% for quetiapine XR, and 3.3% for placebo. Median endpoint change in lipids were as follows: triglycerides (mg/dL), -4.0 for combined lurasidone, -3.0 for haloperidol, +25.0 for olanzapine, +4.0 for risperidone, +9.5 for quetiapine XR, and -6.0 for placebo; total cholesterol (mg/dL), -5.0 for combined lurasidone, -8.0 for haloperidol, +9.0 for olanzapine, +6.5 for risperidone, +6.0 for quetiapine XR, and -5.0 for placebo; similar trends existed for changes in LDL. Median LOCF-endpoint change in glucose (mg/dL) were similar for combined lurasidone (0.0) and placebo (0.0), and somewhat higher for haloperidol (+2.0), olanzapine (+4.0), risperidone (+3.0), and quetiapine XR (+3.0). Minimal-to-no changes were observed at Week 6 LOCF-endpoint in HbA1c. In the longer-term treatment sample, mean change in weight at 12 months on an observed case (OC) analysis was -0.73 kg for the combined lurasidone treatment group; and median changes in metabolic parameters at Month 12 OC were: -2.0 mg/dL for total cholesterol and -5.0 mg/dL for triglycerides.

Conclusions: Based on data from 7 short-term placebo-controlled trials (N=1508 on lurasidone) and19 longer-term trials (mainly open-label; N=2905 on lurasidone), treatment with lurasidone was associated with minimal increases in weight and BMI in short-term treatment and small decreases in weight and BMI in longer-term treatment. In short and longer-term studies, treatment with lurasidone was not associated with disturbances in lipids or glycemic control (glucose, etc)

POSTER 2-23

A Pooled Analysis of the Effects of Asenapine on Persistent Negative Symptoms of Schizophrenia

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Abstract:
Objective: Asenapine and olanzapine reduced negative symptoms of schizophrenia in 2 double-blind, randomized 26-week studies and subsequent 26-week extensions in a study population with persistent negative symptoms (PNS) that also met criteria for predominant negative symptoms. Superiority of asenapine over olanzapine was observed in 1 of the extensions but not in the other extension or in either of the core studies. To more fully explore the efficacy of asenapine on PNS of schizophrenia, we conducted post hoc analyses using pooled data from these 4 trials.

Methods: The 2 core studies and their respective extensions were double-blind, double-dummy, olanzapine-controlled trials. Core study participants (n=949) were randomly assigned to sublingual asenapine (5 mg twice daily [BID] during week 1; 5 or 10 mg BID thereafter; n=485) or oral olanzapine (10 mg once daily [QD] during week 1; 5–20 mg QD thereafter; n=464); extension participants continued existing treatment without rerandomization. Of the 613 participants (asenapine, n=277; olanzapine, n=336) who completed 26 weeks of treatment, 502 (asenapine, n=220; olanzapine, n=282) entered a 26-week extension and 412 (asenapine, n=170; olanzapine, n=242) completed an additional 26 weeks of treatment. Efficacy—16-item Negative Symptom Assessment (NSA-16) scale total score changes from core study baseline to core study endpoint (treatment week 26) or extension endpoint (treatment week 52)—was assessed using a mixed model for repeated measures analysis on the pooled intent-to-treat populations.

Results: Discontinuation due to lack of therapeutic effect was significantly greater with asenapine vs olanzapine for the first 26 weeks for core study participants (13.6% vs 7.3%, p=0.0016) and during the extension for extension participants (5.5% vs 2.1%, p=0.0458). After 26 weeks of treatment, the least squares (LS) mean ± SE NSA-16 total score change from core study baseline did not significantly differ for asenapine vs olanzapine among participants who entered the core studies (–11.1±0.6 vs –11.2±0.6, respectively; p=0.9457) or among participants who entered the extensions (–13.1±0.7 vs –12.2±0.6, p=0.3710). At week 52, the LS mean ± SE NSA-16 total score change from core study baseline was significantly greater for asenapine vs olanzapine among participants who entered the core studies (–14.6±0.8 vs –12.6±0.7, p=0.0497) and extensions (–16.5±0.9 vs –13.6±0.7, p=0.0083).

Conclusion: These pooled post hoc analyses indicate that treatment with both asenapine and olanzapine reduced PNS of schizophrenia in adult study participants. Statistical superiority of asenapine was observed at week 52 but not at week 26. However, these results need to be interpreted in view of the fact that a large portion of participants did not enter the extension studies and those who did enter the extension continued treatment without rerandomization. (This research was supported by Merck, Whitehouse Station, NJ.)

POSTER 2-24

Metabolomic Correlates of Treatment Response in Subjects with Schizophrenia Treated with Lurasidone

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Abstract:
Objective: Lurasidone is a new psychotropic agent with high affinity for D2, 5-HT2A and 5-HT7 receptors, and moderate affinity for 5-HT1A receptors. It has demonstrated efficacy in the treatment of schizophrenia with minimal effects on weight and metabolic parameters. Lurasidone's pharmacological profile suggests the potential for increased glutamate (and related amino acid neurotransmitter) activity associated with lurasidone treatment. The objective of this analysis was to evaluate the metabolomic "signature" of lurasidone, and specifically if there are any potential signals for enhanced CNS availability of glutamate.

Methods: Serum samples for metabolomic analysis were obtained from a subgroup of subjects enrolled in a double-blind, placebo-controlled study of subjects who met DSM-IV criteria for schizophrenia and were experiencing an acute exacerbation of psychotic symptoms. Post-treatment samples at Day 4 and Day 42 were collected from subjects randomized to one of three groups: placebo (n=40), lurasidone 40 mg/d (n=40), and olanzapine 15 mg/d (n=40). Samples were extracted and analyzed on GC/MS and LC/MS/MS platforms. Proprietary software (Metabolon) was used to match ions to an in-house library of standards for metabolite identification and for metabolite quantitation by peak area integration.

Results: In the lurasidone group at Day 42, the serum levels of 25 of a total of 732 biochemicals (3.4%) were significantly changed (11 were significantly increased and 14 significantly decreased). In contrast, for olanzapine the serum levels of 100 biochemicals (13.7%) were significantly changed (54 were increased and 46 decreased). Treatment with lurasidone was associated with significantly increased serum levels of glutamate, glycine and serine compared to placebo as well as olanzapine treatment. In contrast to lurasidone, olanzapine significantly inhibited the activity of oxidoreductases/dehydrogenases and significantly increased sugar alcohol/polyols. Olanzapine also significantly decreased serum essential, long chain fatty acids, and carnitines.

Discussion: In this exploratory metabolomics analysis of schizophrenia responders, lurasidone responders with high levels of improvement in negative symptoms had a significantly higher increase in glutamate levels compared to treatment responders in the olanzapine or placebo groups. Treatment with lurasidone was similar to placebo in its biochemical effects, while treatment with olanzapine was associated with a higher proportion of distinct biochemical changes relative to placebo. These findings need to be confirmed using larger samples that include both treatment responders and non-responders.

POSTER 2-25

Efficacy of Adjunctive Treatment of Schizophrenia with Celecoxib: A Systematic Review

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Abstract: Currently established treatments for schizophrenia are often ineffective or do not improve important symptom domains such as negative or cognitive symptoms. Based on a possible role of inflammatory processes in the pathophysiology of schizophrenia, Celecoxib has been used as an adjunctive treatment, but the efficacy of this medication is unclear.

POSTER 2-26

Outcomes and Costs of Atypical Antipsychotics in Patients with Schizophrenia: Results of a Simulation Model

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Abstract:

Objective: To characterize expected outcomes and costs of treatment of schizophrenia and schizoaffective disorders with atypical antipsychotics.

Methods: We developed a Markov simulation model to estimate expected outcomes and costs among a hypothetical cohort of patients with schizophrenia (including schizoaffective disorder) assumed to begin therapy with aripiprazole, asenapine, iloperidone, olanzapine, quetiapine, risperidone, or ziprasidone. Efficacy of these agents was assumed to be the same; they were assumed to differ only with respect to side effects. Outcomes of interest included therapy discontinuation due to side effects (extrapyramidal symptoms [EPS], akathisia, prolactin disorders, weight gain, metabolic syndrome, diabetes, sedation, somnolence, nausea/vomiting, QTc interval prolongation), duration of therapy, and death. Costs included those of atypical antipsychotics, treatment of side effects, and all other psychiatric care. The periodicity of the model was one month. Model parameter estimates were based on published and unpublished literature and, as necessary, expert opinion; costs were estimated from the perspective of the US healthcare system (2010 US dollars). The model was run for 12 cycles (i.e., one year) for a hypothetical cohort of 25,000 patients. Patients were followed in the model until discontinuation of initial therapy, death, or one year, whichever occurred first. We also ran several one.way and probabilistic sensitivity analyses.

Results: Over a 1.year period, estimated mean time on therapy was 6.7 months for risperidone, 6.8 months for asenapine, 7.2 months for olanzapine, 7.6 months for quetiapine, 8.2 months for iloperidone, 8.4 months for aripiprazole, and 8.6 months for ziprasidone; corresponding rates of therapy discontinuation at one year were 67%, 63%, 70%, 63%, 49%, 46%, and 42%, respectively. Reasons for expected therapy discontinuation varied by agent, but the most frequent one was weight gain. Other important reasons for therapy discontinuation were metabolic syndrome and EPS or akathisia. Estimated monthly costs of therapy were $2718 for risperidone, $2887 for ziprasidone, $3067 for asenapine, $3091 for iloperidone, $3141 for aripiprazole, $3292 for quetiapine, and $3352 for olanzapine. Findings were generally robust in sensitivity analyses.

Conclusions: Among the seven atypical antipsychotics we evaluated, aripiprazole, iloperidone, and ziprasidone had the lowest estimated rates of therapy discontinuation; estimated monthly costs of therapy were lowest for risperidone, ziprasidone, and asenapine. Our findings suggest that tolerability may be an important determinant of adherence with atypical antipsychotics and monthly costs of treatment.

POSTER 2-27

Hallucinations Among Older Adults with Schizophrenia

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Abstract:

Background: We examined the prevalence of hallucinations and associated factors among older adults with schizophrenia living in the community.

Methods: We looked at 198 patients aged above 55years living in the community who had developed schizophrenia before age 45years. We examined the presence, form, type, identity and causes of the various types of hallucinations, including auditory, visual and olfactory. We excluded patients with substantial cognitive impairment. Using George's social antecedent model of psychopathology, we examined 18 predictor variables of any form of hallucinations.

Results: 32% of sample reported any hallucinations in the past 6 months; 58%, 30% and 13% reported one, two, or three types of hallucinations respectively. In bivariate analysis, we found 6 variables associated with the presence of auditory hallucination including depressive symptoms, higher PANSS anxiety score, higher PANSS delusion score, higher PANSS disorganization score, higher lifetime trauma and lower cognitive coping style score. In logistic regression analysis, we found 3 associated variables including depressive symptoms, PANSS delusion score and lower cognitive coping style score.

Conclusion: Auditory hallucinations are usually not benign. Although most had clear good and pleasant voices, almost three-quarters of hallucinators had depression.

POSTER 2-28

Effect of Short-Term Treatment with Lurasidone on Quality of Life in Schizophrenia: Results from the Pearl 3 Trial

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Abstract:

Background: The objective of this study was to evaluate the effect of lurasidone (80 mg/day and 160 mg/day) on quality of life in patients with an acute exacerbation of schizophrenia.

Methods: Patients experiencing an acute exacerbation of schizophrenia were randomized to 6.weeks of double.blind treatment with once.daily lurasidone 80 mg (N=125) or 160 mg (N=121), quetiapine XR 600 mg (N=120; included for assay sensitivity) or placebo (N=122). The outcome measures included the Positive and Negative Symptoms of Schizophrenia Scale (PANSS) total and positive subscale scores, the Negative Symptom Assessment Scale score (NSA.16), and the Montgomery.Asberg Depression Rating Scale (MADRS). Quality of life was measured using the Quality of Well. being (QWB.SA) scale, which assessed community mobility, physical and social activity, somatic, cognitive, and emotional symptoms. QWB combines preference.weighted measures of symptoms and functioning to provide a numerical point in.time expression of well.being that ranges from zero (0) for death to 1.0 for asymptomatic optimum functioning.

Results: At baseline, QWB.SA mean scores were similar for patients randomized to lurasidone 80 mg (0.572), lurasidone 160 mg (0.562), quetiapine XR (0.580), and placebo (0.583). At the Week 6 LOCF (last observation carried forward) endpoint, LS mean QWB.SA scores in the lurasidone 80 mg group (0.672, p=0.049), the lurasidone 160 mg group (0.710; p<0.001), and the quetiapine XR group (0.711, p<0.001) were significantly superior to the placebo group scores (0.631). Endpoint improvement in the QWB.SA score for the lurasidone 80 mg, 160 mg and quetiapine XR groups was correlated with LOCF endpoint improvement in the PANSS total score (r=.0.176, p=0.068; r=.0.353, p<0.001; r=.0.348, p<0.001), the PANSS positive subscale score (r= .0.049, p=0.615; r= .0.280, p=0.004; and r=.0.294; p=0.003), the NSA.16 (r=.0.021, p=0.827; r=.0.200, p=0.046; r=.0.148, p=0.142) and the MADRS (r=.0.059, p=0.541; r=.0.433, p<0.001; r= .0.277, p=0.005), respectively. In the placebo group, significant correlations were also observed between the endpoint change in the QWB.SA score and the endpoint change in the PANSS total (r=.0.387, p<0.001) and positive subscale scores (r=.0.386, p<0.001), the NSA.16 (r=.0.301, p=0.002), and the MADRS (r=.0.391, p<0.001).

Conclusion: In this study, treatment with lurasidone, in once.daily doses of 80 mg and 160 mg, was associated with improvements in health.related quality of life in patients with an acute exacerbation of schizophrenia. While change in quality of life was similar across lurasidone dose groups, correlations between improvement in QWB.SA scores and schizophrenia symptoms were strongest in subjects treated with lurasidone 160 mg compared to the 80 mg dose group.

POSTER 2-29

Long-Term Safety and Tolerability of Lurasidone in Subjects with Schizophrenia: Results of a 6-Month, Open-Label Extension Study

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Abstract:

Objective: The aim of this study was to evaluate the safety and tolerability of lurasidone in the long-term treatment of schizophrenia, and to determine if improvement during the acute double-blind (DB) phase of treatment was sustained.

Methods: Subjects who successfully completed a 6-week, DB, placebo-controlled trial evaluating the efficacy of lurasidone 40 mg and 120 mg, and olanzapine 15 mg (included to confirm assay sensitivity), were eligible to continue in a 6-month open-label extension (OLE) phase in which subjects received

flexible doses of lurasidone in the range of 40-120 mg/day. Safety and tolerability measures included adverse events (AEs), body weight, lipid parameters, prolactin, and ECGs. Efficacy assessments included the Positive and Negative Symptoms of Schizophrenia Scale (PANSS) total score.

Results: The mean PANSS total score, for all subjects (N=246) in the OLE phase, decreased from 96.6 at DB baseline to 66.6 at OLE baseline. During OLE treatment, subjects showed further improvement in the PANSS total score, with a mean score of 54.9 at OLE endpoint. Two AEs occurred with an incidence >10%: akathisia (13.0%) and insomnia (11.0%); an AE was rated as "severe" by 7.3% of subjects; and a total of 12.2% of subjects discontinued due to an AE during OLE treatment. There were no clinically meaningful changes in vital signs, or laboratory and ECG parameters; one subject (0.4%) reported >/=60 msec increase in QTcF, and no subject had a QTcF interval >500 msec. Body weight and BMI remained relatively stable during the open-label extension, except for subjects who had been randomized in the initial DB phase to olanzapine 15 mg: after the switch to open-label lurasidone, there was a mean (SD) reduction of -1.8 (4.9) kg in weight. There were no clinically meaningful changes, from open-label baseline to endpoint, in cholesterol (-7.1 mg/dL), LDL (-2.6 mg/dL), triglycerides (-18.3 mg/dL), insulin (-2.4 mU/L), or whole blood HbA1c (-0.06%). Prolactin, which had increased during the DB phase (+3.2 ng/mL on combined lurasidone; +3.4 ng/mL on olanzapine), showed an overall median decrease (-1.3 ng/mL) during the open-label extension.

Discussion: In this longer-term, open-label lurasidone extension study, subjects maintained improvement, as measured by the PANSS total score and MADRS, for up to 8 months of treatment with flexible doses of lurasidone in the range of 40-120 mg/d. There was no evidence for sustained change in weight, lipids, or glucose over 8 months of lurasidone treatment. Subjects switched from olanzapine to lurasidone showed marked and sustained decreases in weight and lipids. Eight months of treatment with lurasidone was not associated with clinically significant changes in vital signs, ECG, or laboratory parameters.

POSTER 2-30

Meta-Analysis of the Efficacy of Asenapine for Acute Schizophrenia: Comparisons with Placebo and Selected Antipsychotics

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Abstract:

Objective: Asenapine is an antipsychotic indicated in adults for treatment of schizophrenia. To characterize the efficacy of asenapine vs placebo in acute schizophrenia, data from all placebo-controlled 6-week trials were analyzed. To characterize the relative efficacy of asenapine vs selected antipsychotics, all randomized head-to-head comparisons of asenapine to active controls from the same studies and published randomized head-to-head comparisons of selected antipsychotics in the treatment of schizophrenia were analyzed.

Methods: The efficacy of asenapine vs placebo was analyzed using 4 trials with treatment arms in the effective dosage range (5 or 10 mg asenapine twice daily). The primary efficacy outcome, Positive and Negative Syndrome Scale (PANSS) total score change from baseline to week 6, was assessed using last observation carried forward (LOCF) and mixed model for repeated measures (MMRM); PANSS responders were analyzed to illustrate clinical relevance. Network meta-analyses on head-to-head comparisons (including those for which no direct comparisons are available) were conducted using a published database (Leucht et al, Am J Psychiatry 2009;166:152–166) that was updated with data from antipsychotic-controlled asenapine trials. In the 2-stage network meta-analysis, random-effects meta-analyses on PANSS total score changes were first performed for any pairwise comparison; these results were used to enter all comparisons on the PANSS change from baseline with associated variance into a weighted linear regression analysis providing maximum-likelihood–based estimates of the comparative efficacy of the antipsychotics.

Results: PANSS total score change from baseline at week 6 was significantly greater for asenapine vs placebo (LOCF: –3.6 [95% CI: –5.8, –1.3], P=0.002; MMRM: –4.1 [95% CI: –6.6, –1.6], P=0.001), a treatment effect comparable to active controls from the same trials (LOCF: –4.0 [95% CI: –6.5, –1.5], P=0.002; MMRM: –4.8 [95% CI: –7.6, –2.0], P=0.001). PANSS responder rate analyses reported an odds ratio vs placebo of 1.9 for asenapine (95% CI: 1.4, 2.6; P<0.001) and a corresponding number needed to treat (NNT) of 10.2; this effect vs placebo was comparable to that of combined active controls from the same trials (odds ratio=1.7 [95% CI: 1.2, 2.4; P=0.002]; NNT=12.0). Head-to-head network meta-analysis reported comparable efficacy of asenapine vs selected antipsychotics; PANSS differences for asenapine ranged from 3.9 points greater than ziprasidone (95% CI: 0.3, 7.4) to 2.9 points less than olanzapine (95% CI: –5.9, 0.1).

Conclusion: These meta-analyses demonstrate the superiority of asenapine vs placebo for acute schizophrenia. The efficacy of asenapine was comparable to that of combined active controls from the same studies. The network meta-analysis suggests the efficacy of asenapine for acute schizophrenia is comparable to a group of established antipsychotics. (This research was supported by Merck, Whitehouse Station, NJ.)

POSTER 2-31

Paliperidone-Induced Hyperprolactinemia

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Abstract:

Introduction: In children, hyperprolactinemia occurs due to prolactinomas, physiological stress, medications, hypoglycemia or rarely following endocrine abnormalities such as primary hypothyroidism. It is an important side-effect of conventional and some atypical antipsychotic medications. Based on adult and pediatric data, the relative potency of risperidone in inducing hyperprolactinemia is highest among atypical antipsychotics. On the other hand, aripiprazole has minimal impact on the prolactin levels. Instead, by virtue of its partial agonist activities, it may cause slight reduction of prolactin levels. Hyperprolactinemia causes primary or secondary amenorrhea and/or galactorrhea in girls. Boys usually present with galactorrhea and gynecomastia. In both sexes, hyperprolactinemia may delay pubertal maturation and slow linear growth may rarely be the initial presentation. In children and adolescents, antipsychotic induced hyperprolactinemia has been associated with increased risk of benign breast tumors and reduced bone density.

Case: A 7 year old Caucasian girl with agitation, vague psychotic symptoms and some behavioral issues secondary to autism was started on 1 mg risperidone daily. This resulted in effective symptom control, but she presented with tenderness and swelling in the breast area. Her serum prolactin was elevated at 198µg/L. General physical assessment and all other investigations were normal. Risperidone was stopped but the symptoms worsened. The child's family insisted on restarting risperidone. The treatment was reinitiated along with 1 mg Abilify (aripiprazole) after informed consent and discussion of reasons for initiation of aripiprazole. After one month, prolactin level dropped to 27 µg/L. The patient was asymptomatic and denied any tenderness in the breast region.

Results: The patient presented with symptoms of hyperprolactinemia caused by risperidone. Aripiprazole was added to risperidone during the later course of treatment. As a result, significant reduction in prolactin levels was observed. Treatment was well-tolerated and the child was clinically stable.

Conclusion: The patient presents in a risperidone-induced hypodopaminergic state. When aripiprazole is co-administered with risperidone, aripiprazole acts a dopamine receptor agonist by binding to the dopamine receptor more robustly. Hoffer et al reported a study on adult females who were on antipsychotic treatment with risperidone. The hyperprolactinemia successfully improved by the addition of aripiprazole. Bieder et al reported that aripiprazole has negligible effects on prolactin levels. However the effects of aripiprazole are still inconclusive and warrant further studies to assess and validate its effects in hyperprolactinemia. It appears that aripiprazole could be a useful treatment option in normalizing prolactin levels in some patients. Furthermore, our case brought forth an ethical dilemma whether to add one antipsychotic to another, in order to reduce the side effects of first antipsychotic. Another concern is that aripiprazole is very expensive. Thus, a detailed cost effectiveness analysis on aripiprazole might help in treatment decisions.

POSTER 2-32

A 2-Year, Randomized, Open-Label Study of Olanzapine Long-Acting Injection vs. Oral Olanzapine in Schizophrenia Outpatients

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Abstract:

Objective: To assess long-term treatment effectiveness of monthly olanzapine long-acting injection (LAI) compared with that of oral olanzapine.

Method: Outpatients with 2 or more episodes of worsening of schizophrenia in the prior 24 months with a baseline PANSS total score <70 were randomly assigned to open-label treatment with 405 mg/4-weeks of olanzapine LAI (N=264) or 10 mg/day oral olanzapine (N=260) for up to 2 years. Dosing was flexible after the first 4 weeks (150-405 mg/4-weeks olanzapine LAI, corresponding to approximately 5-15 mg/day, or 5-20 mg/day oral olanzapine). Investigators could, at their discretion, taper the previous oral antipsychotic (first 2 weeks only) and/or supplement with oral olanzapine 5 mg/day (subsequent 6 weeks only). The primary outcome measure was time to all-cause discontinuation.

Results: Of the 643 patients who entered the study, 524 were randomized and 243 completed the study. The two treatment groups did not significantly differ in median time to all-cause discontinuation (645 days LAI, 678 days oral; p=.61), discontinuation rate (54.9% LAI, 52.3% oral; p=.60), or relapse rate (31.1% LAI, 29.2% oral; p=.70). Psychiatric hospitalization rates during the study were very low and similar for the two groups (7.6% LAI, 9.2% oral), but duration of hospitalization was significantly shorter for the LAI group (0.4 days vs. 1.8 days, p=.020). There were no incidents of post-injection syndrome and no clinically significant group differences in adverse events or other safety measures. Mean weight change (via MMRM) over the 2-year study did not significantly differ (p=.866) for the two groups (at 1 year, 2.3 kg LAI vs. 2.9 kg oral; at 2 years, 2.1 kg LAI vs. 2.3 kg oral). To control for the higher maximum allowed dose in the oral group, a post hoc analysis was conducted. When dose increases to 20 mg/day after the initial 8 weeks of treatment were statistically treated as a sub-acute relapse, the LAI group had a lower relapse rate (31.1% LAI, 45.8% oral; p<.001) and a longer median time to relapse (379 days LAI, 213 days oral; p<.001) than the oral group, indicating that dose differences may have impacted the primary study findings.

Conclusions: In outpatients with schizophrenia, olanzapine LAI and oral olanzapine did not significantly differ in treatment effectiveness and were well tolerated for up to 2 years of treatment. Study discontinuation for olanzapine LAI was similar to that of oral olanzapine, despite the 3-hour post-injection observation period and other precautionary procedures related to the risk of post-injection syndrome. Supported by Eli Lilly and Company.

POSTER 2-33

Rates of Remission Among Patients with Schizophrenia Treated with Olanzapine Long-Acting Injection

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Abstract:

Purpose: Remission rates during treatment with the long-acting injectable (LAI) formulation of olanzapine have not been extensively examined. This analysis assesses rates of symptomatic remission among patients with schizophrenia who received olanzapine LAI during an international, long-term, open-label study (study F1D-MC-HGLQ, clinicaltrials.gov identifier #NCT00320489).

Methods: Study participants were male or female adult (18 to 65 years) outpatients receiving ongoing treatment for schizophrenia (DSM-IV or DSM-IV-TR). Inclusion criteria included a Clinical Global Impressions—Severity score of =4 and a Positive and Negative Syndrome Scale (PANSS) score of <70 at screening, and an evaluation of being at risk of relapse (=2 episodes of clinical worsening in preceding 24 months requiring increased level of care/hospitalization). Patients received an intramuscular injection of 405 mg olanzapine LAI at study initiation and flexible-dose injections of 150 to 405 mg once every 4 weeks thereafter for a total observation period of up to 2 years (mean monthly dose: 387 mg). Following screening, patient visits were scheduled at baseline and at the end of weeks 1, 2, and 4, and every 4 weeks thereafter. Remission was defined by the consensus criteria (Andreasen et al., 2005) of a score of =3 on all 8 key PANSS items for =6 months (168+ days).

Results: In total, 254 patients provided both baseline and postbaseline values for assessment of remission with olanzapine LAI. An overall remission rate of 57.9% (147/254) was achieved during the study. Among patients not in remission at baseline, 37.5% (39/104) achieved remission, while among patients already in remission at baseline, 72.0% (108/150) were able to maintain remission status.

Conclusions: After switching to olanzapine LAI, nearly 2 in 5 patients with stable schizophrenia but not in remission at baseline were able to achieve symptomatic remission, while nearly three-fourths of those in remission at baseline were able to remain in remission. These findings suggest that treatment with olanzapine LAI is associated with stable long-term outcomes in patients with schizophrenia. This work was sponsored by Eli Lilly and Company.

POSTER 2-34

Operation Clean: Reducing Health Care Associated Infections in an Ambulatory Psychiatry Clinic

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Abstract: Healthcare-associated infections are a leading cause of death in the United States, and can cause needless suffering and expense.(1) In 2011, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) developed Ambulatory Healthcare National Patient Safety Goal NPSG.07.01.01, which requires hand cleaning guidelines and implementation of a program to ensure office cleanliness.(2) At the University of Virginia, we see over 450 patients per month, approximately 5200 patients per year, at our outpatient child and adolescent psychiatry clinic. Patients and families spend time in our clinic waiting room until the doctor calls for them. Children can play with our collection of toys such as Jenga, blocks, mazes, and other games. Often times we see patients putting toys in their mouths and passing them to other people. We have seen children drooling on toys and wiping their noses with blocks. Per clinic policy, housekeeping should be cleaning our toys daily, and clinic staff should remove visibly soiled or potentially contaminated toys when encountered. However, we do not have a rigorous quality assurance system in place to ensure cleanliness and monitor the policy. Our patients and their families may be experiencing significantly more episodes of communicable diseases by coming into contact with contaminated toys. This project will detect the presence, quantity, and types of micro-organisms by swabbing common objects in the clinic waiting room, and growing the samples on agar plates. The results will be analyzed with assistance from the UVA Microbiology department to identify types and quantity. We will then experiment with various disinfectants such as Lysol spray/wipes, soap and water, alcohol, bleach, UV light, etc. Objects will be re-swabbed and re-grown on agar, and results analyzed to see if there was a decrease in total micro-organisms and elimination of potentially hazardous germs like E.Coli. We will survey the parents before and after the cleaning interventions to see if their children are experiencing any notable decrease in contracting communicable diseases. Once we identify the best cleaning intervention (weighing cost, time, and microbiological result data), we will institute that solution in our clinic to minimize health-care associated infections and ensure compliance with JCAHO goals. Results and conclusions will be available by the IPS Conference date.

POSTER 2-35

The Sachs Factor: A Novel Mathematical Model to Predict Patient Growth in Rural Telemedicine Clinics

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Abstract: Telemedicine Psychiatry Clinics are expanding around teh country, especially in rural markets, where shortages of psychiatrists exist. A review of the literature shows little assistance in helping to predict the growth of a new, rural telemedicine clinic. Such information would be vital in helping to allocate resources, budget costs, hire the appropriate staff, and predict fiscal viability. This study proposes a novel mathematical model that predicts patient growth of a new rural telemedicine clinic. Microsoft Excel was used to collect four years worth of demographic information from several new rural telemedicine sites. Different types regressional analysis (linear, exponential, power, logarithmic) were applied to the four-year data. Best fit trendlines showed the coefficient of determination (R2) was highest for the generic exponential model y=a times b^x. The exponential model was also verified through sum of least squares. My equation hypothesizes y=a/1800 x 2.1^x, where y=yearly number of patients seen, a=2010 census county population <18 years old, and x=number of years since the clinic was opened. The variable a/1800 is the predicted starting number of patients halfway through year 0, and was determined by averaging the first-year number of patients midway through the year and applying linear regressional analysis using census information on the number of children in each county. The coefficient 2.1 was determined by taking a population-weighted average of the exponential linear regression coefficient of determination (R2). This equation appears valid for predicting growth in the first four years of a clinic. The equation y=a/1800 x 2.1^x can be used to predict total patients in a new telemedicine clinic in years 0-4. I also hypothesize a Logarithmic model to forecast the future growth of a telemedicine clinic in years 5-10. I tested several types of regressional analysis (linear, exponential, and logarithmic) for years 2-4. The logarithmic regresson had the highest R2 values. Years 5-10 were then forecasted by asking Excel plot future forecast points based on the logarithmic regression equation. Future years 5-10 will require model verification the present time is reached. This computer model makes some assumptions, namely that the children/adolescent psychiatric telemedicine clinic is operating in a rural environment, that no other children/adolescent psychiatric services are available (sole provider), and that supply (staff) can always fulfill increasing demand (new patients).

POSTER 3-1

The Effectiveness of Modern Treatment Modalities on Reducing Recidivism in Sexual offenders: A Systematic Review and Meta-Analysis

Monica Chawla, M.D. (mchawla@psych.umaryland.edu)

Abstract:

Context: Sexual offense crimes are an increasingly focused upon topic in American news and politics. Little is known about effects of any form of treatment on sexual offenders.

Objective: The examiners wished to determine whether any form of treatment for sexual offenders impacted rates of repeated sexual offense in people with history of sexual offense charges. Interventions examined included various forms of therapy, including CBT, multisytemic therapy, and group therapy.

Data Sources: Searches of the Cochrane database, PubMed, and PsychInfo were performed for studies published through September 2010 to identify studies regarding sex crimes.

Study Selection: Studies included were randomized control trials of sex offenders exposed to some form of treatment in an attempt to prevent reoffense. These studies were required to follow subjects for at least 18 months and examined males and females ages 12-65. Two independent raters examined studies meeting criteria to ensure that the inclusion criteria were met. A total of three studies were found to meet eligibility criteria.

Data Extraction: Random-effects meta-analysis was performed with between-study heterogeneity assessed using the Q statistic.

Results: Rates of sexual reoffense in 935 adults randomized to receive treatments showed no significant difference in rates of reoffense. Meta-analysis of these studies shows that overall there is no statistically significant improvement in rates of reoffense compared to offenders who did not receive a variety of treatment modalities (RR 0.96 (CI 0.90-1.02)). Rates of reoffense in 48 adolescents who received treatment versus usual community services showed significant decrease in rates of reoffense in the therapy group suggesting treatment interventions in this population may be more effective than in adult offenders. Each study included showed high risk of bias through Cochrane risk of bias assessments and heterogeneity was calculated I2 =82.8%.

Conclusions: The study results show thus far there are no therapeutic interventions found to be helpful in decreasing rates of sexual reoffense among sex offenders. However, more research is needed, particularly in the juvenile population since research seems promising that this population may show significant improvements in rates of reoffense.

POSTER 3-2

Police Encounters with Persons with Mental Illnesses: An In-Depth View of Encounter Characteristics and Predictors of Resolution, Referral, or Arrest

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Abstract: Approximately 10% of police officers' encounters involve individuals with serious mental illnesses, and officers serve in many ways as gatekeepers to both the criminal justice and mental health systems. The Memphis model of the Crisis Intervention Team (CIT) program has become an exemplary pre-booking jail diversion model across the country, with very widespread implementation. The 40-hour CIT training, along with concomitant local service reforms, aims to improve officer and patient safety, enhance access to mental health services, and reduce unnecessary incarceration for minor violations by people with serious mental illnesses when appropriate. We provide an in-depth examination of 93 CIT-trained and 90 non-CIT-trained officers' actual encounters (n=1,098) with individuals who they suspect to have a serious mental illness, addictive disorder, or developmental disability. Data collection entailed officers completing encounter forms immediately following select interactions during a 6-week period. Some 183 officers provided a median of 4 encounter forms (range, 1–30), detailing subjects' basic demographic characteristics, behaviors, and level of resistance, as well as the officers' perceived risks, use of force, and dispositional decisions. Subjects were generally cooperative (69%) and officers' physical presence and authority (lowest degree of force) was sufficient in many encounters (39%). In encounters that resulted in arrest, a main effect for CIT-training (p=.003) and department (p=.006) was observed. The likelihood that all of an officer's documented encounters would not end in an arrest was twice as high for CIT-trained than non-CIT-trained officers, supporting one of the overarching goals of the CIT model (pre-booking jail diversion). Other interesting findings emerged from analyses examining predictors of dispositions. Encounter-level variables found predictive of disposition included dispatch initiation, encounter during business hours, encounter in a private home, officers' awareness of a mental health or addictive disorder diagnosis, officers' awareness of psychiatric medication use, and risks that were identified. Officer level analyses found CIT-training, age, and years as an officer to be predictors of disposition. Subject-level predictors included suspected mental illness, alcohol or drug problem, or disability; male gender; aged 40 or older; 3 or more symptoms noted; and a higher level of resistance. These findings and pertinent programmatic implications will be presented. Additional research on officers' encounters and patient-level outcomes of the widely implemented, police-based CIT model is clearly warranted.

POSTER 3-3

The Effects of Antidepressants on Neuropsychological Functioning Related to Combat Performance

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Abstract:

Objectives: Psychiatrists are sometimes asked to make recommendations as to if a patient should be allowed to carry a firearm. Unfortunately, there are no established criteria for how such a determination is to be made. The objective of this study was to establish what factors predict aspects of firearms performance, and lay the groundwork for more evidence-based methods of screening.

Methods: Subjects between the ages of 18 and 65 were recruited from military bases and clinics in San Diego. Both psychiatric patients and controls were included. Participants were excluded if they were suicidal, homicidal, psychotic, bipolar, or owned the video game being used. Participants who gave informed consent were asked about demographics, psychiatric symptoms, psychiatric medication and treatment. They were then given a traditional, computerized assessment (the Automated Neuropsychological Assessment Metric) and asked to engage in simulated target shooting and firefights using a video game and a light gun (Lethal Enforcers). Performance in the video game was measured with overall "score," and by recording target accuracy, number of times a person reacted too slowly and got shot, and the number of times that an incorrect (civilian) target was hit. Correlations were examined among firearms performance, psychiatric symptom scores, and traditional measures of neuropsychological function. T-tests were used to examine firearms score between patients and controls, as well as those who were, and were not, taking psychiatric medication. Finally, stepwise linear regression models were constructed to best predict firearms score, and safety (civilian targets hit), based on available information.

Results: Eighty participants, including 65 patients and 15 controls, enrolled in the study. Firearms score was significantly correlated with reaction time ($R=0.41$, $p<0.01$), and tendency to shoot an incorrect target was correlated with go/no-go testing ($R=.31$, $p<0.01$). Psychiatric patients, as a whole, did not score worse with firearms performance than controls, and depression, anxiety and PTSD symptom severity did not correlate significantly with firearms performance (all $p>0.05$). In linear regression modeling, gender and simple reaction time were the best predictors of firearms score. Go/no-go testing, hand steadiness, and procedural reaction time predicted safety.

Conclusions: Being identified as a mental health patient, or self-report of symptoms for depression, anxiety or PTSD did not predict performance in a simulated firearms exercise. Gender and reaction time were the best predictors of simulated combat firearms performance, and go/ no-go testing was the

best predictor of firearms safety. Psychiatrists may be better served to use neuropsychological testing rather than symptom severity in determining who should carry weapons. Further work is needed to establish norms, and examine real world performance.

POSTER 3-4

Predictive Ability of the Treatment Motivation Questionnaire (TMQ) in Substance Abuse Treatment

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Summary:

Background: Motivation is thought to be a powerful predictor of success and prevention of relapse among patients who have gone through the substance abuse treatment. There have been numerous studies relating types of motivation to different problems, but studies of the effects of types of motivation on addiction treatment are scant. The Treatment Motivation Questionnaire (TMQ) was developed to assess four domains of motivation in seeking treatment and abstinence from substance abuse: external motivation, internal motivation, interpersonal help seeking, and confidence in treatment.

Methods: Seventy-five male and female veterans in the Salem Veterans Affairs Medical Center completing the 28 day residential substance abuse treatment program, completed the TMQ in the final week before graduation from the program. We followed these participants for one year and measured how frequently they attended outpatient aftercare group and individual therapy. Substance use was assessed at 3-, 6- and 12-months using the Form-90 interview, collateral report and substance use screens. We evaluated the predictive ability of the TMQ by dividing participants into high, medium and low groups on each of the TMQ scales. Finally, we compared these groups on measures of aftercare attendance and substance use. We hypothesized that veterans scoring higher on the TMQ scale would have better outcomes than those scoring low on these scales.

Results: We found no effects for level of internal motivation, external motivation and confidence in treatment on treatment attendance or substance use following residential treatment. However for interpersonal help seeking we found an effect on aftercare attendance (p =.029). Those participants with a high level of motivation for help seeking were more likely to attend aftercare treatment in the first month following residential treatment than those with a low level of this motivation. However, those with initially low motivation for help seeking were more likely to attend aftercare during the fifth and sixth month following residential care than those with a high level of this motivation.

Conclusions: In general, the results did not support the ability of the internal motivation, external motivation, help-seeking motivation, or confidence in treatment scales of the TMQ to predict treatment adherence or outcome. However future research should examine whether administering the TMQ earlier in treatment may successfully predict treatment outcome. In the current study, those with low levels of motivation may have been less likely to complete residential treatment and would not have been eligible to enroll in this study. Similarly, it is possible that those completing residential treatment had significantly improved their motivation level as a result of being in treatment for three weeks prior to enrollment. This would have diminished the ability of the TMQ to predict treatment outcome in this sample.

POSTER 3-5

Prior Authorization Document and Its Impact on Psychiatric Prescribing

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Abstract:

Background: Prior authorization document is a form that is filled by health care professionals. It is a certification or authorization that an insurer provides prior to medical service occurring. Obtaining an authorization means that the insurer is obligated to pay for the service, assuming it matches what was authorized. Many smaller, routine services do not require authorization. Prior authorization is required for medical services as well as mental health services.

Methods: The MHPA (mental health parity act) signed into law on September 26, 1996, requires that annual or lifetime dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan or health insurance. MHPA applies to group health plans for plan years beginning on or after January 1, 1998.

Although recognition and treatment of mental health disorders have become integrated into routine medical care, inequities remain regarding limits on mental health outpatient visits and higher copayments and deductibles required for mental health services when accessed. Two federal laws were passed by Congress in 2008: The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act and the Medicare Improvements for Patients and Providers Act. Both laws became effective on January 1, 2010 (reference 1). The goal of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity (MHPAE) Act of 2008 is to eliminate differences in insurance coverage for behavioral health (reference 2 and 3 and 4).

Results: In psychiatric prescribing, PA has been extensively used for antipsychotic medication usage. Some studies suggest that PAs may actually lead to higher rates of treatment discontinuation and hospitalization (reference 5). Similarly, for bipolar disorders in various studies (reference 6), PA forms have led to more medication discontinuation rates and reduction of mental health visits after treatment discontinuation (reference 6, 7, 8 and 9).

Conclusions: From the above studies we conclude that despite the mental health parity act and the MHSUD, psychiatric prescriptions are more often required than medical services for prior authorization. We conclude that this leads to more time utilization for the physicians, more frustration for the patients and higher rates of medication discontinuation. We also conclude that this leads patients to become non-compliant on their meds and they can't keep up with their appointments as well. Hence fewer medications should be subject to prior authorization in psychiatry.

POSTER 3-6

Forensic Implications in Neurodegenerative Disease: A Case Study Illustrating the Need for Comprehensive Statewide Adaption of Jail Diversion Programs

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Abstract:

Objective: This pilot study begins with a case report describing rapid deterioration, from unrecognized delirium during a month long incarceration, in a 54 year old Middle Eastern patient with frontotemporal dementia (FTD), to illuminate inherent difficulties in recognizing and treating acquired antisocial behavior stemming from neurodegenerative disease; and then broadens to proffer a solution: a jail diversion template for state-wide adaption.

Background: A central tenet of jail diversion programs is expansion of the current framework on criminal recidivism risk factors in general populations to encompass disparate risk factors of the mentally ill(1). While antisocial personality disorder is a significant risk factor in general populations, the leading cause of criminal recidivism in the mentally ill is fragmented treatment; therefore prevention is contingent upon increasing access to psychiatric services(2). While the framework addresses general psychiatric disorders, its efficacy in successfully diverting patients with FTD remains unknown. Mario Mendez, when discussing moral issues surrounding criminal intent in the FTD population, suggests antisocial behaviors may be acquired through anatomical brain damage, and cites studies that suggest brain dysfunction in 61% percent of habitually aggressive persons(3). Thus, it is important to differentiate acquired sociopathy from antisocial personality disorder when creating jail diversion programs.

Methods: The study design compared the 3 New Jersey county (Atlantic, Essex, Union) pilot diversion programs to determine both the current system limitations and also the most efficient extant post-booking county program. Data was amassed and grouped into the following categories: number of persons assessed, pre-adjudicated, enrolled into post-booking program, successfully linked to mental health programs, and linked to housing. Structural similarities and differences in NJ programs were compared against state diversion programs in Connecticut, Tennessee and Texas.

Results: Successful adjudication was predicated on immediate linkage to psychiatric care. Union county used a centralized review process through their public defender's office to evaluate detainees for diversion which led to an 8-fold increase in successful adjudications prior to prosecution when compared to the other counties. The template derived from the funneling system of the Sequential Intercept Model(4) and balanced the Union county post-booking prototype with a prebooking proposition, inspired by the success of the Memphis, Tennesse police crisis intervention team (CIT), for implementation of state-mandated police corps training to differentiate intentional misconduct from neurodegenerative aggression. An educational protocol guideline to foster this implementation was also created and presented to the state jail diversion task force.

Conclusion: Increasing awareness of neuropsychiatric behavioral changes to better differentiate such pathological processes from criminal recidivism at the earliest possible juncture of the forensic process remains a formidable goal, one integral to improving clinical outcomes and salvaging dignity even amidst neurocognitive decline.

POSTER 3-7

Mental Health Program Organizational Factors and Risk of Hospitalization Among Veterans with Serious Mental Illness

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Abstract:

Objective: This study examined the effects of variations in treatment organization supportive of integrated medical and psychiatric care (care comprehensiveness, care coordination, care continuity, and provider communication) on psychiatric and medical admission status of patients with serious mental illness (SMI).

Methods: Using data from a large national survey of 107 Veterans Administration sites (the Mental Health Program Survey) and national databases of patients with SMI (the National Psychosis Registry), this study operationalized treatment organization measures and examined how these measures were associated with psychiatric and medical admission status of SMI patients during FY2007.

Results: Using a sample of 62, 129 patients, several measures of treatment integration were associated with admission status. After controlling for patient demographic and clinical factors, availability of case management treatments (OR = 1.10, p<.01), increased levels of medical coordination by mental health staff (OR = 1.15, p<.05), and increased timeliness of medical feedback from medical to mental health staff (OR = 1.33, p<.01) were associated with an increased probability of psychiatric admissions within one year. However, patients receiving care at sites with more specialized SMI clinics (OR = .97, p<.05),

more traditional SMI treatments (OR = .95, p<.01), more case management treatments (OR = .95, p<.05), and increased provider/patient matching (OR = .97, p<.01) were less likely to have a medical admission. Increased numbers of recovery-based treatments (OR = 1.06, p<.01) and increased medical screens performed within mental health clinics (OR = 1.05, p<.01) were associated with increased risk of medical admissions after adjustment. Risk of admission was also associated with several patient demographic and illness measures.

Conclusions: Organizational measures of treatment integration allowed for insights into potential factors that influence care outcomes for this symptomatic and high-utilizing group. Additional consideration of the role of mental health staffing and SMI treatment resources in reducing preventable hospitalizations is merited.

Funding sources: VA Advanced Fellowship; VA HSRD IIR 07-115 (PI: Kilbourne)

POSTER 3-8

Relationship Between Mental Health and Body Mass Index

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Abstract:

Introduction: Obesity and overweight is a major health problem in the population. It may lead to many other health problems including increased mortality, hypertension, diabetes mellitus, heart diseases and individual's mental health state. The aim of this study was to assess the relation between Body Mass Index (BMI) and mental health status.

Material and Methods: This cross-sectional was performed in Tabriz, a major city in the northwest of Iran. The study sample was the subjects referred to the Assadabadi regional health center including 500 healthy individuals. Data for sex, age, weight, height, family size, income, education and job were gathered using a validated questionnaire. A 28-items validated questionnaire was also used for the assessment of mental health.

Results: The study sample comprised 127 men and 373 women. The mean age for males and females were 37.9 and 32.9 years, respectively. The BMI in 36.5%of the study subjects was normal, while 33.5 and 22.9 percents of subjects were overweight and obese, respectively. According to the 28-GHQ questionnaire, 51.8 percent of study subjects had normal mental health index where another 48.2 percent suffered of abnormal mental health status. There was a statistical significant association between BMI and mental health status (p=0.015).

Conclusion: Our findings indicated that the body weight and individual psychological factors may have an influencing role on each other. These findings may help clinicians and health authorities in the control and prevention of these health problems in the community.

Keywords: Mental Health, Body Mass Index, GHQ

POSTER 3-9

Differences in Patient Characteristics and Process/Outcome Measures Between Latina and Caucasian High Risk Mothers in a Collaborative Care Program

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Abstract:

Objective: This project compares patient characteristics, process of care measures, and depression treatment outcomes of Latina and Caucasian high risk pregnant and/or parenting women treated in six community health centers participating in a collaborative care program in King County, Washington. To date, few studies have examined patient characteristics of low income Latina and Caucasian mothers treated in collaborative care programs.

Methods: The Mental Health Integration Program (MHIP) is a collaborative care system that treats a diverse safety net population that includes the disabled, veterans, elderly, and high risk mothers in Washington State. Between January 2008 and February 2011, 17,783 patients were treated in MHIP. 408 Latina and 130 Caucasian high risk mothers with probable depression (PHQ-9>=10) at baseline were included for descriptive analysis and Kaplan-Meier survival analysis. The number of follow ups during course of treatment was selected as the process measure. Median time to 50% improvement in PHQ-9 score was selected as the outcome measure. All data were collected as part of general clinical practice.

Results: Latina and Caucasian patients differed on the following baseline demographic and clinical characteristics: age, pregnancy status at baseline, language preference, and baseline PHQ-9 score. Latina patients were less depressed than Caucasian patients at baseline (mean PHQ-9:15.13 and 16.49 respectively, p=0.002). Of the entire sample, 34% reported suicidal thoughts at baseline (no difference between the two groups). During the course of treatment, Latina patients received more follow ups from the care manager (mean number of follow ups: Latina: 7.51, Caucasian: 4.27, p=0.0001). Latina patients had a median time to reach 50% PHQ-9 improvement of 12.14 weeks compared with 15.86 weeks for Caucasian patients (p=0.041).

Conclusion: We found differences in patient characteristics, process indicators, and depression treatment outcomes between Latina and Caucasian high risk mothers in this collaborative care program. Both Latina and Caucasian women were moderately depressed. Although Latina patients had less severe depression than Caucasian patients at baseline, a substantial proportion of both groups were experiencing suicidal thoughts. Latina patients received more follow ups and rapid improvement in depressive symptoms compared to Caucasian patients. These findings present implications for improving clinical outcomes for patients of differing

ethnicities treated in collaborative care programs. In order to understand the differences in both process and outcome measures seen in this study, further studies are needed to examine the relationship between process measures and depression outcomes. The research was supported by grant T32 MH20021-13 (Dr. Katon) from the Health Services Division of NIMH.

POSTER 3-10

A Preliminary Look at the Impact of Peer Navigation Program Designed to Reduce Health Disparities Among Individuals with Serious and Persistent Mental

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Abstract:

Background: Though well documented, health disparities among people with serious and persistent mental illness (SPMI) have largely been unaddressed. Individuals with SPMI have a shorter life expectancy than the general population, with the majority of excess deaths due to cardiovascular disease (CVD), and are not explained solely by increased suicide rates (1). National progress in reducing CVD mortality has not proportionately impacted those with SPMI, suggesting the disparity may be due to a lack of access to both primary and secondary prevention and treatment, stigma, or other factors unique to people living with SPMI. Patient navigators are being increasingly relied upon to reduce barriers to care, improve patient adherence, and enhance care coordination for cancer treatment and screening and as well as other chronic diseases. Navigators are trained peer health educators who help identify barriers, arrange for needed supports, and provide "high touch" services like accompanying patients to appointments. Researchers have found that patient navigation can significantly improve adherence and coordination of care and potentially save lives (2).

Methods: The Peer Navigation Service (PNS) at Boston Medical Center enlisted mental health consumers to serve as peer navigators to help other mental health consumers access and follow through with medical care, specifically to increase the prevalence of screening for CVD (Serum glucose and lipid profile) as specified in best-practice guidelines. Program participants were limited to people with schizophrenia, bipolar disorder, schizoaffective disorder, psychotic disorder, and major depressive disorder with psychotic features.

Results: PNS clients range in age from 23 to 75 (M=45) and over half are male (n=81, 60%). Fifty-six percent of participants are African American, while 30% are Caucasian, and 10% are Hispanic. Most participants had a qualifying diagnosis of bipolar disorder (55%) while schizophrenia (26%) and schizoaffective disorder (16%) represented the second and third most common diagnoses. Forty-four percent of patients receiving PNS have a documented comorbid substance use disorder. Of the subset of participants who were interviewed (n=50), receipt of PNS services was associated with receiving appropriate CVD screening as well as visits with primary care physicians.

Conclusion: Reducing the health disparities experienced by people with serious mental illness requires flexible and innovative solutions. Our preliminary results show promise for the role of Peer Navigators in improving the health care of those with SPMI.

POSTER 3-11

Non-Responders Explain Length of Stay for Acute Psychiatric Admission

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Abstract:

Objective: Hospital services face formidable challenges to reduce costs while maintaining quality care. Hospital administrations exert effort to reduce length of stay (LOS). This study sought to identify LOS related factors in an urban academic medical center psychiatric unit. Medical comorbidity, substance use and involuntary status are linked to increase in LOS but no recent study has examined effects of treatment failure or non-response. We hypothesized that failure to respond may account for substantial variance in LOS and sought to compare this with well-established predictors.

Methods: Data were obtained by chart review of consecutive admissions at University Hospital from July through October of 2009 (N=389). The unit has 12 beds for involuntary admissions (civil commitment)subject to judicial review no later than 20 days after admission. Overall mean LOS was 11.3 days during the study period compared to an expected LOS of 9.5 days (University Hospitals Consortium). The following factors were examined: demographics; administrative (arrival method, commitment status, in hospital transfers); psychiatric; medical comorbidity; medication-related (number and class of prescribed drugs); and disposition status, community or long term care (LTC). Significant predictors of LOS were included in a forced entry hierarchical regression model. Strength of association (effect size) of each predictor was defined as the percentage of explained variance in LOS (change in R2).

Results: At discharge 60% had a psychotic disorder. Nearly 34% had mood disorders while 34% had multiple Axis I diagnoses. Less than half were female (41%); 69% were African American. We identified reliable predictors of LOS in each domain including age>60, presence of psychotic disorder, comorbid substance use, hypertension, involuntary status, and method of arrival, but no single factor explained more than 5% of the variance with the exception of treatment response (unadjusted R2=0.27; p<0.01). When grouped by domain and entered in the following fixed sequence, administrative factors explained 8.7% of the variance in LOS, psychiatric diagnosis, 3.1%, comorbid substance use, 9%, and medication-related

factors, 7.5%. After controlling for these factors, treatment response (community discharge versus LTC) uniquely explained 27.6% of the total variance.

Discussion: Psychiatric patients requiring continued commitment account for more variance in LOS than administrative, psychiatric or medical factors. Despite improved medications and a multidisciplinary team approach, a substantial proportion of inpatients cannot be safely discharged after an acute hospital stay (~3 weeks). This fact should inform decision making by hospital administrators and insurance adjusters who may have unrealistic expectations about LOS. Better pharmacologic treatments coupled with more intense and innovative outpatient support mechanisms may help reduce inpatient stays and costs.

POSTER 3-12

Relationship of Parental Military Deployment to Child Psychiatric Hospitalizations in the US Armed Forces

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Abstract:

Background: Members of the US armed forces have been heavily deployed in support of wars in Afghanistan and Iraq. The stress from deployments to war extends to military children through several mechanisms including loss of a parent for extended periods of time and uncertainty for the parent fs safety.

Objective: Determine the effect of parental military deployment in support of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) on the rates of psychiatric hospitalization in children aged 9 to 17 years.

Methods: This was a retrospective cohort study. Records of children of active duty personnel during fiscal years 2008 and 2009 were linked with their parent fs deployment records. Psychiatric hospitalizations were identified using ICD.10 codes. Odds ratios (OR) of a hospitalization were determined using logistic regression. Potential modifying effects of various independent variables were tested using logistic regression.

Results: A total of 410,746 children aged 9 to 17 years were included along with data on their active duty parent. Mean child age was 12 years (SD: 2.5 years); 50.8% were male. Mean age of active duty parent was 37.6 years (SD: 5.2 years); 91% were male, 90% were married, 60% were white. 2,289 children in the study were hospitalized for a mental or behavioral health disorder in fiscal year 2008 and 2,770 children were hospitalized in fiscal year 2009 with an average length of stay of 27 days (SD: 47 days). 32% of the children had a parent who deployed in support of OIF and OEF during the period of study. The average cumulative length of deployment was 296 days (SD: 136 days). The OR of hospitalization for children with a deployed parent compared with an active duty parent who did not deploy was 1.12 (95% CI: 1.04.1.22; P =0.0036). The OR remained significant after adjusting for a history of prior hospitalizations (P=0.0291) or any significant prior mental health history (P = 0.0366). The OR of hospitalization among children with parents who deployed less than 180 days compared with children whose parents did not deploy was 1.095, although this was not statistically significant (P=0.2122). The OR of hospitalization among children with parents who deployed greater than 180 days was 1.132 (CI 1.039, 1.234 (P=0.0044)). A test of trend was statistically significant (P=0.0035). The risk of psychiatric hospitalization if a parent deploys increased if a child was male (OR 1.16 (P=0.0075)), the active duty parent was male (OR 1.15 (P=0.0007)), the active duty parent was Caucasian (OR 1.16 (OR (0.0022)), the active duty parent was married (OR 1.182 (P<0.0001)) or the child changed residences in the past year (OR 1.24 (P=0.0057)). The OR of hospitalization for mental or behavioral health disorders if a parent deploys is reduced if the active duty parent is single (OR 0.723 (P=0.0142)).

Conclusion: The odds of psychiatric hospitalization increased by 12% among children age 9 to 17 years when a military parent was deployed. The odds of hospitalization increased with increasing length of a parent fs deployment. The odds increased among children who were male or moved in the last year and children whose active duty parents were Caucasian, married or male. The odds were reduced among children with single, active duty parents.

POSTER 3-13

Prevalence and Age-Related Differences in the Utilization of Restraint and Seclusion in Psychiatric Inpatient Care

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Abstract:

Background: The use of restraint and seclusion is highly regulated in psychiatric inpatient settings. However, very little data are available on patient characteristics that lead to restraint and seclusion, including effects of age and specific behaviors that lead to restraint and seclusion. As currently defined many actions commonly taken by parents at home (sending a child to their room, breaking up a fight) are classified as restraint and seclusion. This presentation presents data on restraint and seclusion over a two year period at a private psychiatric hospital, including child, adolescent, and adult inpatients.

Methods: Two years of restraint and seclusion data were analyzed on a total of 3504 unique patients. Types of seclusion included in-room seclusion on the treatment unit and off-unit seclusion in a separate seclusion room. Restraints included short term (<15 minutes) and longer term (>14 minutes) therapeutic holds. In addition oral and IM medication usage was also recorded. A variety of precipitants of these events were examined, including physical and verbal threats, stabbing with or throwing objects, and attempts to elope, hurt one's self or another, or to destroy property.

Results: Out of 3504 cases, 738 cases had one or more seclusion events. Among these cases, the modal number of events was 1 (n=194). Child patients had the highest frequency of events (n=396, M=11.5) and adults had the lowest frequency (n=35, m=3.3). There were notable differences in the types of seclusions experienced, with child patients largely experiencing in room-seclusion on the unit (9.2/11.5 events), while adult patients were much more likely to receive off-unit seclusion (2.9/3.3 events). Every potential precipitant to seclusion, other than attempted self-harm, was more common in children than in adult or adolescent patients. Finally, the level of agitated behavior in this sample was considerable, with child patients averaging over 45 disruptive incidents per admission. In fact, each restraint or seclusion event occurred in response to an average of 2.8 disruptive incidents and the child patients averaged 1.5 serious disruptive events per day.

Discussion: Restraint and seclusion events are rare and when they do happen, their modal frequency was one time per admission. Individuals with high levels of restraint and seclusion were typically children with very high levels of disruptive and dangerous behavior. The typical seclusion event involved being sent to their room with the door open, which is a strategy commonly employed by parents.

POSTER 3-14

Homeless and Housed Inpatients with Schizophrenia: Disparities in Service Access Upon Discharge from Hospital

Vicky Stergiopoulos, M.D. (stergiopoulosv@smh.ca)**, Tara Burra, M.D., Stephen Hwang, M.D., Sean Rourke, Ph.D.**

Abstract:

Objective: This study examines differences in services available at the time of discharge for homeless and housed psychiatric inpatients and explores the determinants of these disparities. Self-reported service use and perceptions of social and health services were also compared.

Methods: Participants diagnosed with schizophrenia or schizoaffective disorder were recruited from an acute psychiatric inpatient unit in an urban general hospital. Thirty homeless individuals and 21 housed controls (matched for diagnosis, gender and age) completed a cross-sectional questionnaire and clinical interview with assessment of functional capacity. Data on services arranged at the time of discharge were extracted from the electronic health record. Factors associated with access to services at the time of discharge were examined using logistic regression models.

Results: Despite a similar duration of hospitalization to housed participants, homeless participants were significantly less likely to have access to a family physician, intensive case management, assertive community treatment, income support or prescription drug coverage at the time of discharge. In multivariate regression models controlling for race, symptom severity, functional capacity and substance use, the duration of homelessness was a negative predictor of accessing housing, income support or intensive community support at the time of discharge from hospital.

Conclusions: Although inpatient hospitalization presents an opportunity to reduce homeless people's barriers to accessing health and social services, our results show inequities for homeless people persist at the time of discharge. Assessing interventions such as treatment guidelines, discharge checklists, and decision support tools to address such inequities should be a system and research priority.

POSTER 3-15

Japanese University Students' Management of Their Health and Their Anamnesis and Clinical History

Mika Tanaka, M.D. (mtanaka@gifu-u.ac.jp)

Abstract:

Purpose: We conducted a questionnaire survey to investigate the management of health and living environment among Japanese university students.

Method: Subjects comprised 4213 students at our university who completed an annual student health check in 2011 and agreed to complete a questionnaire about life situations, including health maintenance measures, anamnesis and present clinical history, employment status, and sleep patterns. Responses from a total of 3704 students (2226 men, 1479 women; 87.9% recovery rate) were analyzed.

Results: A total of 980 students (26.5%) indicated that they had spent time and money on health maintenance at some point in the past. This response was significantly more common in males than in females. Students also reported having experience with health maintenance measures such as "exercise" (n=329), "sports" (n=260), "supplements" (n=199), "massage" (n=79), and "health foods" (n=58). With respect to sleep pattern, most students (n=1935) responded that they usually received 6 hours of sleep. Students were classified into groups to assess anamnesis and whether students regularly performed health maintenance activities was examined in each group. In the "students with psychological anamnesis" group (n= 40), 22 students (55.0%) regularly performed health maintenance activities; this proportion was the highest of all anamnesis groups. Next was the "students with physical anamnesis" group (n=1561), in which 454 students (29.1%) regularly performed health maintenance activities, followed by the "students without anamnesis" group (n= 2103), in which 504 students (24.0%) regularly performed health maintenance activities. Significant differences were observed among the anamnesis groups, and this tendency was also seen in the present clinical history categories. In the "students with psychological present clinical history" group (n= 26), 14 students (53.8%) regularly performed health maintenance activities; this proportion was the highest of all present clinical history groups. Next was the "students with physical present clinical history" group (n=729), in which 213 students (29.2%) regularly performed health maintenance activities, followed

by the "students without present clinical history" group (n= 2949), in which 753 students (25.5%) regularly performed health maintenance activities.

Discussion and conclusion: Almost one-fourth of the surveyed students reported spending time and money to maintain their health at some point in the past. Many students took complementary and alternative medicine supplements and health foods. The present findings suggest that the existence of psychological anamnesis and clinical history affects health maintenance activities among Japanese university students.

POSTER 3-16

Developing Curriculum and Training Opportunities for Psychiatry Residents in Global Mental Health

Karen J Mu, M.D. (karen.mu@gmail.com)**, Ph.D., Tierney Caselli, M.D.**

Abstract:

Objective: The World Health Organization (WHO) global burden of disease statistics indicate that, with the exception of Sub-Saharan Africa, chronic diseases are emerging as the major cause for burden of disease. Among these, neuropsychiatric disease constitute 31.7% of all years lived with disability and 1.4% of all years of life lost [1] As awareness of global mental health disparities has increased, we propose that cross-cultural psychiatric education should be an important part of these efforts. The primary objective of this pilot study was to assess University of California at San Francisco's psychiatry residents' attitudes and interests in Global Mental Health (GMH) training. This data will be used to develop core didactics in GMH for UCSF psychiatry residents, including an international training elective for fourth year residents. The broader objective is to use this data in conducting a needs assessment via a national survey study of psychiatry residency training programs on the existence of and need for training in GMH.

Methods: Surveys were administered to 60 psychiatry residents at the University of California at San Francisco from 2008-2010. Results from 47 residents were collected in 2008 and 2010 and analyzed.

Results: In total, 78% of residents responded to the survey. A majority of residents (89.7%) were interested in participating in a global mental health elective, with 74.5% of respondents specifically interested in participating in a one month GMH elective in East Africa (Uganda). The majority of participants expressed highest interest (70.5%) in clinical training, with 34.1% expressing high interest in Research and 48.8% in education and teaching. Other identified clinical interests include emergent use of ECT, neuropsychiatric manifestations of HIV, substance abuse, and child and adolescent psychiatry.

Conclusion: The majority of respondents expressed a high interest in participating in a global mental health elective. University of California at San Francisco's liaison with Makerere University in Uganda in programs such as general surgery, pediatrics, and internal medicine, is poised to be a potential important and mutually beneficial training site for global mental health for psychiatry residents. There is a disconnect between the desires of psychiatrists in-training to engage in global mental health training, the international clinical needs for better psychiatric care and awareness, and formal opportunities to bridge the two. We plan to broaden this pilot data to a national survey study of psychiatry residency training programs to assess the educational needs and opportunities for training in global mental health. Literature references: 1. Mathers CD and D Loncar: Projections of global mortality and burden of disease from 2002 to 2030. PLoS Med 2006; 3(11):e512. 2. Prince M et al: No health without mental health. Lancet 2007; 370(9590):859-77.

POSTER 3-17

The Toronto Psychiatry Clerkship: Innovations in Curricular Reform

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Abstract:

Background: University of Toronto has 229 Year 3 clinical clerks annually, and is soon to expand in student number and teaching sites. Clerks complete 6-week psychiatry rotations at 5 teaching hospitals, 6 times per year. Until 2008-09, hospital sites provided both clinical and didactic components of the curriculum. Sites were challenged to provide a high quality curriculum that was comparable across sites.

Description: A working group formed in 2007 to review the curriculum, and to propose a model optimizing both teaching quality and resource use. A new clinical clerkship was launched in 2009-10 that centralized and front-loaded the didactic portion of the curriculum, allowing hospital sites to focus on clinical teaching. Clerks each rotation meet together for part of weeks 1 and 4 of their 6-week rotation for harmonized curriculum delivery. Highly rated teachers from across the city lead the centralized group sessions. Interactive and innovative teaching approaches are encouraged, and supported by an educational consultant. A developmental perspective, with integrated child and adult psychiatry teaching across subject areas, is emphasized. More efficient time use allows for new content areas, including Eating Disorders, Somatoform Disorders, Psychotherapy, and expanded teaching in Psychopharmacology.

Evaluation: The new curriculum, student performance and student and teacher course satisfaction will be presented. Comparing 2008-09 (old curriculum) to 2009-10 (new curriculum), there are no significant differences in student performance on OSCE ($t=0.04$; $p=0.96$), short answer question ($t=0.27$; $p=0.79$) or multiple choice question ($t=0.14$; $p=0.89$) testing. Student evaluations of the course are also stable, except improved student ratings of the child and adolescent portion of the curriculum.

Conclusion: A year after curricular reform, data support maintained student performance and course satisfaction with introduction of an updated and more efficient clerkship curriculum.

POSTER 3-18

Is Wikipedia Taking Over Textbooks in Medical Student Education?

Maryam Namdari D.O., 3801 Conshohocken Avenue Apt 509, Philadelphia, PA 19131, **Carolina Retamero M.D.**

Abstract:
Objective: Educators and clerkship directors constantly struggle to recommend the best sources for medical students to obtain scholarly knowledge. In this era of smart phones and other technology at fingertips, it is easier than ever for learners to utilize internet resources. The authors investigate medical students' utilization of non peer-review websites, specifically Wikipedia, and compare its frequency of use to other more conventional study methods like textbooks, in preparation for their Psychiatry Subject Examination.

Methods: 186 medical students who had recently completed their psychiatric clerkship were surveyed regarding the type of learning styles or modalities that work best for them when studying for the rotation and Psychiatry Subject Examination.

Results: The most frequently used study modality was question books specifically designed for shelf preparation (87.63%). Wikipedia was used by 46.77% of students surveyed. Up-to-Date was used by 58.60% of students surveyed. Only 10.21% of students used traditional psychiatric textbooks. Most textbooks used were those made specifically for shelf-preparation (61.82%). All students who reported using Wikipedia also used other methods of studying. Of the students who used Wikipedia, 83.90% also used question books and 65.51% also used Up-to-Date.

Conclusion: Students are likely to utilize several resources to acquire scholarly knowledge during their psychiatric clerkship in preparation for their Psychiatry Subject Examination. The most striking finding was the high percentage of students who used Wikipedia, and the low percentage of students who used traditional psychiatric textbooks. Educators should be aware of the increased use of online non peer-review sites in medical student education.

POSTER 3-19

The Effect of an Experience of Auditory Hallucinations on Medical Students' Perceptions of Mental Illness

Indrani Naskar M.D., 3000 Arlington Ave, Toledo, OH 43614, **Lance Feldman, M.D., B.S.N., Mary Kay Smith, M.D.**

Abstract:
Objective: The objective of the study was to determine the effect of an experience of auditory hallucinations on medical students' perceptions of mental illness.

Method: This study was conducted on all medical students at a large, Midwestern academic medical center completing their core psychiatric rotation. Students voluntarily attended the session, during which the Hearing Voices recording was utilized. Each student received headphones and a listening device (tape player, MP3 player) and was asked to complete a specific task (e.g. make a phone call, purchase food, etc.). Primary study outcome measures were determined through use of a questionnaire developed specifically for this study. Results were quantified based on gender and proposed residency program choice.

Results: After participation in the auditory hallucination exercise, medical students noted that the session was helpful in their overall general medical practice as well as enabled them to better understand the challenges faced by people experiencing auditory hallucinations. Furthermore, through an analysis of the subjective response section of the questionnaire, medical student feedback provided insights into the training model and possible future opportunities for continued integration of experiential learning opportunities into the core psychiatric curriculum.

Conclusions: This exercise, providing a patient-oriented approach to understanding mental illness, can easily be adapted to any core psychiatric rotation. Curriculum development focused on patient's experiences can provide a lasting positive impact on medical student education.

POSTER 3-20

Developing Mental Health Advocacy Training for Psychiatry Trainees

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Abstract:
Objective: Psychiatrist participation in mental health advocacy is vital to ensure growth of quality mental health services in communities with increasingly strained resources. Psychiatrists' competencies and lifelong learning behaviors are forged during residency and fellowship, yet we lack evidence on knowledge, skills, and attitudes of psychiatry trainees and on potential educational interventions related to mental health advocacy. This study assessed trainees' perception of advocacy and their experience, comfort, and likelihood of engaging in advocacy. We then developed, conducted, and assessed a

mental health advocacy training workshop for trainees with the goal of improving knowledge, skills, and attitudes in mental health advocacy.

Methods: Psychiatry trainees in one residency program were anonymously surveyed in an initial needs assessment. Trainees were also surveyed before and after a subsequent mental health advocacy training workshop, which introduced mental health advocacy, presented interactive and didactic training modules in governmental, media, and community advocacy, and discussed ways of incorporating advocacy into trainees' lives and careers. Perceptions were assessed using a Likert scale (LS) ranging from 1 (least) to 5 (most).

Results: In the needs assessment survey, trainees (N=69) felt advocacy is important (mean LS 4.26) and were interested in advocacy training (mean LS 3.75). Trainees felt neutrally about their comfort in governmental, media, and community advocacy (mean LS 3.05, 2.85, 3.25, respectively), but felt unlikely to engage in governmental, media, or community advocacy (mean LS 2.14, 2.03, 2.38, respectively). Attitudes, experience, and training affected likelihood of engaging in advocacy. Following a mental health advocacy workshop, participants (N = 35) had significant increases in their perceived knowledge, skills, and likelihood of engaging in governmental (mean LS knowledge pre 2.35 vs. post 3.56, $p < 0.001$; skills pre 2.41 vs. post 3.41, $p < 0.001$; likelihood pre 2.47 vs. post 2.97, $p = 0.002$), media (mean LS knowledge pre 2.18 vs. post 3.35, $p < 0.001$; skills pre 2.12 vs. post 3.26, $p < 0.001$; likelihood pre 2.18 vs. post 3.03, $p < 0.001$), and community advocacy (mean LS knowledge pre 3.06 vs. post 3.53, $p = 0.002$; skills pre 3.00 vs. post 3.50, $p = 0.004$; likelihood pre 3.24 vs. post 3.56, p 0.086). Participants felt mental health advocacy was similarly important before and after the workshop (mean LS 3.67 vs. 3.73, $p = 0.677$).

Conclusions: Psychiatry trainees value mental health advocacy, but lack comfort and feel unlikely to engage in advocacy. They are interested in mental health advocacy training. An interactive training workshop improved their perceived knowledge, skills, and attitudes towards mental health advocacy. These data can be utilized to develop further interactive educational experiences to improve knowledge, skills, and attitudes in mental health advocacy.

POSTER 3-21

Anxiety Levels Amongst Medical Students

Rishi Gautam (rishgautam@hotmail.com)

Abstract:

Background: The study aims to assess the levels of stress anxiety in medical students and find any correlation with various causative factors.

Objectives: 1.To study the levels of Anxiety amongst Medical Students 2.To compare these levels with different variables and causative factors.

Study Design: Cross Sectional study in a medical college using a standard anxiety questionnaire(Sinha's Comprehensive Anxiety Test). At a premier central government medical college called Vardhman Mahavir Medical College, Safdarjung Hospital, New Delhi, India.

Participants: 310 medical students of all the batches currently studying in the college.

Results: Out of the 310 medical students who participated in the study, 150(48.4%) were found to have high anxiety levels. The prevalence of abnormally high anxiety levels was maximum in students belonging to the 3rd(66.1%),5th(47%),9th(49.3%) semesters. Anxiety levels were significantly higher amongst female students (61.3%) as compared to male students (43.2%) ($p<0.05$). Students living in the hostel had higher anxiety levels(56.1%) than students living at home(38.9%). 66.7% students cited Examinations as most important cause of high anxiety amongst them. No significant relationship was found between anxiety levels and their medium of schooling, or age.

Conclusion: The findings point towards very high prevalence of anxiety amongst medical students, with female students being more prone. Also, examinations instill enormous amounts of stress and anxiety which is clearly evident from very high anxiety levels amongst the students who had their examinations coming up (students belonging to the 3rd,5th and 9th semesters). Alcohol and drug abuse are grave consequences.

POSTER 3-22

Maintenance of Efficacy of Lisdexamfetamine Dimesylate in Adults with Attention-Deficit/Hyperactivity Disorder: Randomized withdrawal Design

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Abstract:

Objective: To evaluate maintenance of efficacy of lisdexamfetamine dimesylate (LDX) using a double-blind randomized withdrawal design in adults with attention-deficit/hyperactivity disorder (ADHD) on LDX >/=6 months.

Method: This multicenter trial enrolled adults (18-55 y) with ADHD on LDX (confirmed for >/=6 months; 30, 50 or 70mg/d final dose at entry), with acceptable tolerability, ADHD Rating Scale IV with adult prompts (ADHD-RS-IV) total score <22, and ratings <=3 on the Clinical Global Impressions-Severity (CGI-S) scale. In a 3-week open-label phase (OLP), participants continued treatment with the prior dose of LDX. Those continuing to meet entry criteria at the end of the OLP were eligible to enter a 6-week double-blind randomized withdrawal phase (RWP). Participants assigned to LDX in the RWP continued on the same dose used to confirm response in the OLP. The primary efficacy outcome was the proportion of adults having ADHD symptom recurrence (both a >/=50% increase in ADHD-RS-IV score and a >/=2 rating-point increase in CGI-S, both vs RWP baseline).

Efficacy assessments also included ADHD-RS-IV and CGI-S. Safety assessments included treatment-emergent adverse events (TEAEs) and vital signs.

Results: Of 123 enrolled adults, 122 were included in the OLP; 116 were randomized (LDX 56; placebo 60) and included in the efficacy analysis. Overall, 56.9% (66/116) of randomized adults were female, 91.4% (106/116) were white, and 7.8% (9/116) were Hispanic. At RWP baseline, mean (SD) ADHD-RS total score for LDX and placebo groups were 10.6 (4.96) and 10.6 (4.82), and CGI-S ratings were 2.1 (0.80) and 2.2 (0.78), respectively. At endpoint, a significantly (P<.0001) smaller proportion of adults taking LDX met criteria for ADHD recurrence and were withdrawn (8.9%; 5/56) vs placebo (75%; 45/60). Of 56 participants taking LDX and 60 taking placebo, 4 taking LDX and 26 taking placebo met ADHD recurrence criteria after 1 week of treatment in the RWP; at 2 weeks, no additional participants taking LDX vs 10 of the remaining participants taking placebo met criteria. During the OLP, 20.5% (25/122) had a TEAE; 1 resulted in withdrawal. During the RWP, 38.8% (45/116 [LDX 27; placebo 18]) had a TEAE; 1 TEAE (placebo group) was a serious AE. No TEAEs had incidence >/=5% in the OLP; TEAEs during the RWP with incidence >/=5% in adults taking LDX vs placebo were headache (14.3% vs 5.0%), insomnia (5.4% vs 5.0%), and upper respiratory tract infection (8.9% vs 0%). Mean changes in vital signs were small and clinically insignificant in the open-label and RWP phases.

Conclusion: In participants receiving long-term treatment, LDX demonstrated maintenance of efficacy vs placebo upon randomized withdrawal. ADHD symptom recurrence tended to occur early following discontinuation of LDX, mostly by 2 weeks, in the RWP. The safety profile of LDX was consistent with previous studies and long-acting stimulant use. Clinical research was funded by the sponsor, Shire Development Inc.

POSTER 3-23

Ziprasidone and Torsades Des Pointes: A Case Report

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Abstract: The Food and Drug Administration (FDA) approved Ziprasidone, a second-generation atypical antipsychotic, in February 2001. Ziprasidone prolongs Qt interval by blocking the rapidly activating component of the delayed rectifier potassium current I(kr). There has been constant dread in psychiatric practice about the use of Ziprasidone due to its propensity to cause QT prolongation and torsades des pointes. So, in this context we present a case of QT prolongation and torsades in a female taking prescribed Ziprasidone. Various causal factors contributing to QT prolongation were found like rheumatoid arthritis, Prozac, hydrxychloroquine, oxycodone overdose, alcohol withdrawal preventing direct causal relationship between Ziprasidone and Torsades.

POSTER 3-24

Risperidone-Induced Hyperprolactinemia

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Abstract:

Introduction: In children, hyperprolactinemia occurs due to prolactinomas, physiological stress, medications, hypoglycemia or rarely following endocrine abnormalities such as primary hypothyroidism. It is an important side-effect of conventional and some atypical antipsychotic medications. Based on adult and pediatric data, the relative potency of risperidone in inducing hyperprolactinemia is highest among atypical antipsychotics. On the other hand, aripiprazole has minimal impact on the prolactin levels. Instead, by virtue of its partial agonist activities, it may cause slight reduction of prolactin levels. Hyperprolactinemia causes primary or secondary amenorrhea and/or galactorrhea in girls. Boys usually present with galactorrhea and gynecomastia. In both sexes, hyperprolactinemia may delay pubertal maturation and slow linear growh may rarely be the initial presentation. In children and adolescents, antipsychotic induced hyperprolactinemia has been associated with increased risk of benign breast tumors and reduced bone density.

Case: A 7 year old Caucasian girl with agitation, vague psychotic symptoms and some behavioral issues secondary to autism was started on 1 mg risperidone daily. This resulted in effective symptom control, but she presented with tenderness and swelling in the breast area. Her serum prolactin was elevated at 198µg/L. General physical assessment and all other investigations were normal. Risperidone was stopped but the symptoms worsened. The child's family insisted on restarting risperidone. The treatment was reinitiated alongwith 1 mg Abilify (aripiprazole) after informed consent and discussion of reasons for initiation of aripiprazole. After one month, prolactin level dropped to 27 µg/L. The patient was asymptomatic and denied any tenderness in the breast region.

Results: The patient presented with symptoms of hyperprolactinemia caused by risperidone. Aripiprazole was added to risperidone during the later course of treatment. As a result, significant reduction in prolactin levels was observed. Treatment was well-tolerated and the child was clinically stable.

Conclusion: The patient presents in a risperidone-induced hypodopaminergic state. When aripiprazole is co-administered with risperidone, aripiprazole acts a dopamine receptor agonist by binding to the dopamine receptor more robustly. Hoffer et al reported a study on adult females who were on antipsychotic treatment with risperidone. The hyperprolactinemia successfully improved by the addition of aripiprazole. Bieder et al reported that aripiprazole has negligible effects on prolactin levels. However the effects of aripiprazole are still inconclusive and warrant further studies to assess and validate its effects in hyperprolactinemia. It appears that aripiprazole could be a useful treatment option in normalizing prolactin levels in

some patients. Furthermore, our case brought forth an ethical dilemma whether to add one antipsychotic to another, in order to reduce the side effects of first antipsychotic. Another concern is that aripiprazole is very expensive. Thus, a detailed cost effectiveness analysis on aripiprazole might help in treatment decisions.

POSTER 3-25

Do Veterans with PTSD Receive First Line Pharmacotherapy for PTSD? Results from the Longitudinal Veterans Health Survey

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Abstract:

Background: Treatment guidelines support the use of selective serotonin reuptake inhibitors (SSRI) and serotonin. norepinephrine reuptake inhibitors (SNRI) as first line pharmacotherapy for patients with PTSD. A central assumption is that the patient will receive an uninterrupted trial of a medication that is both adequate in length (at least twelve weeks) and of sufficient dosage; that is, a gtherapeutic trial. h There has been little research examining patient characteristics associated with receiving first line pharmacotherapy for PTSD.

Objective: The present study uses data from the Longitudinal Veterans Health Study (LVHS), an observational study of Veterans Administration (VA) patients recently diagnosed with PTSD, to examine patient factors associated with receiving first line pharmacotherapy, i.e., a therapeutic trial of an SSRI/SNRI antidepressant.

Methods: The sample consisted of 482 VA patients between the ages of 18 and 69 with a DSM.IV diagnosis of PTSD (309.81) received during any VA outpatient clinic visit between May 31, 2006 and Dec 7, 2007. Patients were randomly sampled from four strata. Veterans from the current conflicts in Iraq and Afghanistan and female Veterans were intentionally oversampled in this national survey. Responses were analyzed, in conjunction with archival and pharmacy databases, to determine if Veterans received first line SSRI and SNRI for PTSD. Multivariate logistic regression models identified associated sociodemographic and survey characteristics.

Results: As expected with oversampling, 50.4% were recent returnees from the current conflicts in Iraq and Afghanistan and 47% were female. The average age was 40 years, 68.8% of the sample self.reported race and ethnicity as white, 19.2% as African American and 14% as Hispanic and Latino. Of the 377 Veterans prescribed a psychotropic medication, 73% received an SSRI/SNRI, of which 61 % (N=168) received a therapeutic trial. In logistic regression models, Veterans who served in Iraq and Afghanistan were just as likely to be started on first line pharmacotherapy as Veterans from prior eras (OR 1.11 C.I 0.71.1.73) but were less likely to complete a therapeutic trial, (OR 0.44 C.I 0.26.0.75, p< 0.01) even when controlling for factors such as index clinic type, amount of PTSD psychotherapy received, severity of symptoms and history of inpatient mental health stay. In a post hoc analysis having a concurrent depression diagnosis moderated the relationship between being a veteran of the current conflicts in Iraq and Afghanistan and odds of receiving a therapeutic trial of first line medication. (OR=0.29, CI=0.09.0.94, p<0.05)

Conclusions: Our study shows reduced levels of prescribing amongst veterans from the current conflicts in Iraq and Afghanistan, a finding which parallels previous patterns of lower mental health treatment utilization in this population. Clinician prescribers should target resources to assess the specific health beliefs of this cohort of Veterans who have PTSD and Depression. Incorporating these findings into treatment plans may, in turn, increase the level of patient engagement in a therapeutic trial of medication. This work was supported by the U.S. Department of Veterans Affairs (VA) Office of Academic Affiliations Advanced Fellowship Program in Mental Illness Research and Treatment; VA Sierra.Pacific Mental Illness Research, Education and Clinical Center; the VA National Center for Posttraumatic Stress Disorder; and the VA P.

POSTER 3-26

Hypothermia Induced by Olanzapine and Risperidone in a Patient with Schizophrenia and Dementia: Diagnostic and Pathophysiologic Considerations

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Abstract:

Introduction: Schizophrenic patients receiving Antipsychotics are noted to have impaired thermoregulation. They most commonly cause Hyperthermia. Hypothermia, traditionally defined as a drop in core body temperature below 35 C (95F), is also a known side effect of both typical and atypical Antipsychotics.

Case Presentation: We encountered Hypothermia in a patient with Schizophrenia, and Dementia during the transition of his medication regimen from Risperidone to Olanzapine. The patient is a 72 year old male with Schizophrenia and Dementia, with chronic periodic paranoia and behavioral problems. His medication regimen has recently been adjusted, where Olanzapine was added while Risperidone was tapered down. He presented confused, with poor muscle coordination and shivering and found to be Hypothermic with a core temperature of 93 F (33.8 C). His Antipsychotic medication was withdrawn and managed in the MICU with Bair Hugger treatment. He encountered other medical complications including COPD exacerbation, but recovered fully after one week.

Discussion: Temperature dysregulation, is a known side effect of Antipsychotic medication. Sudden unexplained death in Schizophrenic patients could be linked to hypothermia. The

mechanism of temperature dysregulation remains unclear. Antipsyhotics induce hypothermia through at least three mechanisms: central inhibition of shivering, central action on the hypothalamus and peripheral vasodilation. Atypical Antipsychotics exert their action through antagonism at Dopamine, Serotonin and Alpha Adrenergic receptors. Seotonin (5-HT) is involved in both central and peripheral aspects of thermoregulation. Dopamine has been implicated in thermoregulation by a central effect on the hypothalamus.

Conclusion: There are several documented cases of hypothermia due to both Olanzapine and Risperidone individually. Both are potent antagonists at the 5-HT 2A Receptor, which can lead to temperature dysregulation. It has been suggested that in Dementia, especially those with white matter disturbances leading to a disconnection between cortical areas (Hippocampus) and Hypothalamus, may contribute to Hypothalamic dysfunction, and temperature dysregulation. Atypical Antipsychotics with potent 5-HT 2A antagonism and documented incidents of hypothermia should be dosed and adjusted with caution in susceptible populations.

POSTER 3-27

The Art of Prescribing Psychiatric Medications: An Educational Approach

Jordan Matus M.D., 111 E. 210th Street, Bronx, NY 10467, **Rebecca Fink, M.D., Santiago Rodriguez-Leon, M.D.**

Abstract: The Art of Prescribing Psychiatric Medications—An Educational Approach Jordan Matus, M.D.; Rebecca Fink, M.D.; Santiago Rodriguez-Leon, M.D. Albert Einstein College of Medicine, Montefiore Medical Center, Bronx NY

Objective: To demonstrate how therapeutic strategies to enhance the effectiveness and adherence of medication use by patients can be formally taught during residency training. While medical school and residency training programs excel at teaching what medications to use in a particular setting, residents are left with little guidance in how to shape the act of prescribing in a way most likely to maximize adherence and capture therapeutic placebo effects. Experienced psychopharmacologists have honed these skills for years, and their knowledge can be taught in a systematic way.

Methods: The results of a prescribing practices questionnaire administered to experienced outpatient clinicians as well as third and fourth year residents in our program will be presented.

Results: Primary outcome data will compare the results of the two groups, with an emphasis on prescribing practices utilized by veteran clinicians which can be formally taught.

Conclusions: A template for ways in which this training can be integrated into a residency training curriculum will be provided. No aspect of this research was supported by commercial funding.

POSTER 3-28

Efficacy of Injectable forms of Haloperidol vs. Ziprasidone vs. Olanzapine in Treatment of Acutely Agitated Patients

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Abstract:

Background: Currently, the most commonly used medications for the management of acute agitation are intramuscular (IM) Haloperidol, Ziprasidone, and Olanzapine. In the Emergency Room setting, a common protocol is the usage of Haloperidol 5 mg IM for agitation along with Lorazepam 1.2 mg IM and Benztropine 1mg IM. Recently, the atypical antipsychotics Ziprasidone 20 mg IM and Olanzapine 10 mg IM have gained dominance as first line treatment of agitated patients. In this study, we compared the efficacy of these two atypical antipsychotics to typical antipsychotic Haloperidol IM.

Methods: We compared the efficacy among injectable forms of three antipsychotics, Haloperidol, Ziprasidone, and Olanzapine in the treatment of agitated patients. Inclusion criteria for patients included initiation of injectable treatment in the emergency room. Then, any further course of injectable treatment during the first 72 hours was followed. All medications given by mouth in between injections were also recorded. The efficacy of each antipsychotic injectable was measured by analyzing two factors: 1. the number of patient hospitalizations needing additional treatment with any of the three antipsychotics; 2. the number of patient hospitalizations needing > 1 additional injection with any of the three antipsychotics.

Results: 52 hospitalizations were analyzed of patients first treated with Haloperidol injectable, 51 hospitalizations of patients first treated with Olanzapine, and 40 hospitalizations of patients first treated with Ziprasidone. In the Haloperidol group, 42% of hospitalizations needed an additional injection, and 15% needed >1 additional injection. In the Ziprasidone group, 43% of hospitalizations needed an additional injection and 25% needed >1 additional injection. Finally, in the Olanzapine group, 55% of hospitalizations needed an additional injection and 25% needed >1 additional injection. Analyzing these results, the Haloperidol and Ziprasidone groups were nearly identical. Also, while it may appear that Haloperidol IM was more effective due to the overall lesser need for additional injections, there were many factors that could cause this to be lower including differences in patient severity, dosages, and confounding variables. Therefore, it cannot be concluded that one injectable medication was more effective than another.

Conclusion: In this retrospective study, one cannot conclude the superiority or greater efficacy of one Injectable Antipsychotic over another as the need for additional injections was nearly identical in the Haloperidol and Ziprasidone groups. Also, the greater percentage for Olanzapine may have been due to a number of uncontrolled factors such as level of agitation or treatment.resistant patients. In addition, the appearance of overall less need for more than one additional injections when starting with Haloperidol IM may be caused by differences in patient severity as patients having varying levels of agitation are all labeled as acutely agitated and treated with the same dosage. Another factor is the presence of a confounding variable. medications given by mouth (PO). Patients who did not require additional injectable medications could be explained in part by response to medications given by mouth. This retrospective study exposes limitations to comparing the efficacy among injectable antipsychotics and the need for a controlled, prospective study.

POSTER 3-29

Uncommon Antidepressant Discontinuation Syndromes Following Taper of Escitalopram and Abrupt Termination of Bupropion

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Abstract:

Background: Antidepressant discontinuation symptoms have been reported since the introduction of tricyclic antidepressants, and have become increasingly common since the advent of selective serotonin reuptake inhibitors (SSRIs). They have also been reported with serotonin and noradrenergic reuptake inhibitors (SNRIs) and other classes of antidepressants.

Objective: We present three cases of unusual antidepressant discontinuation syndromes in patients being treated for major depressive disorder.

Method: The OVID and PubMed databases were searched using the following keywords: serotonin discontinuation syndrome; antidepressant discontinuation syndrome; escitalopram; buproprion.

Results: Two young women who wished to discontinue escitalopram due to sexual side effects reported symptoms of discontinuation despite conservative tapering of the medication over a period of two to three months. In the case of the first patient, she complained of loss of balance, anxiety, nausea and a "tingling" feeling in her body. The second reported, nausea an "uncomfortable feeling in the stomach." A third patient abruptly stopped taking buproprion, believing that it was not helping him, and began to hear command auditory hallucinations of a voice saying, "Just kill yourself." In all three cases, the patients' symptoms resolved quickly upon resumption of their medications.

Conclusion: Discontinuation symptoms are common with both SSRIs and SNRIs, with the result that most clinicians taper these medications over a period of weeks; however some patients may be more sensitive to dosage decreases and require a slow taper over several months. No discontinuation syndrome has previously been reported with buproprion. Clinicians should be aware of the risk of antidepressant discontinuation symptoms which may occur despite a taper of medication, or with a medication which is considered to carry little propensity to cause a discontinuation syndrome. Patients must be educated about the reasons for not stopping antidepressant medication precipitously, and encouraged to report any adverse effects from reduced dosages.

POSTER 3-30

Levetiracetam Induced Psychiatric Sequelae

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Abstract: Levetiracetam is an anti.epileptic drug approved for partial onset seizures, adjunctive treatment for juvenile myoclonic epilepsy, and adjunctive treatment for primary generalized tonic clonic seizures. Its mechanism of action is currently unknown. There have been a number of case reports associated with levetriacetam.induced psychosis (1,2). Studies have shown a prevalence of psychiatric side effects ranging from 1% to 15.7% (3,4,5,6,7), and psychosis from < 1%8 to 1.4% (3,8). Risk factors associated with the development of psychosis appear to be antiepileptic polypharmacy (2,5), history of status epilepticus (3), history of febrile convulsions (3,9), preceding mental illness (1,3,9), prior history of behavior problems (10), and a family psychiatric history (9). This is a retrospective observational study of patients who presented to Dr Jeffrey Nicholl fs epilepsy clinic and were either placed on levetiracetam or had a history of taking levetiracetam. We identified 48 patients who had a negative reaction to levetiracetam in the form of psychiatric phenomenon, and examined the psychiatric precursors leading to such events. Twenty.one (43%) had a negative psychiatric reaction to the drug. Of these patients, 38% developed irritability, 38% depression, 14% anxiety, 4% suicidal ideation, 4% homicidal ideation, 4% psychosis, 14% behavior change, and 19% personality change. Forty.three had a history of depression, 3% anxiety, 9% behavioral abnormalities, and 4% irritability. None had a history of PTSD, schizophrenia, or auditory/visual hallucinations. Sixty two percent were on multiple antiepileptic drugs, in contrast to 77.7% in the group that did not develop psychiatric side effects related to levetiracetam. Of the patients that had a negative psychiatric reaction to levetiracetam, 9% had psychogenic seizures, versus 19% in the group without psychiatric side effects. In the group that did not have a psychiatric side effect, 30% had a past medical history of depression, 14% of anxiety, 11% behavioral problems, and 4% with bipolar disorder. Overall, 52% of non.reaction patients had psychiatric illness versus 62% in the patients who developed a psychiatric side effect after taking the drug. There was a small difference in the patients that developed psychiatric sequelae versus the group that did not. The group that did not

develop psychiatric side effects were more likely to ultimately receive a diagnosis of psychogenic seizure. The majority of the psychiatric side effects were irritability, depression, and personality or behavioral change, although most concerning issues of homicidal ideation, suicidal ideation, and psychosis did develop in a small portion of this group. Further studies with a larger sample size are needed to further distinguish the differences between the two groups.

POSTER 3-31

Antipsychotic Use in the Elderly: A Comprehensive Review

Rohini Ravindran, M.D. (rohini_ravindran@yahoo.com)

Abstract: The use of antipsychotics in the elderly is a challenging decision for most clinicians. However this is a common problem which is heavily debated since psychotic features and symptoms such as agitation are seen in this population as a part of dementia, delirium, and other comorbid conditions. Several studies have been in done to compare data and set forth guidelines. The purpose of this paper is to review all the literature and consider formulating appropriate guidelines accessible to clinicians. It will consider what factors influence the use of certain antipsychotic agents and the potential risks involved. This review will also look at data from various studies regarding the morbidity and mortality associated with use of antipsychotics in the elderly. It will serve to also consider what areas should be considered for further research.

POSTER 3-32

Increased Perspiration: An Unpleasant Side Effect of Antidepressant Medication in the Treatment of Deaf and Hard of Hearing Patients

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Abstract: Iatrogenic increased perspiration is an unpleasant side-effect of antidepressant medication which can happen immediately after the start of the medication or later in treatment. Selective Serotonin Reuptake Inhibitors as well as Tricyclic Antidepressants can cause a increased hyperhidrosis. The exact pharmacological mechanism of this side effect is unknown, as no research data are available. Literature about hyperhydrosis as a side effect as well as the treatment possibilities is mainly based upon case histories or an overview of small groups of patients. Beside busperidone and seldomly carbamazepine other psychopharmacological medication has no such effect. An review of the literature about the psychopharmacological aspects of hyperhidrosis in antidepressant and other psychopharmacological medication will be described. In two case-histories the patients showed an increased perspiration caused by the use of SSRI's. In both cases the causality of drug induced hyperhydrosis was assessed with the Naranjo adverse drug reactions probability scale. The negative effect of increased perspiration as a side effect of antidepressant medication on the life of deaf people will be illustrated. The excessive fluid on the head of the patient can damage the hearing aid or can make it impossible to wear the hearing aid. Important specific psychopharmacological aspects in the treatment of deaf and hard of hearing patients with mood disorders and other non-pharmacological advices will be described.

POSTER 3-33

Questioning the Risk Profile of Selegiline Hydrochloride

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Abstract:

Objective: Because standard psychiatric treatment regimens may not benefit certain patients, the search for alternative efficacious and safe treatment is required [1]. MAO inhibitors are well-known to be effective for a variety of conditions [2, 3], but are infrequently used due to side effect profiles [4]. Selegiline, an MAO inhibitor, has been limited to the treatment of Parkinson's disease [5] and selegiline transdermal has been limited to treatment resistant major depressive disorder [6]. We sought to determine if dietary warnings and concerns about hypertensive crisis were valid for a select group of patients.

Methods: Twenty-five patients, ages 17-66, were selected to receive selegiline hydrochloride based on clinical assessment, including EEG and qEEG data [7, 8]. Patients whose qEEG data included slow alpha rhythms were hypothesized to be selegeline responders. DSM-IV TR diagnoses were noted but not used to stratify patients. Dietary and stimulant restrictions with selegiline were not imposed.

Results: One hundred percent of the 25 patients had no hypertensive crisis. Patients were followed for a mean of 9 months. Based on CGI scores 17 patients had moderate to substantial improvement. Eight patients had sub-optimal results and this medication was discontinued. No adverse effects or events were observed.

Conclusion: Patients who were assessed via clinical exam and EEG criteria had no adverse effect associated with selegiline. The inclusion of EEG and qEEG data may be a variable that allows safe implementation of selegiline at doses which are thought to cause adverse effects. More study is warranted.

POSTER 3-34

Atypical Antipsychotics for the Treatment of Cotard's Delusions

Fernando Espí Forcén, M.D. (ferespi@hotmail.com), **Priyanka Deshmukh, M.D.**

Abstract: We are reporting two cases of patients previously diagnosed with schizophrenia that were admitted to our psychiatric inpatient unit due to the severity of their Cotard's delusions. Cotard's delusions could be underestimated in regular clinical practice nowadays. Nonsuicidal patients suffering this syndrome could respond quetiapine longer acting. Patients having Cotard's delusions and suicidal thoughts would benefit from clozapine or electroconvulsive therapy.

POSTER 3-35

Advanced Paternal Age and Schizophrenia

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Abstract:

Background: Schizophrenia is a chronic devastating psychiatric disorder striking just under one percent of world population. The annual incidence of schizophrenia averages 15 per 100,000 and the risk of developing the illness over one's life time averages 0.7%.[1]There are several factors associated with the incidence of schizophrenia such as urbanicity, male gender, history of migration, environmental factors, genetic factors and many others. The correlation between advancing paternal age (APA) and schizophrenia has been the focus of numerous studies. Increased risk for schizophrenia in children of older fathers is a well-replicated finding regardless of culture and nationality. The focus of studies on this topic has now shifted toward searching for the etiology of this disorder. Literature shows that schizophrenia is affected by multiple genes and environmental factors and that APA is associated with accumulated environmental insults over time suffered by spermatozoa. Four causal mechanisms which have been postulated include: point mutations, chromosome breakage, copy number variants and dysregulation of epigenetics. Etiological heterogeneity, complex patterns of gene-gene and gene-environment interaction and schizophrenia pathophysiology are among the explanations invoked to explain of the etio-pathogenesis of schizophrenia.

Objective: Our objective is to summarize the published information regarding the relationship between APA and schizophrenia as well as to stimulate a discussion concerning the theories of its genetic etiology.

Method: We reviewed literature on the topic of APA and the risk of the offspring developing schizophrenia by performing a comprehensive search using Pubmed and other journal databases. We analyzed the journals from 2001-2010 on the topic and highlighted the relevant information. This led us to develop a thorough investigation on the current theories and known associations between APA and schizophrenia.

Conclusion: Many studies have shown a significant link between APA and the incidence of schizophrenia in the offspring. Several of these studies have corrected for the effects of confounding factors, yet the link between advanced paternal age and schizophrenia remains significant. It has been suggested that each decade of paternal age increases the relative risk of developing schizophrenia by 1.4 in male and 1.26 in female offspring. It is well known that APA is associated with de novo mutations is spermatogonia which could be attributed in large part to the fact that by age 50, male spermatogonia have undergone over 800 cell divisions, in comparison to the oocyte which will have undergone 22 cell divisions. Four distinct mechanisms have been proposed to explain the association between APA and schizophrenia; (1) De novo point mutations (2) Aberrant epigenetic regulation (3) Copy number variants (4) Chromosomal abnormalities. All of these processes occur at higher rates as paternal age increases. Evidence suggests that the first three mechanisms may specifically be related to the biogenesis of schizophrenia. If the association between APA and schizophrenia is related to one of these four mechanisms, one would expect that sporadic cases of schizophrenia should show a stronger association with APA compared with individuals who have a family history of schizophrenia. This finding has been confirmed in a population based study which showed that over one quarter of schizophrenia cases can be attributed to APA.

POSTER 3-36

Characteristics of Patients with Borderline Personality Disorder in a State Psychiatric Hospital

Luba Leontieva, M.D., Ph.D., Robert Gregory, M.D.

Abstract:

Objective: Borderline personality disorder is common across mental health settings and associated with substantial suffering, disability and mortality risk. However, it is often under-diagnosed and there is no prevalence data available for state hospital settings. This study aims to provide a preliminary assessment of the prevalence and characteristics of borderline personality disorder (BPD) within an inpatient unit of a state psychiatric hospital.

Method: In order to improve the quality of care at a state psychiatric hospital, all patients admitted to a 40-bed unit from April 2008 to June 2009 were routinely administered a structured diagnostic interview for BPD. A total of 65 patients were screened and their charts were reviewed.

Results: 20 (31%) met criteria for BPD, but only 8 of them (40%) had a chart diagnosis of BPD. Patients with BPD were significantly more likely to be female (75%), to carry a diagnosis of major depressive disorder, and to have been admitted within the past year than those without BPD. 24% of patients with a primary psychotic disorder also met criteria for BPD. BPD

patients tended to have shorter lengths of stay, but they had significantly more management problems, including incidents of self-harm, episodes of restraint, and stat administrations of medications.

Conclusions: BPD can be a common but under-appreciated co-occurring condition in a state psychiatric hospital. In this setting, BPD is associated with more frequent admissions and numerous management challenges, suggesting the need for comprehensive screening, coordination of care, and specialized treatment programming.

POSTER 4-1

Child and Adult ADHD Impulsivity, Need for a Day Long Treatment: An Open Study with 2 Adults and 5 Children

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Abstract:

Background and Objectives: ADHD has a great impact on academic outcome but often more so in global adjustment (in personal, family and psychosocial areas), of both adult and children. The usually accepted treatment being mainly psycho stimulants as a first choice, is in our opinion an insufficient tool in the sense of full time (day and night, 24 h). Hence we have designed a rather simple combination of Methylphenidate (MPH) and Valproate (VAL) (or Valpromide available in Europe with a similar profile and a common metabolite) to determine in a long-standing follow up study, weather this strategy could improve the overall global adjustment of ADHD pts. (Mainly impulsivity in: the irritability, low frustration tolerance, temper outbursts, fights, and their consequences, etc.; spectrum).

Method: 2 ADULT ADHD, MIXED TYPE males were accepted, ages 18 and 23, Caucasian, middle class university students. 5 children all males, ages 7 to 12, middle class (2 upper)(with co morbidities): All patients were treated trough the school year with MPH at adequate dosages and all year round with VAL, according to their blood levels (lower range). Clinical interviews and Conners Questionnaires among other tools were used to assess their clinical course.

Results: The 2 adults were followed for 12 m and 17 m, and besides a satisfactory academic year, they both referred much less conflicts and mood swings. The 5 children were followed at least 12 months and achieved a good school year and there were less oppositional behaviors, fights or temper tantrums. Families referred a more mature child, which came back to normal much faster than before. The MPH evening rebound was milder as well.

Conclusions: For the purpose of simplicity patient's complexities have not been fully stated. However, it is our impression that, the improvement of their behavior has to be accounted for, mainly to the synergy of MPH and VAL. Larger and methodologically sound studies are needed to better the long-term course of ADHD, at all ages.

POSTER 4-2

Brief Action Planning: A Pragmatic, Stepped-Care, Evidence-Based Application of Motivational Interviewing for the Routine Practice of Psychiatry

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Abstract:

Background and Purpose: BAP is a pragmatic, evidence-based, stepped-care self-management tool; an application of Motivational Interviewing to encourage behavioral activation and adherence in busy practices. BAP has been published by the AMA and used in programs of the CDC, the VA, Robert Wood Johnson Foundation, the Indian Health Service, HRSA, the Patient Centered Medical Home and others. This poster describes pilot performance improvement studies of BAP in practices of psychiatry, general medicine, psychology, and disease management. The 8 core skills of BAP begin, after patient engagement, with an early motivational probe, called "Question One:" "Is there anything you'd like to do for your health in the next week or two?" Question One is generally followed by "SMART" behavioral contracting, elicitation of commitment statements, scaling for confidence, problem solving, presentation of behavioral menus, arranging for accountability, and follow-up. Thirteen advanced skills are used for more difficult, refractory patients with PUB (persistent unhealthy behaviors).

Methods: One psychiatrist, 1 psychologist, 3 internists, 1 nurse practitioner, and 13 social workers were trained to use Brief Action Planning in consecutive and/or selected patients. For consecutive patients, clinicians recorded whether or not they used BAP in each consecutive patient and, if not, why not. In addition, they recorded the results of the BAP dialogue. For use with selected patients on follow-up, clinicians kept tract of the extent to which action plans were accomplished: 50% or more of the plan, part of the plan, or completion of very little or none of the plan.

Results: Overall, among the 6 practitioners participating in consecutive patient studies, between 38-62% of patients were asked Question One, ranging from a low of 33% in an inner-city, low-health literacy internal medicine practice, to a high of 62% in a middle-class outpatient rheumatology nurse practitioner practice. Most common reasons in consecutive patient studies for not asking Question One, were "lack of time," "acuity of medical problem," "language or literacy barriers," or clinician "forgot" to ask. Of patients asked Question One, a very high proportion completed action plans in short periods of time, <10 minutes (80-95%). With respect to completion of action plans in social worker driven telephonic disease management programs, of 186 action plans made with 13 different clinicians, 73% of clients completed 50% or more of action plans, 15% completed some of the action plans, and 12% completed little or none of the action plans. These outcomes are consistent with results of other outcome studies of goal-setting in primary care practices.

Conclusion: BAP seems to be a pragmatic, useful, and well accepted self-management and motivational tool for a wide variety of outpatient and telephonic patient care and disease management settings.

POSTER 4-3

Opening Doors to Recovery in Southeast Georgia: A New Community Navigation Service for Persons with Serious Mental Illness and Psychiatric Recidivism

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Abstract: Although psychosocial disability and functional impairments commonly accrue during the course of persistent serious mental illnesses (often culminating in homelessness, incarceration, and/or repeated hospitalization), many mental healthcare settings—especially in relatively rural regions—have limited or no recovery-oriented case management services available. This poster will present Opening Doors to Recovery in Southeast Georgia, a novel public–private–not-for-profit–academic partnership. With foundation support for both program implementation and a parallel research study, this program is a community-based service that relies on a team of "Community Navigation Specialists" consisting of a licensed mental health professional, a family member of an individual with a serious mental illness, and a person with lived experience in recovery (a certified Peer Specialist). Through the aid of extensive multi-disciplinary/multi-agency partnerships throughout the region, the team of Navigators strives to enhance participants' community integration; support them in developing a meaningful day; ensure access to adequate treatment; and facilitate stable housing, improved relationships, and desired vocational, volunteer, or educational activities. Technological advances include the use of an electronic recovery record and mobile electronic devices for Navigators and for participants when appropriate to their recovery journey. Cross-agency collaborations seek to reduce recidivism; for example, if police officers have an encounter with a program participant, they receive an automated notice of the participant's membership in the program, with directions on how to connect the patient with his or her Navigator. The concurrent research study evaluates effectiveness in terms of reducing recidivism at the state hospital, homelessness, and incarceration, while also aiming to demonstrate improvements in recovery/empowerment, quality of life, and satisfaction with care. Additionally, a formal program evaluation is being conducted. If effectiveness is established, the program's leadership aims to advocate for expanding the program to other regions in the state, perhaps by establishing it as a Medicaid-reimbursable service.

POSTER 4-4

Predictors of PTSD and Major Depression Symptom Severity in a Sexually Abused Adolescent Female – A Case Report and Literature Review

Radha Agepati, M.D. (ragepati@bergenregional.com), **Radha Agepati, M.D., Amin Shamal, M.D., Stephen Castro, MS III, Bharat Nandu, M.D.**

Abstract: Sexual abuse in female children has been shown to increase the risk of psychopathology in adolescence and adulthood. Major depressive disorder and Posttraumatic stress disorder are most commonly associated with this type of abuse. Patient SS, a 16 year old female, had a history of sexual abuse on two different occasions. The patient presented with symptoms of agitation and was ultimately diagnosed with Major Depressive episode (MDE) and Post Traumatic Stress disorders (PTSD). She did not disclose any information of sexual abuse until four years after the incident. Her relationship with her father was highly unstable. She was admitted to the Emergency Room due to an argument between her and her father. We investigated what role delaying disclosure, avoidant behavior, and perceived familial support may have had in the severity of this patient's PTSD and depression symptoms. Literature reference showed that children who delay disclosure of sexual abuse for more than one month and who use avoidant behavior as part of their coping strategy will see an increased incidence of PTSD and MDE. Also, the child's perceived sense of social support from family and peers influences his or her decision to disclose such a traumatic experience.

POSTER 4-5

Characteristics of Patients on Constant Observation and Evaluation of Constant Observation Protocol in a Psychiatric Setting

Radha Agepati, M.D. (ragepati@bergenregional.com), **Radha Agepati, M.D., Amin Shamal, M.D., Hilla Azoulay, M.D., Sree latha Krishna Jadapalle, M.D.**

Abstract:

Background: Constant observation (CO) is an intervention in which continuous one-to-one monitoring is used to assure the safety and well-being of an individual patient or others. The most common reasons for constant observation of the patients are aggressive, violent, suicidal or a high risk of absconding behavior, acutely disturbed, acutely psychotic and difficult to manage. The use of nurses or other staff has proven to bear a high cost at an unknown value or effectiveness. Several studies have been unable to prove the benefits of this practice; therefore, its use in eliminating risk to patients in the ward is being reevaluated. Objective (1) to assess the characteristics and risk factors of patients on constant observation. (2) to evaluate the effectiveness of constant observation policy in our psychiatric inpatient setting.

Methods: A retrospective study was conducted to collect and analyze the data of 50 psychiatric patients on constant

observation at Bergen Regional Medical Center in the time span from January 2010 to March 2011. The electronic medical record system is used to determine some characteristics of patients on CO which includes age, gender, race, duration and the reason for CO, Axis I Diagnosis including Psychiatric Diagnosis and Substance Use, Axis II Diagnosis, Axis III Diagnosis, any major incidents while on CO, specific unit CO was placed on, number of previous CO, interaction with the nursing staff and the outcome.

Results: In our study, males, older age group [>40 years], Caucasians, suicidal and homicidal concerns, fall risks, aggressive behavior and personality changes were identified as risk factors for ordering constant observation. Hypertension [21%] was the only physical diagnoses found to be significant in patients on constant observation. The AXIS I diagnoses found in our CO patients were mood disorders[n=19], psychotic disorder[n=10], bipolar disorder[n=11], substance abuse/dependence[n=10], dementia[n=3], impulse control[n=2], major depressive disorder[n=10], schizophrenia[n=6], schizoaffective disorder[n=6] and Autism[n=1]. Among the 50 patients on CO 40% (n=20) of them were put on constant observation during their previous hospitalizations and 22% (n=11) of them were issued restraint orders during the current CO. Regarding interaction with the observer among 50 patients only 20% (n=10) patients received all available methods of intervention including encouragement and support, calming techniques, environmental safety, behavioral management, and assistance with self care activities. Our results show that the occurrence of CO's is more in child adolescent units and adult acute units in our psychiatric settings and only 20% (n=10) patients out of 50 were transferred from CO to IC (eye contact).

Conclusion: Some of our results regarding the projecting factors for constant observation confirmed the findings of previous studies. Our study emphasizes the importance of downgrading the patients' to IC before discontinuing CO entirely which would likely prevent re-escalation leading to CO again. We recommend effective communication between the CO personnel and the patient, providing appropriate therapeutic interventions helping the patients improve coping skills and decrease the occurrence of incidents while on CO and successful resolution. Due to the lack of effective evidence on appropriate utilization of CO to reduce risk to patients and others, further studies are strongly recommended.

POSTER 4-6

Integrating Symptomatic and Functional Outcome Measures in a Crossover Comparison Trial of Atomoxetine and OROS Methylphenidate in Youth with ADHD

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Abstract:

Objectives: ADHD is the most common childhood behavioral disorder diagnosed in outpatient settings in the United States, and a large majority of youth with the condition are treated with psychostimulants. We conducted a large, double-blind, randomized, cross-over trial to determine which ADHD clinical presentations and/or genotypes respond better to OROS Methylphenidate (MPH; long-acting stimulant) and Atomoxetine (ATX; non-stimulant). This poster examines: 1) the relationship between symptomatic and functional improvement; and 2) whether the relationship between symptomatic and functional improvement is similar or different for the two medications.

Methods: Participants were: 148 male and 45 female, ages 6-17, with any ADHD subtype. Subjects were randomized to receive MPH or ATX for 4-6 weeks, followed by a 2 week placebo wash out, and then 4-6 weeks of treatment with the other drug. Before and after each medication block, ADHD symptoms were measured with the ADHD-RS-IV and functional status was measured with the Weiss Functional Impairment Parent Rating Scale (WFIRS). Medications were given once daily in the AM and titrated to optimal response/tolerability using four dose levels: MPH: 18, 36, 54, 72 mg; ATX: 0.5, 1.0, 1.4, 1.8 mg/kg. Logistic regression analysis was used to examine the relationship between change in symptoms and change in functional status (i.e., to see how much change in functional status depends on symptomatic improvement, by drug), for treatment overall and then for each medication individually.

Results: Preliminary analyses run on the first 77 subjects indicated that symptomatic and functional status were moderately correlated. Both drugs showed significant improvement in ADHD-RS symptoms, whether given in both block 1 and block 2; they also showed significant improvement in functional status pre- to post-treatment, as follows: family: $p < 0.001$, school: $p < 0.01$; social: $p < 0.05$; total: $p < 0.001$, with no significant differences between the two medications. Linear regression analysis of the change in ADHD symptoms versus change in WFIRS total functioning scores indicated significant correlations in the mild to moderate range for both drugs. However, functional improvement with MPH was more closely related to symptomatic improvement than was the case for ATX. These analyses will be updated and the results of the full data set will be presented in October.

Conclusions: ATX and MPH treatment of youth with ADHD produced significant improvements in ADHD-RSIV symptom scores and WFIRS total functional impairment scores. The relationship between symptomatic and functional improvement for each treatment was generally linear. However, treatment related improvements were not uniform across domains; the largest improvements were seen in school, family, and social skills. Change in functional status was more closely related to symptom change for MPH than ATX. The latter finding raises the question of whether the two medications produce clinical improvement via somewhat different mechanisms.

POSTER 4-7

NWP06, A Novel, Extended-Release Methylphenidate Oral Suspension Improves ADHD-Rating Scale Scores in Children with ADHD

Sally Berry, M.D. (sberry1004@hotmail.com)**, Ann C. Childress, M.D.**

Abstract: Attention-deficit/hyperactivity disorder (ADHD) is the most commonly diagnosed childhood neurobehavioral disorder, with CDC prevalence estimates of nearly 1 in 10 children in the US diagnosed with ADHD. An unmet need exists for an extended-release (ER) oral suspension formulation of methylphenidate (MPH) for children who cannot or will not swallow pills.

Objective: Evaluate the efficacy of NWP06, a novel ER oral suspension of MPH in pediatric ADHD patients as measured by the ADHD Rating Scale (ADHD-RS)-a reliable and easy-to-administer instrument for assessing treatment response linked to DSM-IV diagnostic criteria for ADHD.

Method: This randomized, double-blind, placebo-controlled, crossover, multicenter, laboratory school study enrolled 45 pediatric ADHD patients aged 6-12 years old. Diagnosis of ADHD was made by a psychiatrist, psychologist, developmental pediatrician, or pediatrician using diagnostic criteria for ADHD (DSM-IV) and confirmed by a structured clinical interview. Subjects were required to have an ADHD-RS score at screening or baseline greater than or equal to the 90th percentile normative values for gender and age in the hyperactive-impulsive subscale, the inattentive subscale or the total score. Following 4-6 weeks open-label dose optimization, subjects entered a randomized, double-blind treatment sequence (NWP06 followed by placebo, or the reverse) and were assessed in an analog classroom. The ADHD-RS was conducted at screening, baseline and all subsequent visits (Weeks 1-4) prior to the double-blind classroom day. The treatment responses in the open label portion of the study are reported here.

Results: ADHD-RS scores during the open-label phase of the study are summarized below:

	Baseline	Week 1	Week 2	Week 3	Week 4
N	44	44	43	41	39
ADHD-RS					
Total					
	39.3 ± 7.6	27.6 ± 10.8	21.2 ± 11.2	16.9 ± 8.9	12.6 ± 6.3
		(-11.7)	(-17.8)	(-22)	(-26)
Hyperactivity-Impulsivity					
	18.5 ± 5.3	13.1 ± 5.5	9.7 ± 6.1	8.2 ± 5.5	6.0 ± 4.2
		(-5.4)	(-8.6)	(-10.1)	(-12)
Inattentiveness					
	20.8 ± 4.3	14.4 ± 6.2	11.4 ± 6.1	8.7 ± 4.4	6.6 ± 3.5
		(-9.2)	(-6.3)	(-11.9)	(-14)

Values are mean ± SD and change from baseline value in the ITT population. At week 4, 87.2% of children with ADHD, had responded to therapy, as evidenced by a 50% or greater improvement in the ADHD-RS from baseline. The most common adverse events reported were decreased appetite, abdominal pain upper, affect lability, initial insomnia, insomnia and headache.

Conclusions: NWP06 was efficacious in the treatment of ADHD. The ADHD-RS significantly improved during treatment with NWP06 and more than 85% had improvement of 50% or greater. NWP06 was safe and well tolerated with a safety profile similar to ER MPH. This is the first report demonstrating the efficacy of a novel ER oral suspension of MPH in children with ADHD, as measured by improvements in ADHD-RS scores. The research reported here was supported by NextWave Pharmaceuticals.

POSTER 4-8

An Online, E-Learning Spirituality-Based Treatment Program for Depression in Adolescents: Qualitative Exploration of Participants' Experience

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Abstract:

Purpose: The prevalence of depressive disorders in adolescents is on the rise. Given the limited mental health resources available for adolescents, particularly those in rural areas, and the significant burden of disease there is a great need for new treatment options that are accessible, safe, effective and acceptable to adolescents. The benefit of an online, e-learning treatment program is that it is cost-effective, accessible, and can easily be delivered to adolescents in any location with Internet access. A growing body of evidence suggests that spirituality may play a role in the recovery from depression.

Our previous research strongly supports the efficacy of using a self-study, spirituality-based intervention for depression in adults. Our team has created a spirituality-based intervention program for adolescents with major depressive disorder. The program could present an innovative and low cost treatment option for young patients with major depressive disorder.

Methods: *Study Design:* An online, e-learning program was pilot tested in a randomized, wait list controlled trial. Population: Eligible adolescents with major depressive disorder were be randomized one of two study groups: the internet-based spirituality program group or a wait list control group.

Intervention: The intervention consists of a self-study, internet based, modular, eight week teaching program. The program is presented in a multimedia format, and includes teaching of skills such as relaxation and mindfulness techniques. Participants randomized to the intervention group participated in an eight week intervention period followed by a 16 week follow-up phase. All participants placed in the control group participated in the internet-based teaching program after an initial eight week waiting period.

Outcome Measures: The following measures were used throughout the pilot trial: a) depression severity (Children's Depression Rating Scale-Revised), b) depression response and remission rates (Children's Depression Rating Scale-Revised), c) self-rated psychological health (second edition of the Piers-Harris Children's Self-Concept Scale), d) spiritual well-being (Spiritual Well-Being Scale adapted and validated for use in adolescents). Qualitative data was obtained during follow-up interviews after completion of the eight-week program.

Results and conclusions: Qualitative exploration of participants' experiences focuses on how depressed adolescents, and mental health professionals assess the value (strengths and weaknesses) of the online, e-learning treatment program. It is feasible to develop an online, e-learning treatment program for major depression in adolescents. This program model could be relevant for future development of other accessible, cost-effective, online-based treatment programs.

POSTER 4-9

A Pilot Study of Anxiety and Depression Scores in an Pediatric Behavioral Health Outpatient Population: Shared and Unique Variance

Robert Friedberg, Ph.D. (rfriedberg@paloaltou.edu)**, Nina Pacholec, Nathan Chow**

Abstract:

Introduction: The debate regarding whether anxiety and depression in childhood represents unitary or distinctive constructs has been on-going and more recently has intensified. Historically, measures of childhood depression and anxiety are highly correlated. Moreover, the development of the DSM-V and trans-diagnostic approaches to treatment make the issue especially salient currently (Ehrenreich et al., 2009)

Objectives: Accordingly, as an effort to add clarity to this issue, this pilot study investigates the association between the Screen for Child Anxiety Related Emotional Disturbances (SCARED) (Birmaher et al., 1997) and the Children's Depression Inventory (CDI) (Kovacs, 1992) in a clinical population treated at an outpatient pediatric behavioral health clinic. More specifically, it was hypothesized that total scores on the CDI and SCARED would not be significantly related to each other indicating they are measuring separate clinical phenomena. Further, it was hypothesized that both the CDI and SCARED sub-factor scores would be independent of each other.

Methods: 53 children completed the SCARED and CDI at their initial session for outpatient psychotherapy in a behavioral health outpatient clinic. Total scores were culled from the charts. Additionally, SCARED factors (panic/somatic, generalized anxiety, separation anxiety, social anxiety, and school refusal) and CDI factors (negative mood, interpersonal difficulties, ineffectiveness, anhedonia, and negative self-esteem) scores were recorded along with children's age, ethnicity, and gender.

Results: Several correlational matrices were constructed to examine the relationships between and within the measures. Bonferroni correction procedures were employed to avoid Type I error due to multiple comparisons (Curtin & Schulz, 1998). To test the internal consistency of the CDI and SCARED, inter-correlation matrices examining relationship between each measure and their associated factors were calculated. For the CDI inter-correlation matrix, negative mood ($r=.79$, $df=51$; $p<.001$), interpersonal problems ($r=.55$, $df=51$, $p<.001$), ineffectiveness ($r=.86$, $df=51$, $p<.001$) anhedonia ($r=.71$, $df=51$,$p<.001$) and negative self-esteem ($r=.85$, $df=51$, $p<.001$) were all significantly correlated to the CDI total score. Ineffectiveness was significantly correlated with all the other factors:negative mood ($r=.63$, $df=51$, $p<.001$), interpersonal problems ($r=.46$, $df=51$, $p<.001$), anhedonia ($r=.51$, $df=51$, $p<.001$), and negative self-esteem ($r=.68$, $df=51$, $p<.001$). The results for the SCARED yielded similar internal consistency results with the total score being significantly related to all its factors: panic ($r=.78$, $df=51$, $p<.001$), generalized anxiety ($r=.81$; $df=51$, $p<.001$), separation anxiety ($r=.81$, $df=51$, $p<.001$, social anxiety ($r=.84$, $df=51$, $p<.001$), and school refusal ($r=.47$, $df=51$, $p<.001$). All the factors except school refusal were significantly correlated with each other To assess the relationship between the anxiety and depression measures, a correlation matrix was constructed comparing the correlations between the SCARED total scores/factors and the CDI total scores/factors. The results revealed that only the Generalized Anxiety factor of the SCARED was significantly correlated with the CDI ($r.=.41$, $df=51$, $p<.001$).

Conclusions: Overall, the data indicates that the CDI and SCARED scores appear to be independent of each other. Indeed, this finding appears to support their use typical clinical settings.

POSTER 4-10

Autism to Early-Onset Schizophrenia: A Case Study Supporting Genetic Linkage and Treatments

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Abstract:

Background: Individuals who suffer from Autism are said to have "impaired social interactions, impaired ability to communicate, and a restricted range of activities and interests". Individuals with the diagnosis of "schizophrenia" exhibit positive symptoms – hallucinations, delusions, and/or disorganized speech or behavior – or negative symptoms – alogia, avolition, or flattened affect. These two psychiatric disorders, however, are not historically viewed together – each with their own spectrum of symptoms, ages of onset, and response to medications, they are unique even without the separate DSM-IV diagnostic criteria. The genetics and heritability of Autistic Spectrum Disorders and Schizophrenia, while not perfectly understood, have been greatly established. The genetic link between the two psychiatric illnesses – specifically ASD and early-onset schizophrenia – has only been hypothesized, not proven. Childhood-onset schizophrenia, in addition to classic schizophrenic symptoms, also presents with deficits in communication, social relatedness, and motor development. While more similar to Autism than its adult-onset counterpart, early-onset schizophrenia is still dissimilar in its age of onset – before 13. Treatment modalities for both early and adult onset schizophrenia remain the same, however; atypical anti-psychotics are the drugs of choice, followed by typical anti-psychotics.

Method: A comprehensive literature search for articles was conducted using PubMed. Keywords included: 'autism', 'schizophrenia', 'genetic linkage' and 'treatment'. A review of the best clinical management related to our case, and exploration of various treatment modality efficacy was performed.

Case Presentation: A 12 year old Caucasian male previously diagnosed with schizoaffective disorder, bipolar type, and Autism in early childhood who suffers from seizure presented to psychiatric facility for his first psychiatric hospitalization. Previously treated as an outpatient, patient was put on a number of medications including olanzapine, quetiapine, valproic acid, atomoxitine, and levetiracetam. As an inpatient, he received benztropine mesylate, risperidone, oxcarbazepine, Lithium, haloperidol, and paliperidone with only minor improvements. As a last resort, he was started on clozapine, which was greatly beneficial. This patient poses an interesting question, his sequence of diagnoses giving weight to the argument of his Autism Spectrum Disorder leading to the current schizophrenia, as only theorized so far.

Conclusion: Present case serves as both a clinical picture to keep in mind and evidence supporting the careful use of clozapine in individuals with early onset schizophrenia showing drug resistance. Further research needs to be conducted to ascertain the benefit of using clozapine in individuals with early onset schizophrenia showing drug resistance.

POSTER 4-11

Retrospective Study of Bipolar Patients with and without Comorbid Diabetes Mellitus in an In-Patient Psychiatric Setting

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Abstract:

Background: Bipolar disorder (BD) in conjunction with diabetes mellitus (DM) has been studied for over fifty years and has been a new field of interest regarding prevention, treatment, and cost effectiveness. BD is a mental illness, a category of mood disorders, generally characterized with fluctuations in mood ranging from depressive episodes to manic episodes. On the other hand, DM is a chronic metabolic disease that results in a high blood glucose level either from defects in insulin secretion, insulin action, or both. It is a long term illness that causes many complications such as cardiovascular, renal, ophthalmic, pancreatic and psychiatric. In 1980, in a cross sectional study, Lilliker et al. observed a prevalence of 9.9% for DM in Bipolar patients in comparison to prevalence in general population, which was 3.5% (1). Cassidy et al., confirmed the same findings in 1999, in hospitalized patients (2). Studies done by Lilliker proved that prevalence of DM was only 2% in the general population versus 10% in patients with BD. Cassidy further supported Lilliker's study by showing that the prevalence was 9.9% in a sample of 345 patients compared with a prevalence of 3.5% in the general adult population. Regnold et al. in 2002 did a further study of about 53 patients that supported the above findings (3).

Objective: The objective of this study is to find a relationship between bipolar patients with and without comorbid DM in terms of, 1) prevalence of DM in bipolar population 2) effect on the course of disease 3) compliance to the medication and 4) effect on number of hospitalizations.

Method: A retrospective study was conducted on a bipolar population comprising of 922 patients, out of which 61 were selected as bipolar without DM and 21 with comorbid DM. In the first group, subjects of age range 28 to 71 years were selected including 21 females and 40 males. In the second group, subjects were between 28 to 78 years, including 10 females and 11males. The data consists of basic demographic information including age, gender and race, as well as laboratory values, including serum glucose values and other electrolyte abnormalities, taken on each visits. Moreover, a complete psychiatric evaluation was done on admission and discharge. In a subsequent analysis, examinations of these factors were compared between the two groups.

Results: We found out that DM is more prevalent in bipolar populations and these patients have an increased number of hospitalizations as compared to the bipolar population alone, and there is no gender difference in the prevalence of DM.

Conclusion: Our current findings seem to confirm results seen in Cassidy. F., et al. and Lilliker et al., however, we are not sure yet since we are still collecting data for our retrospective study.

References: (1) Lilliker SL. Prevelance of diabetes in a manic-depressive population. Compr. Psychiatry 1980; 21 (4):270-275. (2) Cassidy F, et al. Elevated frequency of diabetes mellitus in hospitalized manic-depressive patients. Am. J. Psychiatry 1999; 156 (9): 1417-1420. (3) Regenold WT, et al. Increased prevalence of type 2 diabetes mellitus among psychiatric inpatients with bipolar I affective and schizoaffective disorders independent of psychotropic drug use. J. Affect. Disord. 2002; 70(1):19–26.

POSTER 4-12

Metabolic Effects of Antipsychotics in Children (MEAC): Primary Endpoint Results

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Abstract:

Background: Rates of prescription of antipsychotic medications in children have increased in recent years, largely driven by use for disruptive behavior disorders. Mental health conditions are associated with higher risk for obesity and diabetes, in part related to adverse effects of psychotropic treatment. The effect of antipsychotic treatment on metabolic risk in antipsychotic naïve children has received limited study. The NIMH-funded MEAC study (PI Newcomer, MH 072912) characterized the effects of 12 weeks of randomized treatment with either aripiprazole, olanzapine or risperidone on direct measures of adiposity and insulin sensitivity in previously antipsychotic-naive children with disruptive behavior disorders.

Methods: Antipsychotic-naive participants aged 6-18 with clinically significant aggression and irritability (score of > 18 on Aberrant Child Behavior Checklist Irritability Subscale) with one or more DSM IV diagnosis indicating a disruptive behavior disorder were enrolled. Participants were randomized to specific antipsychotic treatments following baseline assessments. Baseline and 12 week measures include body composition analysis with Dual Energy X-ray Absorptiometry (DEXA) and abdominal MRI, as well as metabolic testing including hyperinsulinemic euglycmic glucose clamps with stable isotopomer tracing. Primary endpoints were change in whole body and abdominal adiposity, and whole-body and tissue-specific insulin sensitivity. ANCOVA was used to test effects of time and treatment condition on adiposity and insulin sensitivity.

Results: Antipsychotic treatment was associated with adverse changes in adiposity and insulin sensitivity in all treatment groups. Differential effects of treatment were observed on measures of adiposity and other endpoints. For example, time by treatment condition effects were detected on DEXA %fat ($F[2,119]=8.98$, $p<0.0001$). Importantly, treatment resulted in marked improvement in Aberrant Behavior Checklist irritability/aggression subscale scores, with a mean decrease of 16.64 points ($p<0.005$).

Conclusions: Results from the MEAC study indicate rapidly detectable adverse effects of antipsychotic treatment on adiposity and insulin sensitivity, detectable within the initial 12 weeks of treatment, in the context of significant clinical benefit. The results underline the importance of careful attention to the balance of potential risks and benefits during use of antipsychotic treatment in pediatric populations.

POSTER 4-13

The Metabolic Effects of Antipsychotics in Children (MEAC) Study: Baseline Characteristics of Study Participants

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Abstract:

Background: Atypical antipsychotics are increasingly used in children and adolescents to treat aggression and disruptive behavior, common presenting symptoms of many mental disorders in this patient population. Antipsychotic medications can cause adverse changes in body weight and increase cardiometabolic risk in adults. Increasing rates of antipsychotic prescription in children in the context of a national epidemic of childhood obesity puts children with mental disorders at increased risk to develop early signs of cardiometabolic dysregulation. The NIMH-funded study, Metabolic Effects of Antipsychotics in Children (MEAC), is the first to use state-of-the-art techniques to measure the effects of aripiprazole, olanzapine and risperidone on adiposity, glucose and lipid metabolism in children.

Methods: A diagnostically heterogeneous group of antipsychotic-naive subjects ages 6-18 with clinically significant target symptoms of irritability and aggression (score of > 18 on the irritability subscale of the Aberrant Behavior Checklist) were randomly assigned to 12 weeks of treatment with olanzapine (n=46), risperidone (n=49) or aripiprazole (n=49). At baseline and endpoint, subjects undergo body composition analysis with dual energy X-ray absoprtiometry (DEXA) and abdominal MRI as well as metabolic testing, including frequently sampled oral glucose tolerance tests (fsOGTT) and hyperinsulinemic, euglycemic glucose clamps with stable isotopomer tracing. DEXA, clinical anthropomorphic and fasting laboratory measures were obtained at baseline, 6 and 12 weeks. Symptoms of irritability and aggression were

assessed at baseline and endpoint using the Child Behavior Checklist and the ABC.

Results: Baseline characteristics of the MEAC sample (N=144) are as follows: mean age 11.3 +/-2.8 years, with 68.1% male (n=98). Treatment groups were balanced at baseline for gender, age and ethnicity, with approximately half in each group treated with stimulants. The most common primary diagnosis was Attention Deficit/ Hyperactivity Disorder (n=80, 55.6%, all with prior stimulant treatment), followed by Oppositional Defiant Disorder (n=31, 21.5%). This antipsychotic naive pediatric sample entered the MEAC study with a baseline prevalence of overweight or obesity of 34% (13% overweight, 21% obese), compared to the established 32% prevalence (15% overweight, 17% obese) in the general population. Children with elevated or at-risk fasting triglyceride (> 150 mg/dl) accounted for 1.8% of the total MEAC sample, compared to 13.2-14.2% prevalence in the general population. At the 12 week endpoint, pooled treatment groups had a prevalence of overweight and obesity of 48% (22% overweight, 26% obese).

Conclusions: The MEAC study is the first practically designed clinical trial to assess for metabolic changes associated with antipsychotic treatment using gold-standard measures, providing data regarding treatment-associated increases in adiposity and insulin sensitivity in a uniquely at-risk patient population. Baseline demographic, diagnostic and cardiometabolic risk characteristics of the study population are consistent with those in the general population, making final results broadly generalizable to the real-world treatment population.

POSTER 4-14

Comparing Video Game Play in Attention Deficit/ Hyperactivity Disorder and Control Children

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Abstract:

Background: Children with Attention deficit/hyperactivity disorder (ADHD) tend to have difficulty sustaining tasks and play. There has been speculation that this tendency also applies to video game play, with ADHD children playing for shorter durations than children without ADHD. Limited research has been conducted in correlating video game use with ADHD, with one study concluding that there was no difference in video game use.

Objective: This study compares video game playing time, in terms of hours per week and hours per session, between ADHD and control children.

Methods: A randomized sample of 59 children aged 7-18 years presenting in an acute psychiatric setting were administered a 21-item questionnaire to assess the different types of video games that they play, as well as the amount of time spent playing them. From the sample of 59 children, data was not included for a patient if the diagnosis, hours played per week, or hours played per session were not known. This divided our groups into 18 children with ADHD and 37 control children without ADHD.

Results: The 18 children with ADHD averaged 15.3 hours of video game play time per week and 2.8 hours per session while the 37 children without ADHD averaged 12.8 hours per week and 2.4 hours per session. There was no significant difference in either of these groups at 95% and 90% confidence intervals.

Conclusion: There is no significant difference in the video game usage of children with or without Attention deficit/ hyperactivity disorder. Children with ADHD do not play for shorter durations than children without ADHD.

POSTER 4-15

Correlation Between Axis I Diagnosis and Video Games Played

Cristian Penciu, M.D. (cristian.penciu@yahoo.com)**, Syed Hussaini, M.D., Bharat Nandu, M.D., Tasha Barkely, MSIII, Shalini Boodram, MSIII, Annika Chadee, MSIII, Andrew Erian, MSIII, Joann Tye, MSIII, Wesley San MSIII, Pedram Ansari, MSIII.**

Abstract:

Background: Video games were first introduced in the 1970's and since then it has become increasingly popular among children and adolescence as an invariable source of fun and excitement. However, there has been increasing speculation over the years about the negative impact it has on the youths in today's society. Researchers have mainly focused on the addictiveness of video games and the relationship between violent video games and aggressive behavior, however there has been limited research in the correlation between video game playing and the manifestation of DSM IV Axis I disorders among youths. Several studies have concluded that violent video games increase the incidence of impulsiveness, aggressive behavior, cognition, and affect, whereas; other types of games are associated with anxiety and depression. Children with video game addictions were significantly more likely to demonstrate hostility, poor academic performance, low social competence, and poor emotional regulation skills.

Objective: To investigate the relationship between DSM IV Axis I diagnosis and video games played in children who present in an acute psychiatric setting.

Methods: A randomized sample of children who presented in an acute psychiatric setting were chosen to participate in the study. Out of the entire sample, children ages 7-18 who play video games were selected and a 21-item questionnaire was administered to assess the amount of time spent playing video games and its impact on their daily functioning.

Results: A total of 79 participants completed the questionnaire and was found to have the primary DSM IV diagnosis of mood disorder (35%), impulse control disorder (22.8%), attention deficit hyperactivity disorder (20.3%), oppositional defiant disorder (8.8 %), substance related disorder (5%), pervasive

developmental disorder (3.8%), psychotic disorder (3. 8%) and anxiety disorder (1.3%).

Conclusion: There is a positive correlation between DSM IV Axis 1 Diagnosis and video games played among children ages 7-18 years. There is a particularly strong relationship among children who play video games and the Axis 1 disorders, such as attention deficit hyperactivity disorder, impulse control disorder, and major depressive disorder. However, there is a weak relationship among children who play video games and Axis 1 disorders, such as oppositional defiant disorder, substance related disorder, pervasive developmental disorder, psychotic, and anxiety disorders. Parents and mental health professionals need to acknowledge the significance and negative impact of video games on the mental health of children in today's society.

POSTER 4-16

Predictors of Post Discharge Antipsychotic Adherence: Comparison of Quetiapine and Aripiprazole

David Pogge, Ph.D. (dlpogge@aol.com)**, Martin Buccolo, Ph.D., Philip D. Harvey, Ph.D.**

Abstract:

Background: Atypical antipsychotic medications are now used for the treatment of mood disturbances in both adult and adolescent patients. However, there are few data on adherence to these medications in adolescents or its relationship to baseline symptom severity, medication dosage, and eventual treatment response in adolescents. This poster will present the results of a 120-day follow-up study examining the symptomatic, dosing, and treatment response predictors of adherence to antipsychotic medications in adolescent patients.

Methods: Adolescent psychiatric inpatients with major depressive disorder, bipolar disorder, and conduct disorder were treated with doctor's choice of either quetiapine (n=60) or aripiprazole (n=96). These patients were rated at hospital admission and 30 and 120 days after discharge with the Young Mania Rating Scale (YMRS) and the Hamilton Depression Rating Scale-17 (HAMD-17). They were also assessed for adherence to treatment at the 30 and 120 days post-discharge. Weight gain and self reported side effects were also collected.

Results: Both antipsychotic medications were found to reduce HAMD-17 and YMRS scores from admission to the final post-discharge assessment, using a mixed model repeated-measures analysis (all p<.005). Adherence rates were similar at 30 and 120 day assessments: Quetiapine 53%; aripiprazole 69%; quetiapine 48%; aripiprazole 64%. More severe symptoms at psychiatric admission on the HAM-D and higher discharge doses of medication predicted greater adherence to quetiapine at both 30 and 120 days post discharge. These two variables did not predict adherence to aripiprazole and the baseline YMRS did not predict adherence to either treatment. The average dose of quetiapine administered at discharge was only 83 mg in patients who stopped taking the medication, while patients who remained adherent were treated with an average dose of 240 mg. Weight gain was significantly greater with quetiapine (M=4.8 kg) compared to aripiprazole (m=2.2 kg), but was unassociated with adherence. Implications. Both of these medications were found to have efficacy in this open design. Low doses of quetiapine, probably not aimed at primary psychiatric symptoms such as depression, were associated with development of early non-adherence. However, patients with more severe depression manifested extended adherence to quetiapine and adherence to both medications was quite stable from 30 to 120 days after discharge. These data suggest that patients with clear symptomatic targets may receive greater long-term benefits from atypical antipsychotic medications, possibly justifying the risks associated with these treatments.

POSTER 4-17

WITHDRAWN

POSTER 4-18

Assessing and Managing Online Presence: Lessons from the Group for Advancement of Psychiatry (GAP) 2010 Fellows Plenary Session

Aaron Krasner, M.D., 790 Riverside Dr., New York, NY 10032, **David Cochran, MD, PhD., Steve Koh, M.D., MPH, MBA**

Abstract: Blurring of professional and personal boundaries often occurs in the age of social media. Although the Internet holds the promise of greater patient data access and coordination of care with electronic communication technology, physicians need to keep in mind potential concerns regarding increased use of social networking in daily life. It is clear that the interaction of social networking with our professional identity is a complex issue (1, 2). In the era of increased and constant connectedness through internet technology, the practice of medicine is changing (3). The prevalence of personal social networking within the medical community should not be underestimated (1, 4). Psychiatrists should carefully monitor their online presences from medical school through residency and beyond to maintain a clear boundary between professional and personal identities. The public-trust bestowed on to the medical profession is sacred and the impact of private, Web accessible information is often difficult to measure. This is especially true as medicine is moving toward increased use of electronic medical records. There are several areas of potential ethical concern. Confidentiality and medical legal issues need to be carefully evaluated in electronic communication with patients (5, 6, 7). Increased use of technology in psychiatry obscures boundaries, patient-physician relationships and legal responsibility (8, 9), and with increased access to online presence of physicians and patients alike, there is real concern of online information searches that go both ways (10, 11). To explore the prevalence of social media use, personally and professionally, amongst established psychiatric leaders, the 2010 Fellows of the Group for the Advancement of Psychiatry (GAP) surveyed the GAP membership. The GAP organization is a group of

committees that deliberate in a small group format by leaders of American psychiatry who convene twice yearly to collaborate, write, and innovate. Over 250 GAP members were surveyed. The members' online presence and electronic technology use pattern was evaluated. Over 6% of GAP members reported texting with patients, approximately 20% reported online posting of private information about themselves (with just 58% restricting information), 58% reported searching online for themselves and 6% reported searching for patient information online. Over 30% reported emailing with patients but only 7% of them get written consent for using email communication. The survey also showed the perceptions of GAP members towards social networking. Based on these data, we present a discussion of how the online presence impacts professional and personal identity, as well as the ethical issues that arise when practicing psychiatry in the age of the Internet and social networking. Finally, we present our profession's need for a comprehensive set of guidelines covering issues of treatment frame, patient privacy, medico-legal issues, and professional concerns.

POSTER 4-19

In Home Mental Health in Palliative Care?

Jose Edwin Nieves, M.D. (jose.nieves@va.gov)**, J. Edwin Nieves, M.D., Kathleen M. Stack, M.D.**

Abstract: A review of videophone applications in mental health showed the usefulness and frequency of use of videophones in palliative care patients. Palliative care patients especially those that live in rural or distant areas can be at a disadvantage when it comes to palliative care management. Disease progression evaluation, medication management and access to a hospital based palliative care team full range of services are all impacted by distance and by the relative challenges in mobility inherent to the terminally ill. Videophones are a low technology telemedicine alternative that can be used to overcome these factors. They are easy to use requiring only an electrical power source and a telephone line for initial deployment. It is very easy to initiate use in lay persons and clinical staff devoid of previous technological experience. We found 5 1-5 studies comprising 34 subjects where videophones were utilized in a variety of applications to support not only terminally ill patients but also their caregivers. These applications included: 1 Caregiver support and mental health prevention prophylaxis. (1-5). 2 Patient and caregiver psycho education (2). 3 Psychotherapeutic Interventions in palliative care patients (3-4). All studies reported anecdotally ready acceptance of videophones by both patients and caregivers (1-5). There were no reported technical difficulties. Videophones also appear to be equally effective to face to face (F2F) (3-4) to deliver both supportive and cognitive therapy to palliative care patients living in remote rural areas. Videophones are an affordable underutilized telemedicine alternative to bring care to the patients home. Infirmed, terminally ill patients with their limitations on mobility maybe a special patient population that would benefit from their deployment and use. In addition, caregivers to the terminally ill can also benefit from mental health primary prevention and access to a hospital based palliative care treatment team.

POSTER 4-20

WITHDRAWN

POSTER 4-21

Can Anyone Hear Me? A Case Presentation of a 55 Year Old Deaf/Mute African American Female Who Was Referred to the Psychiatric Emergency Department

Eileen Zhivago, M.D. (eileenzhivago@gmail.com)**, Kapila Marambage, M.D., Tara A. S. McKinney, M.D.**

Abstract:

Objective: To demonstrate that patients with hearing impairment have an increased risk of being misinterpreted and being inappropriately sent to be evaluated by a psychiatric team secondary to lack of communication. To be able to evaluate the importance of being able to evaluate for psychosis despite a patient's sensory limitations.

Methods: The patient was a 55 year old deaf and mute African American female who presented to the Psychiatric Emergency Department after her family, who are not able to use American Sign Language brought her to the OB/GYN department to evaluate for pregnancy as the patient had been experiencing facial and abdominal edema as well as upper and lower extremity edema. The patient had also reported having right-sided pain that day which initiated to visit. As no intrauterine pregnancy was noted on ultrasound the patient was referred to psychiatry for evaluation of a psychotic disorder. Upon arrival to our department, the tele-conference was started with a live on-line American Sign Language Interpreter and the patient reported that she had never used such a device in the past. It appeared that the patient adamantly refused that she believed that she was pregnant however was very concerned as she was having generalized edema. She was also experiencing pain and reported that she had had several visits to the ED however was sent home without treatment or amelioration of symptoms which she found frustrating. No evidence of any psychotic or mood disorder was elicited during psychiatric interview.

Results: Upon using telecommunication with a video on-line interpreter proficient in American Sign Language. It was discovered that the patient's family is not able to use American Sign Language and they believed that the patient was pregnant because she was exhibiting edema in both her upper and lower extremities as well as her face and abdomen. As the patient was reporting pain she was brought into the hospital to be evaluated by the OB/GYN service who did not see an intrauterine pregnancy on ultrasound and was therefore sent to be consulted by psychiatry. Once the patient arrived to the Crisis unit a video screen with a live American Sign Language interpreter was utilized. The patient reported that she had never used such a device in the past. The psychiatric team was

able to evaluate the patient and exclude any type of psychotic disorder. Simultaneously, it was discovered that the patient had been having worsening of her edema and new onset right-sided pain. The patient reported being pleased that she was finally able to communicate efficiently and be referred appropriately.

Conclusion: Although time consuming, all reasonable measures of communication must be utilized when dealing with a patient with hearing impairment as to be able to decipher any underlying psychiatric or physical illness.

POSTER 4-22

Comparison of Canadian Triage System to Australian Triage System for Psychiatric Patients

Leslie Zun, M.D. (zunl@sinai.org)**, L. Downey, Ph.D.**

Abstract:

Objectives: The purpose of the study was to compare the Canadian triage protocol to the Australian psychiatric triage protocol for evaluation of psychiatric patients in the emergency department. The secondary purpose was to ascertain whether psychiatric triage better assesses the patient's needs.

Methods: A convenience sample of patients who presented with a psychiatric complaint at triage were given the Canadian triage assessment by the nurse at triage. The study occurred in an inner city level one trauma center with 60,000 patient visits per year. A secondary triage assessment using the Australian psychiatric triage protocol was performed by a research fellow and included the observed and reported elements of the psychiatric triage, agitation assessment, using the Richardson Agitation Sedation Scale (RASS) and the patient's self-assessment of the degree of psychiatric distress and agitation. The study was approved by the IRB.

Results: There was no significant correlation found among the Canadian triage scores, the RASS scores, the self-assessment quiz questions, the total number of minutes spent in the ED, or throughput times. The only significant correlation found was that among the Australian psychiatric triage, the RASS scores (F=18.5, p- .00), and some of the self-assessment quiz questions.

Conclusions: The use of the Canadian triage protocol does not correlate with patients' being seen within the time frames recommended, patients' self-assessment of urgency, and the RASS system of rating symptoms of psychiatric presentations. The Australian system rated patients' presentations as far less urgent than did the standard system. It did, however, correlate with the RASS system and the patients' own self-assessments.

POSTER 4-23

Coming to the Table: Research Ethics and Human Agency in Research with Involuntary Hospitalized Psychiatric Patients

Sami Ahad M.D., 570 West Brown Road, Mesa, AZ 85201, **George Silvers, M.D., Nancy Van Der Veer, Psy.D., David Drachman, Ph.D., Gilbert Ramos, M.A.**

Abstract:

Objective: Much discourse exists on the ethics of including the mentally ill in research and how to properly address informed consent. Involuntarily hospitalized psychiatric patients have the added experience of forced institutionalization that may ultimately compromise their ability to "just say no." Conventional belief is that institutionalization, with its overtures of coercion and undue influence, strongly encourages cooperation. This study compares the consent rate and clinical characteristics of both voluntary and involuntary psychiatric patients who were approached to participate in a minimal risk study. We hypothesized that involuntary patients would be more likely than voluntary patients to engage in research. Such an investigation provides empirical evidence to help evaluate the impact of involuntary hospitalization on aspects of informed consent.

Methods: We examined recruitment records of a minimal risk PTSD screen validation study at a psychiatric acute inpatient hospital and selected 274 voluntary (151) and involuntary (123) patients as subjects for our retrospective chart review. Of these subjects, 135 refused and 139 consented to participate in the original validation study. Data collected include age, gender, major diagnosis, days from admission to consent, GAF, and criteria met for initial psychiatric admission, and compared those refusing to those consenting.

Results: A lower percentage of involuntary patients (38.4%) agreed to participate than did voluntary patients (65.9%), with refusals corresponding at 61.6% and 34.1% respectively for involuntary and voluntary patients (p<.0005). Overall sample characteristics include: 149 males (54.4%), 203 Caucasians (74%), and 32 Hispanics and 32 African Americans (11.7% each). Average age was 38.4 years, with average LOS 35 days. Primary diagnoses included 142 (51.8%) mood disorders, 99 (36.1%) psychotic disorders, and 11 (4%) substance related disorders. When examining by primary psychiatric diagnosis, 48 (33%) of the 142 mood disorder patients refused participation, whereas 94 (66.2%) agreed. Refusals to study participation were more pronounced among the 99 psychotic disorder patients in the sample at 72 (72.8%).

Conclusion: Involuntary patients did not consent to research at a higher rate than voluntary patients in our sample; in fact, involuntary patients were more likely to refuse participation. Psychiatric illness on the other hand, specifically mood disorder and psychotic disorder appeared to have some association to tendency to refuse or consent to research. Further investigation of clinical characteristics and patient background may help elucidate the motivations leading to

individual patient decisions to consent or not. Our research suggests that individuals may possess their own experience that may aid them in autonomous decision making from what we would otherwise predict.

POSTER 4-24

Risk Adjusted Quality Indicators for Psychiatry: A Focus on Strengths and Improvement

Christopher Perlman, Ph.D. (perlchri@homewood.org), **John P. Hirdes, Ph.D., Howard Barbaree, Ph.D., C.Psych., Ian McKillop, Ph.D., Brant Fries, Ph.D., Terry Rabinowitz, M.D., John Morris, Ph.D.**

Abstract: Quality measurement is a complex component of mental health services. Understanding how services are organized, delivered, and effective is vital for ensuring and improving quality and safety. To date, structural and process indicators are common with fewer outcome indicators available. The lack of outcome indicators and, in particular, those designed to reflect clinical change, are a product of limited clinical information available across providers. Limited clinical data also reduces the availability of data for case mix adjustment, an essential application for using outcome quality indicators for comparing services. In Ontario, Canada, a comprehensive clinical assessment system called the interRAI Mental Health (RAI-MH) is uniformly implemented for use in all designated inpatient mental health beds across 71 hospitals. This system measures over 400 items that include observations of mental status, cognitive, social, role, and physical functioning, substance use, and resource utilization. This information can be summarized into indicators to assist with care planning, outcome measures, and an index of resource utilization. A set of 27 Mental Healthcare Quality Indicators (MHQIs) can be derived from the RAI-MH. The MHQIs were defined by a mental healthcare stakeholder group and derived using 30,046 RAI-MH admission and discharge assessments collected from 70 Ontario hospitals as part of the Canadian Institute for Health Information Ontario Mental Health Reporting System. The MHQIs measure improvement and incidence/failure to improve in the following domains: depressive symptoms, psychosis, physical pain, cognitive performance, daily functioning, interpersonal conflict, harmful and disruptive behaviours, and control procedures. For each MHQI domain, regression modeling using generalized estimating equations was employed to choose risk adjustment variables and logistic regression was used to perform risk adjustment to compare MHQI rates among hospitals and regions in Ontario. This presentation will describe the MHQIs available from the RAI-MH, providing examples of why case mix adjustment of the MHQIs is important when comparing services and how the MHQIs can be used to identify opportunities for quality improvement. For instance, patterns of improvement were consistently high across hospitals for depressive symptoms and psychotic symptoms while results for improvement in daily functioning (e.g., medication management) were lower and more variable among hospitals, even after adjusting for case-mix and service type (i.e., long term, acute, forensic). This diversity could be used to examine whether disparities in clinical expertise across health regions contributes to poorer quality. Since the RAI-MH includes applications for care planning and resource utilization, participants will gain an understanding of how the measurement of outcomes using the MHQIs can be linked to both service delivery and funding.

POSTER 4-25

Diagnostic Clarity Using the SCID in a Community Mental Health Setting

Raymond Kotwicki, M.D., 1961 North Druid Hills Road, Atlanta, GA 30329, **Philip D. Harvey, Ph.D.**

Abstract:

Background: Psychiatric diagnoses are important for treatment planning, particularly pharmacological interventions. Some data indicate that clinician diagnoses of some conditions, such as schizophrenia, are convergent with diagnoses generated with structured psychiatric interviews. Other data indicate that clinician diagnoses early in the course of psychiatric illnesses or of certain conditions, such as bipolar disorder, are likely to be changed after reconsideration.

Methods: A structured psychiatric interview procedure for all new admissions, using the Structured Clinical Interview for the DSM (SCID), was implemented at Skyland Trail, a private psychiatric rehabilitation facility offering outpatient and residential psychiatric rehabilitation services. Diagnostic interviews were conducted by clinicians in the admissions department. The stability of diagnoses over the course of treatment (averaging 13 weeks) of one year of consecutive admissions who were all diagnosed with the SCID at admission were compared to stability of diagnoses of patients who were diagnosed by the same clinicians during the 12 month period prior to the implementation of the structured diagnostic procedure.

Results: During the one-year period prior to the implementation of the structured diagnostic procedure, 74.8% (N=176 of 235) of the diagnoses made by the admission clinicians were changed or modified during course of care by the treating clinicians. After implementation of the structured diagnostic procedure, fewer than 5% (N=9 of 193) of the admission diagnoses are changed during similar courses of treatment.

Implications: These results suggest that structured interviews lead to admission diagnoses that are more consistent with the longer-term impressions of patient's clinical condition. It is likely that patients whose diagnosis is decided early in the case of long-term treatment will receive treatments that are more consistent and, in the case of pharmacological interventions, more consistent with approved therapies for their illness.

POSTER 4-26

Recovery Communities: First Person Perspectives of Residents with Dual Diagnosis

Maria Mananita Hipolito, M.D., 2041 Georgia Ave. NW 5th floor, Washington, DC 20060, **Jessica Herrera, M.D., Elizabeth Carpenter-Song, Ph.D., Robert E. Whitley, Ph.D.**

Abstract: Evidence suggests that housing is one of the most crucial community support services necessary for the recovery and rehabilitation of people living with a mental illness. Without the availability of quality affordable and stable housing, other treatment and rehabilitation approaches are jeopardized. Patients will often drop out of treatment and revolve around 'the institutional circuit' of hospital, jail and homeless shelters. The co-occurrence of substance use disorder among people with severe mental illness (SMI) is especially associated strongly with various negative outcomes including unstable housing and homelessness, particularly in urban settings and among ethno-racial minorities. To better understand the nexus of recovery, housing, and urban living, we are currently undertaking a research project entitled 'Creating Communities'. This study involves assessing how stable housing influences recovery within small communities of people living with SMI, almost all of whom are African American. These configurations are labeled 'recovery communities' (RCs). The research team is interested in understanding how the communal living situation of such supportive housing impacts people's processes of recovery and rehabilitation. Focus groups are conducted at quarterly intervals facilitating a longitudinal view of residents' experiences and perspectives on recovery and everyday life in the community. First-person narratives are used to develop a substantive grounded theory of processes of recovery among residents in RCs. Three domains strongly emerged in which residents convey the RCs playing a role in recovery. RCs appear to facilitate recovery through the confluence of (i) the security provided by the physical environment; (ii) the support of the treatment environment and; (iii) the connection to others in the social environment. 'Creating Communities' is being conducted in the context of the Dartmouth-Howard Collaboration, a five-year research and training center grant focusing on the recovery and rehabilitation of African Americans with SMI funded by National Institute on Disability and Rehabilitation Research.

POSTER 4-27

Episodic Paralysis Associated with Varenicline

Carmen Croicu, M.D. (croicu@hotmail.com)**, Susan Bentley, D.O., Michael Stanger, M.D.**

Abstract:
Case: A 40-year-old Caucasian married female without a significant psychiatric history was started on varenicline 0.5 mg daily by her primary care doctor. Two days after the dose was increased to 1mg twice daily she began to experience diffuse weakness in all four extremities. Varenicline was stopped but the weakness progressed and she experienced an episode of complete paralysis lasting for 10 minutes. The patient was admitted to the neurology service and she continued to have episodes of paralysis and weakness. General medical causes of this patient's presentation were ruled out after an extensive medical workup. Two weeks after varenicline was discontinued the patient recovered to full function without any abnormal movement episodes.

Discussion: Case reports reveal interactions between the motor system and varenicline. We postulate that varenicline played an etiological role in symptom presentation. A diagnosis of Psychogenic Non-epileptic Seizure (PNES) was also considered. Imaging studies of conversion disorder suggest neural correlates that could account for the perception of these behaviors being involuntary, however the effect of varenicline on these brain regions is undetermined. Given that resolution of symptoms occurred within 2 weeks after stopping the medication, there is a high likelihood that varenicline was correlated with her episodes of paralysis and weakness. The withdrawal features of smoking cessation may also have contributed and an appropriately anxious response to the unexplained symptoms likely perpetuated the presentation.

Conclusions: 1. The above case highlights further concerns with possible neuropsychiatric side effects associated with varenicline use in patients without psychiatric issues. 2. Patients who are receiving varenicline need to be monitored closely for potential side effects.

POSTER 4-28

The Alpim Syndrome: Anxiety of the Mind and Body

Singh Deepan, M.B.B.S (dr.deepansingh@gmail.com)**, Jeremy D. Coplan, M.D., Dorothy P. Reddy, M.D., Sanjay J. Mathew, M.D., Antonio Bulbena, M.D.**

Abstract:
Objective: The purpose of this study was to describe a distinct syndrome consisting of anxiety disorders, joint laxity, chronic pain disorders, immune disorders and mood disorders. This was to be established by showing a statistically significant relationship among the different disease entities within domains. The authors have dubbed this conglomeration of signs and symptoms- the ALPIM syndrome after the inclusive categories (Anxiety, Laxity, Pain, Immune and Mood).

Method: 76 out-patients, all with a previously diagnosed anxiety disorder were subjected to a questionnaire and examination to detect disease entities inclusive to the ALPIM categories. Data was collected on anxiety disorders, joint laxity, scoliosis, "double jointedness", mitral valve prolapse, easy bruising, fibromyalgia, headache, cystitis, prostatitis, irritable bowel syndrome, asthma, allergic rhinitis, hypothyroidism, chronic fatigue syndrome, unipolar and bipolar affective disorders and tachyphylaxis. The data was analyzed using logistic regression and cluster analyses.

Results: >80% of the patients had a history of panic attacks, tachyphylaxis, fibromyalgia or a major depressive episode and hence these were included in the ALPIM phenotype. The following significant comorbidities were noted: joint laxity with tachyphylaxis (OR=8.5); scoliosis with asthma (OR=5.1); headache with asthma (OR=7.1); bipolar II (OR=6.8) with rhinitis (OR=6.8), asthma with allergic rhinitis (OR=4.4) and bipolar II with chronic fatigue syndrome (OR=3.4). Cluster analysis showed results concurrent with the ALPIM syndrome construct.

Conclusions: Statistically significant relationships were demonstrated between the different domains included in the ALPIM syndrome. The results confirmed our objective of identifying a syndromal relationship between different physical and psychiatric comorbidities. The ALPIM syndrome warrants further examination for clinical, treatment and genetic implications.

POSTER 4-29

Psychiatric Conditions Associated with Psoriasis

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Abstract:

Background: Psoriasis is a chronic disease that can negatively impact many aspects of quality of life. Patients with psoriasis may suffer from pain and discomfort from the disease as well as psychological and social difficulties including stigmatization, embarrassment, and social inhibition. Anxiety, depression, smoking, and alcohol abuse have been found to have a higher prevalence among psoriasis patients than healthy controls. In addition, there is significant amount of mortality due to suicidal ideation. In the literature, Psoriasis had been reported as medication side effects of patients treated with Lithium and Olanzapine and vice versa, Psychosis been reported as consequence of sulfasalazine treatment for Psoriasis.

Method: Literature review of articles available in electronic and text media for the same topic and reporting 2 cases admitted to BRMC.ObjectiveS To search literature for psychiatric comorbidities among patients with psoriasis and see how they are associated to the disease and report two cases of psoriasis with psychiatric conditions admitted to BRMC.

Results: Our literature review has revealed the association between Psoriasis and psychosis and also psoriasis as a side effect from psychotropic Medication. The two most common medications associated with psoriasis were Olanzapine and Lithium. There are case reports presenting the the relationship between the appearance of the symptoms after the initiation of these medications. Studies also revealed psychotic symptoms in patients treated for psoriasis with sulfazalazine.

Conclusion: The role of different drugs in the onset or exacerbation of psoriasis, particularly In patients with previous diagnosis or a family history of the disease has been shown in several studies. Many drugs may be responsible for inducing or triggering psoriasis. We as psychiatrists have the obligation to prevent the onset of psoriasis in patients who are high risk or predisposed to psoriasis as per family history. Once we have a patient who develops dermatologic signs of psoriasis we have to be able to recognize the psychotropic medication as the cause of the new dermatologic condition and help to prevent further exacerbation.

POSTER 4-30

Status Epilepticus, Stroke and Delirium in a Patient with Graves' Disease

Deina Nemiary, M.D., M.P.H. (dnemiary@msm.edu)

Abstract: Hyperthyroidism has been reported to present as a series of neuropsychiatric changes from confusion, anxiety, agitation, delirium and stupor. Seizures secondary to thyrotoxicosis have also being reported. There has been several case reports of stroke associated with thyrotoxicosis, almost exclusively caused by a hypercoagulable state induced by hyperthyroidism. We describe a man with new onset generalized tonic-clonic seizures, an acute ischemic stroke and delirium, all precipitated by acute thyrotoxicosis.

POSTER 4-31

Surviving Aortic Dissection: Does Life Go On?

Janet Shu, M.D., 330 Brookline Ave. Rabb 2, Boston, MA 02215

Abstract: Mood influences physical health and physical problems influence the mental health of patients. In the intersection between cardiology and psychiatry, research has shown that depression predicts mortality after acute coronary events such as myocardial infarction. In the intersection between oncology and psychiatry, multiple papers discuss how patients cope with the mental health consequences of a cancer diagnosis. Most data are based on middle-aged and elderly individuals. Very little is known about how acute cardiovascular events psychologically affect younger adults in their twenties or thirties (based on personal Pubmed review). This report describes the complex issues faced by a man in his mid thirties, with no previous psychiatric history, who is faced with an aortic dissection. The psychiatrist, primary care provider, and cardiologist, communicate and collaborate effectively together to treat the patient's difficult medical psychosocial problems. This case exemplifies the interconnection between medical and psychiatric problems making it clear that providers must work together to provide optimal care. Of interest would be to ascertain whether treatment of depression, known to decrease risk for ACS recurrence, can be applied to hypertensive management as secondary prevention.

POSTER 4-32

The Role of Peer Support in Reducing Disparities in Mental Healthcare for Rural Veterans with Post Traumatic Stress Disorder (PTSD)

Shaili Jain, M.D. (shaili.jain@va.gov)**, Steven E Lindley, M.D., Ph.D., Craig S. Rosen, Ph.D., Josef I Ruzek, Ph.D.**

Abstract: Thirty-two percent of the enrolled veterans from the current conflicts in Iraq and Afghanistan originate from rural and highly rural areas, with many returning to their home communities. Up to 13% of Iraq and Afghanistan veterans have combat-related posttraumatic stress disorder (PTSD) yet access to evidence based mental healthcare in rural and remote areas is often limited. Mentally ill veterans from rural areas experience a greater disease burden and higher chance of incurring more health care costs than their urban counterparts. Examination of 2003-4 data on veterans with a new diagnosis of depression, anxiety or PTSD found that rural veterans were significantly less likely to receive psychotherapy than their urban counterparts. Furthermore the dose of psychotherapy services, for rural veterans who did initiate treatment, was also limited. Early evidence based treatments may prevent chronic PTSD and subsequent adverse events such as substance abuse and suicide yet the availability of rural mental healthcare, that is accessible and acceptable, to Veterans is often limited. This abstract focuses on social determinants of rural populations which contribute to disparities in the provision of good quality healthcare for Veterans living with PTSD. Specific obstacles such as geographical isolation, poverty, stigma, poor adherence and engagement in mental health treatment, overburdened professional staff and inadequate familiarity of professional staff with rural life and culture are highlighted. Incorporating peer support into PTSD treatment approaches has been offered as a potential solution to such obstacles. Peer support is typically defined as a peer, with a history of mental illness, who having experienced significant improvement in their condition, offers services and support to a peer considered to be not as far along in their own recovery from mental illness. In 2004 the Department of Veterans Affairs (VA) created a mental health strategic plan which specifically included recommendations for the hiring of peer support paraprofessionals to improve Veteran engagement in mental healthcare. Here, we draw on data supporting the use of peer support in the VA, thus far, and propose that peer support could potentially reduce disparities for rural veterans with PTSD via the following mechanisms: Increasing social networks via outreach services, destigmatizing decisions to seek mental health treatment, increase engagement and adherence in treatment by emphasizing its relevance, provide health systems navigation and act as a "culture broker" between professional staff and patients. A theory driven model for the successful implementation of such peer support into rural mental health PTSD treatment teams is also offered.

POSTER 4-33

Family Functioning in the Community

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Abstract:

Objective: The goal of this study was to survey a broad spectrum of families in order to obtain up-to-date information on family functioning in a non-help seeking sample, using an established measure of family functioning. In addition, we explored how social support, quality of life and life events related to family functioning.

Method: 95 families with at least one adult member (>/= 18 years) recruited through advertisements and word of mouth, participated in the study. Family members completed questionnaires designed to assess their functioning (FAD-Family Assessment Device), social support (MSPSS-Multidimensional Scale of Perceived Social Support), quality of life (Q-LES-Q- Quality of Life-Enjoyment and Satisfaction Questionnaire), and life events (SRRS-Social Readjustment Rating Scale).

Results: The mean age of the sample was 37 years, mean education 13.4 years and mean income $41,380. 59% identified themselves as White or Hispanic, 19% as African American, 4 % as Asian, while 18% declined to answer. Family mean scores were in the healthy range on all FAD subscales. Family functioning was in the unhealthy range for families with a psychiatrically ill member and for families making less than $20,000 per year. Husbands, wives and children rated their family's functioning similarly. Social support and quality of life, but not life events, were significantly associated with family functioning. Family functioning scores in this study are similar to those reported in 1985 and 1990.

Conclusions: Most non-help seeking families in the community reported healthy family functioning and there is agreement about this by individual family members. Families with very low income and/or a psychiatrically ill member perceived their family's functioning as unhealthy. Social support and quality of life were associated with family functioning while life events were not. The FAD continues to be a reliable measure of family functioning

POSTER 4-34

Capacity Reductions in Acute Public-Sector Inpatient Psychiatric Services: Impact on Patients, the Mental Health System and the Community

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Abstract:

Background: There is general consensus that mental health systems should provide a comprehensive and coordinated continuum of care that includes outpatient and residential

services, as well as acute emergency and inpatient services. Budget shortfalls increasingly lead mental health systems to consider reductions in costly inpatient services. However, the role of inpatient services in the continuum of care is not well understood and there is little evidence about the impact of capacity reductions in the community hospital settings that provide an increasing proportion of inpatient care.

Research question: This study tested the hypothesis that reductions in acute public-sector psychiatric inpatient capacity in a major urban area were associated with negative impacts on patients, the mental health system and the community.

Method: The impact of two discrete service changes that reduced inpatient capacity by fifty percent in a single public-sector general hospital setting was examined using an interrupted time-series design. Indicators of impact were obtained from existing administrative databases for a 33-month period. Indicators included multiple measures of utilization and case mix on the acute inpatient and psychiatric emergency services, suicides among community mental health clients, and psychiatric evaluations conducted in county jails.

Results: Reductions in inpatient capacity were not associated with hypothesized negative impacts, such as increased demand for psychiatric emergency services, decreased access to emergency or inpatient services, or increased recidivism to inpatient care. Similarly, neither the number of suicides among community mental health clients nor the number of jail psychiatric evaluations increased following capacity reduction.

Conclusions: Data from a single urban public-sector setting suggest that acute inpatient psychiatric capacity may be reduced without negative impacts on patients or the community. In this setting, increasing coordination between inpatient and outpatient providers facilitated reductions in inpatient length of stay that made it possible to serve the same number of patients with fewer resources. Other service system adjustments may be more appropriate in other settings and alternative approaches to reducing utilization of high cost inpatient care warrant examination.

POSTER 4-35

The Impact of Religiousness and Sex on Mental Health Service Use Among Community-Dwelling Adults: Results from the Baltimore ECA Follow-Up Study

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Abstract:

Introduction: Despite prior research on the effect of religiousness on mental health outcomes, few studies have examined the effect of religiousness on mental health service (MHS) utilization. The aim of the current study is to examine the influence of internal and external religiousness in the use of various types of MHS, and how this relationship differs between men and women.

Methods: Our sample consisted of 1,071 participants (mean age at wave 3: 48.1 +/- 12.8 SD, female: 62.9%, non-white race: 38.2%) who were interviewed in both wave 3 (1993-1996) and 4 (2004-2005) of the Baltimore Epidemiologic Catchment Area (ECA) follow-up Study. We examined internal and external religiousness factors predicting self-reported MHS use from three sources: mental health professionals, medical doctors, or religious professionals. Internal religiousness was measured by: How important are religious beliefs in your daily life?, Do you encourage people to believe in Jesus and to accept Him as their savior?, When you have problems, how often do you seek spiritual comfort?, When you have decisions to make, how often do you ask yourself what God wants you to do? External religiousness was frequent vs. infrequent church attendance. We used the structural equations modeling (SEM) and logistic regression to assess the relationship between MHS use and both internal and external religiousness while adjusting for DSM-III-R psychiatric disorders.

Results: Among women, but not men, higher internal religiousness predicted significantly lower odds of any MHS use in the subsequent 10 years (OR=.77, 95% CI [.60, .98]), including mental health professionals (OR=.73, 95% CI [.54, .98]) and medical doctor (OR=.72, 95% CI [.56, .95]), after adjusting for the presence of DSM-III-R psychiatric diagnosis. Higher external religiousness also predicted lower odds of MHS use among women, but only from mental health professionals (OR = .64, 95% CI [.40, 1.00]). For both men and women, increased internal religiousness predicted higher odds of seeking help from religious leaders (e.g. minister, priest, or rabbi) in the next 10 years (men: OR=2.04, 95% CI [1.12, 3.74], women: OR=1.51, 95% CI [1.04, 2.43]) while external religiousness had no association with seeking out religious leaders.

Discussion: Our study suggests that women with higher internal religiousness are less likely to utilize professional MHS, while both women and men in the community with higher intrinsic religiousness are more likely to turn to religious leaders for help with mental health problems. Particularly for women, some elements of religion may serve to discourage the use of professional MHS, in favor of seeking religious guidance when faced with mental health problems.

Conclusion: Internal religiousness influences help-seeking behavior for mental health problems among community-dwelling adults, especially women. Service providers may need to be aware of the barriers that women's religious beliefs may pose to seeking professional help. Pastoral caregivers may have a significant role to play in encouraging women to seek professional MHS.

POSTER 4-36

Therapeutic Alliance: Satisfaction and Attrition of Psychiatric Patients in a Mental Health Clinic in Ayacucho, Peru

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Abstract: Neuropsychiatric disorders are among the top three burdens of disease worldwide, and contribute to a significant amount of time lost to disability in low-income nations. However, little to no support is offered to those suffering from mental illness in these nations, and patients who find assistance often discontinue treatment long before reaching an adequate level of functioning. The factors contributing to patient drop-out from mental health treatment programs in low-income nations are under-researched due to limited resources dedicated to evaluating mental health programs. This study examines one of the leading reasons for patient drop-out in high-income nations to determine if program improvement methods currently utilized in those nations can be applied to decrease the early patient drop-out in low-income nations. The strength of the patient-provider relationship (or alliance) and patient satisfaction with the treatment program and clinic were examined via the Working Alliance Inventory (WAI) and Patient Satisfaction with Services questionnaires after one appointment with a psychiatrist or psychologist at a free mental health clinic in Ayacucho, Peru. Measures of satisfaction and the strength of the patient-provider relationship were compared between patients who did or did not return for their second visit within three months. Characteristics of the patients, including age, gender, occupation, income, education level, diagnosis, and history of substance abuse, were also compared between groups, along with clinical experience, treatment style, occupation, and gender of the treating clinician. No differences in patient and clinician characteristics were found between groups. Satisfaction with some aspects of the quality of services varied between groups. Patient drop-out was associated with the clinician's evaluation of the patient-provider relationship, but not with the patient's evaluation. Clinicians prospectively rated patients who did not return as having decreased alliance on tasks, bonds, and goals on the WAI. The results of this study suggest that typical high-income nation satisfaction questionnaires may not be an effective means of evaluation in this patient population, but may be useful in clinicians. The study outcomes will be utilized to establish methods of intervention in clinical and treatment techniques to prevent future patient attrition.

POSTER 4-37

Testing Awareness About Mental Illness in Local Population: a Comparative Study in Karnal (India)

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Abstract:

Introduction: Mental health awareness is defined as the knowledge that the public has about mental health in general, including common mental health disorders, misconceptions associated with mental illnesses and knowledge of effective treatment available. In this study we aimed to assess the level of mental health awareness in Karnal, India.

Methods: A survey instrument developed by the CMHA (Canadian Mental Health association) to measure mental health awareness was used. Data was collected from 50 family members of patients over a two month period at a psychiatric OPD, as well as 100 police personnel undergoing training at the police academy.

Results: Higher educational qualification and living in urban areas was significantly associated with increased mental health awareness and having a higher income was also significantly associated with increased mental awareness. There was no significant difference in between the civil population group and police group.

Conclusion: Our study indicates that mental health awareness among the general population in Karnal is very low. Although higher income individuals who live in urban areas tend to have slightly better scores, this lack of familiarity with mental health issues is prevalent among all subsets of the population. Increased education of population about mental health issues is recommended.

POSTER 4-38

Labels Used by Young People to Describe Mental Disorders: Their Determinants and Impact on Stigma and Help-Seeking

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Abstract:

Background: Mental disorders are common in young people, yet many do not seek help. Recognition and labelling are natural components of the help-seeking process and are targets of community awareness initiatives. However, labels may also elicit stigmatizing beliefs and inhibit help-seeking. More information is needed about the links between labelling, help-seeking and stigma in young people.

Method: A survey of 2802 young people was conducted. Label use, help-seeking preferences, and stigmatizing beliefs were assessed in response to vignettes of a young person with depression, psychosis or social phobia using percent frequencies and logistic regression analyses.

Results: Accurate labelling of the vignette varied for depression (69.1%), psychosis (33.4%) and social phobia (5%), and was associated with increasing age, exposure to campaigns and accuracy of parent label use. Accurate labelling predicted a preference for professionally recommended sources of help with greater consistency than any other labels commonly used. Generic lay labels predicted less intention to seek any help. Regarding stigma, most mental health labels were associated with seeing the person as sick rather than weak. However, for the psychosis vignette, mental health labels predicted perceiving the person in the vignette as dangerous or unpredictable.

Conclusion: The use of accurate labels, and an understanding of the terms that young people may use in place of them, are potentially important factors to consider in the design of effective help-seeking messages for community awareness initiatives. Campaigns promoting recognition and labelling of psychosis may need to proceed with caution and address beliefs in dangerousness and unpredictability.

POSTER 4-39

REACT–PCS: Racial and Ethnic Associations to Consult and Treatment – Psychiatry Consultation Service

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Abstract:

Objective: Diverse patient populations can transform the treatment encounter in various ways; this study examined the impact of race/ethnicity, gender, and age on psychiatric consults. Our hypothesis was that the rate and reasons for consults would differ between minority and Caucasian populations because of cultural misperceptions and biases. We also anticipated a disproportionate rate of psychotic diagnoses in minorities as opposed to mood and anxiety diagnoses in Caucasians, based on prior study findings.

Methods: We conducted a retrospective chart review of 539 psychiatric consults requested in 2006 at Maricopa Medical Center in Phoenix, Arizona, a 718-bed county hospital. Data gathered included: gender, age, ethnicity, department requesting the consult, reason for consult, consult psychiatric diagnosis, length of time from admit to consult, total length of stay, and psychiatric discharge diagnosis. Chi-squared tests, F-tests, Mann-Whitney U tests, and Kruskal-Wallis tests were performed to find correlations between these variables.

Results: Of 539 consults, 312 were male (58%) and 227 female (42%) with a racial/ ethnic breakdown of Caucasian (N=267, 50%), African-American (N=58, 11%), Hispanic (N=134, 25%), Native American (N=24, 4%), Asian (N=3, 1%), and Other/ Unknown (N=53, 10%). Consult ages totaled 41 (8%) aged 0-17, 166 (31%) aged 18-34, 291 (54%) aged 35-64, and 40 (7%) aged 65 and above. Psychiatric consults were requested by the burn unit (N=31, 6%), emergency department (N=37, 7%), internal medicine/family medicine (N=337, 62%), obstetrics/ gynecology (N=25, 5%), pediatrics/PICU (N=33, 6%), and surgery/trauma/ SICU (N=75, 14%) teams. The time to a psychiatric consult request did not differ significantly based on race/ethnicity, age, gender, or requesting department. No statistically significant differences were found when comparing race/ethnicity and gender with consult reasons. However, differences were noted on the reasons for consult by requesting department and age of the patient. Length of stay also differed by requesting department and patient age but not by gender or race/ethnicity.

Conclusion: Although race/ethnicity did not have a statistical impact on reason for psychiatric consults, length of stay, or time to consults, it is important to recognize the subtle roles that ethnicity, race, and gender play in expression and interpretation of patients receiving psychiatric consults. Some observed differences in psychiatric diagnoses between ethnic groups correspond to the literature, however these are not pronounced enough to be significant. We did not account for medical staff ethnic diversity which may moderate bias in treatment encounters. Additionally, overall lower SES among all racial/ethnic groups that was not accounted for may play a role in neutralizing differences. Future investigation should consider caregiver as well as patient characteristics in assessing service delivery of the psychiatric consult.

POSTER 5-1

Acute Urinary Retention Precipitated by Buprenorphine/Naloxone

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Abstract: The patient is a 40 year-old veteran who has a history of PTSD as well as polysubstance dependency (alcohol dependency in sustained remission and prescription pain killer oxycodone dependency) who presented to the Emergency Department one day after being started on sublingual buprenorphine/naloxone at a dose of 8mg bid for treatment of opiate dependence. In addition, he was being treated with venlafazine XR 37.5mg, meloxicam 15mg po q daily, sertraline 100mg po q daily and trazodone 50mg po qhs prn for insomnia. The next morning, the patient awoke with a rash on his chest and inability to urinate. He subsequently took a dose of Benadryl 50mg which relieved the pruritus associated with the rash. However, he continued to experience lower abdominal discomfort due to the urinary retention. He later presented to the emergency department where he had a onetime urethral catheterization. He was observed in the Emergency Room for a period of time and was later discharged after he successfully voided. Following discharge, he discontinued his buprenorphine/naloxone treatment, continued his other medications with no recurrence of the urinary retention. The patient also refused a re-challenge with buprenorphine/naloxone.

Discussion: Buprenorphine / naloxone is FDA approved to treat chronic opiate addiction. Unlike methadone, buprenorphine/

naloxone can be prescribed in doctors' offices. A significant advantage of this medication is that its physiologic and subjective effects are reported as having a ceiling effect for cardiovascular, respiratory, and subjective effects. This does make it attractive for treatment of opiate addiction as it has a lower potential to developing respiratory and cardiovascular depression. The reported adverse effects of buprenorphine/naloxone include respiratory depression, CNS depression, dependence, hepatitis, allergic reactions such as bronchospasm, angioneurotic edema, anaphylaxis and the potential to increase intracholedocal pressure (Ref). In addition, asthenia, chills, headaches, constipation, diarrhea, nausea, vomiting, insomnia, rhinitis, sweating, fevers and flu like syndromes have been reported (Ref). However, acute urinary retention has not been described with the use of buprenorphine/naloxone. There has been a report of the effects of the opiate antagonist naloxone on urinary tract function (Murrat and Feneley year). In a single blind trial of the effect of opioid blockade on lower urinary tract function assessed urodynamically, twenty patients were studied by filling and voiding cystometry and urethral pressure profilometry before and after the administration of the opioid antagonist, naloxone. The authors found a significant rise in subtracted detrusor pressure throughout bladder filling. In the study, cystometric bladder capacity was reduced at both first and urgent desire to micturate. The authors suggest that these effects may represent evidence of an endogenous opioid dependent element in the control of lower urinary tract function. Opioid analgesics (acting by reducing parasympathetic sensation and increasing the tone of the sphincter have also been reported to develop urinary retention after epidural analgesia (ref Verhamme KMC et al). Morphine has also been studied d in relation to urinary functions (Dray and Nunan, 1987). At therapeutic doses, morphine "may increase the tone and amplitude of contractions of the ureter, although the response is variable."

POSTER 5-2

Cost and Utilization Outcomes of Opioid Dependence Treatments

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Abstract:

Background: Approximately 2 million Americans are opioid dependent, with 80% now dependent on prescription opioids. Currently, overdose deaths surpass gunshot fatalities. Heroin dependent individuals lose an estimated 18 years of life by age 65 due to overdose, chronic liver disease and accidents. The cost of heroin dependence in the US in 2000 was approximately $21 billion. Most of the opioid dependent population remains untreated due to problems with access and reimbursement, poor motivation and adherence, and rejection of current treatment options. This study evaluated the healthcare costs associated with treatment of opioid dependence disorder with medications versus no medication and between the four agents approved by the US Food and Drug Administration (FDA).

Methods: In this retrospective claims database analysis, commercially insured adults with opioid dependence were identified from a large US health plan and the PharMetrics Integrated Database. Matching with instrumental variable analysis was applied using baseline demographic, clinical, and healthcare utilization variables for 13,316 patients; half of these patients had used an FDA-approved medication for opioid dependence and half had not. A similar comparison was performed among 10,513 patients treated with once-monthly injectable extended-release naltrexone (XR-NTX; VIVITROL®; n = 156) prior to its FDA approval for opioid dependence, or with a medication approved at the time: oral naltrexone (NTX-PO; n = 845), buprenorphine (SUBOXONE® and SUBUTEX®; n = 7596) or methadone (n = 1916). Over 6-months, including time on and off medication, analyses calculated persistence, utilization, and paid claims for all medications, specialty and general inpatient admissions, outpatient services, and total costs.

Results: Despite higher costs for medications, total healthcare costs over 6 months, including inpatient, outpatient and pharmacy costs, were 29% lower with medication for opioid dependence versus without (P<0.0001). Medication was associated with fewer inpatient admissions of all types (P<0.0001). Despite higher costs for XR-NTX itself, total healthcare costs were not significantly different from NTX-PO or buprenorphine, and were 49% lower than with methadone (P<0.0001). XR-NTX treated patients had fewer opioid-related and non-opioid-related hospitalizations than patients receiving either of the three oral medications (all comparisons P<0.05).

Conclusion: Limitations of this approach include its retrospective nature, lack of randomization, focus on commercial insureds and baseline differences requiring instrumental variable casemix adjustment. Results are that opioid dependent patients who received medication for this disorder had lower total costs and hospital utilization than patients who did not. Among the four medications, the group receiving XR-NTX had no higher or less total costs than those receiving oral medications but had less hospital utilization.

POSTER 5-3

Healthcare Cost Outcomes for Alcohol Dependence: a Comparison of Medication and Non-Medication Treatments

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Abstract:

Background: Four medications have received FDA-approval for the treatment of alcohol dependence: disulfiram; acamprosate; oral naltrexone (oral NTX); and once-monthly injectable extended-release naltrexone (XR-NTX). Nonetheless, the most common treatment of alcohol dependence continues to be psychosocial, even though previous research suggests that the cost of medication treatment is low (Mark et al, 2009). The

goal of the current study was to examine healthcare costs for alcohol dependence treatments.

Methods: This retrospective, propensity-score matched analysis examined adult commercial insureds (N=15,502) with at least one healthcare claim for XR-NTX (VIVITROL®), oral naltrexone (oral-NTX), disulfiram or acamprosate (CAMPRAL®) between 2006-2009, with >/=6 months pre-/post-index enrollment.

Results: In the six months following the index treatment, overall, medication treatment was associated with significantly lower total healthcare costs than treatment without medication ($8,134 vs. $11,677 per patient; P<0.0001). Total healthcare costs were then compared across patients treated with XR-NTX (n=661), oral-NTX (n=2,391), disulfiram (n=3,492) and acamprosate (n=8,958). Despite the higher costs of XR-NTX itself, total healthcare cost per capita, including the cost of the agents, was significantly lower for the XR-NTX group ($6,757) vs. acamprosate ($10,345; P<0.0001), and was not significantly different vs. oral-NTX ($6,595) or disulfiram ($7,107). XR-NTX was significantly more cost-effective than all three oral medications across all inpatient cost parameters (all p values <0.001). These cost savings appear to be driven by the fact that the XR-NTX patient group had significantly longer persistence with treatment compared to all oral agents (P<0.001 for all comparisons) and lower rates of admission to inpatient services (all P<0.01).

Conclusion: Limitations include non-equivalent between-group characteristics at baseline (addressed by propensity-score casemix adjustment), and the need to conclude associative rather than causal relationships. Treatment with XR-NTX was associated with either equivalent, or significantly lower, total healthcare costs over a six-month period, including cost of medication, which appeared to be due to significantly less intensive service utilization.

POSTER 5-4

Gabapentin as an Adjunctive Treatment for Control of Alcohol and Substance withdrawal Symptoms and Cravings

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Abstract:

Background: There has been increasing interest in the use of anticonvulsant medications in the treatment of alcoholism. In the United States, benzodiazepines such as diazepam and chlordiazepoxide are the preferred class of drugs for the treatment of alcohol withdrawal and cravings due to their low cost and high margin of safety. In Europe, different medications have been used for the treatment of alcohol withdrawal, such as clomethiazole, carbamazepine, valproic acid, and phenobarbitol. Gabapentin, an anticonvulsant drug that has been approved by the FDA for adjunct therapy for partial seizures, may offer a valuable alternative. Gabapentin is structurally related to gamma-amino butyric acid (GABA), crosses the blood-brain barrier readily, and is distributed to the central nervous system, promoting GABA amplification. The drug is not metabolized in humans, does not bind to plasma proteins or induce hepatic enzymes, and is eliminated unchanged through renal excretion. Gabapentin has no known abuse potential, few side effects, does not require blood monitoring, and does not affect liver metabolism or the excretion of other medications and no known significant drug-drug interactions. Interest in gabapentin increased after it was shown to have a selective action in decreasing both convulsive and anxiety-related aspects of withdrawal behavior in mice after chronic ethanol treatment. It was also shown to decrease the signs of alcohol withdrawal hyper excitability in mouse hippocampal slices.

Objective: To determine the treatment value of gabapentin as an adjunct for alcohol and substance withdrawal and cravings.

Methods: A retrospective chart review of 180 patients diagnosed with alcohol dependence or abuse was conducted at Bergen Regional Medical Center. Data was collected and analyzed for age, gender, length of stay in the hospital, and patients' medications. Patients having co morbid diagnoses of substance abuse, anxiety disorders were excluded.

Results: Out of the total 180 patients, 12[7%] patients were gabapentin only, 115[64%] were chlordiazepoxide only, 9[5%] lorazepam only, 17[9%] combined gabapentin and chlordiazepoxide, 9[5%] gabapentin and lorazepam, 10[6%] chlordiazepoxide and lorazepam, 4[2%] all three medications and 4[2%] none of the above. Average length of stay in hospital for each of these groups: gabapentin 11 days, chlordiazepoxide 3 days, lorazepam 5 days, gabapentin and chlordiazepoxide 5 days, gabapentin and lorazepam 6days, chlordiazepoxide and lorazepam 4 days, three medications 5 days and none 17 days.

Conclusion: These findings support the hypothesis of gabapentin having a treatment value as an adjunct to the standard protocol medications like chlordiazepoxide and lorazepam and also the need for additional prospective randomized controlled studies regarding usage of gabapentin as an adjunct in the treatment of alcohol withdrawal.

POSTER 5-5

Injectable Extended-Release Naltrexone (XR-NTX) for Opioid Dependence: Efficacy in Clinically Relevant Subgroups

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Abstract:

Background: Heroin use is the leading cause of drug-related mortality and morbidity worldwide.1 Prescription opioid dependence is rapidly rising. Available treatments include opioid maintenance/substitution pharmacotherapy (e.g., methadone or buprenorphine) and non-pharmacologic

psychosocial treatments (halfway house or therapeutic community). Recently, once-monthly extended-release injectable (IM) naltrexone (XR-NTX) was approved by the FDA for the treatment of opioid dependence. The goal of this secondary analysis of a previously reported multi-site clinical trial2 was to examine the efficacy of XR-NTX in clinically relevant subgroups of opioid-dependent patients after detoxification.

Methods: Patients who had completed a detox within the previous week, and were off all opioids for >7 days were randomized to 24 weeks of double-blind treatment with monthly IM XR-NTX 380 mg (VIVITROL®) or placebo (PBO). The primary efficacy outcome was the response profile based on the rate of urine drug test results negative for opioids during the last 20 weeks of the 24-week double-blind treatment period. A multivariate regression analysis was performed to identify treatment response for subgroups based on the following candidate variables: age, gender, drug used, duration of use, duration of detoxification, baseline craving, weight, depression scores, and HIV and hepatitis C status.

Results: For the total sample, a significantly higher proportion of XR-NTX patients (n=126) vs. PBO patients (n=124) had opioid negative urines during the final 20 weeks of double-blind treatment (median: 90% vs. 35%; p=0.0002; total abstinence: XR-NTX 36% vs. PBO 23% (P=0.0002). Treatment with XR-NTX was associated with a significantly higher percent of opioid negative urines (vs. PBO) in various subgroups, including the HIV+ subgroup (90% vs. 22.5%; p=0.0032) and the heroin-only subgroup (95% vs. 50%; p=0.0011). Multivariate regression showed that only younger age (<30 years) was associated with increased abstinence rates for both groups. For treatment effects of XR-NTX vs. PBO, there were no significant interactions with baseline variables. XR-NTX showed a pattern of greater efficacy vs. PBO regardless of: age, gender, baseline depressive severity, years of treatment, days of detoxification, baseline craving, weight/BMI, or HIV or Hep C status.

Conclusions: This was a secondary analysis of a 6-month, multi-site, random-controlled trial with primarily heroin dependent adults in Russia. For the overall study sample, baseline variables were not generally predictive of outcome, with the exception of younger age being associated with greater likelihood of abstinence in both groups. Once-monthly treatment with XR-NTX demonstrated clinically important efficacy in terms of reduced opioid use and improved treatment retention in opioid-dependent patients, both overall and in all studied clinically relevant subgroups.

POSTER 5-6

The Role of Cannabis Use in Schizophrenia, Santa Marta 2009

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Abstract: The United Nations Office Drugs and Crime informed that in 2007, between 172 million and 250 million persons had consumed illicit drugs at least once during previous years, and about 143 millions to 190 millions consumed cannabis in 2007. Marijuana, also known as cannabis, the most illicit drug used in the world, including countries developed as UK and USA. Between 18 and 38 million consumers of cannabis are in ages between 15 and 64 years old. This umber represents a problem to society because there is an increase in the use of cannabis, particularly in adolescent users. In first ages, the development of the brain can be specially influenced by the environment. That is why the medical field is interested in the use of drugs such as cannabis and the influence in young people, to study the effects in this group and if the frequent use can cause schizophrenia. Recent studies demonstrate that the risk to develop schizophrenia is 2 to 25 times higher in persons who have consumed cannabis, in the general population (Odds ratio, 24.17; IC 95 %). In Santa Marta (Colombia) we started an investigation; our main goal was, to find out if there is a relationship between drug abuse and schizophrenic patients. In our study, the prevalence of consumption of cannabis in schizophrenic patients was 19%, this maintains a strong relation compared with findings done by international studies that demonstrated the rate of consumption of drugs of abuse, specially cannabis in the psychiatric population is 17-80.3 % and in the rest of the population of 5.8 - 16.4 %; similar output. The reiterated use of cannabis from very young, above all in subject genetically vulnerable, cause schizophrenias whose first episode is presented after a year of THC consumption, generally before 18 years, with more positive symptoms and less negative than schizophrenics not users, with worse response to the antipsychotic and more relapses in the following 15 years. This seems be due to the fact that in the schizophrenics is produced an similar alteration of the endogenous cannabinoid system at the originated by the cannabis-related poisoning in healthly subjects. In our country, there are no data about the magnitude of this problem. The review of world literature and isolated epidemiological data of our country, suggest that dual diagnosis might represent a serious problem in the course, prognosis and treatment of these patients, and that consumption of cannabis as "negative symptoms modulator", innocuous it is not at all justifiable It exist evidence of the interactions between the use of cannabis and the neurobiology bases of the schizophrenia they reaffirm genetic - environmental hypothesis of the effects of cannabis in the physiopathology of this disease. Nevertheless there's still unclear, and many questions appear such as if the abuse of marijuana constitutes a risk factor, or it can cause by itself schizophrenia. Or if in fact is just a precipitant it in individuals who are genetically vulnerable. Apparently the genetic factors that they contribute to the schizophrenia might be the same that contribute to the addictive behaviors.

POSTER 5-7

Leadership and Administration in Addiction Psychiatry: Utilizing the Evidence

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Abstract:

Background: Modern addiction psychiatry requires a unique set of leadership and administrative capabilities, given the distinct regulatory, financial, and practice pressures faced by the field. Despite this need, there is a paucity of evidence published within the medical literature addressing best practices for leadership and administration within the field of addiction psychiatry. Further, the majority of evidence available from other industry sectors is often incompletely applicable and frequently lacks an empirical basis. The aim of this poster is to introduce this literature and its implications to the practice of leadership and administration within addiction psychiatry.

Methods: Medline records from 1996 to present were searched for subject headings, "Leadership" and "Substance-Related Disorders." The sixty resulting records were sorted by relevance and topic applicability. Business literature on leadership was examined and individual sources were selected and reviewed. Common themes from both medical and business literatures emerged and are summarized.

Results: The limited evidence that currently exists within the medical literature suggests several leadership factors which impact the adoption of new technologies in modern addiction treatment programs. Further, there are specific factors that impact the leadership turnover in addiction treatment organizations. Existing medical and business evidence suggests that leadership is best examined within the framework of system praxis, rather than an individual character competency. The role and importance of apprenticeship – already well integrated into modern medical training – can be applied to leadership development within health care settings. Evidence suggests that leadership mentorship within health care systems ought to be emphasized. Further, current notions of emotional intelligence have implications on how managers can leverage mirroring behavior, utilize social resonance, and employ pattern recognition. There are well-recognized pathways that clinical managers tend to follow in their ascendancy to administrative roles, with common pitfalls accompanying these trends. Recognizing these trends can offer current and future clinician managers insight that is useful in preventing leadership failures.

Conclusions and Implications: Beyond an emerging set of peer-reviewed articles, leadership and administration in addiction psychiatry remains relatively uncharacterized within the medical literature. A body of evidence published outside of the medical literature exists which empirically examines leadership and administrative processes relevant to health care settings. There are sets of definitions of leadership and management that can be functionally employed within health care settings. As with clinical development in medical training, evidence suggests that direct experience within an apprenticeship model has a critical role to play in leadership and administrative development. Because leadership and administration are rarely included topics within formal training curricula, new addiction psychiatrists must develop these necessary skills in alternative formats.

POSTER 5-8

Comorbidity of Substance Use and Other Psychiatric Disorders in an Inner City Homeless Population

Anna-Marieta Moise, B.S. (amoise@georgiahealth.edu)**, Diana Murro, B.S., Luke Smith, B.A., James Gable, Pharm.D., Edna Stirewalt, B.S., Adriana Foster, M.D.**

Abstract:

Background: Comorbidity of schizophrenia and other mental disorders with substance use disorders (SUD) is widely documented. The complex psychosocial and neurobiological mechanisms that lead to this comorbidity are poorly understood but clearly lead to a higher rate of non-adherence, relapse and poorer treatment outcome in individuals affected. We chose to focus on comorbidity with SUD in homeless with mental illness, a vulnerable population who are more likely to stay homeless longer, face more barriers to employment, suffer victimization and have poorer physical health. Approaches to address comorbidity of mental illness and SUD in this population will be discussed.

Methods: Georgia Health Sciences University (GHSU) students were twice awarded the Helping Hands. grant from the American Psychiatric Foundation to identify mentally ill homeless, refer them and provide bus tickets for transportation to behavioral health appointments. From April-2010-April 2011, GHSU medical student volunteers administered mental health screenings to 161 individuals at 4 Augusta homeless shelters. The Mental Health Screening Form III and CAGE-AID were used to screen for history, psychosis, mood, posttraumatic stress disorder, phobias, intermittent explosive disorders, sexual disorders, eating disorders, obsessive compulsive disorders, gambling addiction, learning disabilities, and SUD.

Results: Our sample population consisted of 70% men, 7% women, and 23% whose sex was not reported, with 64% African Americans and 22% Caucasians. 152 participants (94%) screened positive for at least one mental illness. 77.4% had a history of mental health disorders, 46.6% had hallucinations, 52.8% had delusions, 64.6% had depression, 50.3% had PTSD, 50.9% had phobias, 45.3% had intermittent explosive disorder, 12.4% had sexual disorders, 18.6% had eating disorders, 52.2% had bipolar disorder, 55.4% had panic, 34.2 % had OCD, 20.4% gambled, 34.8% had learning disabilities, and 51.6% had SUD. Additionally, 58.67% of participants with hallucinations and 62.35% of participants with delusions had a comorbid SUD. A review of various studies by Volkov (2009) found that 50.8%, 43.1-65%, and 23% of those with

schizophrenia exhibited DSM –IV abuse or dependence of cannabis, alcohol, and cocaine, respectively. In comparison, 0.5%, 5.1%, and 0.09% of the general adult population exhibits signs of cannabis, alcohol, and cocaine abuse, respectively. In our sample, 60% of those with depression had SUD. Davis (2005) found that 28.2% of 1,484 subjects with MDD participating in Sequenced Treatment Alternatives to Relieve Depression, had current SUD, while in other studies SUD has been found in 8.6% to 25% of people with MDD. We present a review of interventions successfully used to treat comorbidity of psychiatric disorders and substance abuse in homeless individuals.

Conclusion: People with schizophrenia and mood disorders are also likely to have a comorbid SUD which worsens prognosis for these illnesses. In homeless people with mental illness there is a great need for complex interventions to treat these illnesses.

POSTER 5-9

Behavioral Surveillance Survey of a Sample of Iranian Injection Drug Users

Saeed Momtazi, M.D. (dr.momtazi@gmail.com)**, Alireza Shoghli, Ph.D., Nureddin MosaviNasab, Ph.D., Mojtaba Fallahnezhad, M.D., Simin Tavasoli Shirvan, M.D., Bahram Haji Karim, M.D.**

Abstract:

Background and Objective: After many decades of smoking was the usual method of abusing drugs especially narcotic ones injection drug use have shown an increasing pattern Injection Drug Users (IDUs) represent more than 69.9% of known HIV/AIDS cases in Iran. The most important causes of HIV among them are syringe sharing and other high risk behaviors such as unprotected sexual practice with different partners. Since IDUs are hard to reach and there is little information about them, this behavioral survey conducted to find out the situation of high risk behaviors among injection drug users in Zanjan a city north-west of the capital Tehran.

Materials and Methods: In this descriptive-cross sectional study, 61 IDUs, inhabitants of Zanjan, were selected in non-random sampling by referring to the most probable sites and places of their presence. Data was collected using a standard Family Health Behavioral Surveillance Survey (BSS) questionnaire designed especially for IDUs.

Results: The entire sample were male and the average age of them was 30.1 (sd 5.8) Among the sample 44.3% were ever married but just 24.6% were living with their spouse at the time of study. Mean duration of non injection and injection drug use was 12.1 (sd 5) and 4.5 (sd 3.5) years respectively, and age of the first injection was 24.5 years, first injection was before the age of 18 in 4 cases. The most frequently injected drug was Heroin (96.7%) and the most non injected one was Cannabis (85.2%). 93.4% had a history of alcohol abuse but during the last month just 9.8% have used alcohol. Among IDUs 55.7% injected 4 or more times per day, and 32.8% reported needle sharing. 100% of the subjects knew the role of used syringe in HIV transmitting. 44.3% had taken an HIV test but just 70.4% of them were aware of their HIV test result. Only 56.6% of sexually active patients have ever used condom during their sexual intercourse.

Conclusion: The early age of starting drug injection, needle sharing, low coverage of HIV testing indicate the significance and priority and service delivery to this very high risk group.

POSTER 5-10

A Case of Pellagra Associated with Long Term Alcoholism

Ömer Senormanci, M.D. (senorman_7@hotmail.com)**, Ömer Senormanci, M.D., Ramazan Konkan M.D.,Oya Güçlü, M.D., Güliz Senormanci M.D.**

Abstract: Pellagra is a systemic, nutritional disease associated with deficiency of vitamin B3 (niacin) and/or tryptophan and often other B vitamins. Pellagra is mostly seen in chronic alcoholics as a result of nutritionally poor diet and malabsorption. We present a pellagra case with long terms of alcohol use, who admitted with pscychiatric complaints to our clinic. Mr. A. is a 44 year old, married, primary school graduate male, who is running a cafe. His socioeconomic status is low. His complaints were irritability, nausea, vomitting, loss of appetite, which were present for 1 month. He has been drinking 100 cl alcohol every day for 33 years. The longest duration of remission was 3 months when he was 13 years old. He experiences sweating, tremor of hands, insomnia, irritability as withdrawal symptoms. In the last 2 years, periodically he has problems in focusing and maintaining attention, delay in reaction time in answering any questions. He has depressive symptoms for 1 year and he had attempted suicide. In the last 2 months, he has diarrhea, vomitting, loss of appetite and erythema, followed by dark discoloration on the dorsal surfaces of his hands. On physical examination, hyperkeratotic plaques with well-defined borders on the dorsal surfaces of both hands, squamous lesions between fingers of both feet, loss of villi and hyperemia on the tongue is detected. He has tremor of both hands and wide-based gait. On psychiatric examination, he was confused, his time orientation was disturbed, self care was poor. Affect was restricted, associations and psychomotor activity were slow. The possibility of pellagra is considered as dermatitis, diarrhea and distortion of cognitive functions are observed. ECG, complete blood count, routine blood biochemical tests, routine urine test, thyroid function tests, VDRL, microscopic examination of gaita, EEG, vitamin B12, folate, cranial MRI, echocardiography, esophago-gastro-duodenoscopy are performed and no significant pathology is detected. As the patient's symptoms did not respond to the oral niacine treatment, niacin malabsorption is considered and the drug containing a mixture of vitamin B1, B2, B6, B12, nicotinamide and dexpanthenol is performed by intramuscular injection and dramatical recovery is seen. Pellagra is characterized by photosensitive symmetrical skin lesions, gastrointestinal disturbances, neurologic and psychiatric manifestations. The syndrome is known as 4

"D's": dermatitis, diarrhea, dementia and death. Skin lesions seen in pellagra are photosensitive rash primarily on the dorsal surfaces of the hands, arms, face and feet. In acute phase, skin lesions are erythema and bullae which resemble sunburn (wet pellagra), but after exposure to sun light, progress to chronic, symmetrical, scaled lesions occurs. Typically they are located on neck (Casal necklace), hands and forearms (pellagra gauntlet). Irritability, concentration problems, anxiety, fatique, restlessness, apathy and depression are common psychiatric and neurological manifestations. Even uncommon, psychosis can be seen in pellagra, especially in pellagroid encephalopathy mostly found in chronic alcoholics. Confusion and eventually death occurs as the disease progresses. Gastrointestinal manifestations are fissures on the tongue and mouth, sourness, loss of appetite, dyspepsia and abdominal pain. Enteritis which can be severe with nausea, vomitting and diarrhea can also be seen. Diagnosis is based on patient's history and physical

POSTER 5-11

Comparison of Advance Medical Directive (AMD) Inquiry and Documentation for In-Patients in Psychiatry Versus Internal Medicine/Surgery

Eche Anunobi, M.D., Roopa Sethi, M.D.

Abstract:

Introduction: AMD are medical instructions that guide a person's medical care if he or she becomes unable to do so in the future. The need to address AMD becomes important especially in inpatient setting if emergency procedures and resuscitation become necessary without warning. The object of this study is to investigate if AMD is utilized less frequently in the inpatient psychiatry setting as compared to inpatient medicine service or inpatient surgery. For the purpose of this research AMD refers to written and not verbal AMD and we focus on 3 main components; Living will, Medical Power of Attorney and DNR order. Living will is a written, legal document that conveys the wishes of a person in the event of terminal illness. Living will is not synonymous with a last will and testament that distributes assets after a person's death. Special Medical Power Of Attorney: A legal document that allows an individual to appoint someone else (proxy) to make medical or health care decisions, in the event the individual becomes unable. DNR (do not resuscitate) order. This states that CPR (cardiopulmonary resuscitation) is not to be performed if breathing stops or your heart stops beating.

Methods: 600 Veterans admitted to the medical, Surgical and psychiatry in-patient unit (200 from each specialty) at the SVAMC over 10 years (1998-2008) were included in the study. Data was obtained by retrospective chart analysis and included relevant demographics, inquiry about AMD; including living will, medical power of Attorney and DNR/Code status. We also looked at timeliness of documentation of AMD and evidence that orders were placed to reflect patient's preferred DNR/Code status.

Results: 600 cases (hospital admissions), with 201 from the medical service, 198 from surgical, and 201 from psychiatric were included in the study. Patient's ages ranged from 27 to 92 years, with a mean of 64.7. Of these cases, 553 were male, 45 were female, Race distribution; Caucasians, 487 cases, African Americans, 106, 4 Hawaiians, 1 Hispanic, 2 Other. A Likelihood Ratio test on the 596 cases with valid data (198 medical, 197 surgical, and 201 psychiatric) showed a statistically significant difference among the three groups ($2 = 6.938$, $p = 0.0311$). However, the percentages of cases in which AMD inquiry was done for medical (33.33%) and psychiatric (34.83%) admissions were nearly the same. Surgical cases (45.18%) were significantly higher in AMD than medical and psychiatric, although even the surgical service. performed AMD in less than half of the admissions. The AMD percentage for the overall sample was 37.5%.There was improvement in the compliance of inquiry and documentation of AMD over time, it was better in the last 5 years of the study period (2003-2008) compared to the initial 5 year period. The only statistically significant correlation was between the length of the hospital admission and the number of days to AMD inquiry ($r = 0.2575$, $p < 0.0001$).

Conclusions: The finding that AMD percentage for the overall sample was 37.5% over ten years was a bit surprising given the push in the medical circle for an increased use of AMD. There was however an improvement in that the compliance of inquiry and documentation of AMD was better in the last 5 years of the study period compared to the initial 5 year period. The improvement may be related to more frequent use of electronic reminders in the VAMC system to help providers comply with requirements like AMD inquiry.

POSTER 5-12

Prevalence of Metabolic Syndrome (MS) in Veterans with Alcohol Related Disorders Alone and Alcohol and Marijuana Related Disorders Combined

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Abstract:

Background: ATP III criteria define metabolic syndrome (MS) as the presence of any 3 of the following 5 traits: 1) Abdominal obesity, i.e. waist circumference in men >102 cm (40 in) and in women >88 cm (35 in); 2) Serum triglycerides =150 mg/dL (1.7 mmol/L) or drug treatment for high triglycerides; 3) Serum HDL cholesterol <40 mg/dL (1 mmol/L) in men and <50 mg/dL (1.3 mmol/L) in women or drug treatment for low HDL-C; 4) Blood pressure =130/85 mmHg or drug treatment for high blood pressure; 5) Fasting plasma glucose (FPG) =100 mg/dL (5.6 mmol/L) or drug treatment for high blood glucose. Various studies have been performed analyzing the relationship between alcohol consumption and MS but studies comparing the prevalence of MS in alcohol related disorders alone to combined alcohol and marijuana related disorders are scant.

Methods: 270 male veterans admitted to the SATP program in Salem VAMC, with an admission diagnosis of alcohol related disorders alone or alcohol and marijuana related disorders combined were included in the study. Diagnoses and related information were obtained from retrospective chart analysis. We obtained information on serum triglycerides, HDL cholesterol, blood pressure and fasting plasma glucose values at admission. As there was no waist circumference, documented in the charts, this ATP variable was not included. Those veterans who met 3 out of the 4 ATP III criteria were considered positive for MS. Lab values were obtained within 3 months of admission to the program.

Results: Prevalence of MS in alcohol related disorders alone was 48.9% (confidence interval was 0.41-0.56) and the prevalence in alcohol and marijuana related disorders combined was 56.72 % (CI was 0.440-0.687). There was not enough evidence to show that the 2 groups differed in proportion of patients with MS (p=0.319). Hypertension, hyperlipidemia and diabetes mellitus were risk factors for MS (p<0.001) for both alcohol related disorders alone and alcohol and marijuana combined. There was a significant difference in mean of ages (p=0.0082) for those having MS (53.82 yrs.) vs. those not having MS (49.9 yrs.) of approximately 4 years. Total alcohol years and intake as well as marijuana intake were not related to the prevalence of MS. In alcohol related disorders, the proportion of patients with MS (48.9%) was significantly different (p<0.001) than the general male population (36.1%). In alcohol and marijuana related disorders proportion of patients with MS (56.7%) was significantly different (p<0.001) than the estimate for the general male population (36.1%).

Conclusions: Prevalence of MS is higher in veterans with alcohol related disorders alone and alcohol and marijuana related disorders combined as compared to the general male population. Hypertension, hyperlipidemia and diabetes mellitus were variables most closely associated with MS which is consistent with what is generally reported.

POSTER 5-13

Tobacco Use Screening and Documentation: Importance in Inpatient Psychiatric Population

Yakir Vaks, M.D. (yakirvaks@gmail.com)**, Bharat Nandu, M.D., Cristian Penciu, M.D., Kenneth Choi, MSIII, Faraz Quirashi, MSIII**

Abstract:

Background: Cigarette smoking is the leading preventable cause of death and disability in the United States. World wide, if present trends continue, 80 percent of deaths occurring in the developing world, can be attributed to tobacco use. The most important causes of smoking-related mortality are atherosclerotic cardiovascular disease, lung cancer, and chronic obstructive pulmonary disease. Tobacco use also increases the risk of cancers at many sites other than the lung; an estimated 30 percent of cancers in the US are tobacco-related. Tobacco smoking can begin to be a factor as early as during pregnancy, and can extend to the point of the severe medical conditions mentioned above. Besides the grave medical consequences of tobacco use, its use has serious implications in the psychiatrically ill populations as well. CYP 2D6 is the major determinant of nicotine metabolism, and individuals with abnormal CYP 2D6 genes metabolize nicotine slowly. CYP 2A6 and CYP 2A1 also participate in metabolism of nicotine. The hydrocarbon agents in smoking (not the nicotine) are known to induce liver enzymes that increase the metabolism of neuroleptic and other psychotropic drugs. This effect may occur through the induction of the CYP 1A2 isoform. All of the above mentioned enzymes are major enzymes involved in metabolism of a variety of psychiatric drugs such as Neuroleptics. It has been previously shown that patients, who smoke, metabolize antipsychotics faster than nonsmoking patients. Due to this, use of tobacco acts as a modifier to the kinetics of metabolism of these psychoactive drugs and becomes an important factor to consider for the prescribing psychiatrist.

Objective: The study seeks to compare the current practice of screening patients for tobacco use by the Emergency Room triage with patients screened by the Initial Psychiatric Evaluation done by the psychiatric team. We will also look at the number of patients that needed to have their nicotine use addressed with nicotine patches, despite having no recorded use on initial psychiatric screening.

Methods: Retrospective reviews of 133 charts were conducted. Data regarding the number of patients that were screened for nicotine use by the Emergency Room triage, screened by the Initial Psychiatric Evaluation, and the numbers of patients that needed nicotine withdrawal management were analyzed.

Results: Out of 133 charts reviewed, the ER triage screened120 patients for nicotine use, out of which, 69 were smokers and 51 were non-smokers. The number of the patients screened for nicotine use during the psychiatric assessment was 13, out of these 12 being smokers and 1 non-smoker. Out of 133 charts screened, 81 were smokers, and 20 out of these needed a nicotine patch.

Conclusion: An alarmingly low number of patients were screened by the psychiatric assessment and had documentation about their tobacco use. Due to this, the number of the nicotine patches prescribed on the inpatient units following admission was greater than the number of patients with documented need for tobacco withdrawal management. Therefore, it is imperative to educate physicians about the necessity of initial screening for nicotine dependence and clear documentation of use, abuse and dependence as appropriate in order for appropriate management to be instituted.

POSTER 5-14

Expectancy Therapy for Smoking Cessation

Charles Wilber, M.Ed., 200 Retreat Avenue, Hartford, CT 06106, **Adam Jaffe, Ph.D., Keera Bhandari. M.A., Megan Ehert, Pharm.D.**

Abstract:

Objective: We developed a new treatment for smoking, Substance Expectations Therapy (SET) based on Social Learning Theory (SLT) approach. Expectancies can be reliably assessed, are modifiable and appear to effect treatment outcome. Recent empirically based substance abuse therapies have demonstrated some efficacy. In addition, it has been noted that some treatments may be poorly suited to particular sub-populations of smokers including those individuals with higher levels of craving, low levels of motivation, and a poor sense of self-efficacy. We compared SET to standard Cognitive Behavioral Therapy for Smoking Cessation (CBT).

Method: 40 smokers were randomly assigned to one of two 12-week, manualized interventions: Substance Expectations Therapy (SET) a new cognitive behavioral therapy designed to reduce dropout and improve outcomes, and Cognitive Behavior Therapy (CBT). Treatment retention and smoking during treatment were the major dependent variables used to explore treatment main effects. Pre hoc hypotheses were developed using three treatment matching variables: craving, motivation, and self-efficacy.

Result: SET participants showed significantly less early dropout (6%), relative to CBT (34%), p<.01, and significantly greater treatment completion (94%) relative to CBT (32%), p<.01. Participants in SET had significantly lower breath carbon monoxide concentrations (Mean=11) than CBT participants (Mean=26) p<.01. Poorly motivated participants with lower self-efficacy receiving SET did better then those receiving CBT.

Conclusion: (1) SET was particularly effective for individuals with higher levels of craving and lower levels of self-efficacy when compared to CBT.(2) SET was particularly effective for individuals with lower levels of motivation and higher cravings. (3) CBT and SET may be equally effective for participants high in self efficacy.

POSTER 5-15

Cognitive Training in the Elderly with Normal Aging and Cognitive Impairment with No Dementia

Charles Wilber, M.Ed., 200 Retreat Avenue, Hartford, CT 06106, **Jaclyn Cmero, M.S.,OTR/L, Karen Blank, M.D., Keera Bhandari, M.A.**

Abstract:

Objective: This study tested the effects of cognitive rehabilitation on a community sample of older adults with complaints of cognitive decline. Two different models of cognitive rehabilitation for older adults were combined and tested: an interactive group model emphasizing general strategic abilities for cognitive decline, and an innovative computer-based cognitive training program emphasizing improvement in neuroplasticity. Cognitive training interventions have demonstrated to be effective and durable in improving targeted cognitive abilities in older adults particularly reasoning related to activities of daily living and also in reducing functional decline in activities of daily living.

Method: This study tested the effects of a treatment combining two cognitive rehabilitation models in comparison to (TAU) on a community sample of 30 adults over age 60 with subjective complaints of decreasing cognition consistent with "Cognitive Impairment, No Dementia" (CIND). Participants in the experimental condition received 10 weeks of combined cognitive remediation. The data determined the efficacy and feasibility of cognitive remediation treatment.

Result: Participants randomized to the experimental 'combined model' showed significant changes in attention, concentration, and memory when compared to Treatment as Usual (TAU) (p<.045), and also reduced functional decline in activities of daily living (p<.03).

Conclusion: 1. We predicted that participants who received cognitive training demonstrated larger improvements in memory skills, goal management, and psychosocial skills than those participants who received TAU. 2. We predicted that participants who receive cognitive training would demonstrate larger improvements in functioning and quality of life measures than those receiving TAU. 3. We predicted that these improvements would persist over a one-year period.

POSTER 5-16

Plasmapheresis Associated Immune Reconstitution Inflammatory Syndrome (IRIS) Precipitating Depression and Suicide Attempts: A Case Report

Vivek Anand, M.D. (VAnandAiims23@gmail.com)**, Richard Bloch, Ph.D.**

Abstract: It is known that chronic inflammatory disease, cancer, autoimmune disease and immunosuppressed states are related to psychiatric symptoms. There is various evidence to support that pathophysiology of depression is related to microglial activation by excess inflammation, loss of astroglia and glutamate receptor activation. We describe a first case where development of immune reconstitution inflammatory syndrome (IRIS) after plasma exchange led to development of depression, multiple suicide attempts and worsening neurological status. Our finding addresses pathophysiology of depression and other psychiatric disorders through an increased inflammatory response perspective.

POSTER 5-17

Citalopram and Nightmares

Gurvinder Arora, M.D. (aroragu@umdnj.edu)**, Gurpreet Sandhu, M.D.,Cecilia Fleser, M.D.**

Abstract: Nightmares occur only in REM sleep. Many studies show that most antidepressants including citalopram prolong REM sleep latency and suppress REM sleep time and are therefore expected to reduce or suppress nightmares. We present a patient in which citalopram actually caused nightmares and which abated after its discontinuation. A seratonergic process therefore seems to be involved in dreaming in some patients. Stimulation of 5HT2 receptors may in some cases is associated with alterations in dreaming activity such as nightmares. This is evident in efficacy of 5HT2 antagonists such as cyproheptadine and mirtazipine in the treatment of nightmares especially in posttraumatic stress disorder. There have been case reports citing other antidepressants, Mirtazipine and Bupropion, causing nightmares. Both of them are known to increase REM sleep. There have also been reports citing venlafaxine and fluoxetine causing nightmares. Citalopram causing nightmares have never been reported before. Clinicians should be aware of this side effect as it can potentially affect treatment adherence.

POSTER 5-18

Delirium and Radiation Induced Leukoencephalopathy

Gurvinder Arora, M.D. (aroragu@umdnj.edu)**, Rashi Aggarwal, M.D.**

Abstract: Delirium is a state of disturbed consciousness which develops over a short period of time,accompanied by changes in cognition and tends to fluctuate during the course of the day. Radiation induced Leukoencephalopathy is a condition involving white matter of the brain involving defects in either the formation or maintenance of the myelin sheath. It can also present as disturbed consciousness which may or may not be accompanied by problems with speech, vision, movements, weakness and fatigue. Patient's continue to lose consciousness, may have seizures and finally lapse into coma before death. It can occur from few months to few decades after radiation therapy. Treatment for RIL is conservative if asymptomatic but studies have shown steroids, anticoagulants, hyperbaric oxygen and monoclonal antibodies to provide symptomatic relief or inhibit tumor growth if that is the cause of RIL. We present a case of delirium secondary to general medical condition superimposed on altered mental status secondary to radiation induced leukoencephalopathy. Altered mental status secondary to RIL can be confused with delirium which can result in inappropriate management and unnecessary interventions. Consulting psychiatrists should be aware of the various subtle and gross clinical presentations of radiation induced leukoencephalopathy to avoid confusion with other causes and to help with diagnosis of this condition, appropriate management and to avoid unnecessary interventions.

POSTER 5-19

Visual Hallucinations Following a Left-Sided Unilateral Tuberothalamic Artery Infarction-Case Report

Sang Soo Lee, M.D. (easynp@gmail.com)**, Dae Yoon Kim, M.D., Jung Soo Kim, M.D.**

Abstract: A 20 year-old man presented with visual hallucinations and no focal neurologic findings. The absence of neurological signs made the diagnosis difficult, but the changes in mental status with word-finding difficulty were the clues to the existence of an encephalopathy that resulted in evaluation for structural pathology. Brain imaging revealed an infarction in the territory of the left tuberothalamic artery. A head magnetic resonance imaging (MRI) scan defined this illness that might otherwise have received delayed treatment.

Introduction: The thalamus is a "relay station" for sensory information from many sensory areas projecting to the cortex.1 Therefore, injury to the thalamus may result in multimodal sensory abnormalities. The tuberothalamic artery supplies the intralaminar nucleus, ventral internal medullary lamina, and mammillothalamic tract in the paramedian thalamus.2 Isolated tuberothalamic infarctions are rare and follow small vessel occlusion.2 Persistence of cognitive and mental status changes after tuberothalamic artery infarction are established.3 The clinical vignette presents a case of an acute encephalopathy with anomia in the absence of focal neurological deficits. This unusual finding could be mistaken for a psychiatric disorder with delays at correct diagnosis and intervention.

POSTER 5-20

Biological Markers in Psychiatry: A Review

Rohini Ravindran, M.D. (rohini_ravindran@yahoo.com)**, Rohini Ravindran, M.D.**

Abstract: One of the biggest challenges a psychiatrist faces is a lack of objectivity with regards to diagnosis. Often this is compounded by patients and their families biased views about their symptoms. This review article is looking at the research as well as data surrounding biomarkers in psychiatric illnesses. Despite the fact these biomarkers are not yet used diagnostically, it does appear to be a promising prospect. Ideally one should be able to rapidly ascertain the presence as well as severity of the disease or response to therapeutic treatment using this biomarker. It should also be easily measurable from bodily fluids such as blood, urine, CSF etc. or through imaging studies. This paper will review all available literature in both areas. It will also consider the advantages, pitfalls, and drawbacks of using biomarkers in clinical practice. Even if data supports using biomarker, it will change the field of psychiatry significantly. Is it better to use biomarkers or rely on patient as well as family history? Or is there a way to integrate both aspects of psychiatry and remain flexible on diagnosis by emphasizing regarding all aspects equal?

POSTER 5-21

WITHDRAWN

POSTER 5-22

Proposed Role of Inflammation in Alzheimer's Disease and the Utility of Nsaids as Adjunctive Treatment: A Literature Review

Syed Hussaini, M.D. (drqhadeer@hotmail.com)**, Bharat Nandu, M.D., Siddharth Joshi, M.S.**

Abstract:

Background: Alzheimer's Disease, well-known as the leading cause of dementia in the world, has catapulted to the 6th leading cause of death in the U.S. At this point in time, definitive diagnosis still relies upon post-mortem histopathological examination of brain tissue for the presence of the two key pathognomic features of the disease—intracellular neurofibrillary tangles and extracellular AB plaques, also known as senile plaques. The search for a definitive cure, i.e. prevention of dementia and inexorable cognitive decline, has been disappointing at best, and the standard of treatment remains management of symptoms. This relates in part to the critical fact that the etiopathogenesis of Alzheimer's Disease (AD) remains frustratingly unclear, multifactorial and complex as it is.

Objective: Our objective is to summarize the published information regarding the relationship between Alzheimer's disease and inflammation as well as to stimulate a discussion related to the role of NSAIDs as an adjunct in the treatment.

Methods: We gathered data on the topic of Alzheimer's disease and the role of inflammation and use of NSAIDS as an adjunct the treatment by performing a comprehensive search using Pubmed and other journal databases. We analyzed the journals from 2001-2010 on the topic and highlighted the relevant information. This led us to develop a thorough investigation on the current theories and known associations on Alzheimer's disease and inflammation.

Conclusion: Recent research into AD has uncovered more concrete evidence attributing a central role to chronic neuroinflammation in the disease process. On this premise that neuroinflammation and pro-inflammatory cytokines are critical to the pathological progression of AD, retrospective epidemiological studies were undertaken to examine the effect of long-term NSAID treatment in patients with comorbidity of an auto-inflammatory condition. Studies suggested that the long-term use of NSAIDs may have a role in primary prevention of AD. This supposition was further supported by in-vitro and in-vivo mouse model studies that did in fact show an attenuation of neuroinflammation and the attendant cognitive decline with long-term NSAID treatment. However, clinical trials in humans testing the effects of NSAIDs on the prevention, progression, or treatment of AD have been equivocal. Two seminal studies, the ADAPT trial and the ACT trial, did not demonstrate any purported inverse association between long-term NSAID use and AD. On the other hand, there have been some studies indicating that other medical therapies like imipramine may have utility in attenuating the neuroinflammation in AD, and perhaps in slowing the progression of the disease. A number of prospective studies have been done and the evidence from these studies has been conflicted—with some studies seeming to support the afore-stated hypothesis and others seeming to stand in direct contradiction to it.

POSTER 5-23

Eating Disorders (AN/BN): Short- and Long-Term Outcome Effects of Inpatient Cognitive Behavior Therapy

Rolf Meermann, M.D. (Meermann@ahg.de)**, Ernst-Jürgen Borgart, Ph.D.**

Abstract: Short- and long-term effects of inpatient cognitive behavior therapy treatment with anorexia or bulimia nervosa patients are analyzed. Short-term effects were investigated with 1226 inpatients with anorexia nervosa (AN) or bulimia nervosa (BN) of the AHG Psychosomatic Hospital Bad Pyrmont/Germany. Almost all patients were female (97%). The mean age was 27.7 years old. The mean duration of the eating disorder was 8.7 years. Our patients received cognitive behavior therapy treatment lasting 56 days on average. At the end of treatment patients filled out a therapy-outcome questionnaire. Additionally, our therapists rated therapy-outcome from their own view. Long-term effects were analyzed in a 2-year follow-up study with 23 inpatients. At the beginning (T1), end of treatment (T2) and two years after discharge (T3) patients were personally interviewed. The effectiveness of therapy was measured by several questionnaires: Psychosomatic Symptom Check-List (PSCL), Beck Depression Inventory (BDI) and Beck Anxiety Inventory (BAI) as well as questionnaires for satisfaction in life, coping with stress and quality of sleep. Short-term effects: 91% of our patients are more or less satisfied with their treatment results. 87% of the therapists state that their patients did more or less improve overall. A reduction of symptoms is rated by 95% of our patients and 91% of the therapists. The ratings of therapy-outcome by therapists and patients are significantly correlated: r=.44 and .42 (p<.001). Therapists seem to be a bit more critical in their ratings. Long-term effects: T-tests show that in almost all measures patients improved significantly (p<.05 to p<.001) from T1 to T2. After T2 patients nearly maintained their progress or even continued to improve slightly. So in all measures the differences from T1 to T3 are significant (p<.05 to p<.001). Our results show that cognitive behavior therapy has substantial therapeutic effects which are relatively stable up to two years.

POSTER 5-24

Prevalence Of Eating Disorder In Medical Students Of Karachi, Pakistan, By EAT-26 And Scoff: Cross Sectional Study

Efaza Umar Siddiqui (efazaumar@hotmail.com), **Syeda Ezz-e-Rukhshan Adil, Akhtar Amin Memon, Efaza Umar Siddiqui, Syed Saad Naeem, Khalid Mahmood**

Abstract:

Objectives: To assess the prevalence of eating disorders among medical students of Karachi by using validated self-administered questionnaires. The earlier these disorders are diagnosed and assessed, the better the chances are for enhanced treatment and fuller recovery. Therefore, we intended to undertake a study to find out the frequency of such disorders among medical students of Karachi and design strategies to overcome them.

Methods: A descriptive cross sectional study was conducted among 435 students attending Aga Khan, Dow and Sindh Medical College, Karachi, with two distinct age groups: 18-21 years and 22-25 years. Data was collected using 2 self administered questionnaires, the SCOFF Eating Disorders Questionnaire and the Eating Attitudes Test (EAT 26), and calculation of subjects' body mass index (BMI). An independent cluster sampling was done for each population. The data was sorted and analyzed in SPSS version 15.

Results: Overall prevalence of eating disorders according to EAT-26 was found to be 108 out of 435 (24.8%), with females 91 (84.25%) and 17 males (15.75%), while according to SCOFF Questionnaire, it was 163 out of 435 (37.5%), with 137 (83.5%) females and 27 (16.4%) males. According to BMI calculation, 55 were severely underweight, 83 underweight, 260 normal, 33 overweight and 4 belonged to obese class 1.

Conclusions: Eating disorders are highly prevalent among medical students of Karachi, being significantly more in females than males. Strategies should be designed to prevent occurrence of such disorders among medical students that would undoubtedly hamper the availability of unassailable medical services in future.

POSTER 5-25

Prevalence of Body-Focused Repetitive Behaviors Among Medical Students of Karachi: A Cross-Sectional Study

Efaza Umar Siddiqui (efazaumar@hotmail.com), **Syed Saad Naeem, Bilal Ahmed, MSc, Haider Naqvi, M.B.B.S., F.C.P.S.**

Abstract:

Introduction: Body-focused repetitive behaviors (BFRBs) that include skin picking (dermatillomania), hair pulling (trichotillomania) and nail biting (onychophagia), lead to harmful physical and psychological sequelae. The objective was to determine the prevalence and the factors associated with BFRBs among students attending medical colleges of Karachi. It is hypothesized that students engaging in BFRBs experience significantly higher levels of anxiety than those without BFRBs. Thus, it is imperative to come up with frequency along with factors to design strategies to decrease the burden and adverse effects associated with BFRBs among medical students.

Methods: A cross-sectional study was conducted among 210 students attending Aga Khan University, Dow and Sindh Medical College, Dow University of Health Sciences, Karachi, in equal proportion. Data was collected using a validated tool, "Habit Questionnaire". Diagnosis were made on the criteria that a student must be involved in an activity = 5 times per day for = 4 weeks. Convenience sampling was done to recruit the participants aged 18 years and above after getting written informed consent.

Results: The overall prevalence of BFRBs was found to be 46 (22%), with females 29 (63%) and males 17 (37%). Among these students, 19 (9.0%) were engaged in dermatillomania, 28 (13.3%) in trichotillomania and 13 (6.2%) in onychophagia. Stress during examinations was one of the major factors found to be associated with BFRBs.

Conclusions: High proportions of BFRBs are reported among medical students of Karachi with stress as a major contributing factor. Key health messages and interventions to reduce stress and anxiety among students may help in curtailing the burden of this disease which has serious adverse consequences.

POSTER 5-26

Acute Right Hemiplegia Subsequently Treated with Tissue-Type Plasminogen Activator (TPA): A Case of Factitious Disorder

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Abstract:

Objectives: Factitious disorder is a well described entity, but can be quite challenging and costly to diagnose definitively. Many patients may not be diagnosed until after expensive, and sometimes rather invasive, work-ups and procedures have been inconclusive. We present the case of a patient who presented to the Emergency Room (ER) with neurological symptoms and received treatment with tPA before being diagnosed with Factitious Disorder.

Method: We describe a 23 year old woman who presented to ER complaining of severe abdominal pain and acute right hemiplegia. On presentation, she reported a history of Transient Ischemic Attacks (TIA), Posttraumatic Stress Disorder (PTSD) and porphyria, for which she had an indwelling medication port, used for weekly hemin infusions. She refused to allow staff to contact friends, family members or previous treating physicians for the purpose of obtaining collateral information. Neurology consult found the initial examination convincing enough for acute stroke. Given her initial presenting symptoms, and with the information then

available, a decision to treat with tPA was made and patient was admitted to ICU for medical management, including porphyria workup. In the ICU, staff quickly noticed patient moving her allegedly paralyzed limbs. Blood cultures returned positive for Enterobacter cloacae, which raised suspicion for Factitious Disorder. Days later, it was discovered that patient had been recently discharged from an affiliated hospital, where she presented with virtually identical complaints and where both stroke and porphyria had been ruled out. Despite her confirmed bacteremia and repeat negative porphyria workup, patient refused to have her medication port removed. During the course of her hospitalization, patient underwent not only tPA and an ICU stay, but also extensive diagnostic testing, intravenous antibiotics, consults to Neurology, Psychiatry, Infectious Diseases and Hematology, physical therapy and legal proceedings for permission to remove the infected medication port. Once the diagnosis of Factitious Disorder was made, she was transferred to the inpatient psychiatric unit for treatment and stabilization. She thereafter stabilized medically and recovered much of her strength. Once stable, she was discharged, but never returned to clinic as scheduled, and was lost to follow-up.

Conclusions: Patients with Factitious Disorder can present with a variety of conditions that can result in invasive treatment and/or procedures that may ultimately prove unnecessary, thereby resulting in significant morbidity and resource consumption. Health care providers may be forced, as in this case, to make decisions regarding emergent care with limited collateral information. If in this case, treating physicians could have accessed patient's records from her recent hospitalization in a more timely fashion, costly diagnostics and potentially unnecessary treatments could have been avoided and patient's Factitious Disorder could have been identified and treated in a more prompt and effective manner. Such cases advocate for the development of universal medical records or alternate mechanisms of enhanced inter-facility communication for the benefit of patient care and effective utilization of limited resources.

POSTER 5-27

Impact of Level of Intelligence on Course of Hospitalization for Clients with Psychiatric Illness

Susanna Kramer, M.A. (susanna.kramer@state.de.us)**, Kun Tang, M.D., Jack Samuels, Ph.D., Gerard Gallucci, M.D., M.H.S.**

Abstract:
Objective: The purpose of this project is to examine the impact of intelligence on the course of inpatient treatment for individuals with psychiatric illness. A number of studies looking at the association between intellectual disability and psychiatric illness have found a significantly higher prevalence of psychosis and psychotropic medication use in those with intellectual disabilities. However, few studies have investigated how intellectual disability affects the assessment, diagnosis, treatment progress and outcomes of individuals with serious mental illness in inpatient psychiatric settings.

Method: The PROFOKS scale is a validated instrument used to assess cognitive impairment in non-elderly adults in community and clinical populations. It has been used to screen consumers at admission to Delaware's only State Psychiatric Hospital, the Delaware Psychiatric Center (DPC), since May of 2010. In this project, we will investigate the association between the score on the PROFOKS scale and hospitalization duration, incidences of aggressive behavior (as represented by Pro Re Nata (PRN) medication orders), substance abuse history, and re-hospitalization rates for a sample of residents of DPC. PROFOKS scores were obtained through chart review. PRN medication orders were obtained from electronic pharmacy records. Demographic characteristics, diagnosis, substance abuse history, length of hospital stay, and any readmissions to DPC were obtained from DPC administrative data records. Regression analyses will be performed in order to determine the relationships among the variables.

Results and Conclusions: Results, conclusions and recommendations for further research and treatment will be presented. We expect to find a significant association between intellectual level and the assessment, diagnosis, symptoms, treatment progress and outcomes of mental disorders, which will inform future treatment and discharge planning for residents of State Psychiatric Hospitals.

POSTER 5-28

Status-Epilepticus and Psychosis of Epilepsy-Treatment Dilemma

Deepa Hasija, M.D. (deepahasija@gmail.com)**, Sree Latha Krishna Jadapalle, M.D., Amel Badr, M.D.**

Abstract: The relationship between psychosis and epilepsy has a very extensive historical background dating back to 400 BC to the present 20th century. Psychosis in epilepsy can be categorized in relation to seizures or treatment: ictal psychosis, postictal psychosis, interictal (chronic) psychosis, forced normalization and de novo psychosis following epilepsy surgery. Ictal psychosis is associated with visual or auditory illusions and hallucinations combined with affective changes. Postictal psychosis occurs in 2–7.8% of epilepsy patients. Complex partial and generalized seizures often cause postictal psychosis which constitutes 25% of psychosis of epilepsy. Wells (1975) suggested that transient ictal psychosis may result from continuous epileptiform discharges without other seizure symptoms. Presently deep brain stimulation technique is under thorough investigation as a prospective treatment choice for epilepsy, which could avoid functional deficits associated with epilepsy surgery and minimize side effects of antiepileptic medications. Responsive Neuro Stimulation (RNS) has shown favorable results in treatment resistant patients by targeting the seizure onset zones and thus also preventing the occurrence of epilepsy and associated psychotic syndromes. The studies conducted to show the safety and efficacy of RNS on small patient populations showed reduction of seizures and was found to be safe

and well tolerated. We report a case of an 18 year old single, Asian female with 11th grade special education and psychiatric diagnoses that include psychotic disorder not otherwise specified (NOS) since 2010 and seizure disorder (unknown etiology) for the past 17 years. The patient was admitted to the ER due to generalized tonic clonic seizures which was followed by psychotic symptoms like auditory and visual hallucinations, agitation, and also persecutory and nihilistic delusions. The patient did not respond to aripiprazole or olanzapine making the treatment more complicated. But haloperidol resolved her psychotic symptoms and stabilized the patient. Considering the side effect profile of haloperidol and the drug interactions between the anti epileptic drugs (AED) and antipsychotics (AP), we sought after a safe and effective treatment option to impede the electrographic seizures and thus prevent the psychotic episodes in such treatment resistant patients. Through our case report we propose further studies on the safety and efficacy of RNS to support the current literature on RNS as the best treatment option in the treatment of resistant psychosis of epilepsy, as it is found to prevent the psychotic episodes by averting the occurrence of the electrographic activity in the brain.

POSTER 5-29

Sleep, Anxiety, and Depressive Disorders in U.S. Community-Dwellers

Daniel P. Chapman, Ph.D. (dpc2@cdc.gov), **Daniel P. Chapman, Ph.D., M.Sc., Yong Liu, M.D., M.S., Stephanie L. Sturgis, MPH, Anne G. Wheaton, Ph.D., Geraldine S. Perry, DrPH, RD, Janet B. Croft, Ph.D.**

Abstract: Depression has long been associated with sleep disturbance in psychiatric nomenclature. Specifically, either hyposomnia or hypersomnis may be signs of depression and are widely described in the literature as such. However, the potential for anxiety to disrupt sleep has received relatively little attention. To better address this issue, we assessed the contributions of self-reported anxiety and depressive disorders on perceived insufficient sleep in a community based sample of 16 states featured in the Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is a population-based survey of non-institutionalized, U.S. civilian adults in which 94,576 respondents in 2008 were asked, "During the past 30 days, for about how many days have you felt you did not get enough rest or sleep?" Participants were also asked, "Has a doctor or other healthcare provider ever told you that you had an anxiety disorer (including acute stress disorder, anxiety, generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, phobia, posttraumatic stress disorder or social anxiety disorder?" and "Has a doctor or other healthcare provider ever told you that you have a depressive disorder (including depression, major depression, dysthymia)?" Adjusted odds ratios (AORs) were calculated from multivariate logistic regression using SAS and SUDAAN. Respondents reporting they experienced insufficient rest or sleep for 14 or more days out of the past 30 days were categorized as suffering from frequent insufficient sleep (27.9%). Among respondents, 4.8% had anxiety alone, 8.5% had depression alone, and 7.5% reported both anxiety and depression. The likelihood of frequent insufficient sleep among those who reported anxiety alone (39.4%) or depression alone (37.9%) was significantly greater, relative to those whoe reported neither anxiety nor depression (24.1%) even after adjustment for age, gender, race/ethnicity, education, employment, and marital status (AOR=1.83[1.58-2.11] and AOR=1.77[1.60-1.96],respectively). Individuals reporting both an anxiety disorder and a depressive disorder had the highest prevalence of frequent insufficient sleep (50.1) compared to those with neither disorder (AOR=2.66[2.39-2.97]). These results suggest that like depressive disorders, anxiety disorders are correlated with frequent sleep insufficiency, while the respondents with a combination of a history of both depressive and anxiety disorders were nearly three times more likely to report frequent insufficient sleep than their peers who reported neither an anxiety nor a depressive disorder. Clinicians may be well-advised to assess sleep sufficiency in patients presenting anxiety disorders, particularly when accompanied by depressive disorders.

POSTER 5-30

Screening for Obstructive Sleep Apnea in Inpatient Psychiatric Population Using Stop-Bang Questionnaire as Part of a Care Process Model

Vanita Jain, M.D. (vanita05@gmail.com), **Michael F. Coudreaut, M.D., Robert J. Farney, M.D., James M. Walker, Ph.D.**

Abstract:

Introduction: Psychiatric patients often present with symptoms of poor sleep, tiredness, fatigue, daytime sleepiness and irritable mood, the same as patients with Obstructive Sleep Apnea (OSA). Recognition of OSA in patients who are being treated for mental health illnesses is important since untreated sleep apnea can contribute to continued symptoms of depression despite multidrug antidepressant and mood stabilizer therapy. Hence early identification and treatment of OSA may augment therapy for psychiatric disorders. We implemented a Care Process Model (CPM) utilizing the STOP-Bang questionnaire (SBQ) for initial screening, overnight oximetry for secondary risk stratification, sleep medicine consultation and inpatient polysomnography when clinically indicated.

Methods: SBQs consisting of eight yes or no questions, based upon snoring, tiredness/sleepiness, observed apneas, hypertension, BMI > 35 kg/m2, age > 50 years, neck circumference > 40 cm and male gender were administered to all psychiatric inpatients. A score of any three affirmative responses was used to dichotomize the population on yes/no responses. Ages of patients in this study ranged between 21-64 yrs and were predominantly Caucasians or Hispanics. Patients with positive SBQs underwent further assessment including overnight pulse oximetries and sleep medicine consultation to assess clinical stability for a sleep study. Patients who

required a sleep study underwent attended polysomnography in the sleep lab or in the psychiatric unit. Further evaluation, treatment (e.g. CPAP therapy) or follow up was initiated based on the results and current standards.

Results: During only the initial 1 month period, 46 of 85 SBQs administered were positive for risk of OSA (54%) and these patients underwent secondary screening with overnight oximetry, of which 26 (56%) were abnormal (desaturation index > 10/h). Among the 26 patients who had a positive oximetry result, Polysomnography (PSG) could be performed in 15 patients who were clinically stable, 5 were discharged before the sleep medicine consult could be conducted, 2 refused further testing, and 4 had previously been diagnosed with OSA. Of the 15 who were studied, there were 3 patients with severe sleep apnea (Apnea Hypopnea Index- AHI >30/h), 7 moderate (AHI>15-30/h), 4 mild (AHI>5-15/h) and one patient had no sleep apnea (AHI<5/h).

Conclusion: Preliminary findings suggest that the STOP-Bang questionnaire may be a useful tool for initial screening of psychiatric inpatients for sleep-disordered breathing. 10/85(12%) of the screened inpatients had at least moderate to severe sleep apnea and would have otherwise gone undiagnosed were it not for routine screening of all patients as part of the care process model. The utility of screening psychiatric inpatients for OSA depends upon having additional resources for further evaluation, implementation of therapy and follow up. Further outcomes studies are needed.

POSTER 5-31

A Collaborative Care Elective for Senior Psychiatry Residents: A Pilot Project and Literature Review

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Abstract: Primary care-based collaborative care for depression is an effective way to treat patients with major depressive disorder (1). The IMPACT model of collaborative care is a well studied, highly effective model of collaborative care that focuses on the treatment of depression in adults older than 65 (2). In this model, a depression care specialist (DCS) (often a registered nurse or clinical social worker) based in the primary care clinic discusses patients with the primary care physicians, then provides direct patient care by completing assessments, following-up on patients' symptoms, developing relapse prevention plans, delivering problem-solving treatment, and numerous other tasks. The DCS is supervised by a psychiatrist; the psychiatrist makes specific treatment recommendations largely based on the information obtained from the DCS. Supervising a DCS is challenging, and requires a unique skill-set. While physicians routinely learn to supervise junior physicians (e.g. on the wards), resident physicians do not often learn how to supervise, advise and teach non-physician clinicians. As collaborative care becomes the standard of care in recognizing and treating depression in primary care, psychiatrists may often be asked to supervise care managers, and to consult on specific cases. We developed a longitudinal elective for a PGY-4 resident (JMC) to participate in the IMPACT model of collaborative care in the geriatrics primary care clinic at Mount Sinai School of Medicine. We will present the details involved in organizing this elective, including part of the implementation strategy. Problems that arose during development of this elective will be addressed, and a literature review of other methods of teaching collaborative care will be presented.

POSTER 5-32

Risks and Benefits of NMDA Receptor Antagonists

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Abstract: NMDA antagonists have been an increasing focus of research over the past several decades. However, further research and their clinical use are limited by a perception that the risks of these medications would outweigh the benefits. We examine the safety profiles of five NMDA antagonists (memantine, riluzole, ketamine, phencyclidine, and ibogaine) and discuss the implications of these profiles on their future as viable therapeutic agents.

POSTER 5-33

Co-Occurring Psychological Problems and Alcohol Misuse in a High Risk Military Population

LCDR Andrew MacGregor, Ph.D., M.P.H., 10555 El Comal Drive, San Diego, CA 92124, **Kevin J. Heltemes, MPH, Sonya B. Norman, Ph.D., Amber L. Dougherty, MPH, Michael R. Galarneau, M.S.**

Abstract:

Objective: Individuals with dual disorder have both a substance abuse problem and a co-occurring mental health disorder, and represent a high risk subgroup in need of targeted intervention. Deployed military personnel face a variety of stressors, including combat experiences and physical injury, which can result in psychological and substance abuse problems. The aim of this study was to identify the prevalence and associated health complaints of persons with dual disorder among a high risk military population.

Methods: US military personnel who sustained a confirmed combat injury and who endorsed moderate-high levels of combat exposure were identified from the Expeditionary Medical Encounter Database (n = 633). The Post-Deployment Health Re-Assessment (PDHRA), completed within a year after overseas deployment, was utilized to identify personnel who screened for alcohol misuse and other mental health disorders (e.g. post-traumatic stress disorder, depression). Outcome groups were classified as dual disorder (screening for alcohol misuse and other mental health disorder) or mental health disorder only (screening for mental health disorder without alcohol misuse). Outcome groups were compared on frequency of the following 11 self-reported health complaints:

headache, dizziness, memory problems, sleep disturbance, tinnitus, numbness, back pain, joint pain, muscle pain, weakness, and irritability.

Results: Overall, 16.4% (n = 104) screened for dual disorder and 31.1% (n = 197) screened for mental health disorder only. Distribution of rank differed by outcome group, with dual disorder having more junior enlisted service members compared with mental health disorder only (52% vs. 37%, p-value = 0.04). Compared with mental health disorder only, those with dual disorder had a higher rate of self reported health complaints, particularly memory problems (57% vs. 34%, p-value < 0.001), irritability (61% vs. 40%, p-value < 0.001), sleep disturbance (67% vs. 48%, p-value = 0.001), and tinnitus (61% vs. 43%, p-value = 0.003). Additionally, those with dual disorder reported a higher mean number of symptoms than mental health disorder only (4.44 vs. 3.17, p-value < 0.001), and were significantly more likely to endorse 5 or more symptoms (51% vs. 31%, p-value = 0.005).

Conclusions: Alcohol misuse and other mental health disorders occur at high rates following combat deployment. Among this high risk military population, approximately 1 in 3 service members screening for a current mental health disorder also screened for current alcohol misuse. Those with dual disorder had a greater burden of overall health complaints compared to service members with mental health disorder alone. This study highlights the importance of understanding the consequences of dual disorder in order to fully address the treatment needs of these patients. More research is warranted to elucidate correlates of dual disorders in order to guide screening and clinical management.

POSTER 5-34

Oxidative Stress Parameters in Alzheimer's Disease: Potential Biomarkers of the Neurodegenerative Process

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Abstract:

Background: Increasing prevalence of Alzheimer's disease, corresponding with increasing aging populations, further complicated by a lack of definitive diagnostic procedures, make diagnosis of Alzheimer's disease a major medical concern of the beginning of 21st century. Early detection of Alzheimer's disease is a demanding problem requiring the consideration of multi-dimensional experiments and data. Potentially, many features could be used to discern between people without AD and those at different stages of the disease. Such features include results from cognitive and memory tests, imaging results, cerebrospinal fluid data, blood markers, and others. Our experiments, strongly suggested that. Free radicals and oxidative stress appear to both directly or indirectly play a major role in cellular processes implicated in neurodegeneration of Alzheimer's disease (AD). Thus, oxidative damage to a range of biomolecules is of particular interest to AD researchers and potential biomarkers of the meurodegenerative process in AD

Aim: In this study the level of oxidative stress in a group of AD patients from a population-based sample was measured.

Patients: 52 AD subjects recruited from a population-based study as well as 27 age and gender matched control patients were examined.

Methods: Plasma malondialdehyde (MDA), a marker of lipid peroxidation was chosen to reflect the level of pathology. In parallel, the level of the tripeptide glutathione (GSH), which scavenges free radical species, was measured as an indicator of the antioxidant protection. Serum total antioxidant status (TAS) was determined as a quantitative assessment of in vivo oxidative status.

Results: GSH levels were significantly reduced in AD compared to AD (0.68 vs. 1.39 mM, P<0.001). Consistent with this, MDA levels were elevated in AD patients compared to controls (3.28 vs 1.43 mM, P <0.001). The level of MDA did not correlate with age (CC =(-) 0.275, P > 0.05). The newly diagnosed patients were younger than the rest of the group. The time from the diagnosis, however, did correlate with age (CC =0.56, P < 0.05). The most pronounced differences in the oxidative stress parameters were found in the newly diagnosed AD group. The level of MDA was higher in both the newly diagnosed AD patients and in those with longer lasting neurodegenerative process in comparison with controls. Both sets of data were statistically significant. GSH was significantly lower in newly diagnosed AD patients when compared to controls. Serum total antioxidant status was calculated for samples from each study group. TAS levels were significantly decreased in AD subjects as compared to control (0.6 vs 1.39 mmol/L, P <0.001). The most pronounced differences in TAS levels were apparent in the AD group with the shortest history of the disease (the time from diagnosis). TAS was significantly lower in newly diagnosed AD patients when compared to controls.

Conclusion: Overall, these data support the idea that an altered oxidative profile is both an early and prominent feature of AD. Further studies into the disease specific affected parameters of increased lipid peroxidation and decreased antioxidant capacity may direct future therapeutic options for targeting the disease at the earliest time after diagnosis.

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